FOUR

Would decriminalisation mean deregulation?

Jonathan Herring, Emily Jackson and Sally Sheldon

Introduction

Current British abortion law combines criminal prohibitions against abortion with an exception, carved out by the Abortion Act 1967, which provides that these offences do not apply where an abortion is performed in line with its requirements (see Chapter One). In the event of decriminalisation, the Abortion Act would necessarily be either very radically revised or repealed in its entirety alongside the removal of the criminal prohibitions. This has led some to worry that important safeguards against unethical or unsafe practice would be lost (for example, Caulfield, 2017: cols 30–1). In this chapter, we consider the basis for such concerns in the light of the legal regulation that would continue to apply following decriminalisation. We concentrate on the law of England, Wales and Scotland. Northern Ireland, where the Abortion Act has never applied, will be considered separately in the following chapter.

As we will show, the concern that decriminalisation amounts to deregulation is misplaced. Rather, abortion services are already (and would remain) subject to a dense web of other regulation, including general provisions of criminal and civil law, licensing and inspection requirements, and professional oversight (see further BMA, 2019). We begin by setting out the regulatory framework that is designed to promote good governance and high quality, patient-centred care in health services. We then move on to focus, in particular, on two issues that have provoked concern in the context of abortion services. First, we explain how the robust regulation of informed consent, confidentiality, counselling and safeguarding would be ensured following decriminalisation. Second, with a large majority of abortions now performed using medicines, we outline how access to abortion pills would be controlled. Finally, we turn to two specific cases that fall outside mainstream health practice: where a woman loses a desired pregnancy due to an assault or the non-consensual administration of pills; and where a backstreet abortion is performed by a professionally unqualified abortionist. Here, we suggest, where criminal sanction may remain appropriate, specific abortion offences are unnecessary as existing general principles of criminal law are sufficient to support prosecutions of morally culpable or dangerous conduct.

A general regulatory framework for safe care

It is rare to enshrine in statute law – as was done in the Abortion Act 1967 – restrictions on where, how and by whom a specific medical procedure can be authorised and performed. However, this does not mean that other modern medicine is practised within a legal vacuum. Rather, healthcare services are subject to significant and detailed regulation – including general requirements of civil and criminal law, licensing requirements and professional norms backed by disciplinary sanction – which foregrounds a concern with ensuring patient safety and promoting best practice. Abortion services are already subject

to the requirements of this general framework and would remain so following decriminalisation.

First, it is a criminal offence to conduct any 'regulated activity' involving the provision of health or social care – including abortion services – without first being registered for this purpose. The relevant law differs slightly in its detail between England, Wales and Scotland. However, in each jurisdiction, registration depends on meeting detailed safety, quality and governance standards, with ongoing compliance monitored through inspection visits. In England, for example, providers of a regulated activity are subject to the detailed requirements laid down in the Care Quality Commission (Registration) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These provide that service users must be treated with dignity and respect and safeguarded from abuse and improper treatment; that care and treatment must be provided in a safe way, with adequate staffing and good governance demonstrated; and that all equipment and premises must be properly maintained and suitable. In addition to these general requirements, which apply to all regulated services, this framework also offers a more flexible and easily updated mechanism for the imposition of requirements on specific areas of practice. For example, non-NHS abortion service providers are required to meet specified standards with regard to record keeping and the treatment of fetal tissue under the Care Quality Commission (Registration) Regulations 2009.[1]

Compliance with these requirements is overseen by the Care Quality Commission (CQC), which has a duty to inspect service providers under the Health and Social Care Act 2008. Where an abortion service provider falls below any of the standards set out in regulation, the CQC can serve improvement notices, cancel or alter a service provider's registration, and – in the most serious cases – bring prosecutions. Similar licensing, inspection and enforcement mechanisms operate in Wales, overseen by the Healthcare Inspectorate Wales (Care Standards

Act 2000; Registration of Social Care and Independent Health Care (Wales) Regulations 2002; Independent Health Care (Wales) Regulations 2011), and in Scotland by Health Improvement Scotland (NHS (Scotland) Act 1978; Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011).

