The law and ethics of abortion

BMA Views

Legal considerations

- England and Wales
- Scotland
- Northern Ireland

Ethical considerations
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Abortion is a very sensitive issue and one on which members of the BMA hold a wide diversity of views. Association policy, however, has been agreed at the BMA’s annual representatives meeting (ARM)

1. Legal considerations

Doctors must act in accordance with the law.

1.1 The law on abortion in England, Scotland and Wales

Abortion in England, Scotland and Wales is governed by the Abortion Act 1967 as amended by the Human Fertilisation and Embryology Act 1990. This states that a registered medical practitioner may lawfully terminate a pregnancy, in an NHS hospital or on premises approved for this purpose, 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 that 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. 

In addition, where a doctor “is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman” the opinion of a second registered medical practitioner is not required. Nor, in these limited circumstances, are there restrictions on where the procedure may be carried out.

The 1990 amendments to the Act removed pre-existing links with the Infant Life Preservation Act 1929 which had made it illegal to “destroy the life of a child capable of being born alive” with an assumption that a child was capable of being born alive after 28 weeks gestation. Thus, terminations carried out under sections 1(1)(b) to 1(1)(d) of the Act may be performed at any gestational age.

The question of what constitutes a “serious handicap” under section 1(1)(d) is not addressed in the legislation. It is a matter of clinical judgment and accepted practice. In assessing the seriousness of a handicap, the following criteria may be used:

- the probability of effective treatment, either in utero or after birth;
- the child’s probable potential for self-awareness and potential ability to communicate with others; and
- the suffering that would be experienced by the child when born or by the people caring for the child.

1.2 The law on abortion in Northern Ireland

The Abortion Act 1967 does not extend to Northern Ireland. The law on abortion in Northern Ireland is different and is based on the Offences Against The Person Act 1861 which makes it an offence to “procure a miscarriage... unlawfully”. The Bourne\(^1\) judgement of 1939, in which a London gynaecologist was found not guilty of an offence under this Act for performing an abortion on a 14 year old who was pregnant as a result of rape, was based on an interpretation of the word "unlawfully" in this Act. The defence argued, and the judge accepted, that in the particular circumstances of the case, the operation was not unlawful since continuation of the pregnancy would severely affect the young woman’s mental health. In reaching this decision, the judge turned to the wording of the Infant Life (Preservation) Act 1929 which gave protection from prosecution if the act was carried out in good faith “for the purpose only of preserving the life of the mother”. This formed the basis of the judgment and extended the grounds for a lawful abortion to include the mental and physical well-being of the woman. Whereas the law in England, Scotland and Wales is covered by the 1967 Act, Northern Ireland has been left with the task of interpreting this word "unlawfully" in the 1861 Offences Against the Person Act using also the 1945 Criminal Justice Act (Northern Ireland) (under which the 1929 Infant Life (Preservation) Act was applied to Northern Ireland) with the precedent set in Bourne.

It is known that abortions are carried out in Northern Ireland and that abortion is lawful in some circumstances. The cases of K and A\(^2\) in 1993 and 1994 respectively confirm this but in the judgment in A the judge stated that:

“The doctor’s act is lawful where the continuance of the pregnancy would adversely affect the mental or physical health of the mother...The adverse effect must, however, be a real and serious one and it will always be a question of fact and degree whether the perceived effect of non termination is sufficiently grave to warrant terminating the unborn child”.

Following a successful High Court Appeal by the Family Planning Association in October 2004, the Department of Health, Social Services and Public Safety (DHSSPS) was instructed by the Court to produce clear guidance for women and doctors on the circumstances in which
abortion would be permissible. Final publication of this
guidance is awaited at the time of writing in 2007.

The BMA has policy supporting the extension of the
Abortion Act to Northern Ireland (Annual Representatives
Meeting 1985 and 2003). In July 2007, however, the
Westminster government clarified in a Parliamentary
Answer that any changes in abortion legislation in
Northern Ireland would have to be instigated by the
Northern Irish public: “We are aware of a body of
opinion in Northern Ireland that considers the current law
on abortion to be either unsatisfactory or unclear, but we
also recognise the strength of feeling for not changing
the existing legislative provision. In such circumstances,
the Government believe that any change to the law
should only come about at the request of a broad cross-
section of the people who live there.” 4

Doctors in Northern Ireland wishing to discuss particular
cases or to seek advice on the law may contact the local
BMA office.

