IN SEPTEMBER 2017, the RCOG Council voted to support the decriminalisation of abortion. This means the College will actively take part in the debate about the post-decriminalisation landscape, ensuring the profession that provides care in this area is represented. To be clear, decriminalisation does not mean deregulation: the College simply wants to bring abortion care out of the legal sphere and into the domain of medical regulation – as with any other medical procedure. This vote coincided with the 50th anniversary of the Abortion Act 1967. The Act was a force for good in the late 1960s, as it brought abortion care out of the back streets and into mainstream medicine, but it is no longer fit for purpose. It wants to bring abortion care out of the legal sphere and into the domain of medical regulation – as with any other medical procedure.

"One in three women in the UK is going to have an abortion by the age of 45"
allows women – if certain strict criteria are met – to have an abortion, but technology and medicine have moved on since the Act was passed, in particular, the availability of abortion medication as an alternative to surgical abortion.

Besides, is it appropriate that in the 21st century a woman can potentially be sent to prison for a decision she has made about her own body? The RCOG believes not. “Abortion services should be regulated; however, abortion – for women, doctors and other healthcare professionals – should be treated as a medical rather than a criminal issue,” says the College’s position statement on the subject.

There is no doubt in the mind of the RCOG’s President, Professor Lesley Regan, that the Council’s vote was the right one. “One in three women in the UK is going to have an abortion by the age of 45. My role is to ignore whether that’s distressing or distasteful for any of us. My role is to make sure that the education of our trainees and the healthcare provision for all the girls and women of this country is of the highest quality,” she says.

Medical advances
There are compelling reasons why abortion law must change. “In 1967, if you came to me to have an abortion your only option was to have a surgical procedure: to be brought into hospital, to be given an anaesthetic and have your uterus evacuated surgically. But now three-quarters of all abortions are done by taking pills,” Lesley says. “So if you come to me in my miscarriage clinic and the scans say the heartbeat’s stopped, I will give you drugs to take home so that you can try and have your miscarriage as comfortably as possible. If you come to me for a termination of pregnancy at exactly the same gestational age, I will insist that you take the drugs in front of me, then you go and miscarry on public transport on the way home. And I really think that’s not a civilised way to behave.”

This is a key concern for independent abortion providers, too. Clare Murphy, director of external affairs at the British Pregnancy Advisory Service (BPAS), which provides not-for-profit services on behalf of the NHS, says: “Two of the key changes we would like to see are home use and much greater involvement of nurse and midwife practitioners, just as we see in miscarriage care but which the current interpretation of the law prohibits. It may sound strange, but in a way our dream is that we don’t exist – so early abortion, for example, could be provided through a GP, and a woman would be able to pick up the pills from her pharmacist. Once we have got rid of legal restrictions that serve no purpose, we can start looking at what a really good, accessible abortion service would look like. We’ve never been able to have that discussion before.

“Decriminalisation has got to be part of the discussion about where the next generation of abortion doctors comes from. Training has to be part of the issue. But getting rid of a stigmatising law – which carries a threat of prosecution that does not apply to any other medical procedure – needs to be another part.”

Future provision
Lesley wholeheartedly agrees, pointing out that the cumulative effect of abortion being a tricky area of medicine to navigate legally has been a de-skilling of the NHS abortion care workforce. “In many parts of the country the provision has broken down,” she says. “For many of
the gynaecologists of my generation, if they’ve met local opposition to abortion services, it’s just been easier to put it aside. On top of this, fragmented commissioning of healthcare services has meant that we now have independent service providers tendering for those services. So for many hospitals it is cheaper to give the tender to BPAS or Marie Stopes International than it is to run the abortion service themselves.”

Some 70% of abortions paid for by the NHS are now in the independent sector, she says. “Therefore only a small proportion of NHS clinicians in my specialty are now exposed to it. And that is the biggest problem. If we don’t turn it around in the next three or four years, when my generation of gynaecologists retires there will not be an abortion workforce because there will be no mentors or trainers.”

Lesley’s fears are borne out in the statistics. Wendy Savage, a retired O&G doctor, researcher and lecturer, has been at the heart of research into UK gynaecologists’ views about abortion since the 1980s. “We did a survey in 1989, and about 90% of doctors were doing abortions, most of them weekly,” she says. “By 2015, half didn’t do abortions any more because women went to BPAS

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**THE HISTORY OF ABORTION IN THE LAW**

**1861**

Abortion is made a criminal offence by the Offences against the Person Act (the Act does not apply in Scotland)

**1929**

Abortion is a criminal offence except when a woman’s life is at risk (Infant Life Preservation Act)

**1967**

Abortion Act makes exceptions to the 1861 Act. It permits abortion up to 28 weeks’ gestation in the UK (excluding Northern Ireland) by a doctor, with the written agreement of a second doctor, on registered premises. This does not apply if a woman’s life is at risk.

The Act is unusual in its provision of a ‘conscience clause’ which allows doctors and other health care professionals to override any contractual obligations and opt out of performing abortions.

**ABORTION ACT 1967**

After much contentious debate and deliberating over wording, the Abortion Act was finally passed on 27 October 1967, and came into force six months later. It had been introduced into Parliament by David Steel, MP, and was given the backing of the government’s advisory committee, chaired by Sir John Peel, then RCOG president.
or another provider. That has huge implications for training: it’s not done in hospital any more.”

**Shifting attitudes**

Something else that has changed in the time that Wendy has been carrying out this kind of research is the proportion of doctors who think it’s up to the woman to decide whether or not to have an abortion: in 1989 seven out of 10 consultants said they were in favour of a woman being able to choose whether to continue a pregnancy in consultation with her doctor. In 2015 that figure was around 90%.

There is support, then, among the O&G workforce for women’s autonomy in deciding whether to continue a pregnancy – however, there’s also a decline in the proportion of doctors who can help a woman make that decision. Wendy has a theory that by making fertility control, including abortions, a subspecialty, more doctors might be encouraged to go into it because it would have its own discrete status. “One of the questions we’ve asked over the years is whether fertility control should be a subspecialty. There’s never been a large majority in favour of that, but an increasing number,” she says – from 26% in 1989 to 51% in 2008.

Whatever the future of abortion care looks like, it is encouraging that the political, medical and social debate is increasingly focusing on decriminalisation. And Lesley Regan wants the RCOG to be at the heart of that debate: “I don’t want to feel that this College has done anything else except support the very best for girls and women in their reproductive lives,” she says.

**FURTHER RESOURCES**

- Take a look at the Termination of Pregnancy virtual issue (bit.ly/2k2isMj). BJOG presents a number of articles about termination of pregnancy, including research papers and a ‘BJOG on the Case’ article.

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**1990**

The upper limit is reduced to 24 weeks (Human Fertilisation and Embryology Act)

**2017**

Women in England, Scotland and Wales still need the approval of two doctors before they can get an abortion.

Women in Northern Ireland can only have an abortion if they are at risk of dying.

The 1861 Act makes abortion outside the exceptions in the Abortion Act a crime punishable by a maximum of life imprisonment.

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**WOMEN FIGHT FOR CHEAP ABORTION, THE GUARDIAN, 1971**

Women’s liberation groups continued to look for improvements to women’s rights and access to abortion after the implementation of the Abortion Act in 1967. The Guardian’s story shows a group demonstrating in the grounds of the RCOG in July 1971. They were demanding that the vacuum aspiration method of abortion be made available, as it could allow women to return home shortly afterwards – this was dubbed ‘lunchtime’ abortion. The RCOG at the time was against the introduction of this method because it wanted further investigation into its safety.