

# The law and ethics of abortion

BMA views

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## Key principles

- Abortion is lawful in England, Scotland and Wales provided the criteria in the Abortion Act 1967 are fulfilled.
- Abortion is lawful in more limited circumstances in Northern Ireland.
- Unless abortion is necessary to save a woman’s life or prevent grave permanent injury, doctors in England, Scotland and Wales have a right of conscientious objection under the Abortion Act. At the same time, patients have a right to receive objective and non-judgmental care. Doctors with a conscientious objection should inform patients of this as soon as possible, and make appropriate arrangements for referral.
- As with all other medical procedures, patients must give the appropriate consent for abortion. From the age of 16, individuals should be assumed to have capacity unless proven otherwise. Decisions involving adults who lack the capacity to consent should be made on the basis of an assessment of their best interests, or “benefit” in Scotland.
- Under-16s can consent if they are deemed competent. Those with parental responsibility for minors lacking capacity can consent to treatment in their best interests on their behalf.
- Patients, both adult and child, have the right to confidentiality. This cannot be overridden except in exceptional circumstances.

# 1. About this guidance

There are few medical procedures as divisive and politically charged as termination of pregnancy. This guidance is intended to provide an up-to-date statement of UK law and ethics so that doctors are aware of their responsibilities and rights regarding termination of pregnancy. It also sets out BMA policy on several aspects of the law.

## 1.1 The BMA view on abortion

The BMA has longstanding policy dating back to the 1970s and 80s supporting the Abortion Act 1967 as “a practical and humane piece of legislation.”

The BMA recognises the diversity of opinion amongst its membership. Policy expressed in this document, however, has been agreed through the well-established democratic procedures for making policy at the BMA’s Annual Representative Meeting (ARM).

The BMA’s advice to its members is to act within the boundaries of the law and their own conscience. Patients are, however, entitled to objective and non-judgmental medical advice and treatment, regardless of a doctor’s personal view.

The BMA abhors any instances of harassment or discrimination of doctors on the basis of their views about abortion, either for or against. Additionally, the BMA deplores anti-abortion organisations picketing abortion services and intimidating patients and staff.

## 2. The Law on Abortion

### 2.1 The law 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. Under the Act, a pregnancy can be lawfully terminated by a registered medical practitioner, in an NHS hospital or premises approved for this purpose, if two 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.”<sup>1\*</sup>

To demonstrate that an opinion has been formed “in good faith” does not mean that authorising an abortion must be the right course of action, simply that the doctor has not been dishonest or negligent in forming the opinion that it is. Courts have generally interpreted a doctor as acting in “good faith” if they act in compliance with accepted medical practice.

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 use of hormonal emergency contraception or intrauterine devices (IUDs) does not constitute abortion. A parliamentary question in 1983 clarified that the prevention of implantation does not equal the “procuring of a miscarriage” as prohibited by the Offences Against the Person Act 1861.<sup>2</sup> “Miscarriage” should be understood as the end of an established pregnancy. This interpretation was tested and confirmed in the case of *R v HS Dhingra*<sup>3</sup> in 1991 and a judicial review in 2002.<sup>4</sup>

#### 2.1.1 Time limits

A pregnancy may only be terminated under section 1(1)(a) of the Act if it has not exceeded 24 weeks. The majority of abortions carried out in England, Scotland and Wales take place under this ground, and the vast majority of those – over 90%, a percentage that has remained relatively constant over the past decade – are carried out at 13 weeks or earlier.<sup>5,6</sup> Early abortion is generally seen as medically preferable due to the lower risk of complications, and can be less traumatic for all involved.

Amendments made in 1990 to the Abortion Act removed pre-existing links to 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. Accordingly, terminations carried out under section 1(1)(b) to 1(1)(d) of the Act may be performed at any gestational age.

Periodically, calls are made for the legislation to be amended to reduce the time limit for abortion, most notably during the passage of the Human Fertilisation and Embryology Act in 2008, and again in 2012 following significant coverage of some senior politicians’ views on the 24-week time limit. Currently, the standard medical threshold of viability is understood to be around 24 weeks’ gestation.<sup>7</sup>

\* Note that the above conditions are lettered and ordered as set out in the Act, which differs from how they are ordered on the HSA1 form.

The BMA has longstanding policy that opposes any change to the current time limit for abortion. Its most recent policy, passed in 2013, held that in light of the technical limitations of screening at earlier gestational stages, it would be unacceptable to change the time limit for abortion.

