Dear Colleagues

GUIDANCE IN RELATION TO REQUIREMENTS OF THE ABORTION ACT 1967

Introduction

1. This letter sets out guidance in relation to the Abortion Act 1967 and is aimed at those responsible for commissioning, providing and managing service provision. It follows similar guidance issued by the Department of Health in England and consultation with clinicians in Scotland.

2. Board Medical Directors are asked to ensure that this letter is brought to the attention of all colleagues in primary care, sexual health clinics, obstetrics and gynaecology and other providers of abortion services.

Requirements of the Abortion Act 1967

3. This letter reminds practitioners of the legal requirements of the Abortion Act and sets out how that law is interpreted by DH and by the Scottish Government.

4. The guidance addresses a number of issues including:

   • best practice in assessing risk to physical or mental health
   • the pre-signing of certificate A and the faxing of certificates
   • the role of the second clinician
   • the role of the multi-disciplinary team
   • abortion on the grounds of gender

5. In addition, the guidance addresses the requirements of completing the “Notification of an abortion performed under Section 1 of the Abortion Act”, the so-called Yellow Form. These are required to be completed and returned to the Chief Medical Officer’s office within 7 days of the abortion being completed.
6. It is crucial that all completed abortions are notified to the CMO, both as a matter of law and for there to be appropriate public and parliamentary scrutiny and trust in the data that are published.

7. This guidance is intended to be supportive of those involved in this sensitive and challenging area of care and to ensure that we continue to provide a high quality, legal service that meets the needs of women.

8. Further guidance is also available from the General Medical Council, British Medical Association, Royal College of Obstetricians and Gynaecologists and the Royal College of Nursing.

Yours sincerely

Aileen Keel

DR AILEEN KEEL CBE
GUIDANCE IN RELATION TO REQUIREMENTS OF THE ABORTION ACT 1967

FOR ALL THOSE RESPONSIBLE FOR COMMISSIONING, PROVIDING AND MANAGING SERVICE PROVISION

Prepared by
Sexual Health Policy Team
Department of Health
London
SW1A 2NS

Adapted by
Sexual Health and Blood Borne Virus team
3EN St Andrews House
Edinburgh
EH1 3DG
Contents

Introduction ................................................................................................................................. 3
Background ................................................................................................................................. 3
Guidance ................................................................................................................................... 4
Annex A ..................................................................................................................................... 8
Annex B ..................................................................................................................................... 9
Introduction

1. It is acknowledged that there have been advances in abortion care since the passage of the Abortion Act. Increasingly, abortions are provided through medical rather than surgical methods, at earlier gestations and there is generally multidisciplinary team involvement. However, apart from amendments made in 1990, the Abortion Act remains unchanged. It is essential that all those involved in commissioning and providing abortion care, including those managing services, should understand the legal requirements placed on clinicians to ensure that their practice is lawful.

2. Abortion is an area in which people can hold very strong views. All those involved in abortion care, particularly clinicians, can be faced with working in a sometimes difficult and challenging environment with a number of vulnerable clients. This guidance is intended to support all those involved in commissioning, providing and managing abortion services to provide a high quality, legal service that meets the needs of women.

Background

3. Following the decision by the CPS in England in August 2013 not to prosecute two doctors investigated for certifying abortions based on the gender of the foetus, the CPS highlighted the lack of guidance for doctors about abortion law. In particular, the statement made by the CPS in relation to those cases highlighted that “there is no guidance on how a doctor should go about assessing the risk to physical or mental health, no guidance on where the threshold of risk lies and no guidance on a proper process for recording the assessment carried out”.

4. In response, the Department of Health agreed to produce guidance on these issues. The guidance does not, and indeed cannot, change the law in relation to abortion, which is governed by the criminal law and the Abortion Act and is ultimately a matter for Parliament and the courts to determine.

