BMA

Decriminalisation of abortion: a discussion paper from the BMA

February 2017

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Thanks are due to members of BMA committees and BMA staff for providing information and comments.

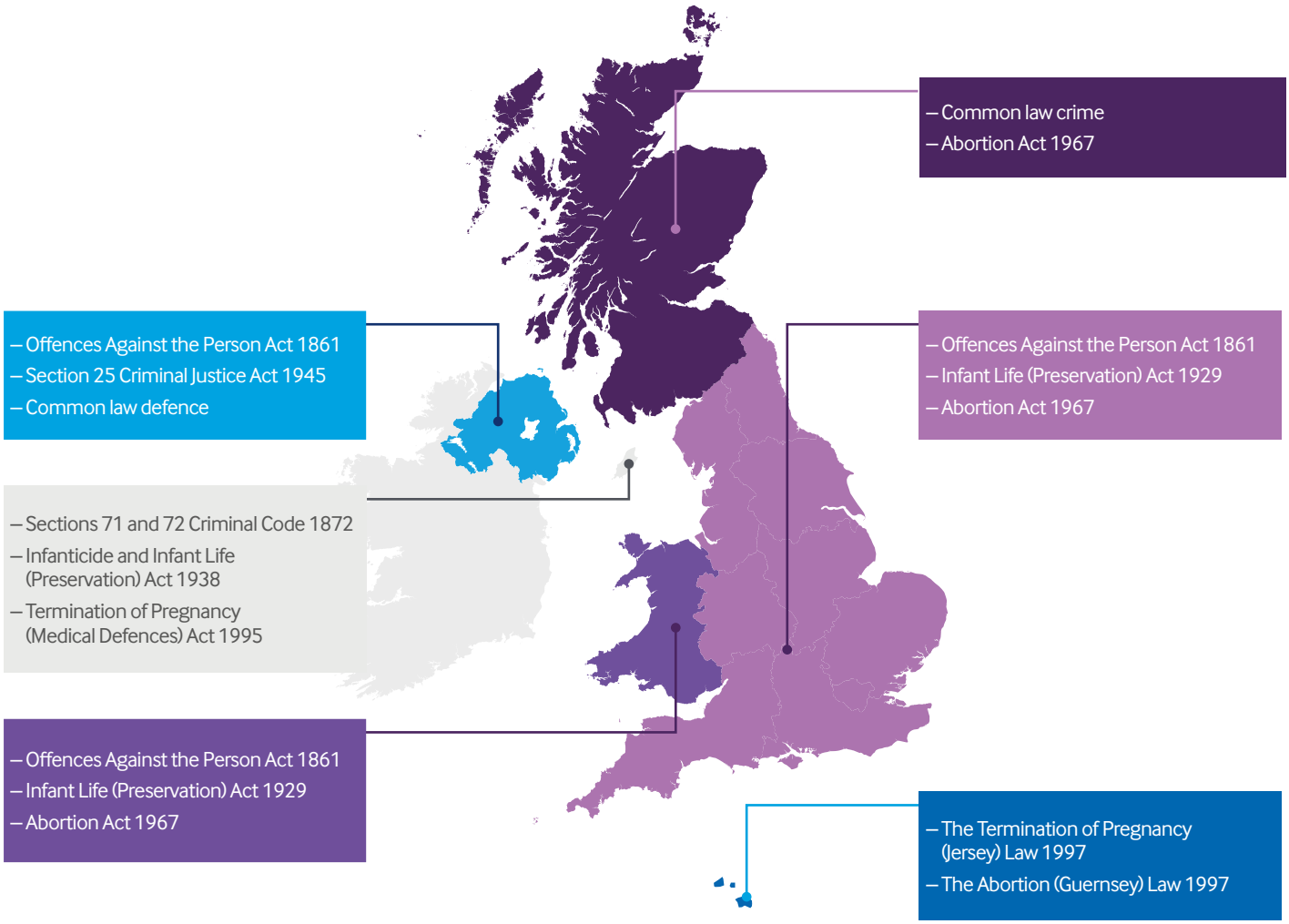
Executive summary

- This year marks 50 years since the enactment of the Abortion Act and there will undoubtedly be reflection on whether current abortion legislation is fit for purpose. It is likely that 'decriminalisation' of abortion will feature in that debate.

- There is no single interpretation of what decriminalisation of abortion would mean in practice and it can be understood in a number of different ways. A range of options is discussed in more detail in this paper; for example, it can mean:

  - *complete/total decriminalisation*: the complete removal of abortion from criminal law
  - *decriminalisation and selective recriminalisation*: the complete removal of abortion from current criminal law and the creation of new criminal offences for a specified set of circumstances relating to abortion
  - *selective decriminalisation:* repealing some and/or amending some or all of the existing criminal law relating to abortion.

Map of the law on abortion



- The BMA currently does not have policy on the decriminalisation of abortion, and this paper does not include recommendations about whether, and if so how, abortion should be decriminalised. Instead, a number of arguments, put forward by others, in favour of and against decriminalisation are set out in part two of the paper. These invite the question – what role, if any, should the criminal law play in setting parameters for the provision and administration of abortion? Would some form of decriminalisation be better than the current legislative framework?

- The current law around abortion is set out in detail in part one of the paper. In summary, induced abortion is a crime throughout the British Isles. There are, however, a range of exceptions to the crime laid out in statute and/or common law.[a]

- Abortion is governed by core statute and common law but is also subject to further specific regulation and professional and clinical standards. In addition, the professional standards, regulation, criminal and civil law that apply to other aspects of clinical care also apply to abortion – for example, the law relating to informed consent and the professional standards set by the GMC (General Medical Council) to support patients and treat them as individuals, respecting their dignity and privacy.

- There have been several criminal prosecutions in recent years relating to abortion. In addition, there have been a number of cases where women have purposefully exposed themselves to the risk of prosecution, or where individuals have deliberately, and unsuccessfully, sought prosecutions of doctors who authorise or carry out abortions. Cases have included:

  - individuals who have illegally supplied abortifacients[b]
  - women who have procured and self-administered abortifacients
  - individuals who have procured abortifacients on behalf of others
  - individuals who have maliciously and covertly tried to procure an abortion or administer an abortifacient; and
  - doctors who have been challenged for their involvement in the provision of abortions they deemed to be lawful.

- Where the Abortion Act 1967 is in place (England, Wales and Scotland), the rate and number of lawful abortions performed overall has remained relatively constant over recent years. What has changed is the increase in the proportion of abortions that are being undertaken earlier on in a pregnancy, and the significant increase in the proportion of total abortions that are being carried out medically, as opposed to surgically.

- In Northern Ireland, where the Abortion Act does not apply but the common law permits abortion in some circumstances, the official number of lawful abortions performed has decreased, but there is a suggestion that the number of unlawful abortions has increased due to the availability of abortifacients online.

- Whatever one's view about the principle of the decriminalisation of abortion, there are some issues on which there appears to be broad consensus. For example:

  - the need for a woman's informed consent[c] to an abortion, or a best interests assessment where a woman lacks capacity
  - the right to conscientious objection by healthcare workers
  - the collection of abortion data
  - the need for clarity about what is and what is not lawfully permitted

a The law can be in the form of statute and common (judge-made) law. In the latter, judges note the precedents in previous cases and rules are extracted from those decisions.
b An abortifacient is an agent that causes abortion.
c A woman's consent will be valid when she has capacity, is adequately informed and voluntarily agrees to treatment, examination or another aspect of healthcare.

  - the need for robust clinical governance in settings where abortion care is provided; and
  - the continued regulation of, and the setting of professional standards in, the provision of abortion services.

- In considering the question of the role of the criminal law in abortion, the following questions may be helpful to focus debate.

  - In what, if any, circumstances should women who self-administer an abortion be subject to criminal sanctions?
  - How should the criminal law and the prosecution services respond to the increasing number of women who are acquiring abortifacients online? If there are to be criminal sanctions, should these apply to both women themselves and suppliers of the abortifacients?
  - In what, if any, circumstances should health professionals who participate in the provision of abortion be subject to criminal sanctions?
  - Should the point of viability be treated as significant in determining whether criminal sanctions should apply in some cases of abortion?

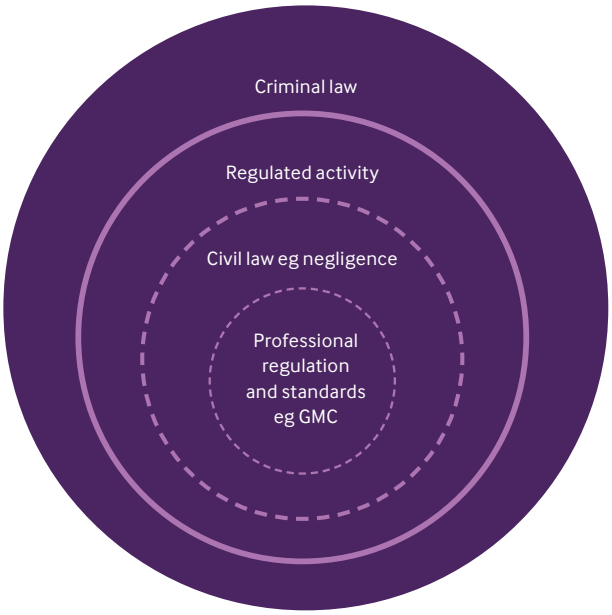
Contents

Introduction

Induced abortion is generally a crime in the UK, although there are a range of detailed circumstances set out in statute and case law where no crime is committed. Any doctor operating within those defined circumstances can lawfully carry out an abortion as a clinical procedure. Outside these defined circumstances, the criminal offences potentially apply both to those who participate in carrying out abortions for others, including doctors, nurses and midwives; and to women who carry out abortions on themselves.

Over recent times, calls to take abortion out of the criminal law – to 'decriminalise' abortion – have gathered momentum. Those calls may have been prompted, at least in part, by recent criminal prosecutions of women under the Offences Against the Person Act 1861.

Decriminalisation could mean several different things in practice, and it is, usually but not inevitably, proposed in conjunction with a broader reform of abortion legislation and changes to its current availability. At a very basic level decriminalisation involves changing the default position so that instead of abortion being a crime for which there are some circumstances in which abortion is lawful, abortion would be lawful with some limited exceptions, such as where the procedure is undertaken on a woman who has capacity without her consent. Removing criminal sanctions need not mean an absence of regulation; limits could still be set, but subject to professional and regulatory, rather than criminal, sanctions for doctors for example. This paper seeks to identify the options and to discuss the benefits and detriments of different legal models relating to abortion.



Parameters to the provision of abortion

This year marks 50 years since the enactment of the Abortion Act for England, Scotland and Wales (passed on 27 October 1967). This will inevitably raise the profile of this issue and increase debate both in the public and professional arenas about whether the current abortion legislation is fit for purpose.

The BMA believes it is important to keep legislation and public policy under review but also believes that there is a responsibility amongst policy-makers, health professionals and the media to base discussion and debate on factual information where available. Such information is often difficult to find. The aim of this paper is to provide a guide to some of the key legal and ethical issues raised by the debate around the decriminalisation of abortion for BMA members, policy-makers and the wider public, in order to facilitate good quality, informed debate about the issue.

