Submission to the UK All-Party Parliamentary Group on Population, Development and Reproductive Health on Abortion in the Developing World and the UK

Summary

We believe that the current regulatory scheme undermines the provision of safe services for women seeking termination of pregnancy.

The generally applicable framework for the regulation of health care services has improved patient care and safety as primary goals. As detailed below this is not the case with current regulation of abortion. Safety regulation, we argue, is now best achieved through the four layers of regulation that are provided for all health services through:

- rules of informed consent,
- development of clinically appropriate treatment regimes by National Institute for Clinical and Care Excellence (NICE),
- oversight of clinics and hospitals by the Care Quality Commission (CQC), and
- professional accountability (fitness to practise, complaints, and litigation).

Consequently, Parliament should reform the law regulating abortion. What such reform would necessarily entail will vary across the United Kingdom; our focus is on reform in Great Britain.

Current law

Abortion in Great Britain is primarily governed by the criminal law. International human rights organisations have condemned the use of criminal law in the regulation of abortion care.¹ The European Court of Human Rights (ECHR) has accepted that the threat of criminal sanction has the potential to have a ‘chilling effect’ on clinical practice.² This matters for the safety of services if it distracts professional attention away from clinical care into defensive practice, a phenomenon that Lord Denning once graphically described unflatteringly as a ‘dagger’ at the doctor’s back.³ The maximum penalty for illegal abortion is life imprisonment.

Repeal of sections 58-59 of the Offences Against the Person Act 1861 (the OAPA) would remove the statutory criminal prohibitions that relate to abortion in England and Wales. This would mean that much of the content of the Abortion Act 1967 (the AA) would be irrelevant. Repeal of sections 58-59 of the OAPA leaves open the question of whether the AA is better reformed or repealed.

The OAPA does not extend to Scotland, although the AA does. Prior to the introduction of the AA, abortion was potentially an offence at common law but could be lawful in certain circumstances (when performed with ‘therapeutic intent’).⁴ As such reform of the law on abortion in Scotland would require clarification of the legality of the procedure at common law.

Abortion laws in Northern Ireland are amongst the most restrictive in the world with fewer than 20 abortions per year being performed in the jurisdiction. The law in Northern Ireland requires a complete overhaul and while the points made in this submission would be relevant to the safety

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¹ For example 'She is not a criminal: The impact of Ireland’s Abortion Law' (Amnesty International, 2015) pp 104-106. https://www.amnesty.org.uk/files/she_is_not_a_criminal_report_-_embargoed_09_june.pdf
² A, B and C v. Ireland (2010) ECHR 2032, Application no 25579/05
³ Hatcher v. Black, Times, 2 July 1954
and efficacy of any future regulations much more work would need to be done in order to facilitate the provision of safe abortion care.

Our aim in this submission is to highlight the ways in which the current legal framework in Great Britain hinders provision of abortion care. Primarily we will focus our critique on features of the AA.

Regulating for safety in the 1960s

The primary regulatory purpose of the AA was safety. When it was passed, abortions were often unsafe, particularly when performed by unqualified people outside of health facilities. The grounds for the legality of terminations are therefore defined in terms of medical risk and the AA consequently limits the locations in which abortions can be performed and the personnel who can perform them. Concerns that doctors might offer terminations inappropriately were further addressed by the peer review requirement of a second opinion, which was designed to ensure some degree of 'colleague control'. In addition to this the AA requires mandatory reporting to the Chief Medical Officer of every abortion performed.

Current Safety considerations

The safety of abortion is now well established. It is recognised by the World Health Organisation (WHO) and the Royal College of Obstetricians and Gynaecologists (RCOG) that when performed properly abortion it is safer than the continuation of pregnancy. This means, as has been noted by the British Medical Association (BMA), that women automatically fulfill section 1.1 (a) & (c) of the AA and as such termination should be routinely available when these conditions are met. This is a result of literal meaning of the AA not any moral assessment.

