

The law and ethics of abortion

BMA views

September 2020 (March 2023 update)



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Key points

- Abortion is lawful in England, Scotland, and Wales provided the criteria in the Abortion Act 1967 are met. In all other circumstances, administering or procuring an abortion is a crime.
- Abortion is lawful in Northern Ireland provided the criteria in the Abortion (Northern Ireland) (No. 2) Regulations 2020 are met.
- Unless abortion is necessary to save a woman's life or prevent grave permanent injury, doctors have a right of conscientious objection under the Abortion Act or the Abortion (Northern Ireland) Regulations. At the same time, patients have a right to receive objective and non-judgmental care. Doctors with a conscientious objection should inform patients as soon as possible and must tell them about their right to see another doctor, making sure they have enough information to exercise that right. If it is not practical for a patient to arrange to see another doctor, the doctor must make sure that arrangements are made for another suitably qualified colleague to take over care of the patient.
- As with all other medical procedures, patients must give the appropriate consent for abortion.
- Under-16s can consent to an abortion if they are competent to do so. Those with parental responsibility for minors lacking competency 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 abortion. This guidance is intended to provide a 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.



BMA policy and views are flagged throughout this document.

Whilst this guidance is focused primarily on UK law, the BMA has long defended the provision of safe abortion internationally. For example, following the overturning of *Roe v Wade*¹ by the US Supreme Court (SCOTUS), the BMA, among other things, co-signed the International Federation of Gynecology and Obstetrics (FIGO) international statement² ‘...*global health care organisations call on all governments to defend access to safe and quality abortion care*’, alongside other UK medical bodies including the Faculty of Sexual and Reproductive Healthcare (FSRH) and Royal College of Obstetricians and Gynaecologists (RCOG). Banning or severely restricting abortion does not prevent abortions. It only prevents safe termination of pregnancy. Restrictions disproportionately impact on the poor, disadvantaged and marginalised in society.

1.1 The BMA view on abortion

The BMA has longstanding policy supporting access to abortion, including recent calls for changes to abortion legislation to reflect changes in the way healthcare is delivered (see later sections).



In 2017 the BMA agreed policy that abortion should be regulated in the same way as other medical treatments. This policy states that abortion:

- i) should be decriminalised in respect of health professionals administering abortions within the context of their clinical practice;
- ii) should be decriminalised in respect of women procuring and administering the means of their own abortion.

The policy does not call for an absence of regulation. Limits could still be set, but they would be subject to professional and regulatory, rather than criminal, sanctions. In addition, criminal and civil laws that apply to other aspects of clinical care would continue to apply to abortion. For example, supplying abortion drugs without a prescription would be a criminal offence under the UK-wide Human Medicines Regulations 2012.

The BMA has produced two resources outlining the details of this policy and how it could work in practice – both are available on the BMA website at www.bma.org.uk/ethics:

- [The removal of criminal sanctions for abortion: BMA Position Paper \(2019\)](#)
- [How will abortion be regulated in the United Kingdom if the criminal sanctions for abortion are removed? \(2019\)](#)

The BMA recognises the diversity of opinion amongst its membership. However, policy expressed in this document has been agreed through the well-established democratic procedures for making policy at the BMA's ARM.