### 2.1.2 Early medical abortion

Early abortion opens up the opportunity, particularly in the first trimester, for a woman to have a medical abortion rather than a surgical abortion, something which is medically safer. A medical abortion involves taking the prescription drugs mifepristone (formerly known as RU486) and then later on (usually two days later) misoprostol. The misoprostol makes the womb expel the embryo/fetus, usually within four to six hours.

An amendment made to the 1967 Act by the Human Fertilisation and Embryology Act 1990 specified 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 only be lawful if carried out on premises approved for surgical terminations.

Currently, both sets of drugs must be administered in an NHS hospital or approved place. In 2008 the Department of Health undertook a review of the safety, effectiveness and acceptability of early medical abortions in non-traditional settings, such as primary care. The study concluded that there was no discernible difference between the pilot non-traditional sites and their comparator sites in terms of safety, effectiveness or acceptability.

In 2011, the British Pregnancy Advisory Service (BPAS) sought a judicial review to challenge the Department of Health's view that legislation required both sets of drugs to be taken in an approved place,<sup>8</sup> rather than permitting women to take the second set of drugs at home. The High Court rejected BPAS's claim whilst going on to say that there was scope within the legislation for the Secretary of State for Health to approve changes to where the drugs could be taken. The then Secretary of State said that such changes would not be introduced without adequate piloting and evaluation in the UK.

### 2.1.3 Abortion for serious fetal abnormality

Under the Abortion Act, 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."<sup>9</sup>

The 1967 Act is silent on the definition of "serious handicap". It is therefore a matter of clinical judgment and accepted practice. The Royal College of Obstetricians and Gynaecologists (RCOG) has detailed guidance for health professionals involved in late term abortions for fetal abnormalities.<sup>10</sup> The BMA believes the types of factor that may be taken into account in assessing the seriousness of a handicap include the following:

- 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
- the suffering that would be experienced by the child when born or by the people caring for the child.

Doctors faced with a potential late-gestation abortion for serious fetal abnormality should be aware that women should be given time to understand the nature and severity of fetal abnormality, and should be offered specialised counselling where appropriate, in order to reach an informed decision about how to proceed. The purpose of ante-natal 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 a pregnancy or seek a termination. Women should not be rushed into making a decision, but if a decision is made to terminate, this should proceed without undue delay. Appropriate support should be provided before and after the termination.

## A note on fetal pain

Whether, and at what stage, a fetus feels pain has been a matter of much debate. 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;<sup>11</sup> others arguing that it is unlikely to feel pain before 26 weeks' gestation;<sup>12,13</sup> and others arguing for some unspecified gestational period in between.<sup>14</sup>

The Royal College of Obstetricians and Gynaecologists' 2011 report *Fetal Awareness – Review of Research and Recommendations for Practice* concluded that the fetus cannot experience pain prior to 24 weeks' gestation, as prior to this point, the necessary connections from the periphery to the cortex are not present. They also found limited evidence to suggest that fetuses can perceive pain after 24 weeks, and noted increasing evidence to suggest that the fetus never experiences a state of true wakefulness *in utero*.<sup>15</sup>

The BMA recommends that doctors should give due consideration to the appropriate measures for minimising the risk of pain, including assessment of the most recent evidence. The BMA suggests that even if there is no incontrovertible evidence that the fetus feels pain, the use of fetal analgesia when carrying out any procedure (whether an abortion or a therapeutic intervention) on the fetus *in utero* may go some way in relieving the anxiety of the woman and health professionals.

### 2.1.4 The requirement for two signatures

The 1967 Act requires the signatures of two registered medical practitioners on the HSA1 form confirming their opinion, made in good faith, that the terms of the Abortion Act are complied with. Although not stated in the Act itself, regulations published in 1991<sup>16</sup> require the two doctors to agree to termination on the same grounds. Where a woman's request would meet more than one of the grounds in the Act, the two doctors must agree which ground is to be specified on the HSA1 form. This requirement for two signatures does not apply in an emergency.