The paper does not go into substantial detail about what, and how, legislation would need to be changed UK-wide, or individually for the four nations, to decriminalise abortion or even whether it is politically achievable in all or any of the four nations. This is potentially complex and beyond the scope of the paper. Instead, the intention is to establish what the principles, aims and intentions of any moves to decriminalise abortion might be – what role, if any, the criminal law should play in setting parameters for the provision and administration of abortion.

What is abortion?

There can be different definitions of the term 'abortion' but for the purposes of this paper, the term abortion refers to the intentional termination of an established pregnancy at any stage of that pregnancy. It does not include the use of emergency hormonal contraception which the High Court has confirmed is not an abortifacient.[1]

The BMA's policy on abortion

The BMA does not have policy on the decriminalisation of abortion. This paper does not include recommendations about whether, and if so how, abortion should be decriminalised; it aims simply to inform debate.

Nevertheless, it is important to recognise that the BMA does not start off from a neutral position in the abortion debate. Although representing members with a wide range of views on abortion, the BMA has clear democratic and representative mechanisms for formally establishing policy on such issues, through its RB (representative body). Through these procedures, the BMA has repeatedly, since the 1970s, agreed policy statements supporting the Abortion Act as a 'practical and humane piece of legislation' and supporting the extension of legislation, including its protections of conscientious objection for healthcare workers, to Northern Ireland. BMA policy also supports making abortion available on the same basis of informed consent as other treatments in the first trimester of pregnancy, removing both the need for women to meet specified medical criteria, and the need for two doctors to approve an abortion under the Abortion Act. A more detailed outline of the BMA's policy on other aspects of abortion legislation and policy can be found in the BMA publication *The Law and Ethics of Abortion: BMA Views*, which is available on the BMA website at www.bma.org.uk/ethics.

Part one – background to the debate

What makes abortion a crime?

The Abortion Act 1967 provides exceptions to the crime of administering or procuring an abortion in England, Wales and Scotland. In addition, the common law provides a defence in limited circumstances (as set out on pages 13-14). That defence applies throughout the United Kingdom but is most relevant in Northern Ireland where the Abortion Act 1967 does not apply.[d]

Abortion remains a statutory crime in England, Wales and Northern Ireland, and a common law crime in Scotland. (The main focus of this paper is abortion in the UK; however, the BMA also represents doctors in the Channel Islands and Isle of Man. Many of the principles and arguments will apply equally to those islands. An outline of the abortion laws for the Channel Islands and Isle of Man can be found at Annex A.)

Offences Against the Person Act 1861 (England, Wales and Northern Ireland)

Under the Offences Against the Person Act 1861 (the 1861 Act), 'unlawful' abortion is a crime in England, Wales and Northern Ireland. The 1861 Act codified the previous common law position that made abortion a crime. The Act states:[3]

> *'58 Administering drugs or using instruments to procure abortion.*
> *Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to imprisonment.*
>
> *'59 Procuring drugs, &c. to cause abortion.*
> *Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor, and being convicted thereof shall be liable to imprisonment for a term not exceeding five years.'*

In recent years, there have been several cases where individuals have been referred to the police under section 58 or 59 of the 1861 Act, with some going on to be successfully prosecuted – see pages 16-18 for a range of cases. (The Law Commission reported to the Government on its review[4] on reforming the 1861 Act in November 2015, but it chose to exclude sections 58 and 59 from the review.[e])

d The circumstances for lawful abortion are sometimes described as 'exceptions' or 'defences'.[2] However, there are no 'statutory defences' to charges under the Offences Against the Person Act 1861 (see page 10) in the same way as 'self-defence' is a potential defence to a charge of violence. In every abortion case, the prosecution needs to prove all the elements of a crime in every criminal case beyond reasonable doubt – to prove beyond reasonable doubt that the facts of the case fall outside those set out in the Abortion Act 1967 (where it applies) (see page 12). If the prosecution fails to prove this, a defendant is entitled to be acquitted. The prosecution also needs to provide evidence to prove that the abortion was carried out 'unlawfully' as that term was defined in *R v Bourne* (UK-wide) (see page 13). There is no onus on the defendant to 'prove' his or her defence or prove that an exception applies. The onus remains on the prosecution to prove that an offence was committed. Accordingly, a doctor is not required to prove that he or she was operating within the scope of the Abortion Act 1967 to establish a defence to a criminal charge in an abortion case.

e The scoping consultation paper for the review noted 'They [bigamy, attempted abortion and concealing birth] are not included in the 1998 draft Bill or in previous Law Commission projects on offences against the person, and raise issues going well beyond the law of offences against the person.' (2.231). *Reform of Offences against the Person: a Scoping Consultation Paper,* (2014) Law Commission Consultation Paper No 217.

Infant Life (Preservation) Act 1929 (England and Wales) and Criminal Justice (Northern Ireland) Act 1945

In addition to the Offences Against the Person Act 1861, section 1 of the Infant Life (Preservation) Act 1929 (England and Wales) and section 25 of the Criminal Justice (Northern Ireland) Act 1945 state:

> *'Punishment for child destruction*
> *'1) Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life:*
>
> *'Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.*
>
> *'(2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive.'*

Police-recorded crime data in England and Wales, for the year ending March 2016, show seven cases of 'intentional destruction of viable unborn child' and seven of 'procuring illegal abortion'.[5] In Northern Ireland, the data for 2014/15 show no cases of 'intentional destruction of viable unborn child' and three of 'procuring illegal abortion'.[6] No more detail is available on these cases. It is not clear from the data, for example, in the cases of 'intentional destruction of viable unborn child', how many of these were cases of abortion and how many were cases of general assaults on women resulting in the death of a fetus she was carrying.

Common law: Scotland

In Scotland, abortion is a crime under common law, however, the criminal law is more focused than the other nations on the intention behind an act. Abortion is a crime if there is 'wicked intent'. Professor Kenneth Norrie, a Scottish legal commentator, notes:

> *'Scots criminal law has a quite different theoretical foundation to English criminal law, being based primarily on the wickedness of the accused's intent and so was able to recognise much more easily than English law that a doctor performing an abortion for therapeutic reasons does not have wicked and felonious intent, and is therefore not acting criminally...'*[7]

There are few criminal cases relating to abortion in Scotland. There is not, therefore, absolute clarity as to what would be considered 'wicked and felonious intent'. For example, it is not clear whether it would be considered criminal nowadays if a doctor provided an abortion, for therapeutic reasons, in a health facility not fulfilling all of the procedural requirements under the Abortion Act 1967, or a woman self-administered an early medical abortion following an online medical assessment.

Most criminal cases pre-date the 20th century, with penalties including banishment from the UK.[8] One more recent case, from 1967, concerns a doctor who pleaded guilty to performing an abortion in a patient's home. The fact that the abortion was performed in the home may have been relevant in considering whether he was acting as a reputable medical man at that time.[9]

The Abortion Act 1967 (see section below) sets out explicit grounds and processes for 'lawful' abortion. Many commentators note that the 1967 Act is more restrictive than what would have been considered 'lawful' abortion under previous Scottish common law.[10] For example, it has been suggested that it is unlikely that the *Bourne* case (see page 13) would have found its way to the Scottish Courts.

Any moves to decriminalise abortion in Scotland would not, therefore, involve repealing any statute, but would, instead require enacting new law clarifying that abortion is not a crime.[11]

Police-recorded crime data for Scotland place abortion under 'other' within the category 'crimes of violence'.[12] It is, therefore, not possible to establish if there have been any reports to the police.

'Lawful' abortion

The Abortion Act 1967: England, Scotland and Wales

The Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) provides that abortions carried out in accordance with the conditions in that Act will not be criminal offences under the Offences Against the Person Act 1861, the Infant Life (Preservation) Act 1929, and common law. It is suggested, therefore, that the Abortion Act 1967 creates a state of 'partial decriminalisation' based on a medical model.[13]

The 1967 Act permits the termination of a pregnancy up to 24 weeks' gestation where two doctors are of the opinion, formed in good faith 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.'*

The 1990 amendments to the Act removed pre-existing links with the Infant Life (Preservation) Act 1929 ensuring that:

> *'No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act [the Abortion Act].'*

As a result, a pregnancy may lawfully be terminated up to birth where two doctors are of the opinion, formed in good faith that:

> *'the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or*
>
> *'the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or*
>
> *'there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.'*

In all circumstances except where termination is immediately necessary to save the life of the pregnant woman, the law requires that agreement is obtained from two doctors and that the abortion takes place on approved premises.

The Act also provides healthcare professionals with a statutory right of conscientious objection, which allows them to withdraw from participating in termination of pregnancy except in circumstances where the abortion is necessary to preserve the woman's life or prevent grave permanent injury.[14]

Common law: primarily relevant to Northern Ireland

The Abortion Act 1967 does not extend to Northern Ireland. Doctors in Northern Ireland must use the clarification provided by previous case law, as reflected in official guidance, to interpret whether a particular abortion can lawfully be provided. Doctors in the rest of the UK who are involved in abortions in circumstances outside those set out in the Abortion Act 1967 are in the same position.

There is legal uncertainty around the precise circumstances in which abortion is lawful in Northern Ireland, and no statutory right for healthcare professionals to conscientiously object to involvement in abortion where it has been deemed lawful.

One of the key cases in interpreting the law is the 1930s *Bourne case,* where a London gynaecologist was found not guilty of an offence under the Offences Against the Person Act 1861 for performing an abortion on a 14-year-old girl who was pregnant as the result of rape.[15] It was held that the Infant Life (Preservation) Act 1929 gave protection from prosecution if the abortion 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'.

Various cases have since confirmed that abortion is lawful in Northern Ireland in some circumstances, notably where a doctor genuinely believes that the pregnant woman would probably suffer serious long-term harm to her physical and mental health if an abortion was not carried out.[16] 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."*[17]

Despite this, there is continuing legal uncertainty over the precise circumstances in which abortion is lawful, in Northern Ireland and in the rest of the UK when carried out outside of the circumstances set out in the Abortion Act 1967. This has been the subject of judicial review in Northern Ireland over the years. A successful High Court appeal by the FPA (Family Planning Association) in October 2004[18] required the DHSSPS (Department for Health, Social Services and Public Safety) to produce clear guidance for women and doctors on the circumstances in which abortion is permissible. After a lengthy process, including two more Judicial Reviews,[19, 20] in 2016 the DHSSPS produced *Guidance for health and social care professionals on termination of pregnancy in Northern Ireland* (2016).[21]

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 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.[22] 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.[f]

f This case was taken by the Northern Ireland Government to the Court of Appeal in Northern Ireland in June 2016. At the time of writing, the judgment had not yet been handed down but, whatever the outcome, a further appeal to the Supreme Court is a possibility.