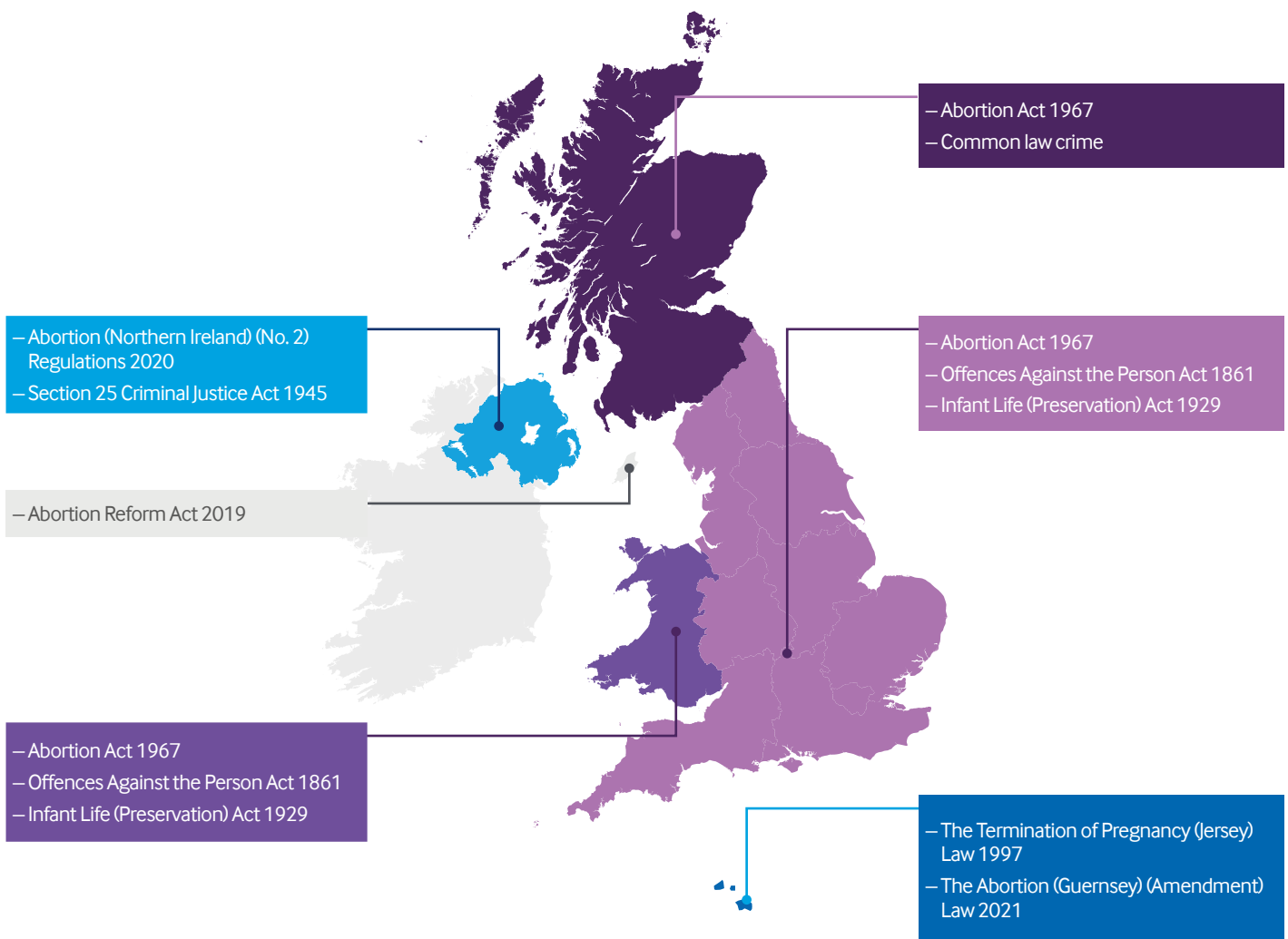
The BMA's advice to its members is to act within the boundaries of the law and their own conscience. Patients are, however, entitled to objective and non-judgmental medical advice and treatment, regardless of a doctor's personal view.

The BMA abhors any instances of harassment or discrimination against doctors on the basis of their views on abortion, either for or against.



Additionally, the BMA deplures any instances of intimidation of patients and staff by protesters outside abortion services. The BMA campaigned for many years for national legislation to introduce “safe”/“buffer” zones outside services to protect staff, women and those accompanying women from harassment and intimidating behaviour.³ At the time of writing, legislation to protect areas outside services had been introduced in Northern Ireland;⁴ was due to be introduced in England and Wales;⁵ and was expected to be introduced in Scotland.⁶

2. The Law on Abortion



In addition to the core statute and common law outlined above, abortion is also subject to further regulation, as well as professional and clinical standards.