5. It was agreed that it would be supportive of doctors if guidance was offered by setting out how the law is interpreted by the Department of Health. This guidance is adapted from that guidance and is aimed at those practicing in Scotland. More detailed guidance for health professionals on abortion is also available from the General Medical Council, British Medical Association, Royal College of Obstetricians and Gynaecologists and the Royal College of Nursing.

6. Although there is no legal requirement for at least one of the certifying doctors to have seen the pregnant woman before reaching a decision about a termination, Scottish Government’s view is that it is good practice for this to be the case. It is recognised however that, with technological advances, this may well mean that a doctor does not physically see the woman, e.g. there could be a discussion by phone or over a webcam. This paragraph should also be read in conjunction with paragraphs 19 and 20 of this guidance.

1 http://blog.cps.gov.uk/2013/10/statement-from-director-of-public-prosecutions-on-abortion-related-cases.html
Guidance

Abortion legislation

7. The Offences Against the Person Act 1861 makes it a criminal offence to intentionally unlawfully procure a miscarriage, including for a woman to procure her own miscarriage. The Infant Life (Preservation) Act 1929 makes it an offence to intentionally kill a child, capable of being born alive, before it has a life independent of its mother. The Abortion Act creates exceptions to these offences in certain limited circumstances.

8. The Abortion Act makes abortion legal where the pregnancy is terminated by a clinician and, except in emergencies, where two clinicians are of the opinion formed in good faith that one of the lawful grounds specified in the Act are met.

Forming an opinion in good faith

9. If there is evidence that either certifying doctor has not formed their opinion in good faith then the doctor performing the termination is not protected by section 1(1) of the Abortion Act and has potentially committed a criminal offence by terminating the pregnancy. It is also possible that the doctor could be acting contrary to their professional duties.

10. Practices have come to light recently which call into question whether doctors have acted in accordance with their legal obligations under the Abortion Act. These practices include the signing of Certificate A (the Green form) by doctors before a woman has been referred, and doctors signing forms relying solely on decisions made about the woman in question by other doctors or members of the multi-disciplinary team without any other information.

Abortion certification

11. Certificate A must be completed, signed and dated by 2 clinicians before an abortion is performed. Certificate A must be kept with the patient notes for 3 years from the date of termination. The form must be completed by both clinicians certifying their opinion, formed in good faith that at least one and the same ground for abortion in section 1(1) of the Abortion Act exists. The certification takes place in the light of their clinical opinion of the circumstances of the pregnant woman’s individual case. The lawful grounds for abortion are set out in Annex A.

Assessing risk to physical or mental health, the threshold of risk and recording how the assessment is carried out

12. Whilst there is no statutory requirement for either doctor to have seen and/or examined the woman, it is Scottish Government’s considered view that both doctors should ensure that they have considered sufficient information specific to the woman seeking a termination to be able to assess whether the woman satisfies one of the lawful grounds under the Abortion Act.

13. This assessment will include consideration of any risk to the woman’s physical or mental health as one of the lawful grounds. The identification of where the threshold of risk to the physical or mental health of the woman lies is a matter for the clinical opinion for each of the doctors.

---

2 Regulation 3(2) Abortion Regulations 1991 S.I. 1991/499
4 See the form in Part 1 to Schedule 1 and regulation 3(ii)(d) of the Abortion Regulations 1991
14. Although the burden of proof would be on a prosecutor to show that an opinion was not formed in good faith, Scottish Government recommends that clinicians should be prepared to justify how they considered information specific to the woman when forming their opinion, for example by recording in the patient record that they have assessed the relevant information and reached the conclusion based on this information. This is in line with guidance from the GMC\(^5\) (see annex B).

15. It should be noted that ultimately, if challenged, the question as to whether an individual doctor formed an opinion in good faith would be for a court to decide based on the facts in the individual case.

**What is pre-signing Certificate A?**

16. In February 2012, CQC inspectors in England identified a number of cases where signatures on certificates predated the referral and assessment of women in a clinic. For example, one woman was referred to the clinic on 20 December and assessed on the 22 December. The certificate reflected that a doctor at the clinic had seen the woman and signed the form on 22 December. However, the signature of the second doctor, also a practitioner at the clinic, was dated 19 December. Therefore, on the information provided, the second doctor had certified the abortion before being assigned the case, and before having any opportunity to consider the clinical files or other specific information to the woman.