1.3 Conscientious objection clause

1.3.1 Legal scope

The Abortion Act 1967 has a conscientious objection
clause which permits doctors to refuse to participate in
terminations but which obliges them to provide necessary
treatment in an emergency when the woman’s life may
be jeopardised. The BMA supports the right of doctors to
have a conscientious objection to termination of
pregnancy and believes that such doctors should not be
marginalised. Some doctors have complained of being
harassed and discriminated against because of their
conscientious objection to termination of pregnancy.
There have also been reports of doctors, who carry out
abortions, being subjected to harassment and abuse. The
Association abhors all such behaviour and any BMA
members who feel they are being pressured, abused or
harassed because of their views about abortion, should contact their regional office for advice
and support.

The scope of the conscientious objection clause, in the
1967 Act, was clarified by a Parliamentary answer in
December 1991.5 This made clear that conscientious
objection was only intended to be applied to participation
in treatment, although hospital managers had been
asked to apply the principle, at their discretion, to those
ancillary staff who were involved in the handling of
fetuses and fetal tissue.

The same view emerged from the House of Lords’
decision in case of Janaway v Salford Health Authority” in
1988 when a doctor’s secretary (Janaway) refused to type
the referral letter for an abortion and claimed a
conscientious objection under the Act. The House of
Lords, in interpreting the word “participate” in this
context, decided to give the word its ordinary and natural
meaning - that is, that in order to claim conscientious
exemption under section 4 of the Act, the objector had
to be required to actually take part in administering
treatment in a hospital or approved centre. In the same
case the judge went on to say that “The regulations do
not appear to contemplate that the signing of the
certificate would form part of the treatment for the
termination of pregnancy”. This would seem to support
the view that general practitioners cannot claim
exemption from giving advice or performing the
preparatory steps to arrange an abortion if the request
for abortion meets the legal requirements. Such steps
include referral to another doctor as appropriate.

Doctors with a conscientious objection to abortion should
make their views known to the patient and enable the
patient to see another doctor without delay if that is the
patient’s wish. Although they may not impose their
views on others who do not share them doctors with a
conscientious objection may explain their views to the
patient if invited to do so. The General Medical Council
advises that: 7

‘If carrying out a particular procedure or giving
advice about it conflicts with your religious or moral
beliefs, and this conflict might affect the treatment
or advice you provide, you must explain this to the
patient and tell them they have the right to see
another doctor. You must be satisfied that the
patient has sufficient information to enable them to
exercise that right. If it is not practical for a patient
to arrange to see another doctor, you must ensure
that arrangements are made for another suitably
qualified colleague to take over your role.’

General practitioners with a conscientious objection, who
are working in a group practice, may ask a partner to see
patients seeking termination. Practices may wish to state
in advance if GPs in their practice have a conscientious
objection to abortion, for example in their practice
leaflets.

The position of medical students was clarified in personal
communication with the Department of Health which
has been passed to the Association for information. This
made clear that the conscientious objection clause can be
used by students to opt out of witnessing abortions. The
BMA’s advice is that those who have a conscientious
objection should disclose that fact to supervisors,
managers or GP partners (whichever is appropriate) at as
early a stage as possible so that this fact can be taken
into account when planning provisions for patient care.

The Scottish Executive published guidance in September
2004 on the information about abortion that may be
included in job advertisements, and descriptions and the
questions that may be asked at interview.8 At the time of
writing there is no equivalent guidance for England and
Wales.

1.3.2 Distinction between legal and moral duties
In some cases a distinction can be made between the legal and ethical obligations. Whilst noting the legal view, the BMA considers that some things which arguably fall outside the legal scope of the conscience clause, such as completion of the form for abortion, are arguably an integral part of the abortion procedure. In this case, the BMA considers that completion of a form for abortion falls morally within the scope of the conscience clause. Other preliminary procedures, such as clerking in the patient, are incidental to the termination and are considered outside the scope of the conscience clause both legally and morally. Generally it will not be beneficial for women undergoing termination to be cared for by health professionals who feel distressed or unhappy about their involvement. Nevertheless where such tasks are unavoidable, health professionals must pursue a non-judgemental approach to the women concerned.

