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Author: Emily Ottley

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Abortion on Request: A Desirable Response to the Criminalisation of Abortion in England and Wales?

Emily Ottley

New abortion law coming into effect within Northern Ireland, the Isle of Man and Ireland in the last couple of years provides further impetus to reform the aging abortion law in England and Wales that criminalises abortion. Made long ago, the law now seems to be inconsistent with a more liberal public attitude to abortion and significant medical advances, including in abortion care. This paper will consider whether s1(1)(a) of the Abortion Act 1967 should be replaced by a provision making abortion available on request up to 24 weeks of pregnancy, in order to liberalise access to abortion. Two arguments in favour of such a response will be examined: (a) incompatibility of the current law with human rights obligations and (b) respect for autonomy. It will conclude that the law should indeed be reformed in this way.

Introduction

In England and Wales, the Offences Against The Person Act 1861 makes it a criminal offence, punishable by life imprisonment, to terminate a pregnancy.[1] Doctors have a defence where the termination is performed in compliance with the terms of the Abortion Act 1967.[2] Made during the reign of Queen Victoria (1837-1901) and as the British Broadcasting Corporation (BBC) broadcast the first television programme in colour (1967), both statutes are now antique. Even the most recent amendments to the Abortion Act 1967, made by the Human Fertilisation and Embryology Act 1990, are now 30 years old. There have been significant advances in medicine since 1861, both with regards to medical practice in general[3] and abortion care specifically.[4] Although public attitudes towards abortion seem to depend

[1] Offences Against The Person Act 1861, s58 and s59.

[2] Abortion Act 1967, s1.

[3] For example: free healthcare; improved hygiene practices; better education/training for medical professionals; and developments in technology.

[4] For example, medical abortion (taking medication rather than undergoing surgery) which was first used by the British Pregnancy Advisory Service during the 1990s.

on the particular circumstances,[5] Clements and Field note that, 'the general direction of travel [since 1967] has been liberalising, especially when it comes to elective abortions…'[6] In contrast to this aging abortion law in England and Wales, there are examples of very recent reform within neighbouring islands. The most recent of these is the Abortion (Northern Ireland) Regulations 2020, which came into force earlier this year.[7] Other examples include the Isle of Man's Abortion Reform Act 2019 and the Irish Health (Regulation of Termination of Pregnancy) Act 2018, which came into force last year.[8] Considering how to reform English and Welsh abortion law is therefore particularly timely. Moreover, much can be learned from these new laws - which will be examined in more detail later in this paper.

Many aspects of the current law in England and Wales may restrict women's access to abortion. For example, the criminalisation of abortion,[9] the existence of a provision allowing those who object to abortion by virtue of conscience to refuse to participate in treatment,[10] and the high threshold for abortion on grounds of foetal abnormality.[11] Further, there is a notable absence of express provisions for buffer zones outside abortion clinics,[12] and the law does not facilitate a formal review procedure where a woman is refused an abortion by doctors.[13] It stands to reason that the financial, time and emotional burdens on women are made greater by the law making it more difficult to access abortion. Women facing access issues may even resort to terminating their pregnancies at home without proper instruction or medical supervision, using pills bought online.[14] This is a modern manifestation of backstreet abortion.

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[5] Ben Clements and Clive Field, 'Abortion and public opinion in Great Britain: a 50 year retrospective' (2018) 39 Journal of Beliefs and Values 429, 441.

[6] ibid.

[7] 31 March 2020. Note: although the Northern Ireland Act 1998 gives the Northern Irish Assembly responsibility for the regulation of abortion in Northern Ireland, the recent change in the law there was actually made by the Westminster Parliament in the absence of a restored Northern Irish Executive. Section 9 of the Northern Ireland (Executive Formation etc) Act 2019 repealed sections 58 and 59 of the Offences Against The Person Act 1861(s9(2)) and required the UK government to make regulations setting out a new legal framework that would comply with the recommendations of the Report of the Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (s9(4)).

[8] 24 May 2019 and 1 January 2019 respectively.

[9] Offences Against The Person Act 1861, s58 and s59.

[10] Abortion Act 1967, s4(1). Note: there is an exception where abortion is 'necessary to save life or prevent grave permanent injury' - s4(2).

[11] There must be a 'substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be seriously handicapped'- Abortion Act 1967, s1(1)(d).

[12] Compare this to Victorian law, for example. See: *Public Health and Wellbeing Act* 2008 (VIC) s185A-s185H (inserted by *Public Health and Wellbeing Amendment (Safe Access Zones) Act* 2015 (VIC) s5).

[13] Compare this to Irish law, for example. See: Health (Regulation of Termination of Pregnancy) Act 2018, s13.