#### 2.1.4.1 Pre-signing of forms

In January 2012, the Care Quality Commission (CQC) identified evidence during one inspection that HSA1 forms were being pre-signed by doctors. A subsequent investigation into whether this practice was widespread found clear evidence of pre-signing at 14 out of the 249 locations inspected.<sup>17</sup> A 2013 letter from the Chief Medical Officer for England stated that the pre-signing or "counter-signing" of HSA1 forms was "unacceptable" and "incompatible with the requirement [of the law] to form an opinion in good faith."<sup>18</sup> Guidance from the Department of Health asserts that it considers pre-signing of forms "without subsequent consideration of any information relating to the woman" to be incompatible with the requirements of the Abortion Act.<sup>19</sup>

The General Medical Council's (GMC) *Good Medical Practice* makes it clear that doctors are personally accountable for their professional practice, and must be able to justify their decisions and actions and demonstrate that they formed their opinion in good faith. The BMA believes that the practice of pre-signing is always likely to raise questions about whether the decision was made in good faith. However, there may be some circumstances where the pre-signing of HSA1 forms is not necessarily incompatible with the requirement of the Abortion Act for a doctor to have formed an opinion in good faith. For example, a doctor could prepare a stock of pre-signed forms in advance of being away from clinic, which are only used where the doctor verbally authorises their use following a telephone conversation or other communication, during which they decide, in good faith, that the woman's circumstances fit within the statutory grounds. These circumstances, however, should be seen as exceptional, and in the BMA's view, it would be inadvisable to routinely pre-sign HSA1 forms.

There is no legal requirement for the doctor to personally examine a woman seeking termination. Indeed, there is the option on the HSA1 form for one or both of the doctors to certify that they have not seen or examined the woman. In 1981 the courts confirmed that abortion was a procedure carried out by a multi-disciplinary team, and that whilst the doctor should accept overall responsibility for all treatment with regard to a termination of pregnancy, they do not need to personally conduct every stage of the procedure, and can rely on information gathered by other members of their team in forming their opinion.<sup>20</sup> Nevertheless, doctors must be satisfied that the conditions of the Abortion Act have been met.

BMA policy, passed in 2007, is that in the first trimester, the need for a woman to meet specified medical criteria, and for two doctors to approve an abortion, should be removed, so that abortion in the first trimester is available on the same basis of informed consent as other treatments. This policy is based partly on the fact that, from a clinical perspective, abortion is safer when carried out early in pregnancy. Given the risks associated with pregnancy and childbirth, and the risks of a woman having to continue a pregnancy against her wishes (compared with the minor risks associated with early medical abortion), there will always be medical grounds to justify termination in the first trimester.<sup>21</sup> The requirement for two signatures in these circumstances has the potential to create delays and unnecessary barriers to access, where earlier termination is medically preferable. In addition, no other medical procedure requires the agreement of two medical practitioners, making current abortion law increasingly out of step with the emphasis on patient autonomy elsewhere in medicine. The BMA's 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 Sex selective abortion

Sex selective abortion is the practice of terminating a pregnancy based upon the sex of the fetus. It has been the subject of considerable media and political attention recently, although reports of widespread abortion for reasons of gender preference in the UK remain largely anecdotal. Whilst there may be some evidence to suggest that sex selective abortion is practised elsewhere in the world, ongoing analysis of gender ratios in Britain has repeatedly found "no evidence for gender selective abortions occurring in Great Britain."<sup>22</sup>

Abortion solely on the basis of parental preference of fetal gender, where there are no health implications (for the fetus or for the woman), does not meet one of the legal grounds for an abortion under the 1967 Act, and is therefore unlawful. The Department of Health's guidance states that abortion on the grounds of gender alone is illegal.<sup>23</sup> The only example given of where it would be lawful to terminate a pregnancy where gender is a factor is where there is a substantial risk of the fetus being born with a serious sex-linked condition. In the BMA's view, however, it is possible that another of the legal grounds for abortion could be met as a consequence of fetal gender, or that women who have a gender preference may meet the legal grounds for abortion for reasons unconnected to their preference.

The BMA believes that it is normally unethical to terminate a pregnancy on the basis of fetal sex, except in the case of severe sex-linked disorders. However, as part of their assessment, doctors should consider all relevant factors, which may include the woman's views about the effect of the sex of the fetus on her physical and mental health. Doctors may come to the conclusion, in a particular case, that the effects on the physical or mental health of the pregnant woman of having a child of a particular sex would be so severe as to provide legal and ethical justification for a termination. If two doctors formed the opinion, in good faith, that there was a greater risk to the woman's health from continuing the pregnancy than there would be from termination, abortion would be lawful.<sup>24,25</sup> The GMC has confirmed that its understanding of the Abortion Act is that fetal gender could be a contributing factor in determining that one of the lawful grounds for abortion has been met.