1.3.3 Conscientious objection applied to contraceptive services

There has, in the past, been some uncertainty about whether certain types of contraceptives, such as hormonal emergency contraception and intra uterine devices should be classed as abortifacients which could be issued only under the terms of the Abortion Act. This question was resolved by a Parliamentary answer in May 1983 in which it was clarified that the prevention of implantation does not constitute the “procuring of a miscarriage” within the terms of the Offences Against the Persons Act 1861. This interpretation was tested and confirmed in the case of R v HS Dhingra in 1991 and by a judicial review in 2002.

Judicial review on emergency hormonal contraception

The Society for the Protection of the Unborn Child applied for a judicial review of the decision of the Secretary of State for Health, in 2000, to make emergency contraception available from pharmacists without a prescription. The claimant contended that the “morning after pill” was not a contraceptive but an abortifacient because it procured a miscarriage within the meaning of the 1861 Offences Against the Persons Act. Its use, therefore, would only be lawful if prescribed by two doctors, as required by the Abortion Act 1967. The Secretary of State argued, however, that the meaning of “miscarriage” was the loss of a fertilised egg that had become implanted in the endometrium of the uterus. Since emergency hormonal contraception caused the loss of an egg before implantation, there was no miscarriage and therefore no criminal offence.

The High Court judge held that the decision turned on the meaning of “miscarriage” now and not its meaning in 1861. Today, miscarriage is taken to mean the termination of an established pregnancy and therefore the application was dismissed. R v Secretary of State for Health

Although, legally, the use of contraceptives designed to prevent implantation does not constitute an abortion, the BMA recognises that some doctors, believing that life begins at fertilisation, may have an ethical objection to their use. Doctors holding this view are not obliged to prescribe these forms of contraception but must ensure the patient has access to another doctor who will be willing to comply with the request; this may include a referral. Guidelines on the use of emergency contraception are available from the Faculty of Family Planning and Reproductive Health Care.

1.4 Early medical abortion

Since 1991 mifepristone (formerly known as RU486) has been available in England, Scotland and Wales for early medical abortions. These must comply with the terms of the 1967 Act (as amended). A 1990 amendment to the Abortion Act specifies that the power to approve premises for termination of pregnancy includes the power to approve premises for the administration of medical terminations. Without this amendment, the administration of mifepristone would have been lawful only if carried out on premises approved for surgical terminations.

1.5 Late abortion for fetal abnormality

Under the law in England, Scotland and Wales, a pregnancy may be terminated at any gestation if 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”. Practical guidelines for health professionals involved with terminations for fetal abnormality are available from the Royal College of Obstetricians & Gynaecologists.

Women need to be given time to understand the nature and severity of fetal abnormality and, with the help of specialised counselling where appropriate, to reach a decision about how to proceed. The purpose of antenatal screening is to extend the choice available to the pregnant woman and to allow her to make an informed decision about whether to continue with the pregnancy or seek a termination. Women should not be rushed into making these important decisions but, if a firm decision is made to terminate the pregnancy, this should proceed without undue delay. Health and other appropriate professionals should provide support before and after the termination.

1.6 Selective abortion of multiple pregnancy

Until 1990 the legality of selective reduction of multiple pregnancies was unclear. This was clarified by section 37(5) of the Human Fertilisation & Embryology Act which amended the Abortion Act to explicitly include “in the case of a woman carrying more than one fetus, her miscarriage of any fetus”. Thus, selective reduction of pregnancy would be lawful provided the circumstances matched the criteria for termination of pregnancy set out in the 1967 Act (as amended) and the procedure was
carried out in an NHS hospital or premises approved for terminations. The same ethical and legal considerations apply to termination of all or part of a multiple pregnancy as to the termination of a singleton pregnancy. Under the new section 5(2) of the Abortion Act selective reduction of a multiple pregnancy may lawfully be performed if:

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

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

Thus it has been suggested that a general risk of serious handicap to the fetuses, if the multiple pregnancy is not reduced, would not be covered by the Act and the risk must be to a specific fetus. 