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. The Abortion Act provides exceptions to the crime of administering or procuring an abortion.^a

^a Abortion remains a common law crime in Scotland; and a statutory crime in England and Wales, under the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929. Further detail can be found in the BMA discussion paper *Decriminalisation of abortion: a discussion paper from the BMA* (February 2017), and *UPDATE on the decriminalisation of abortion* (March 2017) – both available at www.bma.org.uk/ethics. Abortion was partially decriminalised in Northern Ireland under the Northern Ireland (Executive Formation etc) Act 2019 but aspects remain a crime under the Criminal Justice (Northern Ireland) Act 1945 and some new criminal sanctions were introduced under the Abortion (Northern Ireland) (No.2) Regulations 2020. See section 2.2 on the law in Northern Ireland.

Under the Abortion 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.”^{7, b}

To demonstrate that an opinion has been formed “in good faith” does not require that the authorisation of an abortion 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 considered that a doctor is acting in good faith if they have complied with accepted medical practice.

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. In these limited circumstances, there are no restrictions on where the procedure may be carried out.

The use of hormonal emergency contraception or IUDs (intrauterine devices) does not constitute abortion. A parliamentary question in 1983 clarified that the prevention of “implantation in the womb of any fertilised ovum” does not equal the “procuring of a miscarriage” as prohibited by the Offences Against the Person Act 1861.⁸ “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* in 1991,⁹ and by a judicial review in 2002.¹⁰

2.1.1 24-week time limit

A pregnancy may only be terminated under section 1(1)(a) of the Abortion Act if it has not exceeded 24 weeks.^c The majority of abortions carried out in England, Scotland and Wales take place within this time, over 90 per cent of which are carried out at 13 weeks or earlier.¹¹ This percentage has remained relatively constant over the past decade. Early abortion is generally seen as medically preferable due to the lower risk of complication.

Amendments made in 1990 to the Abortion Act replaced a pre-existing link to the Infant Life (Preservation) Act 1929 which 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 the remaining grounds may be performed at any gestational age (section 1(1)(b) to 1(1)(d) of the Abortion Act).

^b 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.

^c It was confirmed that this meant “that a woman will have exceeded her 24th week of pregnancy once she is 24 weeks + 0 days pregnant, which will commence from midnight on the expiration of 23 weeks + 6 days.” *R (On the application of British Pregnancy Advisory Service) v The Secretary of State for Health and Social Care* [2020] EWCA Civ 355 (10 March 2020), at 73. Available at www.bailii.org/ew/cases/EWCA/Civ/2020/355.pdf (accessed 22 March 2023).

Periodically, calls are made for the legislation to be amended to reduce the 24-week time limit for abortion.

The concept of viability underpins much of the parliamentary debate around this time limit, despite it being difficult to define.^{d, e} Viability – which takes into account gestation, as well as aspects such as birth weight and underlying medical conditions – is just one factor, however, when considering the abortion time limit.

Despite provisions for abortion post 24 weeks for serious fetal abnormality under the Abortion Act 1967, there are concerns that women are sometimes encouraged to make decisions before the 24-week time limit due to doctors' anxieties about the risk of criminal prosecution if their clinical judgment is challenged in relation to a later abortion. This is compounded by the fact that conditions can sometimes not be evident or develop until after 20 weeks; and some hospitals only arrange for pregnant women to have the fetal anomaly scan at 22 weeks when organs and structures are sufficiently developed to permit detailed examination by ultrasound.^f

The BMA believes it is critical that women are given the time to make the right decision for them, whether to continue or end a much wanted pregnancy in the second or third trimester, when a diagnosis of a serious or fatal fetal abnormality is made.



The BMA has longstanding policy that opposes any change to the current time limit for abortion. BMA policy agreed in 2013, holds 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 (EMA)

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 (between 24 and 48 hours later) misoprostol. Misoprostol causes the womb to expel the embryo/fetus, usually within four to six hours.

When the Abortion Act was written into law, medical abortions were not possible. As such, the Abortion Act required that all abortions be performed in premises approved for surgical terminations. After mifepristone and misoprostol were licensed for use in the UK, the Abortion Act was amended by the Human Fertilisation and Embryology Act 1990, which expanded the power to approve premises for termination of pregnancy to include the power to approve premises for the administration of medical terminations. This amendment made it possible for medical abortion to be administered in approved places outside of NHS hospitals.