[14] Abigail Aiken, Katherine Guthrie, Marlies Schellekens, James Trussell and Rebecca Gomperts, 'Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain' (2018) 97 Contraception 177, 179. Note: The researchers found that, over a 4

Detailed consideration of all these aspects here is precluded by the limited space available. Instead, the criminalisation of abortion will be the focus of this paper.

The paper will begin by examining the impact of criminalisation on women's access to abortion. This section is intended to explain *why* the criminalisation aspect in particular needs reviewing. Next, the paper will briefly explain abortion on request as a potential response to the criminalisation of abortion. In Section 3, the paper will consider whether s1(1)(a) of the Abortion Act 1967 should be replaced by a provision making abortion available on request up to 24 weeks of pregnancy. Two arguments in favour of such reform will be examined: (a) incompatibility of the current law with human rights obligations and (b) respect for autonomy. It will conclude that English and Welsh law should indeed be reformed in this way.

Before moving on it might be helpful to note briefly that the discussion here relates to England and Wales only because the United Kingdom (UK) Parliament in Westminster is responsible for abortion law in both nations.[15] In contrast, abortion is a devolved matter in Scotland.[16] However, similar arguments could potentially be used to advocate for reform in Scotland, as the Abortion Act 1967 also applies there.

1. The Impact of Criminalisation on Women's Access to Abortion

In England and Wales, women can only terminate their pregnancies (lawfully) in circumstances where the Abortion Act 1967 affords a defence to doctors carrying out the procedure. These circumstances are, 'that the pregnancy has not exceeded its twenty fourth week and that the continuation 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…',[17] 'that the termination is necessary to prevent grave or permanent injury to the physical or mental health of the pregnant woman',[18] 'that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated',[19] and 'that there is substantial risk that if the child were born it would suffer

month period, 519 women (who resided in England/Scotland/Wales) had attempted to access abortion pills through the website 'Women on Web'.

[15] Abortion is an exception to Welsh devolved health powers (Government of Wales Act 2006, sch 7A para 144). Therefore, the regulation of abortion in Wales is a matter reserved for the Westminster Parliament.

[16] Abortion is no longer an exception to Scottish devolved health powers, as s53 of the Scotland Act 2016 repealed sch5 part 2 para J1 of the Scotland Act 1998. Therefore, the regulation of abortion in Scotland is a matter for the Scottish Parliament.

[17] Abortion Act 1967, s1(1)(a).

[18] ibid, s1(1)(b).

[19] ibid, s1(1)(c).

from physical or mental abnormalities as to be seriously handicapped.'[20] Therefore, women *can* terminate their pregnancies in a range of circumstances - despite the criminalisation of abortion. This is in stark contrast to the law in Malta, where no explicit defence exists to the provision in the Maltese Criminal Code that makes abortion illegal there.[21] Malta is the only country in Europe where abortion is prohibited in all circumstances.

Nevertheless, criminalisation restricts women's access to abortion in England and Wales because doctors act as 'gatekeepers',[22] controlling women's access to abortion. Although the National Health Service (NHS) website clearly states that 'the decision to have an abortion is yours [the woman's] alone',[23] this conflicts with what the law itself says. The Abortion Act 1967 requires that 'two registered medical practitioners are of the opinion, formed in good faith', that one of the specified grounds are satisfied.[24] On a literal reading of the statute, it is for doctors to decide whether any of the circumstances listed above exist. In practice, it is likely that a woman seeking an abortion under s1(1)(a) of the Abortion Act 1967 would be able to get one, given that the criteria are almost always met.[25] Nevertheless, this does not change the fact that the law makes it the doctors' decision. Indeed, the Royal College of General Practitioners acknowledges that, 'It is a critical element under the Abortion Act [1967] that two doctors must agree that one of these grounds exists.'[26] Although this does not necessarily prevent a woman having an abortion, it does make accessing one more difficult because there are hurdles imposed by the law that a woman will have to overcome. It may also cause delays in accessing abortion services, which concerned the House of Commons Science and Technology Committee.[27]

Criminalisation restricts access also because it contributes to the stigmatisation of abortion. As a consequence of stigmatisation, women may find the abortion process more emotionally