Subsequently, at the end of 2016, the former Northern Ireland Minister for Justice, David Ford, introduced a private member's bill to make abortion lawful on the grounds of FFA. The *Abortion (Fatal Foetal Abnormality) Bill*, as introduced, included conscientious objection provisions.[g] As a consequence of the Northern Ireland Assembly being dissolved in early 2017, however, the Bill fell. David Ford pledged to submit the Bill again if re-elected.

A devolved issue?

The earlier outline of what makes abortion a crime and when an abortion is 'lawful' has already highlighted the legal differences between the four nations of the UK. Any future changes to abortion legislation may be further complicated by the different devolution settlement models and whether all aspects of abortion legislation fall under devolved powers, which will in turn depend on whether abortion is considered to be a health, criminal justice and/or human rights issue. From a human rights perspective, all (at present) are required to pass legislation which is compatible with the European Convention on Human Rights (ECHR),[h] although it is the UK Government that is the signatory to the Convention, not the individual nations.

Criminal justice is devolved in Northern Ireland and Scotland, which means that any repeal of, or amendment to, the criminal law regarding abortion could not be effected by the UK Government in those nations.

Health is a devolved issue in all nations, however, abortion is cited as an exception under devolved 'health' powers in Wales under the Government of Wales Act 2006. The UK Government therefore currently remains responsible for Welsh abortion legislation.[23] Scotland repealed a similar exception under 'health' in March 2016 when the Scottish parliament obtained powers over abortion legislation in Scotland, through section 53 of the Scotland Act 2016.[24]

In Northern Ireland, health and criminal justice are both devolved issues, but in April 2016 a group of UK Government shadow ministers wrote to Westminster's joint committee on human rights arguing that abortion is a human rights issue and is not, therefore, a devolved matter.[25] If so, the UK Government may potentially have a role in ensuring individual nations' compliance with the ECHR. In addition to this debate, there are ongoing challenges to Northern Ireland's abortion legislation on a human rights basis from within Northern Ireland and externally.[26]

In addition to the core legislation affecting abortion, there is more general legislation, regulation, and professional standards, and specific clinical guidelines, that vary in their application to the UK as a whole or separately to an individual nation or nations (see the section below on the regulation of abortion).

g The Bill can be found on the Northern Ireland Assembly website at www.niassembly.gov.uk/assembly-business/legislation/2016-2017-mandate/non-executive-bill-proposals/abortion-ffa/ (Accessed 19 January 2017).

h For example, the Northern Ireland Act 1998 notes under section 6 that 'A provision of an Act is not law if it is outside the legislative competence of the Assembly... A provision is outside that competence if any of the following paragraphs apply... it is incompatible with any of the Convention rights'.

	Health	Criminal justice	Human rights (the UK is the signatory to the ECHR and other human rights instruments)	Regulation of health professionals
Northern Ireland	Devolved	Devolved	Mixed	Reserved
Scotland	Devolved	Devolved	Mixed	Reserved
Wales	Devolved/ Defined (Welsh Assembly can legislate on health, but abortion is an exception)[i]	Not a defined power (UK Government retains powers)	Mixed	Not defined

Even if the UK Government continues to be responsible for some aspects of the law that may affect abortion, it is anticipated that the UK Government would be reticent to use its powers in relation to abortion in the devolved nations.

The precise details of what, and how, legislation would need to be changed UK-wide or individually for the four nations to decriminalise abortion are, however, beyond the scope of this paper. Instead, the intention of this paper is to establish what the principles, aims and intentions of any moves to decriminalise abortion might be.

The regulation of lawful abortion

Where an abortion is lawfully carried out as a clinical procedure, it is subject to further regulation and standards. For example, abortion provision is regulated by:

– The Abortion Regulations 1991 (England and Wales);[27] The Abortion (Amendment) (England) Regulations 2002;[28] The Abortion (Amendment) (England) Regulations 2008;[29] The Abortion (Amendment) (Wales) Regulations 2002;[30] The Abortion (Amendment) (Wales) Regulations 2008;[31] and The Abortion (Scotland) Regulations 1991,[32] which set out conditions for the central reporting and analysis of abortion data

– Care Quality Commission (Registration) Regulations 2009: Regulation 20 (England),[33] which sets out the regulation that applies to registered persons who carry on or manage the regulated activity of termination of pregnancies and are not an English NHS body. For example, independent healthcare clinics must be registered with the CQC (Care Quality Commission) to carry out abortions (they must also be approved by the Secretary of State for Health to perform abortions under s1(3) of the Abortion Act 1967)

– The Health and Social Care Act 2008 (Regulated Activities) (England) Regulations 2010, Sch 1 para 12,[34] that lists abortion as a regulated activity.

Further direction is outlined in governmental guidance:

– *Guidance in relation to requirements of the Abortion Act 1967: For all those responsible for commissioning, providing and managing service provision.* Department of Health (England) (2014)[35]

– *Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion).* Department of Health (England) (2014)[36]

i At the time of writing the Government of Wales Bill 2016-17 was progressing through Parliament. The Bill could change the devolution model for Wales from a 'defined' powers model of devolution, to a 'reserved' powers model similar to that of Northern Ireland and Scotland. The progression of the Bill can be found at http://services.parliament.uk/bills/2016-17/wales.html (Accessed 19 January 2017).

– *A Framework for Sexual Health Improvement in England.* Department of Health (England) (2013)[37]

– *Guidance for health and social care professionals on termination of pregnancy in Northern Ireland.* Department of Health, Social Services and Public Safety (Northern Ireland) (2016).[38]

Individual healthcare professionals administering and caring for women seeking or undergoing abortion will also be subject to general and specific professional and clinical standards. For example, the GMC's *Good Medical Practice,*[39] and the RCOG's (Royal College of Obstetricians and Gynaecologists) clinical guidelines *The Care of Women Requesting Induced Abortion* (2011).[40] The usual rules governing clinical practice also apply, for example:

– ensuring women receive timely, good quality information about implications and the options open to them to enable informed consent
– supporting and treating women as individuals, respecting their dignity and privacy
– following the correct decision-making process when a patient lacks capacity; and
– acting within competency.

The civil and criminal law that applies to other aspects of clinical care also applies to abortion – for example, the law relating to:

– medical negligence and gross negligence manslaughter
– wilful neglect or ill-treatment[41]
– assault.

Prosecutions in the UK

There have been a number of prosecutions in recent years relating to the unlawful procuring or administration of abortion (primarily under the Offences Against the Person Act). For completeness all recent available cases are cited below.

Individuals illegally supplying abortifacients

– *Gurpreet Kaur and Surinder Khurana* (2015): A 51-year-old woman, Gurpreet Kaur, was sentenced to 27 months in prison for supplying abortifacients to clients of the Rana Ayurvedic Centre in West London. Surinder Khurana absconded and never appeared before court. Police were alerted to the pair in late 2012-early 2013 when a number of women attended Ealing Hospital with complications arising from attempting to procure abortions.[42,43]

– *Dmitirij Selkov* (2015): A 29-year-old man was sentenced, at Southwark Crown Court, to 12 months in prison, suspended for two years, and ordered to pay a £1,000 fine for his involvement in the sale and supply of counterfeit medicines and the illegal supply of prescription-only medicines contrary to Section 9(1) of the Fraud Act 2006. Amongst other things, he supplied counterfeit versions of erectile dysfunction medications, such as Viagra, and the abortifacient misoprostol.[44, 45]

Women self-administering abortifacients

– *Women prosecuted* (2016): A woman in south Belfast was given a three-month jail sentence, suspended for 12 months, after admitting buying abortifacients online and then self-administering them in the first trimester of her pregnancy.[46] Her two housemates became aware of the fetal remains in the bin and a week later reported her to the police. The case has generated much debate. Precious Life believes the sentence is too lenient, whereas Amnesty International has argued that women should not be criminalised and has called the conviction 'appalling'.[47]

  In October 2016, it was reported that another woman was reported to the police and charged with self-administering abortifacients after she sought medical help.[48] If true, this may be because of Section 5 of the Criminal Law Act (Northern Ireland) 1967 which places a legal duty, unique to Northern Ireland, on everyone to report to the police information they may have about the commission of a relevant offence (ie 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. The recent Northern Ireland DHSSPS guidance on abortion states, however, 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.'*[49]

– *Natalie Towers* (2015): A 24-year-old woman from County Durham pleaded guilty and was sentenced, at Newcastle Crown Court, to two-and-a-half years in prison for unlawfully procuring her own miscarriage at 32-34 weeks' gestation.[50] She had bought abortifacients online. Her barrister reported that she had been suffering from a depressive episode at the time and was emotionally unstable.[51]

– *Sarah Catt* (2012): A 35-year-old North Yorkshire woman, Sarah Catt, was over 38 weeks' pregnant when she took misoprostol purchased over the internet. She had sought an abortion some weeks earlier from the BPAS (British Pregnancy Advisory Service) but had been informed that she was over the legal time limit for an abortion in her circumstances. She stated that she had acted alone, burying the body and refusing to disclose its location. She pleaded guilty to procuring her own miscarriage under the Offences Against the Person Act 1861 and was sentenced to eight years' imprisonment.[52]

  The first judge in the case noted that she could instead have been prosecuted under section 1 of the Infant Life (Preservation) Act 1929 for destruction of a child capable of being born alive. He went on to say 'Section 1(2) of that Act provides a presumption in law that if a woman is pregnant for 28 weeks, the child *en ventre sa mere* [in the womb] is capable of being born alive.'[53]

  In a subsequent appeal hearing, Sarah Catt's sentence was reduced from eight to three-and-a-half years.[54] The appeal judge, Lady Justice Rafferty, noted that the initial judge had declined to adjourn for the preparation of a psychologist's report. A post-sentence psychologist report concluded that Sarah Catt had a 'maladaptive coping style', lacked maturity in relation to emotional demand, and during five pregnancies had either concealed the pregnancy or presented too late for termination.