^d Gestational age is not the only factor to take into account when considering viability. Many other individual factors come into play – for example, birth weight, any underlying medical conditions, whether it is a multiple pregnancy and the gender of the fetus. A more detailed discussion on viability can be found in the BMA discussion paper *Abortion time limits: a briefing paper from the BMA* (2005).

^e The British Association of Perinatal Medicine's (BAPM) framework for practice – *Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation A Framework for Practice* (October 2019) – notes, for example, that "... the outcomes for babies actively managed at 22 weeks of gestation appear similar to those of babies at 23 weeks of gestation at the time of the 2008 BAPM Framework for Clinical Practice...". The new BAPM framework also notes that "decision making for babies born before 27 weeks of gestation should not be based on gestational age alone". It remains the case that there is a very high mortality and morbidity below 24 weeks gestation.

^f This was highlighted in a statement from the charity Antenatal Rights and Choices (ARC) which notes that "A reduction in the [24-week time] limit would add an extra level of stress to an already traumatic situation." Available at www.arc-uk.org/about-arc/policy-updates/#abortion (accessed 22 March 2023). (ARC is a national charity that helps parents and healthcare professionals through antenatal screening and its consequences.)

Following changes made in response to the COVID-19 pandemic, women can also now choose to have early medical abortions (EMA) at home in England,¹² Scotland¹³ and Wales.¹⁴ Approval has also given to allow for telephone and video consultations and remote prescribing provided certain conditions are met.



The BMA supported making changes brought in during the COVID-19 pandemic permanent, UK-wide. Eligible women can now continue to access EMA remotely in England, Wales and Scotland, if they choose to.

The Northern Ireland Department of Health also has the power to allow for further remote provision¹⁵ after the Abortion (Northern Ireland) Regulations 2020 came into force, but it had not yet used these powers at the time of writing. (See section 2.2 on the law in Northern Ireland.)

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.”¹⁶

The Abortion Act is silent on the definition of “serious handicap”. It is therefore a matter of clinical judgment and accepted practice. The RCOG (Royal College of Obstetricians and Gynaecologists) has detailed guidance for health professionals involved in late abortions for fetal abnormalities.¹⁷ The BMA believes the factors that may be taken into account in assessing the seriousness 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 abortion for serious fetal abnormality should be aware that women should be given information and time to understand the nature and severity of fetal abnormality, and should be offered specialised counselling where appropriate, in order to assist them in reaching an informed decision about how to proceed. The purpose of prenatal screening is to expand the choices 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 the pregnancy, 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.¹⁸ The RCOG 2022 report *Fetal Awareness Evidence Review* concluded that the “evidence indicates that the possibility of pain perception before 28 weeks of gestation is unlikely”.¹⁹

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 Abortion Act requires the signatures of two registered medical practitioners on a form (named the HSA1 form) confirming that in their opinion, which is made in good faith, the terms of the Abortion Act have been satisfied. Although not stated in the Abortion Act itself, regulations published in 1991 require the two doctors to agree to the termination on the same grounds.²⁰ Where a woman's request would meet more than one of the grounds in the Abortion 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 CQC (Care Quality Commission) 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.²¹ 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."²² Guidance from the DHSC (Department of Health and Social Care) 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.²³

The GMC's (General Medical Council) *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 requirements of the Abortion Act. For example, a doctor could prepare a stock of presigned 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. However, these circumstances 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.²⁴ Nevertheless, doctors must be satisfied that the conditions of the Abortion Act have been met.



BMA policy agreed in 2007, states that in the first trimester the requirement that a woman meet specified medical criteria, and for two doctors to approve an abortion, should be removed. This would mean abortion in the first trimester would be available on the same basis (informed consent) as other medical treatments. This policy is based partly on the fact that, from a clinical perspective, abortion is safer when carried out early in pregnancy. (This policy sits alongside BMA policy calling for the decriminalisation of abortion – see section 1.1).