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[20] ibid, s1(1)(d).
[21] Chapter 9 of the Laws of Malta, Criminal Code, Article 241.
[22] Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79 MLR 283, 315.
[23] National Health Service, 'Overview: Abortion' (*NHS Health A-Z*, 24 April 2020) <https://www.nhs.uk/conditions/abortion/> accessed 8 August 2020. See also: Royal College of General Practitioners, 'Position Statement on Abortion' (RCGP 2012) 3 <https://www.rcgp.org.uk/policy/rcgp-policy-areas/abortion-position-statement> accessed 3 April 2020.
[24] Abortion Act 1967, s1(1). Note: in an emergency the opinion of just *one* registered medical practitioner is sufficient - Abortion Act 1967, s1(4).
[25] British Pregnancy Advisory Service, 'Britain's Abortion Law: What is Says and Why' (BPAS 2013) 7 <http://www.reproductivereview.org/images/uploads/Britains_abortion_law.pdf> accessed 16 September 2020.
[26] Royal College of General Practitioners (n 23) 2.
[27] House of Commons Science and Technology Committee, *Scientific Developments Relating to the Abortion Act* (HC 2006-7, 12-I) para 99.

challenging or even be dissuaded from accessing abortion services[28] because they feel that they are doing something wrong and/or that others will perceive it that way. This stigma may also affect doctors, potentially limiting the availability of abortion services. This is because doctors who fear prosecution might interpret the criteria more narrowly than the law requires. This is what the European Court of Human Rights (ECtHR) has called the 'chilling effect' of criminalisation on doctors,[29] although this chilling effect is admittedly less likely in England and Wales, where the circumstances in which abortion is permitted are fairly wide. (The ECtHR's comments were made in two cases dealing with Polish abortion law, which permits abortion only in very limited circumstances.)[30] Even if doctors are not afraid of prosecution, in England and Wales, the availability of abortion services is limited by the fact that fewer doctors are willing to carry out abortions after the first trimester (14 weeks from the first day of a woman's last period.)[31] Although this may not prevent a woman having an abortion, it does make accessing one more difficult if she has to incur the delay and expense of travelling elsewhere in the country for the procedure.[32] Even if this is the result of doctors' personal convictions rather than perceived stigma, it may add to the stigma already experienced by women seeking an abortion.

Given the impact of criminalisation on women's access to abortion, a review of this aspect of the current law seems justified. In order to liberalise access to abortion, s1(1)(a) of the Abortion Act 1967 could be replaced by a provision making abortion available on request up to 24 weeks of pregnancy. This response will be explained briefly in the next section.

2. Abortion on Request

Abortion on request enables women to access abortion and doctors to provide it without having to satisfy any particular grounds determined by the law. Instead, a woman can have an abortion solely at her own request, for any reason. As such, abortion on request has a similar effect, in practice, to decriminalising abortion. This is where abortion is removed from the ambit of the criminal law, and terminating a pregnancy is treated in the same way as any

[28] Kirsten Shellenberg, Ann Moore, Akinrinola Bankole, Fatima Juarez, Adekunbi Kehinde Omideyi, Nacy Palomino, Zeba Sathar, Susheela Singh and Amy Tsui, 'Social stigma and disclosure about induced abortion: results from an exploratory study' (2011) 6 Global Public Health S111, S120-S122. Note: The researchers found that women they spoke to (from Mexico, Nigeria, Pakistan, Peru and the USA) reported 'intense feelings of shame and judgement' and 'guilt and sadness'. The researchers also acknowledge the *possibility* that some women choose not to terminate their pregnancies as a result of the stigma surrounding abortion, but concede that their study cannot, and was not designed to, prove this.

[29] *RR v Poland* ECHR 2011-III 209, para 193; *Tysiąc v Poland* ECHR 2007-I 219, para 116.

[30] O planowaniu rodziny, ochronie plodu ludzkiego i warunkach dopuszczalności przerywania ciąży (1993 r DZ U Nr 17, poz 78, art 4a).

[31] Roger Ingham, Ellie Lee, Steve Clements and Nicole Stone, 'Reasons for Second Trimester Abortions in England and Wales' (2008) 16 Reproductive Health Matters 18, 20.

[32] ibid.

other medical procedure. Therefore, providing for abortion on request is compliant with the Council of Europe's recommendation to 'decriminalise abortion within reasonable gestational limits.'[33]

Abortion on request typically exists within a model of legalisation. This is where abortion is legalised in particular circumstances, by simply permitting abortion within a specified gestational period. The only condition set by the law, therefore, is that the woman has not exceeded X weeks of pregnancy. The new laws in Northern Ireland, the Isle of Man and Ireland all adopt such a model. In Northern Ireland, 'a registered medical professional may terminate a pregnancy where a registered medical professional is of the opinion, formed in good faith, that the pregnancy has not exceeded its 12th week.'[34] On the Isle of Man, 'during the first 14 weeks of the gestation period, abortion services may be provided upon request by or on behalf of a woman.'[35] In Ireland, 'a termination of pregnancy may be carried out in accordance with this section by a medical practitioner where, having examined the pregnant woman, he or she is of the reasonable opinion formed in good faith that the pregnancy concerned has not exceeded 12 weeks of pregnancy.'[36] Abortion on request is also available in many other European countries, including Austria,[37] the Netherlands,[38] Denmark,[39] Sweden,[40] and France.[41] That English and Welsh law seems to be inconsistent with the approach taken by many European neighbours is not, in itself, an argument in support of permitting abortion on request. Instead, these examples are offered merely to assist with the explanation of such an approach, and to support the case that it should at least be considered.