Individuals purchasing abortifacients on behalf of others

– *Mother prosecuted* (2016): A mother who bought abortifacients for her under age teenage daughter is due to stand trial at Belfast Crown Court. A judicial review of the decision to prosecute was subsequently granted.[55]

Individuals covertly procuring or administering abortifacients

– *Ajaz Ahmed* (2010): A man was sentenced to four years' imprisonment for procuring an abortion, but the conviction was subsequently quashed as the circumstances did not meet the terms of section 59 of the Offences Against the Person Act. Ajaz Ahmed sought an abortion for his non-English speaking wife who was 16-17 weeks' pregnant. He misrepresented her wishes to healthcare professionals. She believed she was seeking a minor operation to cure something wrong with her blood. The misrepresentation came to light when an Urdu-speaking nurse intervened. She subsequently left her husband and had the child.[56]

– *Dr Edward Erin* (2009): The married respiratory consultant was sentenced to six years in prison, and struck off the medical register, for attempting to procure his lover's miscarriage without her knowledge. His sentence was subsequently extended by two years for perverting the course of justice. He wrote false prescriptions for drugs to procure a miscarriage. He ground the drugs up and hid them in drinks he gave to his pregnant lover. Despite his attempts to end the pregnancy, the woman went on to have the child.[57, 58]

Associated cases

There have been a number of recent cases where women have purposefully exposed themselves to the risk of prosecution, or where individuals have deliberately sought prosecution of doctors who refer for or perform abortions, including:

- **Women purposefully risking prosecution (2015-2016):** There have been a number of recent cases in Northern Ireland where women have purposefully risked prosecution. For example, in May 2016, three women (aged 71, 68 and 69) walked into a police station with a prepared statement saying they had taken delivery of abortion pills for women too afraid to have them delivered to their homes.[59] The women were questioned and then released pending a report to the Public Prosecution Service. In June 2016, with police monitoring events, a drone delivered abortion pills to women in County Down, which the women then proceeded to take.[60] This follows previous action, including the report that 215 women had written to the Public Prosecution Service in 2015 stating that they had taken or procured abortifacients in Northern Ireland.[61]

- **Sunday Times investigation (September 2014):** Criminal charges were dropped against a doctor for allegedly encouraging or assisting with either the unlawful administration or supply of misoprostol with intent to procure a miscarriage. The original charge related to an investigation by *The Sunday Times* newspaper involving an undercover journalist conducted in September 2012,[62, 63] a so-called 'fake Sheikh' case. In September 2016 the MPTS (Medical Practitioners Tribunal Servic)[64] found, however, that the doctor's fitness to practise was impaired by reason of his misconduct 'which involved a blatant disregard for the safeguards designed to protect members of the public'. His misconduct was fundamentally incompatible with continued registration. He was, therefore, struck off the medical register.

- **Telegraph sting (2012-present):** *The Daily Telegraph* carried out an undercover investigation, which allegedly showed three doctors arranging abortions solely on the basis of the gender of the fetus – the cases involved pregnancies at 8, 12, and 18 weeks' gestation. The investigation, subsequent media coverage and parliamentary debate highlighted a high level of misunderstanding of abortion legislation. The GMC, CQC and the police investigated the allegations. The doctors had conditions placed on their registrations by the GMC's interim orders panel.[65] In September 2013 the DPP (Director of Public Prosecutions) announced that no doctors would face prosecution.[66] Subsequently, there was an unsuccessful private prosecution against the doctors by an anti-abortion campaigner.[67, 68] In October 2015, the MPTS suspended one of the doctors for three months for falsely recording a reason for an abortion.[69] It has been reported that the legal case against the doctors and the issues it raised are being pursued in the European Court of Human Rights.[70]

- **Jepson case (2003-2005):** The Reverend Joanna Jepson sought a judicial review of the decision of the Chief Constable of West Mercia Constabulary not to pursue a prosecution of doctors who terminated a pregnancy at more than 24 weeks' gestation, where the grounds for the abortion had been cited as 'bilateral cleft lip and palate' in the annual publication of the abortion statistics.[71] After further investigation by the police, the CPS (Crown Prosecution Service) announced in March 2005 that the doctors involved would not face prosecution. The Chief Crown Prosecutor for West Mercia CPS said that the doctors had decided in good faith that a substantial risk existed that the child would be born with a serious fetal abnormality.[72] The RCOG published a Q&A on abortions for fetal abnormality during the passage of the Human Fertilisation and Embryology Act in 2008 that notes 'that cleft lip and/or palate are, in some cases, indicators of serious congenital malformations'.[73]

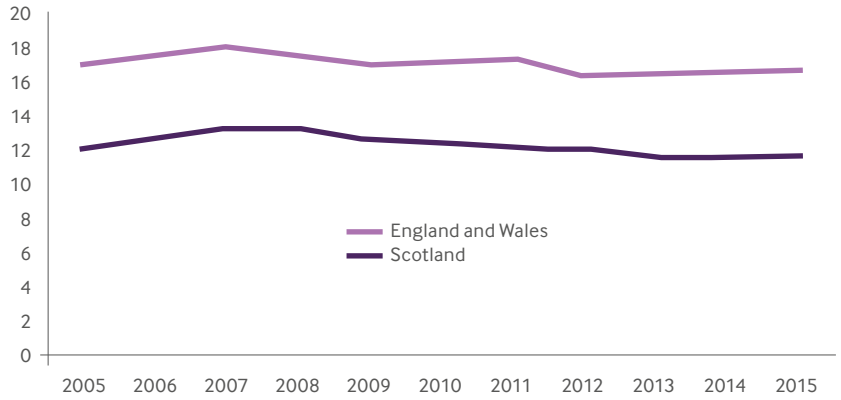
Abortion in the UK today

Statistics

The rate and number of abortions performed overall in the UK has remained relatively constant over recent years in England, Wales and Scotland, where the Abortion Act is in place. (The Abortion Act requires all abortions to be reported centrally. These data are then collated and annual abortion statistics are published.)

The most recent data from 2015 show that 185,824 abortions were carried out for women resident in England and Wales;[74] and 12,082 abortions were carried out in Scotland.[75] The abortion rate per 1,000 women aged 15 to 44 over the last 10 years can be found below:

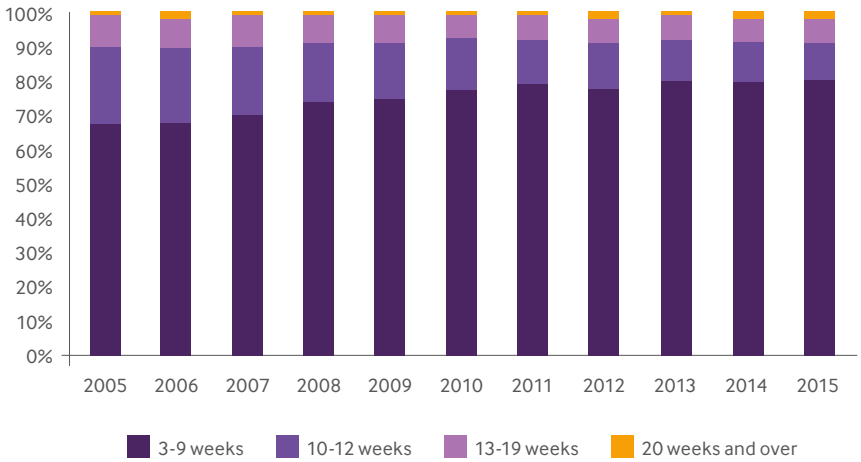
Abortion rate per 1,000 women of child bearing age 2005-2015



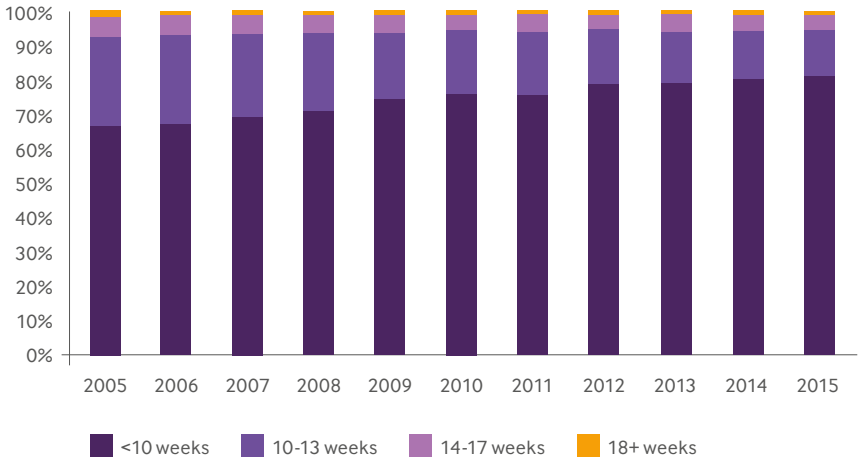
Over the last 10 years, there has been an increase in the proportion of abortions being undertaken earlier on in a pregnancy. For example, in 2015, in England and Wales, 92% of abortions were carried out at under 13 weeks' gestation, and 80% were at under 10 weeks; in Scotland, 94.7% of abortions were carried out at under 14 weeks' gestation and 72.5% were at under nine weeks. The proportion of abortions being undertaken at 24 weeks or over has remained relatively constant. In 2015, in England and Wales 0.1% (230) of the total number of abortions took place at 24 weeks or over, almost exclusively on the grounds of serious fetal abnormality.[76]

The data below show the percentage of abortions by gestation. Data are tabled separately for the nations due to the different parameters for collating the data.

Abortions by gestation weeks, residents of England and Wales, 2005-2015

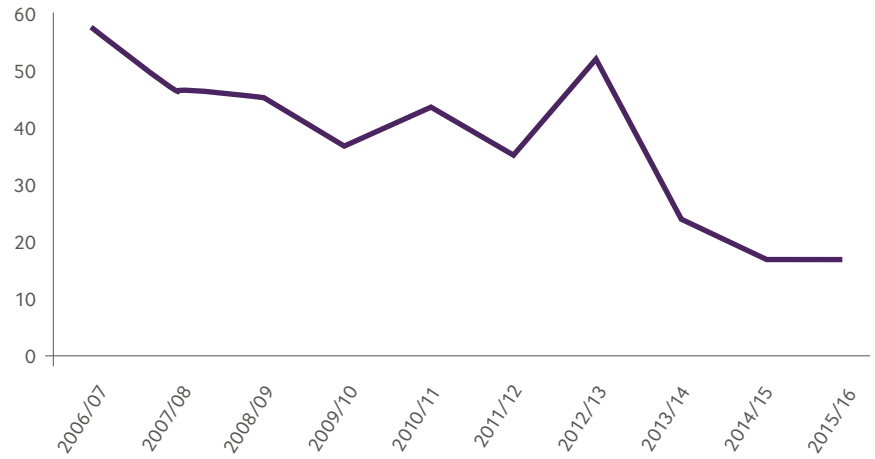


Abortions by gestation weeks, Scotland, 2005-2015



In Northern Ireland, where the Abortion Act does not apply but the common law permits abortion in some circumstances, the number of lawful abortions performed has decreased. Only 16 abortions were performed in Northern Ireland in 2015/16.

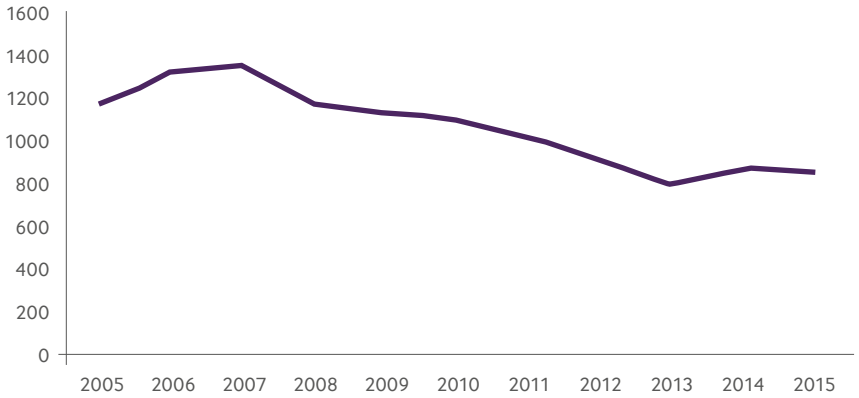
Numbers of lawful abortions in Northern Ireland 2005-2015[77]



It has been suggested that one of the reasons lawful abortions may have decreased is that some doctors are fearful of performing abortion due to uncertainties over the criminal law in Northern Ireland.[78]

Women from Northern Ireland are known to travel overseas for abortions, primarily to England. The number of women from Northern Ireland who are recorded as having travelled to England and Wales for an abortion has recently decreased.