### 2.1.6 Reduction of multiple pregnancy

High-order multiple pregnancies are known to be associated with higher rates of mortality and morbidity for both mother and child. Whilst the risk of multiple pregnancy can, and has been, reduced through careful monitoring of ovulation induction and limiting the maximum number of embryos used in IVF treatment, it cannot be avoided in all cases.

Pre-1990, the legality of selective reduction of multiple pregnancy was unclear as the 1967 Act referred only to the termination of a “pregnancy”, and in selective reduction, the pregnancy itself is not terminated. Section 37(5) of the Human Fertilisation and Embryology Act 1990 clarified and amended the Abortion Act 1967 to include section 5(2) which states that:

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

- (a) The ground for termination of the pregnancy specified in s.(1)(d) of that section 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.”

Accordingly, selective reduction of pregnancy would be lawful provided that the circumstances met the criteria for termination of pregnancy set out in the 1967 Act, and the procedure was carried out in an NHS hospital or premises approved for terminations. 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 that risk must be to the specific fetus.<sup>26</sup> However, where there is an increased risk to the mother as the result of a multiple pregnancy, selective reduction may be lawful under section 1(1)(a), (b) or (c) of the Act.

The BMA considers selective termination to be justifiable where the procedure is recommended for medical reasons (both physical and psychological). Women who have a multiple pregnancy should be carefully counselled where medical opinion is that continuation of the pregnancy without selective reduction will result in the loss of all the fetuses, but they cannot be compelled or pressured to accept selective abortion. Where there are no medical indications for aborting particular fetuses, the choice should be a random one.

### 2.1.7 Counselling

Whilst counselling can be seen as an important part of the abortion procedure, there is no legislative requirement for the provision or offer of counselling. There have been repeated calls at a parliamentary level, most recently during the passage of the Health and Social Care Act in 2011,<sup>27</sup> to make it mandatory for women seeking abortions to receive independent counselling. Supporters cite concerns that current arrangements, where many abortion clinics offer counselling, create a conflict of interest, whilst critics of this view believe that mandating independent counselling merely creates barriers to accessing abortion services.

[The BMA supports the universal availability of impartial and non-directive counselling for women considering abortion, but believes there is no evidence to warrant implementing mandatory and independent service provision, separate from abortion providers.](#)

## Abortion and mental health

Evidence supporting a link between abortion and mental health problems is scant and controversial. In 2011, the Academy of Medical Royal Colleges published *Induced Abortion and Mental Health*, which undertook a systematic review of mental health outcomes of induced abortion. It concluded that having an abortion does not increase the risk of mental health problems – rather, it is having an unwanted pregnancy that is associated with an increased risk of mental health problems, regardless of whether the pregnancy is carried to term or terminated. The most reliable indicator of post-abortion mental health problems is having a history of mental health problems.<sup>28</sup>

### 2.1.8 Conscientious objection

#### 2.1.8.1 Legal scope

Section 4 of the Abortion Act 1967 is a conscientious objection clause which permits doctors to refuse to participate in terminations, but which obliges them to provide treatment necessary to save the life or to prevent grave permanent injury to a pregnant woman.

Despite a doctor's right to conscientiously object, patients are entitled to receive objective and non-judgmental medical advice and treatment. Paragraph 52 of the General Medical Council's (GMC) *Good Medical Practice* states that:

"You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role."<sup>29</sup>

The BMA believes that a doctor's conscientious objection must be made clear to the patient as soon as possible, and patients must be able to see another doctor as appropriate. Referral in these circumstances need not always be a formal procedure. However, it is not sufficient to simply tell the patient to seek a view elsewhere. Doctors should not impose their views on others, but may explain their views to a patient if invited to do so. The BMA has produced more detailed guidance on doctors' personal beliefs which can be found on the BMA website.<sup>30</sup>

GP practices may wish to state in advance if any GPs in their practice have a conscientious objection to abortion, for example in their practice leaflets, so that patients are aware ahead of making an appointment.

Unreasonable delay in referral, with the intention, or the result, of compromising the possibility of a woman obtaining a termination is wholly unethical, and may leave the practitioner open to litigation or professional sanctions. The Royal College of Obstetricians and Gynaecologists (RCOG) has issued guidance on recommended referral times.<sup>31</sup>

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. Equally, there have been reports of doctors who do carry out abortions being subject to harassment and abuse. The BMA abhors any instances of harassment or discrimination of doctors on the basis of their views on abortion, and would encourage any members experiencing such behaviour to contact a BMA employment advisor for support and advice.