For abortion on request to liberalise access to abortion, it must respond to the negative impacts of criminalisation discussed in Section 1. The first of these is that doctors act as legal gatekeepers, controlling women's access to lawful abortion. Abortion on request would make it clear, in law, that abortion is the woman's own decision, by removing the two doctor requirement. The second impact is the stigmatisation of abortion, which may make the abortion process more emotionally challenging from women or even dissuade them from accessing abortion services. Abortion on request potentially address both issues, although evidence from the Australian state of Victoria suggests that it may not do so completely. In 2008, abortion was made available on request up to 24 weeks in Victoria.[42] Researchers

[33] Council of Europe, *Access to Safe and Legal Abortion in Europe*, Resolution 1607 (2008) para 7.1.
[34] The Abortion (Northern Ireland) Regulations 2020, SI 2020/345, regulation 3.
[35] Abortion Reform Act 2019, s6(2).
[36] Health (Regulation of Termination of Pregnancy) Act 2018, s12(1).
[37] §97 Abs 1, 1 StGB.
[38] Wet afbreking zwangerschap, *Stb* 1981, 257 §3.
[39] LBK nr 1202 af 14.11.2014 bekendtgørelse af sundhedsloven §92.
[40] Lag (1974:595) abortlag, 1§.
[41] Art L2212-1 CSP.
[42] *Abortion Law Reform Act 2008* (VIC) s4.

interviewed experts in abortion provision in 2014-15 to examine the impact of the reforms.[43] All those interviewed agreed that abortion on request had achieved 'shifting the power in decision making from doctors to women.'[44] However, they also agreed that there remains a stigma surrounding abortion.[45] As such, the researchers concluded that a change in the law was not sufficient *on its own* to achieve this goal,[46] but that it was a 'necessary step.'[47] This suggests that other factors may also contribute to the stigmatisation of abortion. Similarly, Sheldon (writing about the Victorian reforms) notes that, 'While legislation can offer important legitimation of abortion services, it will not instantly remove the stigma…'[48] This suggests that it may take time for attitudes to change.

3. Should England and Wales Allow Abortion on Request?

This section will consider whether s1(1)(a) of the Abortion Act 1967 should be replaced by a provision making abortion available on request up to 24 weeks of pregnancy. To recap, s1(1)(a) of the Abortion Act 1967 currently provides that doctors will not be guilty of a criminal offence for performing an abortion, if two of them agree 'that the pregnancy has not exceeded its twenty fourth week and that the continuation 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…' Two arguments in favour of such a response will be examined: (a) the incompatibility of the current law with human rights obligations and (b) respect for autonomy. A potential reply to these arguments (that abortion on request already exists de facto) will also be considered.

3A: Incompatibility of the current law with human rights obligations

Writing in the Medical Law Review, Scott notes that abortion on request may offer a solution to a compatibility issue between English/Welsh law and the European Convention on Human Rights (ECHR).[49] Scott argues that the criminal prohibition of terminations carried out in the first trimester, except where taking the pregnancy to term would involve greater risk to the woman's physical/mental health than having an abortion, *unjustifiably* interferes with

[43] Louise Keogh and others, 'Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia' (2017) 43 Journal of Family Planning and Reproductive Health Care 18, 18.
[44] ibid, 22.
[45] ibid.
[46] ibid.
[47] ibid.
[48] Sally Sheldon, 'Abortion law reform in Victoria: lessons for the UK' (2017) 43 Journal of Family Planning and Reproductive Health Care 25, 25.
[49] Rosamund Scott, 'Risks, Reasons and Rights: The European Convention on Human Rights and English Abortion Law' (2015) 24 MLR 1, 28.

women's right to respect for private and family life.[50] This is afforded to women by Article 8 of the ECHR.[51] It is already clear from ECtHR jurisprudence that abortion regulation amounts to an interference with Article 8 and must be justified.[52] For an interference with Article 8 to be justified it must be in accordance with law, necessary and have a legitimate aim.[53]