Number of women giving country of residence as Northern Ireland who have sought abortions in England & Wales 2005-2015



For a number of reasons, these figures may be lower than the reality. There are, for example, anecdotal reports of women not giving Northern Ireland postcodes when accessing abortion services.

Women from Northern Ireland also travel to Scotland for abortions. During the years 2005-2015, 20 women from Northern Ireland are reported as undergoing abortions in Scotland, but as with England and Wales this figure may be lower than the reality.[79]

Meanwhile, although the overall number of lawful abortions appears to be decreasing for women from Northern Ireland, there is some suggestion that the true number of unlawful abortions may be increasing as more women seek medical abortions through online pharmacies and other suppliers.

A recent study in the BJOG (British Journal of Obstetrics and Gynecology)[80] shows that one online pro-choice organisation – WoW (*Women on the Web*) – has experienced a doubling in the number of women from the Republic of Ireland and Northern Ireland (the data are grouped) requesting medical abortion in the last five years. In 2015, 1,438 Irish women contacted WoW requesting a medical abortion.

Northern Ireland's DHSSPS recognises the possibility that women in Northern Ireland are purchasing abortifacients online in its recent guidance:

> *'6.5 Health and social care professionals may encounter women whom they suspect have used drugs purchased from the internet. The primary concern in such a situation, as with all matters of care, is to ensure that the woman is appropriately treated.*
>
> *'6.6 There are a number of websites which sell abortifacient drugs. Some use online or telephone based questionnaires to test whether the woman is an appropriate subject for the service offered; many do not. There is no guarantee that drugs supplied by these websites are what they are purported to be, and there is no effective medical supervision of any woman who decides to use them.*
>
> *'6.7 There is no way of determining the extent of the use of such services in Northern Ireland, however, it is likely that they are being used. Their use to secure a miscarriage in Northern Ireland is likely to be an offence under the Offences Against the Person Act 1861.*
>
> *'6.8 Unless the woman herself provides the information, a health professional is unlikely to be able to tell whether a miscarriage has occurred naturally or has been caused by abortifacient drugs and if it has been, whether the drugs were administered lawfully (in Great Britain, for example) or otherwise.'*[81]

More detailed data on abortion for all four nations can be found at Annex B.

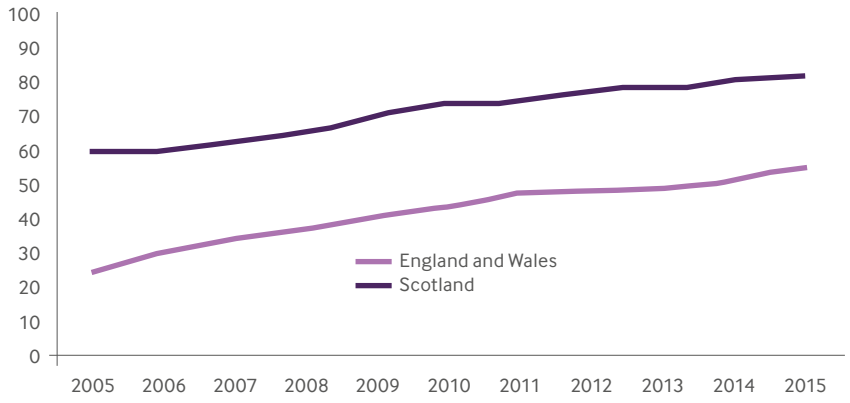
Medical abortion

In the UK, a medical abortion involves taking the prescription drugs mifepristone[j] and then later on (usually two days later) misoprostol. The misoprostol makes the womb expel the embryo/fetus, usually within four to six hours. As with other abortion, medical abortion is a safe procedure for which major complications and mortality are rare.[82] Both mifepristone and misoprostol are on the WHO's (World Health Organization) model list of essential medicines ('where permitted under national law and where culturally acceptable').[83]

Under the Abortion Act 1967 (England, Wales and Scotland) both sets of drugs must be administered in NHS or other approved premises, but women can go home after taking the second dose of drugs to complete the abortion, an option many women take.

One of the key changes in abortion provision in recent years has been the significant increase in the proportion of total abortions that are carried out medically with mifepristone and misoprostol, as opposed to surgically via one of a number of techniques (for example, vacuum aspiration and D&E (dilatation and evacuation)). In England and Wales the number of medical abortions has more than doubled in the last 10 years, accounting for 55% of total abortions in 2015. In Scotland there has also been a huge increase with 81.1% of the total number of abortions being carried out medically in 2015.

Percentage of abortions undertaken medically 2005-2015



The vast majority of abortions are performed in the first trimester of pregnancy. This enables more women to have a medical abortion, rather than a surgical abortion. For example, 63% of abortions under 10 weeks' gestation were carried out medically for residents of England and Wales in 2015 and 88.4% of abortions under nine weeks' gestation were carried out medically in Scotland. The RCOG guidelines recommend that women should be offered a choice of methods, medical or surgical, appropriate for the gestational age.

In addition to the increase in the proportion of lawful abortions being carried out medically, recent cases under the Offences Against the Person Act 1861 suggest that women are also increasingly seeking to unlawfully self-administer medical abortions (see page 21 for *BJOG* study). Mifepristone and misoprostol are prescription-only drugs and are, therefore, regulated; however, these drugs are readily available from overseas pro-choice organisations (some of which also provide an initial medical assessment and advice for women taking the drugs) and other online pharmacies. One journalist recently purchased 'abortifacients' online and had them tested at Queen's University in Belfast. It was reported that the drugs were capable of ending a pregnancy but were not licensed for use in the UK.[84]

j It was known during its clinical research phase as RU486.

Part two – decriminalisation

Calls to take abortion out of the criminal law – to decriminalise abortion – are not new but have gathered momentum in recent years. These calls have primarily focused on repealing or reforming sections 58 and 59 of the Offences Against the Person Act 1861 (see page 10). The basic principle underpinning many of the calls for decriminalisation is that 'where self-induced or requested by the pregnant woman, the destruction of an embryo or fetus would no longer form an independent ground for criminal sanction'.[85] While there are different interpretations of decriminalisation, fundamentally it is about changing the default position so that instead of abortion being a crime for which there are exceptions, abortion would be lawful with some exceptions.

The decriminalisation debate

The debate has gathered momentum due to a number of events, including:

- the RCM (Royal College of Midwives) calling for decriminalisation[86]
- the subsequent 'Not In Our Name' campaign[87] against the RCM position
- the 'We Trust Women' campaign[88] to decriminalise abortion, initiated by BPAS and supported by the RCM and the FPA (Family Planning Association), amongst others
- Amnesty International UK launching a petition to, amongst other things, 'Stop the criminalisation of women and girls who access abortion services' in Northern Ireland[89]
- the Abortion (Decriminalisation): Ten Minute Rule Motion, which seeks to 'bring in a bill to amend sections 58 and 59 of the Offences Against the Person Act 1861 to decriminalise consensual abortions; and for connected purposes.'[90] The Private Member's Bill is scheduled to be introduced in the Westminster Parliament in spring 2017.

The BMA has not, thus far, contributed to the debate as the BMA does not have policy on the decriminalisation of abortion.

What does 'decriminalisation' mean?

In order to have an informed debate about the decriminalisation of abortion it is important to be clear what decriminalisation might mean. Debate in the UK and reform in other countries illustrate that there can be different models of decriminalisation.

- **Complete/total decriminalisation.** Under this option abortion is removed, in full, from the criminal law. The fact that abortion is not a crime does not, however, mean that there can be no barriers or restrictions to access. There are different ways in which restrictions could be applied. In Canada, for example, although it is no longer a crime, there are both professional and health service restrictions applied to the availability of abortion (see page 32). In addition, legislation could establish a set of statutory duties relating to abortion. Failure to comply with the duties would constitute an issue for professional regulation rather than the criminal law.

  While under these models abortion itself would not be a criminal offence, some criminal offences related to abortion would still apply. For example, administering drugs to a woman with the intent to terminate her pregnancy, without her knowledge or consent, is likely to constitute the offence of 'maliciously administering poison' so as to inflict grievous bodily harm. Supplying abortion drugs without a prescription would be a criminal offence under the UK-wide Human Medicines Regulations 2012.[91]

Further, in England, the carrying out of abortion services by medical providers is a 'regulated activity' for the purposes of the Health and Social Care Act 2008.[k] It is an offence to provide regulated activities in England without registering with the CQC.[l]

– **Decriminalisation and selective recriminalisation.** Under this option abortion is removed, in full, from criminal law, and new criminal offences are created for some circumstances. This could be where there are no other criminal sanctions that could be relied upon, or where there are existing provisions but they are considered inadequate and/or there is a perceived need to be explicit that an act is a crime – for example, where an abortion is carried out by an unqualified individual. This is the model that applies in parts of Australia (see page 32).

  Another possible approach would be to establish a licensing authority similar to the HFEA (Human Fertilisation and Embryology Authority).[92] This would provide a statutory regulatory mechanism for approving institutions at which abortion procedures are carried out, and then provide that any abortions carried out at such an institution would be lawful (possibly provided the abortion was carried out in accordance with the terms imposed by the regulator). As with assisted reproduction, it would be a criminal offence to undertake certain activities without a licence from the statutory body or to carry out activities in breach of the terms of the licence. This would enable the broad principles to be covered in primary legislation (statute) with more detailed provisions in a code of practice or in licence conditions, making them easier to amend to reflect changes over time.

– **Selective decriminalisation**. Under this option aspects of abortion are taken out of the criminal law but some remain: for example, in England, Wales and Northern Ireland, repealing or amending the Offences Against the Person Act but leaving the Infant Life (Preservation) Act in place (see pages 10-11). This would decriminalise abortion up to 28 weeks' gestation in those jurisdictions. The existing provisions may be retained to permit lawful abortions after 28 weeks where it is necessary to prevent grave permanent injury to a woman or risk to her life and, under the Abortion Act in England and Wales, in the event of serious fetal abnormality **(see March 2017 update).**

  In theory the same practical outcome could be achieved in England, Scotland and Wales by amending the Abortion Act to provide an exception to the crime of abortion when the fetus is below 28 weeks' gestation (as noted previously, some might argue this is extending the current 'partial decriminalisation' of abortion). But, under this model, abortion itself would still remain a crime, albeit with a broader range of exceptions, and so would not achieve the change in the default position that some advocates seek.

Quite separate from the debate on decriminalisation of abortion, a number of changes to the Abortion Act have been proposed. These proposals are not discussed in this paper, which is concerned primarily with the nature and shape of the criminal law.