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.²⁵ The requirement for two signatures in these circumstances has the potential to create delays and unnecessary barriers to access. 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 in previous years, however reports of widespread abortion for reasons of gender preference in the UK remain largely anecdotal. Whilst there may be some evidence to suggest that it is practised elsewhere in the world, ongoing analysis of gender ratios in Britain have repeatedly found “no evidence for gender selective abortions occurring in Great Britain.”²⁶

Abortion solely on the basis of parental preference of fetal gender, where there are no health implications (for the fetus or for the woman), cannot satisfy any of the grounds in the Abortion Act, and is therefore unlawful. The DHSC’s guidance states that abortion on the grounds of gender alone is illegal.²⁷ Further, that the only circumstances in which 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. However, in the BMA’s view 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 alone, 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 gender 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 gender 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.²⁸

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 pregnancies

High-order multiple pregnancies are known to be associated with higher rates of mortality and morbidity for both woman and fetuses. Whilst the risk of multiple pregnancy can be, 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 Abortion Act referred only to the termination of a “pregnancy”, and in selective reduction, the pregnancy itself is not terminated. However, section 37(5) of the Human Fertilisation and Embryology Act 1990 clarified and amended the Abortion Act 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 section 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 section (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 Abortion Act. 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 any risk must be to the specific fetus.²⁹ However, where there is an increased risk to the woman 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 to make it mandatory for women seeking abortions to receive independent counselling.³⁰

Supporters cite concerns that current arrangements, where abortion clinics offer counselling, create a conflict of interest. Meanwhile critics of this view believe that mandating independent counselling merely creates barriers to accessing abortion services.



The BMA supports the availability and offer of impartial and non-directive counselling to women considering abortion, but believes there is no evidence to warrant implementing mandatory, independent counselling services, separate from the services provided by 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.³¹

A more recent 17-year-long observational study of more than half a million Danish women aged 18-36 years concurs with this earlier report. The study compared the risk of non-fatal suicide attempts before and after a first, first-trimester abortion and concluded that “the risk of suicide attempt is the same before and after the abortion, indicating that although women who have had an abortion are at higher risk of non-fatal suicide attempts, this cannot be attributed to the abortion itself.”³²

2.1.8 Conscientious objection

2.1.8.1 Legal scope

Section 4 of the Abortion Act 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 GMC's *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."^{33,34}



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.³⁵

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 RCOG has issued guidance on recommended referral times³⁶ and NICE (National Institute of Health and Care Excellence) recommendations on waiting times.³⁷



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. The BMA abhors any instances of harassment or discrimination of doctors on the basis of their moral views on abortion, whether these views are in favour of or against abortion. We would encourage any members experiencing such behaviour to contact a BMA employment advisor for support and advice.

The case of *Janaway v Salford Health Authority* clarified that the word "participate" in the Abortion Act should be given its ordinary and natural meaning.³⁸ As such, the conscientious objection clause is limited to those who take part in the administration of the procedure in a hospital or approved clinic. In the *Janaway* case, this meant that a doctor's secretary could not conscientiously object to typing a referral letter for abortion services. 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 case of *Doogan and Wood v Greater Glasgow & Clyde Health Board* considered whether the scope of the conscientious objection clause may be broader than had previously been conceived.³⁹ However, this view was rejected by the Supreme Court at the end of 2014.

Department of Health (now Department of Health and Social Care) correspondence shared with the BMA 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 as soon 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 (now Department of Health and Social Care) 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.⁴⁰ In 2003 the Department of Health confirmed to the BMA that its guidance was not intended to cover career posts that had little content other than termination of pregnancy. Trusts can, therefore, explicitly advertise where duties of career posts are exclusively for termination of pregnancy.

Similar guidance was published in Scotland in 2004.⁴¹

2.1.8.3 Moral scope

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

Generally, it will not be beneficial for women undergoing termination of pregnancy 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 does not apply to Northern Ireland.

A new legal framework for abortion was established in 2020 under the Abortion (Northern Ireland) (No.2) Regulations 2020.⁴² Under the regulations:

“3. A registered medical professional^g may terminate a pregnancy where a registered medical professional is of the opinion, formed in good faith, that the pregnancy has not exceeded its 12th week.

“4. (1) A registered medical professional may terminate a pregnancy where two registered medical professionals are of the opinion, formed in good faith, that –
(a) the pregnancy has not exceeded its 24th week; and
(b) the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman which is greater than if the pregnancy were terminated.

(2) In forming an opinion as to the matter mentioned in paragraph (1)(b), account may be taken of the pregnant woman’s actual or reasonably foreseeable circumstances.