In addition to general advances in safety there have also been advances in abortion methods, particularly medical abortion regimes involving the administration of mifepristone and misoprostol. Home administration of misoprostol is considered an appropriate care pathway for those women who have elected for medical management of miscarriage. However, as mentioned above the AA sets out a requirement that abortions may only be performed in specified places; either NHS premises or places authorised by the Secretary of State for Health. This means that clinicians have not been permitted to develop an abortion care pathway that facilitates home use of misoprostol for abortion.

The WHO states that “[a]llowing home use of misoprostol following provision of mifepristone at the health-care facility can… improve the privacy, convenience and acceptability of services, without compromising on safety”. There is no clinical reason to require women to make multiple

6 Abortion Act 1967, s.(2)
8 BMA, First Trimester Abortion: A Briefing Paper by the BMA’s Medical Ethics Committee (ARM: London, 2007). For further discussion of the implications of this see Rosamund Scott 'Risks, reasons and rights: the european convention on human rights and English abortion law' Medical Law Review 24 (2016) 1-33
9 See for example: https://www.guysandstthomas.nhs.uk/resources/patient-information/gynaecology/medical-management-of-miscarriage.pdf
10 Sections 1(3) & (4)
11 http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1
trips to the hospital or clinic. There are however risks if they are sent home facing the possibility that they will start to miscarry while travelling. Findings of a study undertaken by Sally Sheldon details how “[s]ome clinics now offer treatment protocols (including same day or near simultaneous administration of mifepristone and misoprostol) that are known to be clinically less effective” in order to avoid a woman having to travel back to the clinic.12

In 2011, judicial review proceedings found that the Secretary of State for Health (SoS) has powers to permit such a care pathway.13 However, because these powers are discretionary in nature, it was decided that it was not for the judiciary to interfere with the substantive decision not to exercise them. The legal case for exercising the power to make regulations for home use is stronger since this decision. The SoS is now required, as a result of the Health and Social Care Act 2012, to discharge his duties in order to secure the continuous improvement in the outcomes of services (NHS Act 2006, s 1A(2)), ‘in particular’ in terms of effectiveness, safety and quality of patient experience (NHS Act 2006, s 1A(3)). We believe that the continuing failure to make available a protocol for home use of misoprostol places him in breach of those duties.

In addition it could be argued that failure to allow for home use breaches a woman’s article 8 rights to private and family life. Although there isn’t a substantive right to abortion in ECHR jurisprudence it is now well established that where abortion is lawful it must accessible.14 Having to travel to a clinic on multiple occasions for the administration of the drugs (particularly problematic if a woman needs to travel long distances, arrange childcare, or arrange time off work) is burdensome. In the absence of an argument for clinical efficacy or safety, restrictions on home use could be seen as disproportionate barrier that renders abortion inaccessible for some and thus infringes on their article 8 rights.

Regulating for safety in 2017

The CQC framework for oversight of quality and safety in health provision has its origins in the Bristol Royal Infirmary Inquiry. Providers are not permitted to carry out regulated activities (which include the termination of pregnancy) unless registered with the CQC and are subject to inspections and regulatory action. The effectiveness of this was demonstrated by the CQC’s suspension of services at Marie Stopes International clinics in 2016.15

In the 1960s, there was no law on informed consent in the UK and it was merely a matter of professional discretion how to counsel women. This changed radically with the decision of the Supreme Court in Montgomery v Lanarkshire Health Board in 2015.16 Clinicians are now obliged to take care to ensure that women are aware of all reasonable options for their care, of any risks or side effects that a reasonable woman would regard as material, and additionally of any specific matters that might be more important to them than to others. This provides considerably greater protection against poor risk assessments and failures to ensure women can make informed choices.