Second, professional bodies exercise significant oversight over healthcare practice. Doctors are regulated by the General Medical Council, which operates with the overriding function of protecting, promoting and maintaining the health and safety of the public (Medical Act 1983). The General Medical Council issues a range of general guidelines that have relevance to abortion care (for example, GMC, 2007; 2008; 2012; 2013a; 2013b). Where the conduct of a doctor is found to pose a risk to the safety of patients or public confidence in doctors, the General Medical Council can suspend a doctor's right to work, require him or her to work under supervision or to undergo further training, or withdraw his or her licence to practice medicine. Likewise, the Nursing and Midwifery Council exercises oversight over nurses, midwives and nursing associates, who are required – again at risk of losing their right to practice – to act in accordance with the requirements to prioritise people, to practise effectively, to preserve safety, and to promote professionalism and trust (NMC, 2018).

Abortion service providers are also required to follow the detailed guidance offered by expert and professional bodies (or to offer a compelling explanation for any departure from it). The providers of a regulated activity are required to take account of any nationally recognised guidance relating to the services that they deliver (Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Likewise, the General Medical Council expects doctors to demonstrate the maintenance of their skills, requiring an awareness of, and an adherence to, professional guidelines (GMC, 2013a). These two mechanisms give regulatory teeth to the detailed and comprehensive best practice guidelines on the

organisation of abortion services, different abortion methods, and information to be given to patients produced by the Royal College of Obstetricians and Gynaecologists (RCOG, 2011b) and the National Institute for Health and Care Excellence (NICE, 2019), along with any guidance regarding specific aspects of services (for example, RCOG, 2010a; 2010b).

Third, it is important that women accessing abortion services are protected by the same principles of civil and criminal law that apply in the context of any other health service, since no regulatory framework, however robust, has ever succeeded in fully avoiding human error. Notably, all health professionals owe a duty of care to their patients and, where they fall below the standard of care that might reasonably be expected and a patient suffers harm as a result, they can be sued in negligence (*Bolam* 1957; *Bolitho* 1998). In the most serious cases, there may also be the possibility of a criminal prosecution for wilful neglect (sections 20–21, Criminal Justice and Courts Act 2015); for health and safety offences (section 7, Health and Safety at Work Act 1974); or for gross negligence manslaughter (*R v Adomako* 1994; *R v Misra* 2004). Those accessing NHS abortion services also have recourse to the general NHS complaints system.

Currently, independent sector abortion service providers are also subject to a separate approval process under section 1(3) of the Abortion Act 1967 that significantly predates, and today operates in parallel with, the general registration process for those offering a 'regulated activity'. This further approval process requires that service providers demonstrate their adherence to the terms of the Abortion Act; to the general requirements imposed on those who offer 'regulated activities'; and to the Department of Health's *Required Standard Operating Procedures* (RSOPs) (DH, 2014). If abortion were to be decriminalised, this additional approval process would likely disappear along with the other restrictions enshrined in the Abortion Act. While this would have the welcome consequence of sweeping away the unnecessary bureaucracy of two parallel approval processes, there is no reason to anticipate

that it would compromise important safeguards regarding patient safety. On the contrary, scrutiny of the RSOPs – the large part of which is devoted to listing regulatory requirements that have independent force – illustrates the extent to which the legal framework for ensuring high quality abortion care is already to be found in general provisions of law and not in the specific framework governing abortion. As explained in this chapter, these provisions would continue to apply following any process of decriminalisation.

Informed consent, counselling, confidentiality and safeguarding

While it is important to make robust provision within abortion services for informed consent, confidentiality, safeguarding and access to counselling for those women who want it, the current criminal law framework plays no role in this regard. When two doctors certify that they believe, in good faith, that a woman's circumstances fit within one of the statutory grounds in the Abortion Act 1967, they are not playing any role in ensuring that the woman has voluntarily given informed consent to the termination. Or, if woman lacks capacity, it is not the Abortion Act which charges doctors with ensuring that a termination is carried out only if it would be in her best interests. If abortion were to be decriminalised, other mechanisms would continue to be in place to ensure that women voluntarily give informed consent to termination, and that the best interests of women who lack capacity are protected. Similarly, the confidentiality of a patient's abortion records is not protected by the Abortion Act, but by the rules which apply to all other sensitive information about a patient's medical treatment.