The BMA considers selective termination to be justifiable where the procedure is recommended for medical reasons. Women who have a multiple pregnancy should be carefully counselled where medical opinion is that continuation, without selective reduction, will result in the loss of all the fetuses but they cannot be compelled or pressured to accept selective abortion. The Association does not, however, consider it acceptable to choose which fetuses to abort on anything other than medical grounds. Where there are no medical indications for aborting particular fetuses, the choice should be a random one. The Association would not consider it acceptable, when making this decision, to accede to the parents’ desire for a male or a female child.

1.7 Abortion on grounds of fetal sex

Fetal sex is not one of the criteria for abortion listed in the Abortion Act of 1967 and therefore termination on this ground alone has been challenged as outwith the law. There may be circumstances, however, in which termination of pregnancy on grounds of fetal sex would be lawful. It has been suggested that if two doctors, acting in good faith, formed the opinion that the pregnant woman’s health or that of her existing children would be put at greater risk than if she terminated the pregnancy, the abortion would be arguably lawful under section 1(1)(a) of the Abortion Act. The Association believes that it is normally unethical to terminate a pregnancy on the grounds of fetal sex alone except in cases of severe x-linked disorders. The pregnant woman’s views about the effect of the sex of the fetus on her situation and on her existing children should nevertheless be carefully considered. In some circumstances doctors may come to the conclusion that the effects are so severe as to provide ethical justification for a termination. They should be prepared to justify the decision if it were challenged.

2. Ethical Considerations

2.1 Moral arguments

People generally take one of three main stances on abortion: pro-abortion, anti-abortion and the middle ground that abortion is acceptable in some circumstances. The main arguments for each of these positions is set out below.

2.1.1 Arguments used in support of abortion

Those who support the wide availability of abortion consider that abortion is not wrong in itself and need not involve undesirable consequences. These arguments tend not to recognise fetal rights or to acknowledge the fetus to be a person. According to some, abortion is a matter of a woman’s right to exercise control over her own body. Moralists who judge actions by their consequences alone could argue that abortion is equivalent to a deliberate failure to conceive a child and since contraception is widely available, abortion should be too. Some think that even if the fetus is a person, its rights are very limited and do not weigh significantly against the interests of people who have already been born, such as parents or existing children of the family.

Most people who support this position do so on the basis that the overriding principle is the woman’s right to choose what happens to her body. This use of the language of “choice” conveys approval regardless of the type of pressures the individual faces and any constraints on her freedom to make a genuine choice.

2.1.2 Arguments used against abortion

Some people consider that abortion is wrong in any circumstances because it fails to recognise the rights of the fetus or because it challenges the notion of the sanctity of all human life.

Some argue that permitting abortion diminishes the respect society feels for other vulnerable humans, possibly leading to their involuntary euthanasia. Those who consider that an embryo, from the moment of conception, is a human being with full moral status, see abortion as killing in the same sense as the murder of any other person. Those who take this view cannot accept that women should be allowed to obtain abortion without legal repercussions, however difficult the lives of those women or their existing families are made as a result.

Such views may be based on religious or moral convictions that each human life has unassailable intrinsic value, which is not diminished by any impairment or suffering that may be involved for the individual living that life. It is also argued that abortion treats humans merely as a means to an end in that abortion can be seen
as a discarding of a fetus in which the pregnant woman no longer has any interest. Many worry that the availability of abortion on grounds of fetal abnormality encourages prejudice towards any person with a handicap and insidiously creates the impression that the only valuable people are those who conform to some ill-defined stereotype of “normality”.

Some people who oppose abortion in general, concede that it may be justifiable in very exceptional cases such as where it is the result of rape or the consequence of exploitation of a young girl or a mentally incompetent woman. Risk to the mother’s life may be another justifiable exception but only where abortion is the only option. It would thus not be seen as justifiable to abort a fetus if the life of both fetus and mother could be saved by any other solution.

2.1.3 Arguments used to support abortion in some circumstances

Many people argue that abortion may be justified in a greater number of circumstances than those conceded by anti-abortionists but that it would be undesirable to allow abortion on demand. To do so might incur undesirable effects, such as encouraging irresponsible attitudes to contraception. It could also lead to a devaluation of the lives of viable fetuses and trivialise the potential psychological effects of abortion on women and on health professionals.