^g Under the regulations a “registered medical professional” means – (a) a registered medical practitioner; (b) a registered midwife; (c) a registered nurse, Abortion (Northern Ireland)(No.2) Regulations 2020, s2(2).

“5. A registered medical professional may terminate a pregnancy where a registered medical professional 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.

“6. A registered medical professional may terminate a pregnancy where two registered medical professionals are of the opinion, formed in good faith, that – (a) the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or (b) the continuance of the pregnancy would involve risk to the life of the pregnant woman which is greater than if the pregnancy were terminated.

“7.(1) A registered medical professional may terminate a pregnancy where two registered medical professionals are of the opinion, formed in good faith, that there is a substantial risk that the condition of the fetus is such that – (a) the death of the fetus is likely before, during or shortly after birth; or (b) if the child were born, it would suffer from such physical or mental impairment as to be seriously disabled.

(2) In the case of a woman carrying more than one fetus, anything done to terminate the pregnancy as regards a particular fetus is authorised by paragraph (1) only if that paragraph applies in relation to that fetus.”

The regulations also set out where abortions can be carried out,⁴³ and certification⁴⁴ and notification requirements⁴⁵ for registered medical professionals.

The regulations introduce new criminal sanctions for abortions that are not administered in accordance with the regulations.^h Further details on when these sanctions will apply are given in the explanatory memorandum accompanying the regulations. It is noted, for example, that:

“... the [UK] Government acknowledges that the fear of prosecution under the previous abortion law in Northern Ireland had a chilling effect on doctors in providing abortion services. This new framework will be a significant change in relation to the provision of reproductive healthcare in Northern Ireland and medical professionals will be required to make decisions, diagnoses and prognoses which can be finely balanced. It is also recognised that these decisions are not without controversy given the moral and ethical nature of the subject of abortion and that there are differing views within the medical profession as well as among the wider population. In recognition of these factors and to provide medical professionals with confidence to treat women in accordance with the framework, basing decisions on their clinical judgment, and acting in good faith in the interest of their patient, proceedings may not be brought under regulation 9, 10 or 11 without the consent of the Northern Ireland Director of Public Prosecutions (DPP).”⁴⁶

It was anticipated that there would be a period between the regulations coming into force and the full implementation of an extended abortion service in Northern Ireland – in this time further guidance would be developed and a commissioning structure established.

^h Sections 58 and 59 of the Offences Against the Person Act 1861 were repealed in Northern Ireland in 2019 under section 9(2) of the Northern Ireland (Executive Formation etc) Act 2019 (available at www.legislation.gov.uk/ukpga/2019/22/section/9/enacted (accessed 22 March 2023)) but new criminal sanctions were introduced under sections 9, 10 and 11 of the Abortion (Northern Ireland)(No.2) Regulations 2020.

At the time of writing, early abortion services have been established in Northern Ireland within one of the five Health and Social Care (HSC) Trusts (Belfast, Northern, South Eastern, Southern and Western). If treatment is needed that is not available in Northern Ireland, care can be accessed in Great Britain, without charge and without having to pay for travel and accommodation, via a central booking system.⁴⁷



Ahead of these recent developments, and the UK Government making clear that services would be commissioned,⁴⁸ the BMA passed policy in 2022 recognising the failure to commission sufficient and safe abortion services within Northern Ireland, ultimately “endangering the lives of women and depriving them of their rights”.

Doctors in Northern Ireland wishing to discuss or seek advice on these developments may contact the BMA’s medical ethics and human rights department or the local BMA office. (Doctors in Northern Ireland should also be aware of the duty to report some underage sexual activity in Northern Ireland (see section 3.2.3)).

2.2.1 Conscientious objection

Doctors in Northern Ireland now have a legal right to conscientious objection under section 12 of the Abortion (Northern Ireland) (No. 2) Regulations 2020. As in the other three UK nations, the conscientious objection clause is limited to those who take part in the administration of the procedure (see section 2.1.8) and treatment must still be provided which it is necessary to save the life, or to prevent grave permanent injury to the physical or mental health, of a pregnant woman.