Informed consent and safeguarding

To carry out any medical procedure which involves touching, without the patient's informed consent, is a battery and

an assault. Consent will be valid if it is given voluntarily, by someone who has the capacity to consent, and who understands, in broad terms, what the treatment involves. Hence, even if abortion is taken out of the criminal law, if a termination is carried out on a woman who has not voluntarily consented to it, she would not only have a civil claim in battery and in negligence, but also the person who carried out the termination would be likely to face a criminal charge of assault.

If a doctor were to suspect that a woman seeking an abortion was being pressurised by her partner or another family member, and that she did not, in fact, wish to terminate her pregnancy, he or she could not be confident that the woman had given a valid consent to termination. Doctors cannot rely upon a consent which has not been given voluntarily. So if a doctor were to terminate a pregnancy when he or she knows, or ought to have known, that the woman was not freely consenting to it, then he or she might be found to have committed both the tort of battery and the crime of assault.

Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, regulation 18, the registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. In addition to these legal requirements to ensure that the person receiving medical treatment has consented to it, the CQC's Inspection Framework for Termination of Pregnancy (CQC, 2018) further requires providers to demonstrate that they ensure that women attending for abortion are certain of their decision, understand its implications and are seeking abortion voluntarily. If the pregnant woman does not speak English, relying upon her partner or another family member to translate for her is not good practice, and the CQC's framework prompts inspectors to ask whether in 'areas where ethnic minority groups form a significant proportion of the local population, are processes in place to aide translation during the consent process?'

Providers are likewise required to demonstrate that clinicians who care for women requesting abortion 'should be able to identify those who require more support than can be provided in the routine abortion service setting, for example young women, those with a pre-existing mental health condition, those who are subject to sexual violence or poor social support, or where there is evidence of coercion' (CQC, 2018; see further, RCOG, 2011b).

In addition to these abortion-specific requirements, doctors' ordinary responsibilities for safeguarding vulnerable adults and children would continue to apply after decriminalisation. If a doctor suspects that a child or an adult who lacks capacity is subject to abuse or neglect, he or she has a duty to inform the appropriate agency. For adults who have capacity, the duty is to work with the patient in order to help him or her to seek appropriate help, although in exceptional circumstances, where there is clear evidence of an imminent risk of serious harm to the individual, it can be appropriate to disclose information without her consent (RCPCH, 2014; HM Government, 2018).

Doctors' responsibility for obtaining informed consent from their patients is increasingly regarded as an aspect of the partnership model of medical decision-making, whereby both the doctor and the patient have expertise to bring to a decision about what medical treatment is appropriate (GMC, 2008; *Montgomery v Lanarkshire* 2015). Doctors have specialist skills in diagnosis and treatment, and they are sources of expert advice on the risks and benefits of different procedures, but the decision about what treatment is best for the individual patient, in the light of her priorities and interests, is ultimately one which the patient is uniquely well-placed to make for herself. For example, let us imagine that a serious fetal abnormality is detected at the 20-week anomaly scan. The doctor can advise the woman of the implications of that abnormality for a child's health and wellbeing but the pregnant woman knows better than the doctor how well she and her family would cope with the care of a child with that condition.

There is also a considerable body of good practice guidance which helps doctors to understand what the partnership model of medical decision-making involves. The General Medical Council's *Consent: Patients and Doctors Making Decisions Together* instructs doctors that, 'you must work in partnership with your patients to ensure good care', and that, in so doing, they must 'listen to patients and respect their views about their health', 'maximise patients' opportunities, and their ability, to make decisions for themselves', and 'respect patients' decisions' (GMC, 2008).

The partnership model also applies to abortion and doctors will discuss the risks, side-effects and implications of abortion with the pregnant woman, who will be able to weigh up whether termination is the best decision for her. However, in theory, this is superseded by the requirement under the Abortion Act that two doctors, rather than the woman herself, must determine whether termination poses less risk to her health than continuing the pregnancy. This is wholly at odds with modern medical practice. It casts an intimate medical decision as one which is *not* to be made by the patient herself, in the light of her own priorities and values, but as one that is to be made paternalistically, on her behalf, by two doctors.