As Scott notes, the interference here is clearly in accordance with law.[54] Firstly, there are specific statutes authorising the interference.[55] Secondly, although abortion law in England and Wales is perceived by many as being fairly liberal,[56] it is made clear to the general public that criteria must be met for an abortion to be legal. For example, through the websites of the British Pregnancy Advisory Service[57] and Marie Stopes.[58] Further, the full legal texts can be accessed online via the legislation.gov.uk website.[59] Given this transparency, the 'accessibility requirement' is also likely to be satisfied.[60] Finally, the legislation is formulated precisely enough to allow individuals to foresee what criteria they must meet and the consequences of terminating a pregnancy outside the permitted circumstances, satisfying the 'foreseeability requirement.'[61]

Scott suggests that a legitimate aim could be the protection of morals and/or the rights and freedoms of others,[62] but this seems unlikely. Attempting to ensure that abortions are not undertaken 'without due moral reflection'[63] and/or 'encouraging respect for foetal life'[64] assumes that such reflection resolves an unresolvable moral argument. The ECtHR has held

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[50] ibid, 15.
[51] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) art 8(1).
[52] *A, B and C v Ireland* ECHR 2010-VI 185, para 216; *Tysiąc v Poland* (n29) paras 105-7; *RR v Poland* (n29) para 180-1.
[53] ECHR art 8(2).
[54] Scott (n49) 10.
[55] Offences Against The Person Act 1861, s58 and Abortion Act 1967, s1(1)(a).
[56] Not just the public, but academics too. See for example: Daniel Fenwick, 'The modern abortion jurisprudence under Article 8 of the European Convention on Human Rights' (2013) 12 Medical Law International 249, 275; Sally Sheldon, Jane O'Neill, Clare Parker and Gayle Davis, 'Too Much, too Indigestible, too Fast'? The Decades of Struggle for Abortion Law Reform in Northern Ireland' (2020) 83 Modern Law Review 761, 762-3.
[57] British Pregnancy Advisory Service, 'Abortion: Frequently asked questions - is abortion legal?' (*British Pregnancy Advisory Service*) <https://www.bpas.org/abortion-care/considering-abortion/abortion-faqs/> accessed 11 August 2020.
[58] Marie Stopes UK, 'Abortion law in the UK' (*Marie Stopes UK*) <https://www.mariestopes.org.uk/abortion-services/abortion-and-your-rights/> accessed 11 August 2020.
[59] *Silver and Others v UK* (1983) Series A no 61, para 87.
[60] *The Sunday Times v UK* (1979) Series A no 30, para 49.
[61] ibid.
[62] Scott (n 49) 11.
[63] ibid.
[64] ibid.

(most recently in *A, B and C v Ireland*[65] and previously in *Open Door Counselling and Dublin Well Woman v Ireland*[66]) that the restrictions relating to abortion in each case pursued the legitimate aim of the protection of morals. However, it is clear that these conclusions were based on (what the ECtHR believed to be) the views of the Irish people at the time, and the court did not rule out that such a conclusion could be invalidated by a change in their views.[67] Since the views of people in England and Wales have been found to be generally quite liberal,[68] it is less clear that the protection of morals would be considered a similar legitimate aim here, were the ECtHR to consider the matter.

It is also doubtful that a foetus would be considered an 'other' to be protected. This is because the ECtHR has previously held that a foetus is not a rights holder.[69] No ECtHR jurisprudence specifically considers how 'others' should be interpreted. However, even if it is not necessary to have Convention rights, as Scott suggests,[70] it is not obvious that 'belonging to the human race'[71] or being a 'unique organism' (but not a person)[72] will be sufficient to be designated an 'other'. Therefore, the protection of the rights and freedoms of others is also unlikely to constitute a legitimate aim.

Scott does not consider whether the legitimate aim might be the protection of health, even though the protection of women has been cited as one of the reasons for both the criminalisation of abortion[73] and the framework of the Abortion Act 1967.[74] Although the lawful grounds contained within the Abortion Act 1967 have reduced incidence of dangerous backstreet abortions,[75] concern for *physical* health cannot explain the continued criminalisation of abortion, given that medical and surgical abortions are now low risk procedures and 'generally very safe.'[76] This is in contrast to pregnancy and giving birth, which are still