The case of *Janaway* clarified that the word “participate” in the Act should be given its ordinary and natural meaning, and so the conscience clause is limited to those actually taking part in the administration of the procedure in a hospital or approved centre.<sup>32</sup> In this case, it meant that a doctor’s secretary could not claim a conscientious objection for typing a referral letter. 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.” Accordingly, it appears to indicate that GPs do not have a legal right to claim exemption from giving advice or performing the preparatory steps to arrange an abortion, if the request for abortion meets the legal requirements.

The recent case of *Doogan and Wood* considered whether the scope of the conscientious objection clause may be far broader than had previously been conceived, but this view was rejected by the Supreme Court at the end of 2014.<sup>33</sup>

Personal communication with the Department of Health in the early 90s clarified that the conscientious objection clause can be used by medical students to opt out of witnessing abortions. The BMA would advise any student with a conscientious objection to disclose this fact to supervisors, managers or GP partners at as early a stage as possible so that this can be taken into account when planning patient care.

#### 2.1.8.2 Questions about abortion in job applications

The Department of Health published guidance in 1994 on the information about abortion that may be included in job advertisements and descriptions and the questions that may be asked at interview.<sup>34</sup> In 2003 the Department of Health confirmed in personal communication that its guidance was not intended to cover career posts that had little content other than termination of pregnancy. Trusts can, therefore, explicitly advertise when duties of career posts are exclusively for termination of pregnancy.

Similar guidance was published in Scotland in 2004.<sup>35</sup>

#### 2.1.8.3 Moral scope

In some cases a distinction can be made between legal and ethical obligations, and there may be some tasks that fall outside the legal scope of the conscience clause but fall morally within it.

Generally, it will not be beneficial for women undergoing termination to be cared for by doctors who feel distressed or unhappy about their involvement in a procedure, and so providing individual patients are not disadvantaged, and continuity of care for other patients can be maintained, requests from doctors to opt out of involvement in termination procedures should be considered and accommodated wherever possible.

Where such tasks are unavoidable, health professionals must pursue a non-judgmental approach to the woman concerned.

## 2.2 The law in Northern Ireland

The Abortion Act 1967 does not apply to Northern Ireland. The law on abortion in Northern Ireland is still based on the Offences Against the Person Act 1861, which makes it an offence to “procure a miscarriage...unlawfully.” The *Bourne* case, where a London gynaecologist was found not guilty of an offence under this Act for performing an abortion on a 14-year-old girl who was pregnant as the result of rape, was based on the interpretation of the word “unlawfully.”<sup>36</sup> It was held that the Infant Life (Preservation) Act 1929 gave protection from prosecution if the act was carried out, in good faith, “for the purpose only of preserving the life of the mother.” In the *Bourne* case, this was said to cover cases where continuing the pregnancy would leave the woman “a physical or mental wreck.”

Thus, in the absence of legislation, the courts in Northern Ireland are left with the task of interpreting the word “unlawful” in the 1861 Offences Against the Person Act using the Criminal Justice (Northern Ireland) Act 1945 (which applies the Infant Life (Preservation) Act 1929 to Northern Ireland) and the precedent set in *Bourne*. Various cases have confirmed

that abortion is lawful in Northern Ireland in some circumstances.<sup>37</sup> In the judgment in *A*, the judge clarified the legality of abortion:

“The doctor’s act is lawful where the continuance of pregnancy would adversely affect the mental health 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.”<sup>38</sup>

Despite this, there is continuing legal uncertainty over the precise circumstances in which abortion is lawful, and this has been the subject of judicial review over the years. A successful High Court appeal by the Family Planning Association in October 2004 required the Department for Health, Social Services and Public Safety (DHSSPS) to produce clear guidance for women and doctors on the circumstances in which abortion is permissible. Guidelines for health professionals were issued in 2009 but were withdrawn following legal challenge in 2010.

After a lengthy process, including further judicial review, in 2016 the DHSSPS produced *Guidance for health and social care professionals on termination of pregnancy in Northern Ireland*.<sup>39</sup> The guidance states that an abortion is lawful only where:

- it is necessary to preserve the life of the woman; or
- there is a risk of real and serious adverse effect on a pregnant woman’s physical or mental health if she continues with the pregnancy, which is either long term or permanent.

The guidance came shortly after Northern Ireland’s Human Rights Commission (HRC) successfully brought judicial proceedings<sup>40</sup> that found that Northern Ireland’s restrictive law on abortion on the grounds of FFA (fatal fetal abnormality) and sexual crime (rape and incest) (up to the date when the fetus becomes capable of an existence independent of the mother) is incompatible with Article 8 of the European Convention on Human Rights – the right to respect for private and family life. Unless this decision is reversed on appeal, it is now up to the Northern Ireland Assembly to amend the law to ensure that abortions are available for FFA and sexual crime. The BMA will continue to monitor the situation and update guidance accordingly.