17. The pre-signing of certificates calls into question whether a doctor could turn his or her mind to a specific woman’s circumstances and form a good faith opinion about which, if any, of the lawful grounds under the Abortion Act might apply (see annex A). In subsequent investigations the CQC identified a further 14 services where there was clear evidence of pre-signing certificates. Poor practice identified included photocopying of signatures on forms. Scottish Government considers pre-signing of forms (without subsequent consideration of any information relating to the woman) to be incompatible with the requirements of the Abortion Act.

**Signing Certificate A based on the decisions of another doctor**

18. It has also come to light that, in some cases, the second clinician might simply sign a certificate based on the decision of the first clinician, relying solely on that doctor’s judgment to provide a second signature without considering any information specific to the woman concerned.

19. An example of where this situation could arise would be where an “on-call” doctor is asked to sign Certificate A without access to the patient records to form their opinion in good faith with no other information specific to the woman being available. Junior doctors, in particular, may feel under pressure to comply with such a request.

20. The purpose of the requirement that 2 doctors certify the ground(s) for termination is to ensure that the law is being observed; this provides protection for the woman and for the doctors providing the termination\(^7\). One of the 2 certifying doctors may also be the doctor that terminates the pregnancy. The clear intention of the Act is for each doctor to consider the woman’s circumstances in forming a good faith opinion. This is reflected in the recognition that the doctors may find that different grounds are met (although they must both find the same ground is met for the abortion to be lawful\(^8\)). Treating certification by one or either doctor as a ‘rubber stamp’ exercise is therefore contrary to the spirit of the

---

\(^5\) Section 19, Good Medical Practice, General Medical Council (2013)

\(^6\) Section 71, Good Medical Practice, General Medical Council (2013)

\(^7\) Scientific Developments Relating to the Abortion Act 1967, Twelfth Report of Session 2006-7, House of Commons, Science and Technology Committee

\(^8\) Regulation 3(ii)(d) Abortion (Amendment) (England) Regulations 2002 S.I. 2002/887
Act and calls into question whether that doctor is in fact providing an opinion that they have formed themselves in good faith rather than relying solely on a colleague’s opinion, however trusted that colleague’s judgement may be. Scottish Government considers the signing of forms without consideration of any information relating to the woman to be incompatible with the requirements of the Abortion Act.

The role of the Multidisciplinary Team (MDT)

21. It is acknowledged that the MDT, including nurses and counsellors (it is possible that the MDT would include a midwife where a congenital abnormality has been diagnosed antenatally) plays an important role in supporting women seeking an abortion and in obtaining information from women. Clinicians can rely on information obtained by members of the MDT but it is Scottish Government’s interpretation of the law that clinicians should themselves review the information before reaching an opinion, for example by considering the paperwork or speaking to members of the team. Clinicians must be satisfied that they can justify how they reached their decision in good faith if later challenged. The opinions required under the Act are clearly those of the clinician, not of any other member of an MDT, however experienced or trusted. Scottish Government does not think that the Act can be read to enable the opinion required to be that of another person entirely, or the opinion of a team as a whole. Clinicians may, of course, take into account the opinions and views of colleagues in forming their own opinion and it is often important to do so, but the opinion provided must be their own.

Faxing of Certificate A

22. If the first doctor signs and dates Certificate A, which is faxed to the second doctor who then signs and dates the faxed copy certificate then, although they will have technically signed and dated two separate certificates, it is Scottish Government’s view that the doctors will have complied with the requirements as to certification set out in the Abortion Regulations 1991 ("the Abortion Regulations). However, as set out above, it is still expected that both doctors should take positive steps to obtain information specific to the woman seeking a termination as part of reaching their decision as to whether there are grounds under the Abortion Act.