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[65] *A, B and C v Ireland* (n 52) para 227.
[66] *Open Door Counselling and Dublin Well Woman v Ireland* (1992) Series A no 246-A, para 63.
[67] ibid, para 63; *A, B and C v Ireland* (n 52) para 226.
[68] Elizabeth Clery, John Curtice and Roger Harding, 'British Societal Attitudes 34' (NatCen Social Research 2017) 107 <https://www.bsa.natcen.ac.uk/media/39196/bsa34_full-report_fin.pdf> accessed 2 April 2020.
[69] *Vo v France* ECHR 2004-VIII 67, para 84.
[70] Scott (n 49) 12.
[71] *Vo v France* (n69) para 84.
[72] *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245, 256.
[73] *R (Smeaton)* v *Secretary of the State for Health* [2002] EWHC 610 (Admin), [2002] FCR 193 [332].
[74] HC Deb 22 July 1966, vol 732, col 1075; House of Commons Science and Technology Committee (n 27) para 85.
[75] HC Deb 6 November 2017, vol 630, col 1302.
[76] National Health Service, 'Risks: Abortion' (*NHS Health A-Z*, 24 April 2020) <https://www.nhs.uk/conditions/abortion/risks/> accessed 21 July 2020. For medical evidence of this, see for example: Karima Sajadi-Ernazarova and Christopher Martinez, 'Abortion Complications' (*StatPearls* 24 May 2020) <https://www.ncbi.nlm.nih.gov/books/NBK430793/> accessed 15 September 2020; Nancy Adler, Henry David, Brenda Major, Susan Roth, Nancy Russo and Gail Wyatt, 'Psychological responses after abortion' (1990) 248 Science 41.

associated with 'substantial' risks.[77] Writing in the Oxford Journal of Legal Studies, Sheldon uses this to support her argument that criminalisation is no longer useful because it does not achieve its own aims.[78]

Alternatively, the legitimate aim might be the protection of *mental* health. For example, perhaps the future mental health of women depends on having done some moral reflection. Nevertheless, both Scott[79] and Sheldon[80] suggest that a woman may 'herself have given serious moral consideration to the question of termination prior to approaching a doctor, independently of the terms of legal access to abortion.'[81] Moreover, there seems no grounds to argue that women cannot be supported (by doctors or others) to access counselling without regulating abortion through the criminal law. For example, the offer of counselling would arguably form part of doctors' legal and ethical duty to act in patients' best interests, as with any other medical treatment. Therefore, any attempt to justify the interference with Article 8 is likely to fail at the legitimate aim stage.

Even if the legitimate aim of criminalisation is the protection of foetal life, as Scott assumes,[82] the interference appears to fail at the necessary stage.[83] Scott argues that there will almost always be a greater risk in going to term than having a termination during the first trimester and so 'to impose a requirement to this effect as a condition of access to abortion in all cases is unnecessary.'[84] For an interference to be necessary, there must be a 'pressing social need' for the interference, it must be 'proportionate to the aim', and there must be 'relevant and sufficient reasons' for it.[85] Scott notes that the law 'cannot be said to respond to a pressing social need' because, as per the so-called 'statistical argument',[86] very few women seeking an

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[77] Andrew McGee, Melanie Jansen and Sally Sheldon, 'Abortion law reform: Why ethical intractability and maternal morbidity are grounds for decriminalisation' (2018) 58 Australian and New Zealand Journal of Obstetrics and Gynaecology 594, 595. For medical evidence of this, see maternal mortality rates in the UK: Marian Knight, Kathryn Bunch, Derek Tuffnell, Judy Shakespeare, Rohit Kotnis, Sara Kenyon, Jennifer J Kurinczuk (eds), 'Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17'(MBRRACE-UK 2019) <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf> accessed 15 September 2020.

[78] Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36 OJLS 334, 348-351.

[79] Scott (n 49) 11.

[80] Sally Sheldon, 'A Missed Opportunity to Reform an Outdated Law' (2009) 4 Clinical Ethics 3, 4.

[81] Scott (n 49) 11.

[82] ibid, 12.

[83] ibid, 15.

[84] ibid, 15.

[85] *The Sunday Times v UK* (n60) para 62.

[86] British Medical Association, *First Trimester Abortion: A Briefing Paper by the BMA's Medical Ethics Committee* (ARM 2007) 2-4; House of Commons Science and Technology Committee (n 27) paras 93-95 [citing the submission of the Royal College of Gynaecologists Obstetricians]; British Medical