These types of argument are based on the premise that the embryo starts off without rights, although having a special status from conception in view of its potential for development, and that it acquires rights and status throughout its development. The notion of developing fetal rights and practical factors, such as the possible distress to the pregnant woman, nurses, doctors or other children in the family, gives rise to the view that early abortion is more acceptable than late abortion.

Some people support this position on pragmatic grounds, believing that abortions will always be sought by women who are desperate and that it is better for society to provide abortion services which are safe and which can be monitored and regulated, rather than to allow “back-street” practices.

2.1.4 The BMA’s view on abortion

In the 1970s and 1980s the BMA approved policy statements supporting the 1967 Abortion Act as “a practical and humane piece of legislation” and calling for its expansion to Northern Ireland. The BMA does not consider that abortion is unethical but as with any act having profound moral implications, the justifications must be commensurate with the consequences. Patients are entitled to receive objective medical advice regardless of their doctor’s personal views for or against abortion. Furthermore, a doctor could be sued for damages if, because of a failure to refer, a delay is caused which results in the woman being unable to obtain a termination.

At the BMA’s Annual Representatives Meeting (ARM) in 2005, a detailed briefing paper on abortion time limits was prepared that considered the peer-reviewed published data on survival rates and the longer-term health of babies born at early gestation in the UK. Doctors representing the membership debated the issue, voted, and concluded that there should be no reduction in the current 24-week limit under the Abortion Act 1967.

At the 2007 ARM the issue of first trimester abortion (up to around 13 weeks of pregnancy) was debated. As a result of this debate the BMA has policy that the Abortion Act 1967 should be amended so that first trimester abortion is available on the same basis as any other medical treatment – on the basis of informed consent. Therefore, first trimester abortions should not need the signature of two doctors’ and women seeking such abortions should not need to meet specified medical criteria. The policy is based partly on the fact that, from a clinical perspective, abortion is safer carried out early in pregnancy. Given the relative risks of early abortion compared with pregnancy and childbirth, virtually all women seeking an abortion in the first trimester will meet the current medical criteria for abortion. If enacted, the proposed amendment would help to ensure that women seeking abortions are not exposed to unnecessary delays, and consequently, to later, more costly and higher risk procedures. BMA policy is clear that any changes in relation to first trimester abortion should not adversely impact upon the availability of later abortions.

2.1.5 Fetal pain

Whether, and at what stage, a fetus feels pain has been a matter of much debate and past practice has been partly influenced by Department of Health advice. Interpretation of the evidence on fetal pain is conflicting with some arguing that the fetus has the potential to feel pain at ten weeks’ gestation, others arguing that it is unlikely to feel pain before 26 weeks gestation and still others arguing for some unspecified gestational period in between.

There is clearly a need for further research to provide more conclusive evidence about the experiences and sensations of the fetus in utero. In the meantime the BMA recommends that, when carrying out any surgical procedures (whether an abortion or a therapeutic intervention) on the fetus in utero, due consideration must be given to appropriate measures for minimising the risk of pain. This should include an assessment of the most recent evidence available. Even if there is no incontrovertible evidence that fetuses feel pain the use of pain relief, when carrying out invasive procedures, may
help to relieve the anxiety of the parents and of health professionals.

2.2 Consent

2.2.1 The competent adult

With consent to termination of pregnancy as with consent for other medical procedures, there are certain criteria which must be met in order for the consent to be valid. The woman must have sufficient competence to understand the procedure and its alternatives in broad terms and to make a decision, the consent must be voluntary and the decision must be made on the basis of sufficient, accurate information.

In England and Wales the Mental Capacity Act 2005 outlines a four-stage test of capacity. In order to be able to make a competent decision, an individual must be able to:

1. To understand the information relevant to the decision;
2. to retain the information relevant to the decision;
3. to use or weigh the information; and
4. to communicate the decision (by any means).

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed. This formulation is a good working test for assessing capacity to consent to or refuse medical treatment both in relation to adults and children.