Girls and women who lack capacity

The Abortion Act 1967 plays no role at all in protecting the interests of girls and women who lack capacity, whose interests are instead protected by the common law, by statute and by good practice guidance, all of which would continue to be in place if abortion were to be decriminalised.

Under 18s

If a girl is 16 or 17 years old, she is able to give a valid consent to termination, in the same way as if she were an adult (under the Family Law Reform Act 1969 in England

and Wales, and under the Age of Legal Capacity Act 1991 in Scotland). If she is under 16, but has sufficient understanding in order to make a decision for herself (*Gillick* 1986; Age of Legal Capacity Act 1991: section 2(4)), she can give a valid consent to abortion. She also has a right of confidentiality in relation to her termination, which means that her parents have no right to be consulted or informed (*Gillick* 1986; *Axon* 2006).

Parents can take medical decisions for children who are not yet *Gillick*-competent (England and Wales), or 'capable of understanding the nature and possible consequences of the procedure or treatment' (Scotland), subject to the possibility of being overruled by the court if the decision they wish to take is not in the child's best interests. In practice, however, the courts have been clear that it would be very difficult to imagine the circumstances in which it would be in the best interests of a girl who lacks capacity to terminate her pregnancy against her wishes, or, conversely, to force her to carry her unwanted pregnancy to term (*Re X (A Child)* 2014).

Adults who lack capacity

Where an adult pregnant woman lacks capacity, then under the Mental Capacity Act (MCA) 2005 in England and Wales and the Adults with Incapacity (Scotland) Act 2000, decisions about her pregnancy, including the decision to terminate it, should be made in her best interests (in the language of the MCA), or in order to benefit the woman (in the language of the Adults with Incapacity (Scotland) Act). Unlike non-therapeutic sterilisation, abortion is not one of the special cases for which court approval should be sought routinely. Rather, the decision should be brought before the Court of Protection in England and Wales or the Court of Session in Scotland only where there is doubt over whether the woman lacks capacity, or whether termination is in her best interests (*An NHS Trust v D* 2003; SCIE, 2011).

When deciding whether termination is in the best interests of a pregnant woman who lacks capacity, her wishes and feelings are of central importance (Adults with Incapacity (Scotland) 2000, section 1(4)(a); MCA 2005, section 4(6); *Re AB (Termination of Pregnancy)* 2019). That means that even if a woman would be unable to look after her baby, and the local authority would be likely to take the child into care immediately after birth, if a woman does not want a termination, it is very unlikely to be in her best interests (*Re AB (Termination of Pregnancy)* 2019). As King LJ has explained, 'carrying out a termination absent a woman's consent is a most profound invasion of her Article 8 rights' (*Re AB (Termination of Pregnancy)* 2019).

It is important to remember that – unlike any other medical procedure – where a decision is made by the woman's treating doctor, or by a court, that termination is in the woman's best interests, this is currently insufficient for the procedure to go ahead. Rather, in addition, the Abortion Act requires two doctors to certify that the woman's circumstances also fit within the statutory grounds. It could be argued that if the UK's capacity legislation is thought to offer sufficient protection to vulnerable women in the context of sterilisation, organ donation and the withdrawal of life-prolonging treatment, it is odd that a decision which has been taken in the woman's best interests (in England and Wales), or in order to benefit her (in Scotland), is not likewise the end of the matter in relation to termination.

Counselling

All women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor, with this offer repeated at every stage of the care pathway and post-abortion counselling available for those women who request it. No provision for this is made in the Abortion Act. Rather, these requirements are enshrined

in professional guidelines (RCOG, 2011b; NICE, 2019) and regulation (CQC, 2018). Following decriminalisation, provision for counselling would thus continue in exactly the same way as currently.