abortion during the first trimester will be unable to satisfy s1(1)(a) of the Abortion Act 1967.[87] As such, it does not reduce the number of abortions that occur. There is also a question as to the weight/importance of such an aim, and therefore whether it can be considered 'pressing'. The law is also disproportionate to the aim of protecting foetal life because, as Scott asserts, *all* women are subject to the criteria.[88] One response to Scott might be that the ground is very easily satisfied, so it is proportionate because it does not ask too much of women. However, an obvious response is that imposing a legal hurdle is needless when almost all women will satisfy it. Scott further suggests that 'while the reasons for the crime and lawful grounds…are relevant to the aim of protecting foetal life, they do not appear *sufficient* to justify the interference'.[89] This is because it does not appear that the provisions substantially contribute to achieving protection for foetal life. In 2019, 202,975 abortions were carried out under s1(1)(a) of the Abortion Act 1967,[90] the vast majority at less than 10 weeks' gestation.[91] Given the liberality of the lawful grounds, Sheldon claims that criminal prohibition does not prevent pregnancies being terminated.[92] Another aspect of protecting foetal life might be condemning the destruction of foetal life where it does occur, such that the general public understand the law as conveying a message of strong disapproval regarding the termination of pregnancy. However, Sheldon claims that criminal prohibition does not achieve this either.[93] Although a few high profile incidences of unlawful late-term and self-induced abortions have been visible to the general public via the mainstream media,[94] Sheldon notes that they may quite reasonably believe that the law is fairly permissive[95] - especially regarding terminations carried out during the early stages of pregnancy.

Association, *Memorandum of Evidence to the Science and Technology Committee Inquiry into the Scientific Developments relating to the Abortion Act 1967, August 2007* (2007) para 2.

[87] Scott (n 49) 15

[88] ibid.

[89] ibid.

[90] Department of Health and Social Care, 'Abortion Statistics, England and Wales: 2019' (Department of Health and Social Care 2019) 10 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf> accessed 23 July 2020.

[91] ibid, 10-11.

[92] Sheldon (n 78) 352.

[93] ibid, 355.

[94] For example: Chris Brooke, 'Eight years for the cheating wife who used drugs bought online to abort baby TWO days before it was due to be born' *Mail Online* (17 September 2012) <https://www.dailymail.co.uk/news/article-2204471/Sarah-Catt-Eight-years-cheating-wife-used-drugs-bought-online-abort-baby-TWO-days-born.html> accessed 22 July 2020; Georgia Simcox, 'Police investigate death of unborn baby after woman took 'pills by post' abortion drugs while 28 weeks pregnant - four past the legal limit' *Mail Online* (23 May 2020) <https://www.dailymail.co.uk/news/article-8349739/Police-investigate-death-unborn-baby-woman-took-abortion-drugs-home-28-weeks-pregnant.html> accessed 22 July 2020.

[95] Sheldon (n 78) 356.

Therefore, the interference with Article 8 ECHR by s1(1)(a) of the Abortion Act 1967, as it applies to the first trimester, does not appear justified. Scott expressly states (many times throughout her paper) that her argument is made with specific regard to the first trimester.[96] She explains her decision to focus on the first trimester by recognising that most terminations are performed under s1(1)(a) of the Abortion Act 1967 before 12 weeks.[97] Further, Scott bases her conclusion on the 'statistical argument'[98] which, as described by the British Medical Association[99] and Royal College of Obstetricians and Gynaecologists,[100] holds that s1(1)(a) of the Abortion Act 1967 will almost always be satisfied in the *first trimester*. However, it is not clear why Scott's argument could not apply to *all* abortions performed under s1(1)(a) of the Abortion Act 1967 (ie. up to 24 weeks). A 'pre-determined legal balance between a pregnant woman and foetus'[101] seems to exist beyond the first trimester, given that there will almost always be a greater risk in going to term than having an abortion - even at 24 weeks. The 'medical evidence is clear' on this point, as a report by the British Pregnancy Advisory Service (that Scott herself cites) notes.[102] By extension of Scott's argument then, the conclusion reached here is not limited to the first trimester. Rather, it is that the interference with Article 8 ECHR by s1(1)(a) of the Abortion Act 1967 cannot be justified. Given that abortion on request effectively provides women with a right to abortion, offering it as a solution to this incompatibility may seem at odds with the disinclination of the ECtHR to find that Article 8 ECHR recognises a right to abortion.[103] However, a provision making abortion available on request up to 24 weeks of pregnancy would fall short of a general right to abortion of the kind that the ECtHR seem reluctant to recognise.