2.2.2 Adults who lack capacity

Decision-making in relation to adults who lack the capacity to consent on their own behalf is governed in England and Wales by the Mental Capacity Act 2005, and in Scotland by the Adults With Incapacity (Scotland) Act 2000; in Northern Ireland, decisions are covered by the common law. A decision relating to a termination of pregnancy for an incapacitated adult would need to comply with the relevant legislation. The BMA has separate guidance on both pieces of legislation, however the relevant points with regard to abortion are outlined below.10

The central tenet of the English and Welsh legislation is the principle of “best interests” and in Scotland “benefit”. Although the Adults with Incapacity (Scotland) Act uses the term “benefit”, in the BMA’s view it is likely that this term can be interpreted in a similar way to “best interests”. If, however, health professionals working in Scotland were recommending an intervention in the incapacitated person’s best interests that was unlikely to provide clinical benefit, they should consider taking legal advice.

Health professionals presented with a pregnant woman lacking the capacity to give a valid consent must use their professional judgment to assess her best interests. It is important to remember that an individual’s best interests extend beyond medical best interests alone. The incapacitated persons’ past and present wishes and feelings, beliefs and values should be taken into consideration. An essential part of the assessment of best interests will also involve a discussion with those close to the patient, including family, friends, carers, or a proxy decision maker, where practical and appropriate; and also bearing in mind the patients right to confidentiality (see below).

There is no mandatory requirement to seek court approval to perform an abortion on an adult who lacks capacity;20 although in cases of doubt, it would be advisable to seek a second opinion. In the following circumstances, however, cases decisions should be referred to the court:

- where there is a dispute about capacity;
- where the patient may regain capacity during or shortly after pregnancy;
- where the decision of the medical team is not unanimous;
- where the patient, the potential father, or the patient’s close family disagree with the decision;
- where the procedures under section 1 of the Abortion Act have not been followed; or
- where there are other exceptional circumstances, for example the pregnancy is the patient’s last chance to conceive.21

The need for an abortion to be considered in respect of a women who lacks capacity may raise questions about that patient’s ability to consent to sexual intercourse and is likely to require investigation as to whether a criminal offence has occurred. The BMA and Law Society have jointly issued guidance on the law relating to mental capacity and sexual relationships (chapter 10 of Assessment of Mental Capacity22). This recognises the right of mentally disordered people to enter voluntarily into sexual relationships but also focuses on the obligation to protect vulnerable adults from abusive relationships. If there are grounds to believe that the pregnancy has resulted from unlawful sexual intercourse (rape of an unwilling woman or one who is unable to consent), immediate steps must be taken to protect the woman (and others who may be at serious risk) from further possible abuse.

2.2.3 Competent minors

Any competent young person, regardless of age, can independently seek medical advice and give valid consent to medical treatment. This legal position was established in the 1985 House of Lords’ ruling in the Gillick case.23 Thus people under 16 are legally able to consent on their own behalf to any surgical, medical or dental procedure or treatment if, in the doctor’s opinion, they are capable of understanding the nature and possible consequences of the procedure. It is clearly desirable for young people to have their parents’ support for important and potentially life-changing decisions. Sometimes, however,
young patients do not wish their parents to be informed of a medical consultation or its outcome and the doctor generally should not override patients' views. Doctors have an obligation, however, to encourage the patient voluntarily to involve parents. Young patients are likely to need help and support if the treatment sought has serious implications, such as contraception, abortion, or treatment for sexually transmitted disease. In very exceptional cases where the doctor has reason to believe that the pregnancy is the result of child abuse, incest or exploitation, a breach of confidentiality may be necessary and justifiable. The patient should be told in advance that secrecy in such cases cannot be guaranteed and must be offered appropriate help, counselling and support.

The main exception to these general rules is if the young woman is a ward of court, in which case the courts will need to approve a termination or other serious medical intervention. It is thus particularly important that it is always clear from the medical records that the child is a ward of court. Similarly if a young woman seeking termination is in care she should be encouraged to involve the local social services. If she refuses to consent to information being shared, legal advice should be sought before proceeding with the termination.