Decriminalisation: the debate

Agreeing on an appropriate balance between the moral and legal status of the fetus, and the moral and legal claims of pregnant women is an essential part of the abortion debate and is likely to influence views on the decriminalisation of abortion. There is a wealth of literature regarding the balancing of these two considerations. The BMA has traditionally adopted a gradualist approach to the issue, which is outlined below.

k Under para 1, schedule 1 of the the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'The termination of pregnancies' is listed as a regulated activity.

l There are currently no specific provisions relating to abortion set by equivalent authorities in Northern Ireland (The Regulation and Quality Improvement Authority), Scotland (Healthcare Improvement Scotland) or Wales (Healthcare Inspectorate Wales), although a provider may be registered by virtue of other factors. The Northern Ireland Assembly Committee for Justice discussed the issue in some detail in relation to the Justice Bill in January 2015 (*Hansard*, 14 January 2015). Available at http://data.niassembly.gov.uk/HansardXml/committee-11334.pdf (Accessed 19 January 2017).

There can also be an important distinction between the moral code that individuals adopt for themselves and the legal rules that an elected parliament makes, which set the limits that society places on the conduct of everyone.

It is entirely morally and logically coherent for an individual to take a position on the permissibility or impermissibility of some action without thinking that theirs is the only reasonable position available, and certainly without being committed to any particular position on whether or not the law should permit it. This principle extends to debates about abortion. Thus how an individual approaches the moral status of the fetus and pregnant woman for themselves may well be very different to how that person believes the law should be framed.

This paper touches very briefly on some of the key positions to aid discussion of decriminalisation, but for more detailed explorations of the positions, readers are advised to consider some of the many articles and books that consider the issue in more depth.

The moral and legal status of the fetus

The question of when life begins or, more precisely, when the fetus begins to have rights that society should recognise morally and/or legally, in particular a right to life, has been debated for many years and continues to be an issue on which members of society take different views. No amount of moral discourse will elucidate 'the answer' to this question because it is not a question of fact, but one of belief. Given the need for clear laws and guidelines, the range of views within society needs to be assessed in order to find a way forward that is broadly acceptable to most people, accepting that not everyone will accept that position and also recognising that societal views may change over time.

The point at which people attach moral significance to the embryo or fetus varies across a wide spectrum, and those beliefs are likely to influence their views on the role of the criminal law in abortion. For example, moral significance is sometimes attached to the following stages of development.

– **From conception:** some take the view that 'the human being is to be respected and treated as a person from the moment of conception'.[93] This position is based on the view that at the moment of the fusion of the gametes a new individual is created. Some people also believe that every human being, from the moment of conception, has a 'spiritual soul' directly created by God. A variation on this approach is to view the embryo not as 'a person' from the moment of conception but a 'potential person' or a 'person with potential', who should be afforded the same legal status and protection as other human beings. In law, a fetus has not be afforded the same legal status although it has been described as a 'unique organism'.[m,94]

– **The development of the primitive streak:** the development of the primitive streak at around 14 days after fertilisation is considered by some to be a morally significant stage of development. Until this point it is possible for twinning to occur. The embryo could result in either one individual or more than one. It is argued, therefore, that it is not until after this point that the new individual is truly formed. This position has been supported in legislation as the limit up to which human embryos may be used for research purposes.[95]

m Lord Mustill in the House of Lords in Attorney-General's Reference (No. 3 of 1994) [1998] A.C. 245 stated *'The mother and the foetus were two distinct organisms living symbiotically, not a single organism with two aspects. The mother's leg was part of the mother; the foetus was not... I would, therefore, reject the reasoning which assumes that since (in the eyes of English law) the foetus does not have the attributes which make it a 'person' it must be an adjunct of the mother. Eschewing all religious and political debate I would say that the foetus is neither. It is a unique organism. To apply to such an organism the principles of a law evolved in relation to autonomous beings is bound to mislead.'*

– **The development of brain functioning, sentience, self-awareness or the capacity to experience pain:** it has been argued that a person comes into existence when the brain starts to function or certain functions start. The development of the brain provides the capacity for sentience and for the organism to have some form of consciousness and awareness.[96] It is because of our brains that human beings are considered to have special attributes to which we attach special moral value – such as the capacity to be autonomous, to think reflectively and to have free will.[97] The ability to experience pain is sometimes referred to as being relevant. A RCOG report from 2010 noted that fetuses are said to not experience pain prior to 24 weeks' gestation,[98] as prior to this point, the necessary connections from the periphery to the cortex are not present. The RCOG report also found limited evidence to suggest that fetuses can perceive pain between 24 weeks and birth, and noted increasing evidence to suggest that the fetus never experiences a state of true wakefulness in utero. These findings are supported by the ACOG (American Congress of Obstetricians and Gynecologists).[99]

– **Viability:**[n] for others, it is the stage at which the fetus is capable of independent existence outside the pregnant woman's uterus that the fetus achieves moral status. At this stage it is no longer entirely dependent upon the pregnant woman for its life and, given the right circumstances, would be capable of long-term survival with support of individuals other than the woman. The concept of viability underpins much of the debate, and the current 24-week time limit in the Abortion Act.[100]

– **Birth:** birth has been put forward as being morally significant in terms of the status of the fetus for two reasons. First because it is the stage at which an independent being comes into existence, not reliant solely on the pregnant woman; and secondly because after birth, treatment can be given to the child without needing to carry out invasive techniques on the pregnant woman. Before birth the woman's consent needs to be sought for any intervention, whereas after birth the child's interests are the only relevant factors to take into consideration in making treatment decisions. Birth is also legally significant, because legal personhood is acquired when a child has an existence separate from its mother.[o] Those who challenge the moral significance of birth argue that there is no fundamental physiological or moral difference between the fetus in utero and the baby after birth.

– **The development of self-awareness:** at the other end of the spectrum are those who do not believe that moral status is achieved until the individual has developed the capacity for self-awareness. On this basis a newborn would not be considered to have full moral status, since it lacks the ability to value its own existence;[101] such capabilities do not develop until some months after birth. For many people this conclusion is totally counter-intuitive and abhorrent.

Many people have difficulty with pinpointing the stage at which they believe the fetus achieves moral status of differing degrees and do not believe that the fetus has no moral status until a particular stage of development, after which it deserves full and absolute protection. They therefore take more of a gradualist approach whereby the fetus is seen

n Viability is difficult to define. It can mean that the fetus is capable of being born alive but may die shortly afterwards, or it can mean that an infant is capable of surviving into childhood with no, or minimal, disabilities. Even if a fetus reaches a gestational age, which is considered the minimum for 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. Another factor when considering viability is whether fetal viability relates to the minimum stage possible for any fetus to survive, whether it refers to the viability of a particular individual fetus, or whether it refers to the stage at which the majority survive. For a more detailed discussion on viability see the BMA discussion paper *Abortion time limits: a briefing paper from the BMA* (2005).

o It had been suggested that the right of everyone to have their life protected by law, under Article 2 of the European Convention of Human Rights, could extend to the unborn. This was rejected in 2004 in the case of *Vo v France*. In that case the European Court of Human Rights held that Article 2 did not confer a right to life that extended to a fetus. Given the wide degree of variance on this point in the domestic law of individual states, determination of the commencement of the right to life came within the margin of appreciation, which gives states discretion regarding interpretation where no consensus exists in Europe. This 'broad margin of appreciation' was noted again in 2010 in the case *A, B and C v Republic of Ireland* [2010] ECHR 2032.

as gaining in moral status as it develops. The practical implication of this is that as the fetus develops, and therefore gains moral status, the greater the justification required for terminating the pregnancy. This has been the basic approach adopted by the BMA.[102] The gradualist approach is also reflected in the provisions of the Abortion Act 1967 which permits the pregnant woman to override any emerging rights of the fetus in circumstances which have been defined by Parliament. The gradualist position was also adopted by the highly influential Warnock Committee[103] when it considered embryo research, and this position was subsequently reaffirmed by the Donaldson Committee[104] and by the House of Lords Select Committee on Stem Cell Research.[105]

The moral and legal claims of the pregnant woman

In addition to considering the moral status of an embryo or fetus, it is argued that it is also important to consider the moral status of women and the legal and moral rights, choices, responsibilities and obligations they may have when pregnant, taking into account, for example:

- **Autonomy:** a key tenet in 20th and 21st century medical law and ethics, autonomy is the ability to think, choose, decide and act for oneself. This consideration is underpinned by the importance society generally places on individual autonomy and self-determination, which has grown considerably in the last 50 years. Many of those who call for the decriminalisation of abortion base their arguments on the woman's right to choose what happens to her body.

- **Limits to autonomy:** all concepts of autonomy are subject to limits. Hence, for example, one can only be autonomous if (a) one has capacity and (b) to the extent that the exercise of autonomy does not adversely impact on the autonomy of another. Hence legally and morally, it is widely accepted that there are limits to autonomy. Individuals can choose and act in ways that are harmful to themselves but they do not have the same liberty to choose or act in ways that would harm others. Whether a fetus should count as an 'other' in this respect is a question on which different views are held. The moral relevance of the rights of the fetus in this context depends on the status afforded to the fetus at different stages of its development. Pregnancy is unique in that any assertion of moral or legal rights for the fetus inevitably adversely impacts on the autonomy of the woman. Thus the assertion of moral or legal rights of the fetus inevitably imposes moral or legal duties on the pregnant woman.

  A range of views on the scope of a pregnant woman's autonomy is evidenced in discussions, not only about abortion, but about the choices a woman makes while pregnant – from the choices she makes about medical intervention during her pregnancy and childbirth, to the day-to-day choices she may make about the food she eats, her alcohol consumption, smoking, and the activities she engages in while pregnant.

- **Liberty and the right to physical integrity:** autonomy is important but there are other moral considerations in relation to the woman, including liberty and the right to physical integrity. As one commentator on the abortion debate noted:

  > *'the denial of abortion ...infringes upon women's rights to liberty, self-determination, and physical integrity. To be forced to bear a child is not just an "inconvenience"...To carry a pregnancy to term is an arduous and risky undertaking, even when voluntary...many women enjoy (much of) their pregnancies; but for those who remain pregnant against their will the experience is apt to be thoroughly miserable."*[106]

- **Impact and risks of pregnancy:** some argue that pregnancy is not a neutral state, but, as noted above, there is an impact on the liberty and physical integrity of a woman – there can be negative and positive implications of pregnancy (and subsequent labour and parenting) for a woman's physical, mental and emotional wellbeing. In addition to the physical toll of pregnancy and childbirth, including the small risk of maternal death, a woman's sleep, mobility, diet, mood, work, leisure and relationships can be affected. The

impact of this may be affected by the circumstances of a particular pregnancy including, but not only, whether the pregnancy was planned and/or wanted.