Confidentiality and data protection

Information about a woman's termination of pregnancy is undoubtedly sensitive personal information, and further disclosure of it is protected at common law, by her right to privacy under the Human Rights Act 1998, and by the General Data Protection Regulation 2018. Under the Abortion Regulations 1991, every abortion must be reported to the appropriate Chief Medical Officer, and the Regulations place restrictions upon any further disclosure of this information. If abortion were to be decriminalised, this is not a reason to stop collecting data about the incidence of abortion in England, Scotland and Wales, and similar reporting duties could be imposed through a new set of Regulations.

Regulation of abortion medicines

In 2018, 71 per cent of abortions performed in England and Wales and 86 per cent of those in Scotland were medical rather than surgical (DHSC, 2019a; ISD, 2019). Medical abortions involve the sequential administration of two prescription-only medicines, mifepristone and misoprostol, in order to end the pregnancy and trigger a miscarriage. If abortion were to be decriminalised, the law which applies to the provision of prescription-only medicines would continue to impose considerable restrictions upon the supply and use of mifepristone and misoprostol.

Medicines can only receive a marketing authorisation under the Human Medicines Regulations 2012 if they are proved to be safe and effective. The Human Medicines Regulations also ensure that medicines which are supplied for human use meet

appropriate quality standards. Supplying counterfeit or fake medicines is a criminal offence under statute in England and Wales (section 2, Fraud Act 2006) and common law in Scotland.

Medicines are classified as 'prescription only' in order to ensure that only properly qualified and registered healthcare professionals act as gatekeepers to anyone wishing to access them. The General Medical Council's good practice guidance for doctors specifies that doctors must not prescribe any medicines unless they have 'adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs' (GMC, 2013a: para 16(a)).

It is a criminal offence for someone who is not properly qualified and registered to prescribe and supply a prescription-only medicine (regulation 214, Human Medicines Regulations 2012). Hence the owners of any 'online pharmacy', which claims to sell mifepristone and misoprostol without a prescription would be committing a criminal offence in the UK. In practice, such websites are often based overseas, and it is therefore more difficult for the UK regulator of medicines, the Medicines and Healthcare Products Regulatory Agency (MHRA) to control their activities. If the website is registered in another country, the MHRA would inform the relevant regulatory authority in that country.

There are also restrictions upon advertising. Prescription-only medicines cannot be directly marketed to consumers, and regulation 283 of the Human Medicines Regulations 2012 further provides that 'A person may not publish an advertisement that is likely to lead to the use of a medicinal product for the purpose of inducing an abortion'.

Non-consensual termination of pregnancy

The current law has little difficulty in dealing with cases where the defendant terminates, or seeks to terminate, the victim's pregnancy without her consent. Indeed, in recent years, in England and Wales, the primary use for the offences under

section 58 of the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929 has been in cases where the defendant causes a woman (frequently his former or current sexual partner) to lose a wanted pregnancy. For example, in *R v Magira* 2008, a husband, who was unhappy about his wife's pregnancy, mixed abortion pills into her food without her knowledge, which made her ill, but did not cause a miscarriage. He was convicted of administering a poison or noxious thing with intent to secure a miscarriage under section 58 of the Offences Against the Person Act. He received three years and nine months' imprisonment.

Even if those offences were abolished, however, other offences are committed in such cases. The general offences of assault occasioning actual bodily harm (section 47, Offences Against the Person Act 1861) and causing/inflicting grievous bodily harm (sections 18 or 20, Offences Against the Person Act 1861) apply. Under the current law, grievous bodily harm has been defined as really serious bodily harm and it is left to the jury to determine if an injury falls within that description (*R v Bollom* 2003). It seems very likely that a jury would conclude that a non-consensual termination would constitute grievous bodily harm and, indeed, it seems in the reported cases that they have been willing to do so. In *R v Wilson* 2016, the defendant attacked the pregnant victim (his former sexual partner), deliberately stamping on her stomach. He was convicted of intentional infliction of grievous bodily harm (as well as 'child destruction' under the Infant Life (Preservation) Act 1929). Indeed, in such cases it can be easier to charge one of the general assault offences than to rely on section 58 of the Offences Against the Person Act or the Infant Life (Preservation) Act, because there is no need to prove that the defendant knew the victim was pregnant or that he was intending to terminate the pregnancy.