Doctors in Northern Ireland should also follow the GMC’s guidance on personal beliefs and medical practice.⁴⁹

As noted before, 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 GMC’s *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.”^{33,34}

2.2.2 Women in Northern Ireland and abortion

Hundreds of women from Northern Ireland have travelled to England, Scotland and Wales each year for abortion.⁵⁰ In 2017, it was announced that abortion services in England, Scotland and Wales would be funded and made freely available for women ordinarily resident in Northern Ireland.⁵¹ This funding currently continues whilst a service is being developed in Northern Ireland. Doctors treating these women should be aware of the particular support these women might require and make appropriate provision for aftercare.

At the time of writing, in the absence of a fully commissioned service in Northern Ireland based on the new legal framework, it is unclear when, or if, women will stop travelling to access abortion services in the other nations; or when funding of these services in the other nations will stop for women ordinarily resident in Northern Ireland.

2.3 The law in the Channel Islands and Isle of Man

The main focus of this guidance is abortion in the UK; however, the BMA also represents doctors in the Channel Islands and Isle of Man. Many of the principles outlined in this guidance will apply equally to those islands. An outline of the abortion laws for the Channel Islands and Isle of Man can be found below. Women are known to travel from the islands to the UK to access abortion services.

2.3.1 Jersey

The Termination of Pregnancy (Jersey) Law 1997 codifies and amends the customary law of Jersey. Abortion is “not to be unlawful”:

- “where it is necessary to save a pregnant woman’s life”;
- “to prevent grave permanent injury” to a pregnant woman’s physical or mental health;
- before 24 weeks where 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”; or
- before 12 weeks if “the woman’s condition causes her distress” and the requirements for consultation set out in the law have been complied with i.e. two consultations not less than seven days apart, with the woman having received information about counselling and adoption, amongst other things.

The law also sets out a right to conscientious objection (except where abortion is necessary to save the life of, or prevent grave injury to the physical or mental health of, a pregnant woman), and other conditions regarding who can perform an abortion, where abortions can be carried out, who should be consulted (including registered medical practitioners from specified specialties in some circumstances), and the recording of the grounds on which an abortion is lawful.

2.3.2 Guernsey, Herm and Jethou

In 2021, the Guernsey state approved new reforms to decriminalise abortion.⁵² In addition to decriminalising abortion, the reforms include:

- removing the requirement for two medical practitioners to certify an abortion;
- increasing Guernsey’s gestational limits in line with those in England;
- removing criminal sanctions relating to a woman in respect of ending, or attempting to end, her own pregnancy;
- allowing early medical abortion procedures to be completed at the woman’s home; and
- additional detail on the scope of conscientious objection and duty to refer.

2.3.3 Isle of Man

The Abortion Reform Act 2019 sets out the criteria for abortion on the Isle of Man.

Abortion can be provided:

- during the first 14 weeks of the gestation period upon request by or on behalf of a woman;
- from the beginning of the 15th week and end of the 23rd week of the gestation period, upon request by or on behalf of a woman if the registered medical practitioner is of the opinion, formed in good faith, that one or more of the following applies:
 - the continuation of the pregnancy would pose a substantial risk of serious injury to the woman’s life or health.
 - there is a substantial risk that the foetus is or will be affected by a significant physical or mental impairment which
 - (a) will have a seriously debilitating effect on the child; or (b) will result in the death of the fetus in the womb.
 - if, according to the woman, the pregnancy resulted from rape, incest or other unlawful intercourse.
 - if, according to the woman, there are serious social grounds justifying the termination of the pregnancy.

- from the start of the 24th week of the gestation period abortion services may be provided upon request by, or on behalf of, a woman if the registered medical practitioner is of the opinion, formed in good faith, and after taking such specialist medical advice as appears to the practitioner to be appropriate, that –
 - the termination is necessary to prevent grave long-term injury to her health;
 - the continuance of the pregnancy would involve risk to her life, greater than if the pregnancy were terminated;
 - there is a substantial risk that because of its physical or mental condition the fetus would die before or during labour;
 - there is a substantial risk that, were the child born alive, –
 - (i) the child would die shortly after birth because of severe fetal developmental impairment; or
 - (ii) the child would suffer a serious impairment which is likely to limit both the length and quality of the child's life.