– **An individual entity:** some view the fetus not as a separate being but as part of the pregnant woman's body and any action taken in relation to the fetus necessarily involves the pregnant woman too. Whilst this balancing of rights and obligations has been the subject of much debate, the law on this point is clear: a pregnant woman with capacity has the absolute right to refuse medical intervention, including caesarean section, even if that decision will result in the death of a healthy, viable fetus.[107] It is not the case, however, that the embryo or fetus is totally without legal protection. There are, for example, limits applied to the availability of abortion and, in some countries of the UK, a child may sue a third party (but, in most circumstances, not its mother) for damages caused by negligent acts in the antenatal period.[108]

– **Moral versus legal obligations:** in law, pregnant women with capacity have the same right as everyone to consent to and refuse any treatment or medical intervention, even if a refusal results in the woman's and/or fetus's avoidable death.[109] Various methods have been tried to encourage women to reduce risky behaviour that might have a negative impact on the fetus they are carrying, but the law cannot intervene in any way to protect a fetus from the woman's behaviour during pregnancy.[110]

  The legal perspective may be clear, but the ethical debate continues about the extent, if any, to which pregnant women have responsibilities or moral obligations towards the fetuses they are carrying. Ethically, it is often argued that women have some duties to the fetus even though its claims may not override the woman's claim to autonomy over her body. Even if a woman is perceived to have moral responsibilities towards the fetus, that does not necessarily mean that she can or should be forced, legally or ethically, to fulfil those duties.

Arguments in favour of decriminalisation

The BMA does not currently have policy on the decriminalisation of abortion. The following arguments have been made by others in favour of decriminalisation, in a wide range of publications, media and settings.

– **The law needs updating to reflect changes in societal views and attitudes, and changes in clinical practice:** it is believed that the current law does not reflect modern-day attitudes towards abortion or towards women's autonomy, liberty and physical integrity. Nor does the current law recognise or reflect more recent changes in clinical care – for example, care is now delivered by multidisciplinary teams and abortions can be administered medically rather than surgically. On a practical level, it is argued that decriminalisation will be part of the solution to ensure equitable provision and access to safe abortion services for *all* women, including those with complex needs, irrespective of their economic or social resources. The current threat and stigma of criminal sanctions may deny some women access to services, where healthcare professionals are reticent, or are not permitted, to be involved in all aspects of the provision of a safe abortion service.

– **Autonomy:** it is argued that the criminalisation of abortion is a remnant from the 19th century when societal attitudes were very different, particularly towards women. Criminalisation of abortion reflects a deep mistrust of women (and doctors) being able to make moral choices. It denies women fundamental rights to make decisions about their own bodies. Abortion should be treated in the same way as other medical decisions, with treatment occurring 'in the same way any other clinical decisions are reached, through discussion between the woman, her doctor/s and other medical staff'.[111]

– **Removing unacceptable stigma:** abortion is prima facie a crime, with exceptions. It is argued that this creates a 'chilling' climate where women who are having an abortion, and the doctors who perform them, are seen as doing something morally questionable. This is despite the fact that abortion is a common medical procedure. For example, one in

five pregnancies ended in an abortion in England and Wales in 2014.[112] It is unacceptable that a medical procedure that is fundamental for a woman to exercise her reproductive autonomy continues to be underpinned by criminal legislation that is stigmatising for both the women and the healthcare professionals involved in the provision of abortion services.

- **The risks for doctors:** doctors who are performing abortions that they consider to meet the legal grounds can face the threat of criminal prosecution if their judgment is called into question – for example, their interpretation of 'serious handicap' under the Abortion Act (see outline of the *Jepson* case at page 18). Although doctors can justify their actions by showing that they have acted 'in good faith', the impact on doctors of facing legal questioning, or of being challenged through the media, should not be underestimated. Even in cases where the legal grounds for an abortion are clearly met, they can risk criminal prosecution if questions are raised about whether the specific procedures required by the law have been followed – for example, the UK Government recently stated that a doctor's 'wilful non-compliance with the notification requirements [of the Abortion Act] is a criminal offence and would be reported to the police to investigate'.[113] The Government subsequently noted that 'the Abortion Act 1967 ...provides that any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations... shall be liable on summary conviction to a fine without limit'.[114] Some have suggested that those who oppose abortion are increasingly challenging doctors and invoking criminal law to further restrict access to abortion or to discourage doctors from participating.

- **Safer provision of abortion:** it is claimed that decriminalisation in conjunction with a broader reform of abortion legislation will improve abortion provision, by removing unnecessary barriers and reducing current fears of criminal prosecution, which may be deterring doctors' involvement in abortion. This will enable women to undergo an abortion at an earlier stage of their pregnancy, which is safer for women.

- **Giving women the time to make the right decision for them:** it is argued that decriminalisation may also improve the experience of women who have to make the difficult decision whether to end a much wanted pregnancy in the second or third trimester. For example, in England, Wales and Scotland, women are able to seek abortions up to birth for serious fetal abnormality (ground E) but there are concerns that women may be 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. After a diagnosis of serious fetal abnormality, women may need more information and time to make a decision about how to proceed. Some women may at first choose to end the pregnancy but later, after more consideration or after seeking more information, change their minds. Other women may initially choose to continue with the pregnancy but after more consideration may choose to have an abortion. Permitting and ensuring women are able to access abortion for serious fetal abnormality after 24 weeks ensures that they have the time needed for them to make the right decision for them and their family.

- **Preventing unsupervised abortions:** international comparisons have been interpreted as showing that 'criminalising abortion does not prevent it [abortion] but, rather, drives women to seek illegal services or methods'.[115] Decriminalisation does not necessarily mean unfettered access – restrictions could remain in place via specific legislation, or through regulation, professional practice and availability of services – but it would 'discourage the illegal importation of abortifacients that are being used without quality controls or medical supervision'.[116] Countries where abortion has been decriminalised, for example Canada and parts of Australia, which have regulations in place, have not experienced a subsequent rise in abortion rates, particularly for third trimester abortions.[117, 118]

- **Criminalising women in 'hard' cases is the wrong response:** it has been argued in some of the cases where women have self-administered abortions in the third trimester that criminal sanctions are not an appropriate response. Instead these women

need appropriate support and, where necessary psychological intervention, which a decriminalised response would be able to provide.

– **Appropriate accountability:** there are few medical procedures as divisive and politically charged as abortion. Concern has been expressed that this has meant that processes and procedures for delivering abortion services have not been kept in step with other societal changes. This is due, in part, to anxieties about opening up the abortion debate in Parliament. Decriminalising abortion could mean that parameters could be widely consulted upon and agreed by regulatory and professional authorities instead. This would ensure services are fit for purpose, equitable and primarily developed by those who deliver and those who access abortion services.

Arguments against decriminalisation

The BMA does not currently have policy on the decriminalisation of abortion. The following arguments have been made by others against decriminalisation, in a wide range of publications, media and settings.

– **Decriminalisation is unnecessary – legislation for 'lawful' abortion should be reformed:** it is argued that the full or selective decriminalisation of the law is not the most appropriate way to respond to the cases cited to support such a change (see pages 16-18). It has been suggested that, instead the Abortion Act 1967 should be reformed and/or extended, where necessary, to address some of the current restrictions women experience when accessing abortion.

– **The moral status of the fetus:** it is argued that the criminalisation of abortion is an important indication of the gravity of the issue, reflecting the important moral status of the fetus. Ensuring unlawful abortion remains a crime, with associated criminal penalties, means that there is an appropriate and proportionate deterrent and punishment for those considering or acting outwith the law.

– **'Hard' cases would be better dealt with through specific prosecutorial guidance:** in the cases of women who have brought about the end of their pregnancy in the third trimester (see page 17), it is argued that it is appropriate for the criminal law to be engaged. It is for the prosecution services to evaluate the evidence of the crime and whether prosecution is in the public interest. Where the woman involved is vulnerable, either because of poor mental health or for other reasons, these factors can be taken into account by the relevant authorities. Instead of decriminalising abortion, specific prosecutorial guidance could be developed that considers public interest factors tending in favour of, and against, prosecution.

  It should be noted that the criminal law should already be interpreted in favour of a defendant, and has the ability to take account of diminished responsibility and other mitigating factors. Specific prosecutorial guidance may not alter the outcome in similar future cases, but it would ensure transparency of the factors that must be taken into account when considering such cases. Guidance could ensure consideration of factors including the motivations, vulnerability and psychological state of women who end their own pregnancies. Infanticide is a crime, for example, but within infanticide legislation there is already an acknowledgment that a mother's responsibility for the crime may be reduced by a disturbance of her mind.[119]

– **The need for effective deterrents:** it is claimed that there is a role for the criminal law in upholding and enforcing certain values. This role may be discharged by punishing certain actions, and by using the possibility of punishment to discourage them. Thus criminal law sanctions, whether they be in the form of imprisonment or a fine, may be an appropriate way to reduce the number of abortions carried out in circumstances that many would find morally unacceptable – for example, self-aborting a healthy fetus up to full term.

- **Unsafe abortion:** concern has been expressed that the decriminalisation of abortion could lead to an increase in unqualified individuals and vulnerable women administering both surgical and medical abortions. This would be unsafe for women, potentially resulting in 'botched' abortions and risks to the health and lives of women, due, for example, to counterfeit medicines, inappropriate prescribing, or no, or inappropriate medical assessments before, during and after an abortion.

- **Insufficient accountability:** many of the calls to decriminalise abortion focus on setting parameters through regulatory authorities and clinical and professional standards. Others argue, however, that parliaments must retain the responsibility to ensure appropriate scrutiny and oversight of the detailed regulation of abortion. This enables citizens, through the democratic process, to lobby their representatives. Abortion is too charged an issue to be left to regulatory and professional authorities. Abortion is not just like any other medical treatment.

- **A good compromise:** it is unlikely that there will ever be universal agreement on the issue of abortion. It is suggested that the current legislative framework is a 'good compromise' on a highly contentious issue. On one hand the status of abortion as a crime acknowledges that abortion is not morally neutral, but the law allows abortion on a number of medical grounds. It is argued that in practice, the exceptions created through the Abortion Act are working, and most women in England, Scotland and Wales who seek an abortion, particularly in the early stages of pregnancy, are able to access one under the medical criteria.[120]

- **More restrictive access in reality:** even some of those who support decriminalisation express concern that opening this debate up could result in unintended negative consequences. Given the nature of the abortion debate there is a risk that opening it up could result in a more restrictive statute. Another possible risk is that if the decriminalisation of abortion is successful, the compromise will be more restrictive regulation and professional standards. Either way, there is a risk that there may be reduced access to abortion for women.

- **Abortion as an alternative to contraception:** some have expressed concern that decriminalising abortion could discourage the use of effective contraception. Women might normalise abortion and use it as an alternative to contraception.

International experience

Abortion remains a crime in many countries. There are countries, however, where abortion has been decriminalised – for example, Canada and some Australian states and territories – either by:

- complete/total decriminalisation of abortion, but still professional and health service restrictions eg in Canada; or
- decriminalisation of abortion, and the creation of new criminal offences for some circumstances, for example, where an abortion is carried out by an unqualified individual eg in parts of Australia.