The Supreme Court in Montgomery was concerned about two issues. First, that disclosure was a matter of the personal opinions of doctors not scientifically based. Second, that it did not address the things that mattered to patients. Following Montgomery disclosures will be more extensive. It will be incumbent on the medical profession to ensure that reasonable treatment options are

15 Montgomery v Lanarkshire Health Board [2015] UKSC 11
explained to women. However, as indicated above, one of those treatment options (medical management at home), is prevented by the law from being available. In other areas of clinical practice, it would be expected that NICE would develop clinical guidelines to assist doctors in informing patients, but the scope of this is currently limited by legal constraints that are not clinically indicated.

Although by no means perfect, procedures for professional discipline have been much improved since the AA was passed. Up until the mid-1980s, the General Medical Council (GMC) showed little interest in the proper conduct of medicine and would ‘strike off’ doctors only in very extreme circumstances. Since then, it has developed extensive guidance on ‘Good Medical Practice’ and the disciplinary jurisdiction has become much more effective. There have been very few prosecutions of medical professionals under the law relating to abortion in recent years; the Director of Public Prosecutions has pointed out the requirement to prove ‘bad faith’ makes it unlikely that this will change. However, there are examples of doctors facing disciplinary sanction for malpractice in the area of abortion provision. Malpractice litigation was almost unknown in the 1960s, but there is now significant experience in the legal professions of bringing actions on behalf of patients who have suffered from negligent care. Such litigation provides redress for those adversely affected by clinicians who practise unsafely.

This highlights how normal accountability mechanisms are far more appropriate to identify malpractice and ensure safe and effective care than the provisions contained in the AA. As mentioned above, the potential for serious criminal sanction in this area could negatively impact patient care and could reduce the number of clinicians willing to provide abortions.

Safety risks created by the current law

- The requirement of a second opinion can potentially build delay into the care pathway. As early terminations are generally safer than later ones, this creates a health risk to women that is solely the result of the regulatory framework. Given that the safety of terminations is now such that they should routinely be lawful, second opinions are unnecessary in these cases. Previous Parliamentary Inquiries have recognized this and called for the second opinion requirement to be removed.

- The refusal by the SoS to permit home administration of misoprostol denies women in Great Britain a safe and effective treatment option and potentially breaches his obligations under the Health and Social Care Act 2012.

- The necessity for involvement of a doctor means that options for inter-professional care that can be developed in other clinical contexts cannot be developed with confidence for terminations of pregnancy. Generally, as noted by the RCOG, “Abortion is not a complex procedure. A range of providers, including nurses and midwives, have been shown to be competent to deliver abortion services safely in a number of settings”.

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17 'Director of Public Prosecutions publishes fuller reasons for decision not to prosecute doctors over abortion case' http://www.cps.gov.uk/news/latest_news/dpp_abortion_case_fuller_reasons/
18 See for example: http://www.mpts-uk.org/static/documents/content/Majied RIDHA 9 September 2016.pdf also available at webcache.gmc-uk.org/minutesfiles/Ro%20PUBLISHABLE%203223752%20September%202016.docm
of Nursing v Department of Health and Social Security \(^{21}\) case found a pragmatic solution to this in the context of 1980s practice but it remains a limitation that the law has created without regard to clinical issues.

The AA does not address issues of competence and quality. Its existence diverts attention from questions of acceptable practice within abortions services to those of legality.

**Conclusion**

For these reasons, we have concluded that current abortion law breaches the first principle of medical ethics ‘first do no harm’ and that the regulatory framework of AA should abandoned in favour of the more effective regulatory regime that promotes safety in health care generally:

- NICE is best placed to develop appropriate clinical care pathways, and support the application of the enhanced informed consent law;
- the CQC is best placed to regulate practice in hospitals and clinics; and
- the GMC (or other relevant professional regulatory bodies) is best placed to provide govern professional standards and conduct.

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Jonathan Montgomery is submitting this evidence in a personal capacity. In addition to being Professor of Health Care Law, University College London, he is Chair of the Health Research Authority and a member of the European Group on the Ethics of Science and New Technologies. However, he is not in any way representing the views of those bodies or those of public bodies with which he has previously been associated.

\(^{21}\) Royal College of Nursing v Department of Health and Social Security [1981] AC 800