When consulted by a young woman under 16 requesting abortion the doctor should consider in particular:

- Whether the young woman understands the potential risks and possible longer-term effects of the proposed termination.
- Whether the young woman has sufficient maturity i.e. "Gillick competence" to make this decision and give a valid consent.
- Parental support. The value of parental support must be discussed with the patient. Doctors should encourage young people to discuss their situation with parents but must provide reassurance that their confidentiality will be maintained. If the young woman is unwilling to inform her parents of the consultation there may be another adult, perhaps an aunt or a friend of the family, in whom she would be prepared to confide. The importance of support during and after the termination should be discussed.
- Appropriate communications with the patient's own GP. If the doctor consulted is not the patient's own general practitioner, the young woman should be encouraged to consent to information being provided to her GP. It should be explained that this is in her own medical interest and an assurance given that confidentiality will be maintained but that, if she refuses, her wishes will be respected.

Requests by young people for abortion and contraceptive services, without parental involvement, can raise serious ethical dilemmas for doctors. The BMA takes the view that establishing a trusting relationship between the patient and doctor at this stage will do more to promote health than if doctors refuse to see young patients without parental consent. Further information is available in Confidentiality and Under 16s, available from the BMA Medical Ethics Department.

The Department of Health has published guidance for health professionals on the provision of advice and treatment for people under 16, on contraception, sexual and reproductive health.

2.2.4 Incompetent minors

If a young woman is pregnant and is not considered to be Gillick-competent she should be encouraged to involve her parents in decision-making and the parents may, legally, consent on her behalf. The word "parents" includes other holders of parental responsibility including, in relation to a child in care, the local authority. Relatives who are not holders of parental responsibility cannot consent to treatment for a minor. If the young woman refuses consent to parental involvement the Official Solicitor's office has advised that legal advice should be sought about whether the parents should be informed, against her wishes, and whether the termination can proceed. This may require an application to the courts.

2.2.5 Partners' views

The decision to terminate a pregnancy, within the broad framework accepted by society, rests with the woman and her doctors. Legally, the woman's spouse or partner has no right to demand or refuse a termination. It is, however, good practice to encourage women to discuss such decisions with their partners. Where a woman refuses to share information with her partner, confidentiality must be maintained unless there are exceptional reasons to justify a breach of confidentiality.

2.3 Confidentiality

2.3.1 Adults

Patients have a right to expect that doctors will not disclose any personal health information to a third party without consent. Women seeking termination of pregnancy are likely to be particularly concerned about the confidentiality of this information and doctors should be sensitive to this.

Sometimes doctors are asked to remove information about previous terminations from a patient's medical records. The BMA advises doctors to be very wary of removing relevant medical information from a patient's record, especially if further consultations or treatment have arisen on the basis of this information. To remove relevant medical information may make the doctor's later decisions appear unsupported and could also be detrimental to the future care of the patient.

If the doctor consulted is not the patient's own general practitioner, the woman should be encouraged to
consent to information being provided to her GP. If, however, she refuses to consent to the sharing of this information her wishes should be respected. Where such consent is withheld and the patient’s GP is a fundholder, the procedure will be chargeable to the Health Authority in order to ensure that confidentiality is maintained.27

2.3.2 Minors
The duty of confidentiality owed to a person under 16 is as great as the duty owed to any other person. An explicit request by a patient that information should not be disclosed to particular people, or indeed to any third party, must be respected except in the most exceptional circumstances, for example, where the health, safety or welfare of some person would otherwise be at serious risk. The exceptions set out above, where the child is a ward of court, or is in care, should be noted.

3. Summary
The Abortion Act requires doctors to make an assessment in the context of each case. They must assess the potential impact of the pregnancy and birth on the woman’s physical and mental health and the well-being of existing siblings. Blanket rules cannot be applied to such sensitive and difficult decisions, which require an understanding of the woman’s individual needs. A decision to terminate a pregnancy is never an easy one. In making these decisions, patients and doctors should ensure that the decision is supported by appropriate information and counselling about the options and implications.

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References
6. Janaway v Salford HA [1988], 3 All ER 1079 HL.
18. See, for example, Glover V, Fetal Stress and Pain Responses – The First Nine Months at a symposium arranged by the Women and Children’s Welfare Fund Making the pre-born and premature comfortable and pain free. 10 November 1995.