The law also sets out counselling provisions, a right to conscientious objection (except where abortion is necessary to save the life of, or prevent grave permanent injury to, a pregnant woman), and other conditions regarding who can perform an abortion, where abortions can be carried out, and prohibited conduct in access zones outside abortion services.

3. Consent and confidentiality

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.

Guidance from the RCOG on the care of women seeking abortion recommends that services have processes in place to identify coercion or issues which make women particularly vulnerable, including child protection needs and domestic abuse/genderbased violence. Services should also refer to and signpost appropriate support services in a timely manner.⁵³ The joint NICE (National Institute of Health and Care Excellence) and RCOG guideline also signposts consent and safeguarding requirements to make decisions.⁵⁴

3.1.2 Adults lacking capacity

Under the Mental Capacity Act 2005 (England and Wales), a person is regarded as lacking capacity to make a decision if, as a result of an impairment of, or a disturbance in the functioning of the mind or brain, they are unable to:

- a) understand the information relevant to the decision;
- b) retain the information relevant to the decision;
- c) use or weigh the information; and
- d) 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. Case law has emphasised that the inability to make a decision must be a result of the impairment or disturbance in the functioning of the mind or brain.

Where an adult is deemed to lack capacity, decision making on their behalf is governed by the Mental Capacity 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 was enacted in 2016, however timescales for the implementation of the Act are unclear.)

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 seeking 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 discussion, as appropriate, 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.⁵⁵ However, in cases of doubt, it would be advisable to seek further clinical advice. 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 (England, Scotland and Wales) have not been followed; or
- where there are other exceptional circumstances, for example, the pregnancy is the patient's last opportunity to conceive.⁵⁶

The need for abortion to be considered in respect of a woman who lacks capacity, and who lacked such capacity at the time of conception, 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.⁵⁷ 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 best interests and mental capacity, including an interactive assessment tool, can be found online on the BMA website.⁵⁸

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 v West Norfolk & Wisbech Area Health Authority*.⁵⁹ In the later case of *R (Axon) v Secretary of State for Health*, the Court of Appeal (England and Wales) confirmed that the principles in *Gillick* will apply to decisions about treatment and care for sexually transmitted infections, contraception and abortion. The precedent set by both cases has since been translated into GMC guidance.⁶⁰

The law is clear that a parent's refusal to give consent for a termination cannot override the consent of a competent young person.⁶¹



The BMA sometimes 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.⁶²

In 2004, the DHSC published more detailed guidance on the provision of advice and treatment for matters of sexual and reproductive health for under-16s.⁶³

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, e.g. *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; and
- 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.⁶⁴ Where a woman does not wish 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 an abortion have a right to expect that doctors will not disclose personal health information to a third party without consent. Women seeking termination may be particularly concerned about confidentiality, and doctors should be sensitive to this.

The NICE (National Institute of Health and Care Excellence) and Royal College of Obstetricians and Gynaecologists (RCOG) guideline recommends that:⁶⁵

“1.1.18 Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the abortion might be shared with healthcare professionals not directly involved in their care.”



Due to the sensitive nature of abortion, doctors will sometimes receive requests from patients to remove information about abortion 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. However, if 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 serious 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.⁶⁶

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 cases of *Gillick* and *Axon*, and outlined in GMC guidance, which states that when providing contraceptive, abortion and STI advice and treatment “You should keep consultations confidential even if you decide not to provide advice or treatment...other than in ...exceptional circumstances”.⁶⁷ For example, exceptional circumstances “where there is an overriding public interest in the disclosure; when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure; or when disclosure is required by law.”⁶⁸

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 issues related to sexual and reproductive health, with potentially 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 children’s 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.⁶⁹

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 being someone known to the police or child protection agencies as having had abusive relationships with children or young people.⁷⁰

In such cases, the patient should be told as soon as possible 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 (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.

Under the Act, doctors are, therefore, 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 Offences (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.

For further information about this guidance, BMA members may contact:

Tel: **0300 123 1233**

Email: ethics@bma.org.uk

Non-members may contact the BMA by phone or e-mail:

Tel: **0300 123 1233**

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