Doctors in Northern Ireland wishing to discuss, or seek advice on, particular cases may contact the medical ethics and human rights department or the local BMA office. (See also section 3.2.3 on the duty to report.)

[BMA policy supports the extension of the Abortion Act to Northern Ireland. The Westminster government has made clear that any changes in abortion legislation in Northern Ireland would have to be instigated by the Northern Irish public. In a 2007 Parliamentary answer, it was stated that “any change to the law should only come about at the request of a broad cross-section of the people who live there.”<sup>41</sup>](#)

Hundreds of women from Northern Ireland travel to England, Scotland and Wales each year for abortion.<sup>42</sup> Doctors treating these women should be aware of the particular support these women might require and make appropriate provision for aftercare.

### 2.2.1 Conscientious objection

Doctors in Northern Ireland should follow the GMC’s guidance on moral and religious views. They should be aware, however, that as the Abortion Act 1967 does not extend to Northern Ireland, they do not have a statutory right to conscientiously object to involvement in abortion where it has been deemed lawful.

## 3. Ethical considerations

### 3.1 Consent

Termination of pregnancy cannot proceed without patient consent, except when a patient lacks capacity and termination is in the patient's best interests. There are a number of different factors which must be taken into account in the consent process, depending on the age and capacity of the patient.

#### 3.1.1 Competent adults

It is a fundamental principle of medical law that adults have the right to make decisions on their own behalf, and are assumed to have the capacity to do so, unless proven otherwise. If capacity is challenged, the responsibility for proving that an adult lacks capacity falls upon the person challenging it.

As with all other medical procedures, a woman seeking abortion should be provided with sufficient, accurate information to help her make a decision, and her consent must be freely and voluntarily given. The Royal College of Obstetricians and Gynaecologists' guidance on the care of women seeking abortion recommends that services should have processes in place to identify coercion or issues which make women particularly vulnerable, including child protection needs and domestic abuse/gender-based violence. Services should also refer to and signpost appropriate support services in a timely manner.<sup>43</sup>

#### 3.1.2 Adults lacking capacity

Under the Mental Capacity Act 2005, a person is regarded as being unable to make a decision if, as a result of an impairment or disorder of the mind or brain, they are unable to:

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

Where an adult fails any part of this test, the entire test is failed and she does not have the relevant capacity to give consent.

Where an adult is deemed to lack capacity, decision making for them is governed by the 2005 Act in England and Wales; the Adults with Incapacity (Scotland) Act 2000 in Scotland; and by the common law in Northern Ireland. (The Mental Capacity (Northern Ireland) Act 2016 Act will be implemented following the completion of the Mental Capacity Act codes of practice.)

Where individuals lack capacity, the central tenet of the English and Welsh legislation, and the common law in Northern Ireland, is "best interests", and in Scotland "benefit." It is the BMA's view that these terms can be interpreted in largely the same way. However, any practitioners working in Scotland and recommending an intervention in an incapacitated person's best interests that is unlikely to provide clinical benefit should consider taking legal advice.

Health professionals presented with a pregnant woman lacking capacity to give valid consent, who meets the legal grounds for abortion, should use their professional judgment to assess whether it is in her best interests to continue with the pregnancy, or to terminate the pregnancy. It is important to remember that assessing best interests extends beyond medical best interests alone, and doctors should consider the incapacitated woman's past and present wishes, feelings, beliefs and values. An essential part of this assessment will involve a discussion with those close to the patient, including any proxy decision-maker, with due consideration to confidentiality.

The courts have confirmed that there is no mandatory requirement to seek court approval to perform an abortion where issues of capacity and best interests are clear.<sup>44</sup> However, in cases of doubt, it would be advisable to seek a second clinical opinion. In the following circumstances, cases 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 disagrees 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 opportunity to conceive.<sup>45</sup>

The need for abortion to be considered in respect of a woman who lacks capacity is likely to raise serious questions about her ability to consent to sexual intercourse, and may require investigation as to whether a criminal offence has occurred. The BMA has produced guidance jointly with the Law Society on the law relating to mental capacity, which recognises the rights of all people to voluntarily enter into sexual relationships, but also focuses on the obligation to protect vulnerable adults from abusive relationships.<sup>46</sup> If there are grounds to believe that a pregnancy has resulted from unlawful sexual intercourse (sexual intercourse without consent is rape), immediate steps should be taken to protect the woman (and others who may be at serious risk) from possible further abuse.