Within Europe, the UK is not alone in its recent discussions of decriminalisation. In 2016, Belgium's Ecolo party tabled a Bill to remove abortion from the Belgium penal code so it would no longer be considered a crime.[121] At the end of 2014, Luxembourg politicians supported the reform of abortion legislation, including removing abortion from the penal code.[122]

Elsewhere, in January 2016, the ACHPR (African Commission on Human and People's Rights), through the mechanism of the Special Rapporteur on the Rights of Women in Africa, launched a continental campaign for the decriminalisation of abortion in Africa.[123]

Canada

Induced abortion was decriminalised in 1988 following the case of *R v Morgentaler*[124] where a group of doctors purposefully set out to challenge section 251 of the Criminal Code, which set out the conditions for abortion. The Court held that the Criminal Code was unconstitutional and violated women's rights under section 7 of the Canadian Charter of Rights and Freedoms – the right to 'life, liberty and security of the person'. Section 251 (but now section 287) remains in the Criminal Code but has no force or effect due to it being unconstitutional.

There are, therefore, no federal restrictions on abortion but there can be regulations and restrictions within the individual provinces and territories. However, access to abortion in Canada can depend on a number of factors, including funding and the availability of healthcare staff willing to perform the abortion, licensing of abortifacients, province and gestation.[125, 126]

Australia

There is no unified national abortion law in Australia. The Offences Against the Person Act 1861 (see page 10) was initially adopted by the colonies in the late 19th century. Australia now consists of six states and 10 territories, some of which have independence in relation to abortion legislation. Some retain legislation based on the 1861 Act,[127] but some have decriminalised all, or further aspects of, abortion, for example:

ACT (Australian Capital Territory): abortion is decriminalised as a consequence of section 3 of the Crimes (Abolition of Offence of Abortion) Act 2002,[128] which states that 'Any rule of common law that creates an offence in relation to procuring a woman's miscarriage is abrogated'. Abortion is decriminalised but continues to be regulated by the Health Act 1993[129] which outlines conscientious objection provisions and states that only a doctor can carry out an abortion, in an approved medical facility, otherwise it is an offence. No grounds or time limits for abortion are stated within the 1993 Act.

Victoria: abortion is decriminalised as a consequence of the Abortion Law Reform Act 2008,[130] which repealed the abortion provisions of the Crimes Act 1958[131] (similar to the Offences Against the Person Act 1861) and abolished common law offences relating to abortion. The 2008 Act sets out, however, specific criminal offences if an unqualified person performs an abortion, and defines 'serious injury' to include the destruction of a fetus other than in the course of a medical procedure. The 2008 Act sets out some procedural direction – for example, doctors should consult with at least one other medical practitioner for abortions after 24 weeks' gestation, and obligations of medical practitioners who have a conscientious objection.

Part three – where next?

This year marks 50 years since the enactment of the Abortion Act and there will undoubtedly be reflection on whether current abortion legislation is fit for purpose. It is highly likely that decriminalisation will feature prominently in that debate.

The aim of this paper is to provide information to facilitate an informed debate on the specific question of what, if any, role the criminal law should play in relation to abortion. If there were to be a change in the role of the criminal law, there are a range of policy options as discussed on pages 23-24:

– complete/total decriminalisation
– decriminalisation and selective recriminalisation
– selective decriminalisation.

In considering these options – and the appropriate role of the criminal law more generally – it is helpful to consider the type of circumstances in which the existing criminal law has been invoked to date. These are described on pages 16-18 but include cases where:

A. individuals have illegally supplied abortifacients
B. women have procured and self-administered abortifacients at various stages of pregnancy
C. individuals have procured abortifacients on behalf of others
D. individuals have maliciously and covertly tried to procure or administer an abortion
E. doctors have been challenged for their involvement in the provision of abortions they deemed to be lawful.

Whatever one's view about the principle of the decriminalisation of abortion, there are some issues on which there appears to be a broad consensus. The following principles would need to be protected in any law or regulation that replaces the current legislative framework.

1. Abortion must only be permitted in cases where the woman gives informed consent, or in cases where the woman lacks capacity and an abortion is determined to be in her best interests.
2. Health professionals must have a statutory right to conscientiously object to participating in abortion.
3. There should be a central collection of abortion data (subject to agreed appropriate confidentiality protections) to ensure future services are fit for purpose.
4. There must be clarity about what is, and what is not, lawfully permitted, so that health professionals are clear about the scope of their clinical discretion.
5. There should be robust clinical governance in settings where abortion care is provided.
6. There should be the continuation of some degree of regulation and the setting of professional standards in the provision of abortion services.

Agreement on the importance of these principles does not imply agreement about how those principles should be protected.

As mentioned on page 23, it may be that some of the cases – for example the cases of the illegal supply of counterfeit drugs and the malicious covert administration of drugs – could be captured by aspects of criminal law quite separate from legislation on abortion.

Key questions

In considering the role of the criminal law, the following questions may be helpful to focus debate.

– In what, if any, circumstances should women who self-administer an abortion be subject to criminal sanctions?

– How should the criminal law and the prosecution services respond to the increasing number of women who are acquiring abortifacients online? If there are to be criminal sanctions, should these apply to both women themselves and suppliers of the abortifacients?

– In what, if any, circumstances should health professionals who participate in the provision of abortion be subject to criminal sanctions?

– Should the point of viability be treated as significant in determining whether criminal sanctions should apply in some cases of abortion?

Annex A – the law in the Channel Islands and Isle of Man

Jersey

The Termination of Pregnancy (Jersey) Law 1997[132] 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'
- 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 ie two consultations not less than seven days apart, having received information about counselling and adoption, amongst other things.

The law also sets out, amongst other things, 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.

In 2015, 191 abortions were carried out on Jersey – 48% of these were medical abortions; 85% were undertaken at less than 10 weeks' gestation and 98% were on the grounds of 'distress'.[133] In the same year, nine women who reported their residence as Jersey had abortions in England or Wales.[134]

Guernsey, Herm and Jethou

The Abortion (Guernsey) Law 1997[135] sets out both the criminal offence and when abortion is lawful.

Abortion is lawful if two recognised medical practitioners are of the opinion, formed in good faith, that:

- abortion is 'immediately necessary to save the life of the pregnant woman'
- abortion is 'necessary to prevent grave permanent injury to the physical and mental health of a pregnant woman'
- the pregnancy has not exceeded 24 weeks' gestation and 'that, at the time of the diagnosis, 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'
- the pregnancy has not exceeded 12 weeks' gestation and 'the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family'.

The law also sets out, amongst other things, a right to conscientious objection (except where abortion is necessary to save the life of a pregnant woman), and other conditions regarding who can perform an abortion, where abortions can be carried out, and the recording of the grounds on which an abortion is lawful.

Data on the number of abortions that are undertaken in Guernsey, Herm and Jethou are not publicly available. In 2015, eight women who reported their residence as Guernsey had abortions in England or Wales.[136]

Isle of Man

Sections 71 and 72 of the Criminal Code 1872 (offences relating to procuring a miscarriage)[137] set out an offence almost identical to that of the Offences Against the Person Act 1861 (see page 10). In addition, the Isle of Man has the Infanticide and Infant Life (Preservation) Act 1938.

The Termination of Pregnancy (Medical Defences) Act 1995[138] permits abortion if the hospital surgeon terminating the pregnancy and another medical practitioner are of the opinion, formed in good faith, that:

- 'the continuance of the pregnancy would involve a substantial risk (other than such risk as is normally associated with pregnancy and childbirth) to the life of the pregnant woman greater than if the pregnancy is terminated'
- abortion is 'necessary to prevent grave permanent injury' to the physical and/or mental health of the woman
- there is a 'substantial risk' that the fetus is not viable or (up to 24 weeks'gestation) will suffer from a serious abnormality as to have a 'serious handicap... which is not capable of being cured or substantially relieved by treatment or the passage of time'
- the pregnancy is of less than 12 weeks' gestation and there is evidence the pregnancy is the result of rape, incest or indecent assault.

A number of conditions must be met, including who should be consulted – for example, in cases where injury to the woman's mental health is the basis for the decision to end a pregnancy, the woman must see a consultant psychiatrist who acts as the 'second medical practitioner'. In cases of sexual assault the woman must report this to the police and sign an affidavit, or give evidence under oath, before the termination can be considered. In January 2017, politicians on the Isle of Man agreed to review the current legislation.[139]

Fewer than 10 women are reported to undergo abortions on the Isle of Man each year.[140] In 2015, 105 women who reported their residence as the Isle of Man had abortions in England or Wales.[141]

Annex B – abortion statistics

England and Wales

Abortion statistics for England and Wales are published annually by the Department of Health. The latest year for which data are available is 2015 and a summary of the key points for that year is given below.[142]

- For women resident in England and Wales, the total number of abortions remains fairly constant at 185,824, a 0.7% increase on 2014, and a 0.3% decrease on 2005.
- For non-residents, 5,190 abortions were carried out in hospitals and clinics in England and Wales. The 2015 total is the lowest number in any year since 1969.
- 92% of abortions were carried out at under 13 weeks' gestation, and 80% were at under 10 weeks.
- The proportion of medical abortions increased again, with 55% of abortions being medical abortions.
- Grounds for abortions:

Ground	Definition	% (number) of total abortions
A	The continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated.	Grounds A and B – ~0.1% (219)
B	The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.	
C	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.	98% (181,231)
D	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 existing children of her family.	1% (1,158)
E	There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.	2% (3,213)
F	It was necessary to save the life of the woman (in an emergency, certified by the operating practitioner as immediately necessary).	Under grounds F or G – 3 cases were performed
G	It was necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (in an emergency, certified by the operating practitioner as immediately necessary).	

Scotland

Abortion statistics for Scotland are published annually by the ISD (Information Services Division) Scotland. The latest year for which data are available is 2015 and a summary of the key points for that year is given below.[143]

- The number of terminations in Scotland increased by 306 between 2014 and 2015 to 12,082, a rise of 2.6%.
- 94.7% of abortions were carried out at under 14 weeks' gestation, and 72.5% were at under 9 weeks' gestation.
- The proportion of medical abortions increased again, with 81.1% of abortions being medical abortions.
- Grounds for abortions:

Ground	Definition	% (number) of total abortions
A	The continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated.	0.1% (11)
B	The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.	Risk of disclosure – values suppressed
C	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.	98.3% (11,877)
D	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 existing children of her family.	0.0% (6)
E	There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.	1.5% (186)
F	It was necessary to save the life of the woman (in an emergency, certified by the operating practitioner as immediately necessary).	Risk of disclosure – values suppressed
G	It was necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (in an emergency, certified by the operating practitioner as immediately necessary).	Risk of disclosure – values suppressed

Northern Ireland

In 2015/2016, 16 abortions were carried out across Health and Social Care Trusts in Northern Ireland;[144] 833 women from Northern Ireland sought abortions in England and Wales in 2015[145] – breakdown below – and 20 women sought abortions in Scotland over the period 2005-2015.[146] There are anecdotal reports of women not giving NI postcodes when accessing abortion services and so these figures may be lower than the reality.

Gestation in weeks	% (number) of total abortions
3 - 9	73% (604)
10 - 12	15% (122)
13 - 19	11% (89)
20 & over	2% (18)
Total	**100% (833)**

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