23. As the certificate will contain sensitive personal data, it must be processed (transmitted, stored, disposed of etc.) in accordance with the Data Protection Act 1998 (DPA). The DPA permits the “sensitive personal” data to be transmitted from one doctor to another if the patient explicitly consents, or the processing is necessary for medical purposes and is undertaken by a health professional or by someone who is subject to an equivalent duty of confidentiality. Data Protection Principle 7 requires that: ‘Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data’.

24. There are some recent examples of fines being imposed by the Information Commissioners Office (ICO) where faxes containing sensitive personal data were sent to the wrong fax number. For example an NHS Trust in London was fined £90,000 for persistently committing this error. Abortion providers therefore need to consider whether fax is a sufficiently secure method of transmitting the forms. Providers’ should consider the ICO’s guidance about the use of faxes:


---

9 Section 35, Good Medical Practice, General Medical Council (2013)
10 Regulation 3(2) Abortion Regulations 1991 S.I. 1991/499
12 Paragraph 7, Schedule 1, Data Protection Act 1998
Abortion on the ground of gender

25. Abortion on the grounds of gender alone is illegal. Gender is not itself a lawful ground under the Abortion Act (see annex A for the lawful grounds under Section 1(1)). However, it is lawful to abort a foetus where two clinicians are of the opinion, formed in good faith, “that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped”, and some serious conditions are known to be gender-related.

Completion of “Notification of an abortion performed under Section 1 of the Act” – the Yellow form

26. Section 2 of the Abortion Act requires all clinicians terminating a pregnancy to give notice to the Chief Medical Officer (CMO). It is a criminal offence for clinicians not to notify the CMO of every termination they perform. In Scotland, the Abortion Regulations require that the notification form be submitted to the CMO within 7 days of the procedure. This notification is used by as an aid to checking that terminations are carried out within the law. Notification forms require detailed information relating to the procedure, including the names and addresses of the doctors who certified there were lawful grounds under the Abortion Act, gestation, method used and place of termination. Every form is checked and monitored by officials authorised by the CMO. Data derived from the forms is used to publish annual statistics on abortion. It is crucial that all abortions performed are notified to the CMO, both as a matter of law and for there to be appropriate public and parliamentary scrutiny and trust in the data that are published.

27. Currently, a significant number of notification forms received are returned to clinicians because of missing, incomplete or invalid data. The main errors that occur are missing doctors’ names on page one, missing gestation and missing ground information, both on page four. Incomplete forms will be returned to either the clinician terminating the pregnancy or to the place of termination. Incomplete forms are a financial burden: they generate additional work for those completing the forms and for those who process them on behalf of the CMO. The MDT may have a role in filling in the detail of the form but the clinician terminating the pregnancy is the person legally responsible for giving notice to the CMO. Scottish Government therefore recommends that clinicians always check the form before signing it and returning it to the CMO. Clinics and hospitals should have protocols and processes in place to ensure that notification forms are being returned in a timely and accurate manner.

Role of the clinician in abortion procedures

28. For medical abortions, the Courts have determined that provided the clinician personally decides upon and initiates the process of medical induction and takes responsibility for it throughout the termination, the protection under the Act applies to both the clinician and any other person participating in the termination under his or her authority. The nurse or midwife would not be responsible for leading or directing the procedure or care, or taking the overall decisions, this is firmly the responsibility of the doctor. The Nursing and Midwifery Council’s (NMC) Code will apply to all actions taken or decisions made by the nurse or midwife.

---

13 Abortion (Scotland) Regulations 1991.
Annex A

Grounds for Abortion under Section 1 of the Abortion Act

(1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—

(a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or existing children of her family; or

(b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

(c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

(d) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection (1) of this section, account may be taken of the pregnant woman’s actual or reasonably foreseeable environment.
Annex B

Relevant Guidance from Good Medical Practice, General Medical Council (2013)

(1) Section 19: “Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.”

(2) Section 35: “You must work collaboratively with colleagues, respect their skills and contributions”

(3) Section 71:

“You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.”