Further information on assessing mental capacity, including an interactive assessment tool, can be found online on the BMA website.<sup>47</sup>

### 3.1.3 Competent minors

Any young person, regardless of age, can independently seek medical advice and give valid consent to medical treatment if, in the opinion of the doctor, they are capable of understanding the nature and possible consequences of the procedure. This was established in the House of Lords' ruling in *Gillick*.<sup>48</sup> The later case of *Axon*<sup>49</sup> confirmed that the *Gillick* principles applied to decisions about treatment and care for sexually transmitted infections, contraception and abortion.

The law is clear that a parent's refusal to give consent for a termination cannot override the consent of a competent young person.<sup>50</sup>

The BMA frequently receives queries from doctors concerning children and young people seeking medical care without an adult. Whilst requests by young people for serious medical treatments, such as abortion, without parental involvement can cause anxiety amongst doctors, the BMA takes the view that establishing a trusting relationship between doctor and patient will do more to promote health than a blanket refusal to see young patients without parental consent. Further advice and information on the treatment of children and young people can be found in the BMA's *Children and young people toolkit*.<sup>51</sup> More detailed guidance on the provision of advice and treatment for matters of sexual and reproductive health for under-16s is available from the Department of Health.<sup>52</sup>

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

- consider whether the young woman understands the potential risks and possible longer-term effects of abortion
- consider whether she has sufficient maturity, i.e. *Gillick* competence to make the decision and give valid consent
- encourage her to discuss the situation with her parents, or alternatively, another adult whom she feels she can trust
- discuss the importance of support during and after the termination
- if the doctor is not the patient's own GP, encourage the young woman to consent to information being shared with her GP.

### 3.1.4 Minors lacking capacity

If a young person is assessed as lacking competence, someone with parental responsibility may legally consent to a termination on her behalf. In all cases, the patient's views must be heard and considered. If a young woman refuses to permit parental involvement, legal advice should be sought about whether the parents should be informed against her wishes, which may require an application to the courts. At all stages, the first duty of health professionals remains the welfare of the patient, who may benefit from referral to specialist counselling.

As with adults lacking capacity, if a doctor considers a young patient to be unable to consent to a termination of pregnancy, this raises the question of whether she was also able to consent to sexual intercourse.

### 3.1.5 Involvement of partners

The law is clear that a decision to terminate a pregnancy rests with the woman concerned and her doctor, and that a woman's partner has no legal right to demand or refuse a termination.<sup>53</sup> However, it is good practice to encourage women to discuss the decision with their partner. Where a woman refuses to share information with her partner, confidentiality must be maintained unless there are exceptional reasons to justify a breach.

## 3.2 Confidentiality

### 3.2.1 Adults

As with all other medical procedures, patients seeking a termination have a right to expect that doctors will not disclose personal health information to a third party without consent. Women seeking termination are likely to be particularly concerned about confidentiality, and doctors should be sensitive to this.

Due to the sensitive nature of abortion, doctors will sometimes receive requests from patients to remove information about previous terminations from their medical record. The BMA's view is that doctors would need to have exceptional reasons for removing clinical information from a patient's medical record. Removing key medical information may make a doctor's later decisions appear unsupported, particularly if further consultations and treatment have arisen as a result of this information, and could also be detrimental to the future care of the patient.

If the doctor consulted is not the patient's own GP, the woman should be encouraged to consent to information being shared with her own GP. If, however, she refuses to consent to the sharing of this information, her wishes should be respected.

This right to confidentiality can only be breached in exceptional circumstances. As noted above, the need for an abortion to be considered in respect of a woman who lacks capacity may raise questions about her ability to consent to sexual intercourse and may lead the doctor to believe that a crime has been committed. This may warrant breaching confidentiality to disclose information in order to prevent the woman (and others who may be at serious risk) from further harm.<sup>54</sup>

### 3.2.2 Minors

The duty of confidentiality owed to a person under 16 is the same as the duty owed to any other person. This was confirmed by the courts in the case of *Axon*,<sup>55</sup> where it was held that parents had no right to know whether girls under the age of 16 were seeking advice about abortion. It is clearly desirable for young people to have their parents' help and support for important and potentially life-changing decisions such as abortion. Whilst young patients should be encouraged to share information with their parents or legal guardians, they cannot be compelled to do so. The BMA has frequently argued that if young people believe consultations with doctors are not confidential, they will be put off seeking help for sexual and reproductive health related issues, with potential serious ramifications for their long-term health.