The poisoning offences found in sections 23 and 24 of the Offences Against the Person Act 1861 are also important here. Section 24 states that 'whosoever shall unlawfully and

maliciously administer to or cause to be administered to or taken by any other person any poison or other destructive or noxious thing, with intent to injure, aggrieve, or annoy such person' is guilty of an offence. Section 23 is similarly worded but covers cases where the victim's life is endangered or they suffer grievous bodily harm. A very senior judge, Munby J (as he then was) seems to have accepted *obiter dicta* that these offences could be used to punish a defendant who had sought to terminate a victim's pregnancy without her consent through the surreptitious administration of pills (*R (Smeaton)* 2002: para 274).

There is, therefore, plenty of scope within the current criminal law to deal with cases where a defendant is seeking to terminate a victim's pregnancy without her consent. Indeed, we cannot imagine such a case where a criminal offence would not be committed, even if section 58 of the Offences Against the Person Act and the Infant Life (Preservation) Act were abolished. While it is thus highly unlikely that such an amendment is required, if Parliament deemed it desirable for the removal of any doubt, it might nonetheless choose to amend the existing offences to provide explicitly that the surreptitious administration of pills falls within the poisoning offences and that an assault on a pregnant woman that terminated a pregnancy would be treated in law as 'grievous bodily harm'. This latter proposal was made by the Victorian Law Reform Commission (VLRC, 2008: 8), which suggested accompanying decriminalisation of abortion with an amendment to the law criminalising the causing of serious injuries. This provided that '[s]erious injury includes: the destruction (other than in the course of a medical procedure) of the fetus of a pregnant woman, whether or not the woman suffers any other harm'.

Reform in relation to sentencing might also be considered, though again, in our view, this is not necessary as the matter is adequately dealt with by the current law. A defendant who attacked a pregnant woman, terminating her pregnancy, could be charged with the same offences under sections 23

or 24 as could a defendant who attacked a woman who was not pregnant. However, under the current law, the loss of a wanted pregnancy will be treated as an aggravating feature which would indicate an increased sentence. In *R v Wilson* 2016, an 18-year sentence was held to be justified, with the court placing particular weight on the intentional termination of the pregnancy through the attack. The maximum sentence for intentional infliction of grievous bodily harm is life and so this sentence could have been imposed even without a conviction under the 1929 Act.

Medically unqualified providers

It has been questioned whether, if the relevant offences under the Offences Against the Person Act and Infant Life (Preservation) Act (in England and Wales) and the common law (in Scotland) were abolished, it would then become lawful for someone who does not have the appropriate qualifications or training to provide an abortion (Caulfield, 2017 30–1). There are two main reasons why this should not be a concern.

First, it is an offence to falsely pretend to be a doctor, nurse, or midwife (section 49 of the Medical Act 1983; section 44 of the Nursing and Midwifery Order 2001; and, for England and Wales, section 2 Fraud Act 2006). That would clearly cover anyone who was purporting to be medically qualified at performing abortions, but in fact was not. It would not, however, apply to someone who was open about not having any medical qualifications.

Second, as confirmed in the infamous decision of the House of Lords in *R v Brown* 1993, any medical procedure that involves contact with the body of a patient is *prima facie* a criminal offence. It could be an assault occasioning actual bodily harm (section 47, Offences Against the Person Act) or inflicting/causing of grievous bodily harm (sections 18 and 20 Offences Against the Person Act), depending on the severity of the harm. However, for such offences, the consent of the patient only

provides a defence in a list of exceptional circumstances, one of which is 'reasonable surgical interference'. The precise scope of this exception was considered by the Court of Appeal in *R v BM* 2018, which concerned a tattooist who had engaged in body modification (including ear removal and tongue splitting) on clients with their consent. When charged with offences of causing grievous bodily harm, he sought to rely on the medical treatment exception. The Court of Appeal rejected this defence, explaining it could not be used by people not qualified to practise surgery:

> elective surgery would only be reasonable if carried out by someone qualified to perform it. The professional and regulatory superstructure which governs how doctors and other medical professionals practice [sic] is there to protect the public. The protections provided to patients, some of which are referred to in the medical evidence before the judge, were not available to the appellant's customers or more widely to the customers of those who set themselves up as body modifiers. (para 42)

The Court of Appeal went on to explain that those lacking medical qualifications were not in a position to ensure that the patients had the capacity to make the decision to consent to the treatment, or had been properly informed of the risks. Notably, they explained that the fact the 'surgery' was performed with skill and in sterile conditions did not affect their decision. Nor was the fact the clients were willing to consent to the treatment, knowing the defendant was not medically qualified. This case makes it clear that a person who performs a surgical termination of pregnancy, which would otherwise be an assault occasioning actual bodily harm or grievous bodily harm will be guilty of an offence under the Offences Against the Person Act because they cannot rely on the medical treatment exception.

There is, perhaps, one issue of debate. It is only necessary to rely on the medical treatment exception if the treatment

involves actual bodily harm or a more serious harm. While later abortions performed by dilatation and evacuation would certainly fall into that category it might be questioned whether earlier procedures performed by vacuum aspiration procedures would also do so. Actual bodily harm has been defined by the courts as any hurt which interferes with the health or comfort of the victim, which is more than transient and trifling (*R v Chan Fook* 1994). The approach taken by the House of Lords in *Brown* is that this is assessed without taking into account the consent of victim. Given the courts' emphasis on ensuring that medical procedures are offered by those trained to ensure informed consent, it seems likely that even a safely performed vacuum aspiration procedure would constitute a bodily interference which is more than transient and trifling. It should also be remembered that, as outlined earlier, abortion is a 'regulated activity', meaning that it is a criminal offence to offer services without first being registered to do so.

Conscientious objection

Finally, it should be noted that the Abortion Act also offers a safeguard designed to protect the interests of those healthcare professionals who are opposed to abortion for religious or moral reasons, providing that 'no person shall be under any duty … to participate in any treatment authorised by this Act to which he has a conscientious objection' (section 4(1), Abortion Act 1967). If abortion were to be decriminalised, abortions would no longer be 'authorised by this Act' and statutory protection of conscientious objection rights would thereby disappear.

It is a moot point whether statutory protection of conscientious objection rights is necessary. Notably, the statutory right does not cover those doctors who choose to opt out of certifying that an abortion is justified under the Abortion Act, as certification must legally take place *before* treatment for the termination of pregnancy begins and thus cannot logically

constitute 'participation in any treatment' (*Doogan* 2014: para 36; *Janaway* 1989: 572). Nonetheless, doctors' right to opt out of certification is widely respected in practice and is entrenched in employment law, the contractual arrangements made by the NHS with GPs and the employment contracts made with hospital doctors (*Doogan* 2014: para 36).

Whether or not to entrench a statutory right of conscientious objection post-decriminalisation would be a matter for Parliament. The Abortion Bill 2018, sponsored by Diana Johnson, made such provision.

Conclusion

If the specific criminal offences against abortion in England, Wales and Scotland were to be abolished, the Abortion Act would become redundant and should thus also be repealed. Such moves would necessarily be the result of statutory reform, allowing Parliament the opportunity to retain any provisions of the Act that it believes to serve an ongoing purpose. For example, Parliament might choose to make specific provision for conscientious objection. While in our view this is not necessary, Parliament might also amend existing assault and poisoning offences to put beyond any doubt that they apply to non-consensual abortion.

In other respects, as we have described earlier in the chapter, abortion is – and would remain – subject to a dense web of other regulation. It is these provisions which already do the important work of ensuring that services are of a high quality; and that they are offered with close attention to the need for robust consent, confidentiality, counselling and safeguarding. In rare cases – involving non-consensual or unsafe abortions offered by unqualified providers – criminal sanction would remain appropriate. As previously described, in our view, it is already so available under the general provisions of criminal law.

We have not sought to address moral, theological or political arguments regarding the decriminalisation of

abortion. We have, however, demonstrated that any concern that abortion would be left unregulated following such a reform are ungrounded and should therefore not play a role in those debates.

In sum, decriminalisation does not amount to deregulation.