As with the case of adults lacking capacity, a young person's need for an abortion may give rise to concerns about her ability to consent to sexual intercourse. Doctors should be aware that in England, Scotland and Wales they do not need to inform police or social services of all underage sexual activity. (See below for information on Northern Ireland.) However, where a young person is under the age of 13, they are considered in law to be unable to consent. All information about sexual activity involving children under 13 should usually be shared. Any decision not to disclose should be discussed with a named or designated doctor for child protection, and the decision and reasons underlying it should be recorded.<sup>56</sup>

There may be circumstances where a doctor has reason to believe that the pregnancy is the result of child abuse, incest or exploitation, and here a disclosure may be necessary and justifiable. The GMC recommends that information be shared about abusive or seriously harmful sexual activity involving any child or young person, including that which involves:

- (a) a young person too immature to understand or consent;
- (b) big differences in age, maturity or power between sexual partners;
- (c) a young person's sexual partner having a position of trust;
- (d) force or the threat of force, emotional or psychological pressure, bribery or payment, either to engage in sexual activity or to keep it a secret;
- (e) drugs or alcohol used to influence a young person to engage in sexual activity when they otherwise would not;
- (f) a young person's sexual partner is someone known to the police or child protection agencies as having had abusive relationships with children or young people.<sup>57</sup>

The patient should be told in advance in such cases that confidentiality cannot be guaranteed, and should be offered appropriate help, counselling and support.

### 3.2.3 Duty to report in Northern Ireland

Section 5 of the Criminal Law (Northern Ireland) Act 1967 places a duty, unique to Northern Ireland, on everyone to report to the police information they may have about the commission of a relevant offence (i.e. one with a maximum sentence of five years or more.) There are few exceptions to the law. For example, "medical confidentiality" is not, in and of itself, understood to be an exception. This means that doctors are under a duty to report unlawful abortion. The recent Northern Ireland DHSSPS guidance on abortion states that:

"Health and social care professionals must balance the need for confidentiality of patients with the obligation to report unlawful terminations of pregnancy to the police and the need to protect others from risk of serious harm."<sup>58</sup>

Under the Act, doctors are also under a duty to report to the police evidence of sexual activity taking place involving a young person under 16, even where the activity is entirely mutually agreed and non-exploitative. This section was amended by the Sexual Offence (Northern Ireland) Order 2008 to exclude from the duty to report information about an offence under Article 20 of the Order (sexual offences against children committed by children or young persons). Doctors are not therefore under a duty to report sexual activity involving a child aged 13 to 15 years old where the other party is under 18. The duty to report still applies where one of the parties is under 13 or over 18.

Where doctors are unsure of their duties and obligations, they should seek advice.

## 4. Summary

Abortion is lawful in England, Scotland and Wales, provided that the criteria set out in the Abortion Act 1967 are fulfilled. Abortion is lawful in Northern Ireland in far more circumscribed cases. The Abortion Act requires doctors to make an assessment in the context of each individual case, including assessing the potential impact of pregnancy and birth on a woman's physical and mental health and the wellbeing of existing siblings. As with all medical decisions, any decision must be supported by the provision of appropriate information about all available options and implications.

Under the law in England, Scotland and Wales, doctors are able to exercise a right of conscientious objection to participation in termination of pregnancy, unless the abortion is necessary to preserve the woman's life or prevent grave permanent injury. However, patients also have a right to receive objective and non-judgmental care. Where doctors wish to conscientiously object, they should explain this to their patients and make suitable arrangements for their care to be provided elsewhere.

As with all medical procedures, patients must give appropriate consent to a termination of pregnancy. It is a general principle that from the age of 16 individuals are assumed to have capacity unless proven otherwise. Decisions involving adults who lack the capacity to consent should be made on the basis of an assessment of their best interests, or "benefit" in Scotland. Under-16s can consent if they are deemed competent. If a young woman under the age of 16 is incapable of consenting, those with parental responsibility can consent to treatment in her best interests on her behalf.

Women seeking termination of pregnancy, both adult and child, have the right to confidentiality. This can only be breached in exceptional circumstances, for example, where a doctor believes a child has been abused, and that she or other girls are at risk of serious harm. In Northern Ireland specific rules apply where a relevant offence has been committed (see section 3.2.3).

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