3B: Respect for Autonomy

A second argument for abortion on request is that women, rather than doctors, should be making abortion decisions. Medical paternalism is now considered outdated in both medical ethics and medical law, and a key aspect of the current doctor-patient relationship is doctors working 'in partnership' with patients.[104] Sheldon notes that current abortion law reflects 'the

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[96] Scott (n 49) 3, 4, 6, 9, 11 and 15.
[97] ibid, 9 and 15.
[98] ibid, 15.
[99] British Medical Association (n 86).
[100] Royal College of Obstetricians and Gynaecologists (n 86).
[101] Scott (n49) 15.
[102] British Pregnancy Advisory Service (n 25). See for example: Elizabeth Raymond and David Grimes, 'The comparative safety of legal induced abortion and childbirth in the United States' (2012) 119 Obstetrics and Gynaecology 215.
[103] For example: *Tysiąc v Poland* (n 29) paras 105-106; *A, B and C v Ireland* (n 52) para 214.
[104] General Medica Council, 'Consent: patients and doctors making decisions together' (GMC 2008) 6 <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent> accessed 23 July 2020; General Medical Council, 'Good medical practice' (GMC 2013) 16 <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice> accessed 14 August 2020.

doctor knows best paternalism…which characterised medical practice in the 1960s.'[105] As Sheldon recognises,[106] a similar sentiment is reflected in the judgment of the Supreme Court in *Montgomery v Lanarkshire Health Board*[107] - a case that arose in the context of clinical negligence.[108] The Supreme Court expressly rejected medical paternalism[109] and endorsed the view that patients (including those who are pregnant) are 'persons holding rights, rather than…passive recipients of the care of the medical profession'.[110] Central to the decision in this case was that most patients are capable of making their own decisions, even when they relate to potentially complex medical issues.[111] However, not everyone agrees that the Supreme Court were wholly committed to the rejection of medical paternalism. Indeed, Cave has suggested that the underlying approach of the Supreme Court was paternalistic because they endorsed a therapeutic exception,[112] whereby information can be withheld from a patient if the doctor believes that it would cause them serious harm.[113] This does seem to suggest a willingness of the Supreme Court to accept that decisions should be made by doctors in some circumstances. Nevertheless, this ultimately does very little to undermine the prioritisation of autonomy by the Supreme Court, given how limited the exception is.[114]

Although *Montgomery* underlines the Supreme Court's commitment to autonomy, and the legal obligation of doctors to maximise it, it does not oblige them to provide whatever treatment the patient wants. Instead, doctors must offer all possible available treatment options for the patient to choose from.[115] This is consistent with the distinction made in law (and philosophy[116]) between demanding and refusing treatment.[117] As Lord Phillips, in the

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[105] Sally Sheldon, 'The Abortion Act's paternalism belongs to the 1960s' *The Guardian* (22 March 2012) <https://www.theguardian.com/law/2012/mar/22/abortion-act-needs-reform> accessed 3 April 2020.
[106] Sheldon (n 78) 295.
[107] [2015] UKSC 11, [2015] AC 1430.
[108] The case concerned a doctors' obligation to fully inform patients about material risks and treatment options (ibid [87]). Mrs Montgomery had not been told about the risk of shoulder dystocia associated with delivering her baby (who subsequently suffered severe disabilities) vaginally (ibid [1]-[2]).
[109] ibid [81].
[110] ibid [75].
[111] ibid [81].
[112] Emma Cave, 'The ill-informed: Consent to medical treatment and the therapeutic exception' (2017) 46 Common Law World Review 140, 140-1.
[113] *Montgomery v Lanarkshire Health Board* (n 107) [85].
[114] The Supreme Court stressed that it is only a 'limited' exception, that should not allow doctors to '…prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be a contrary to her best interests' (ibid [91]). The Court was also clear that there was no question of the therapeutic exception applying in this case, even though the doctor had withheld the information, in part, to avoid Mrs Montgomery requesting a caesarean (which would not have been in her best interests) (ibid [95]).
[115] ibid [87].
[116] Positive versus negative rights.
[117] The right to refuse treatment is well established in law. Competent adult patients have the right to contemporaneously refuse treatment, even where: it would not be in the patient's best interests (*Airedale NHS Trust v Bland* [1993] AC 789, 891 and 864); the patient's reasons are 'irrational,

Court of Appeal, expressed, 'Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. In so far as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.'[118] One might reasonably ask, therefore, how a woman being able to access an abortion solely at her own request could be justified. However, this would not be irreconcilable with existing principles because access would not be based *simply* on the woman's request, but on a presumption that she knows when it is her best interests not be pregnant. Doctors, of course, have a legal and ethical duty to act in their patients' best interests.

In the case of women requesting abortion, there will almost always be a greater risk to health in going to term than having an abortion.[119] Best interests is a much broader concept than just physical and mental health however, and includes financial and environmental factors.[120] These broader best interests are arguably beyond the understanding of a woman's doctor, since the factors motivating a woman to terminate her pregnancy may not be medical.[121] As Sheldon notes, 'doctors are not always best placed to make…social judgments.'[122] A woman is surely best placed to judge her best interests in the context of her own personal circumstances. Whilst a woman may not be an expert on the medical aspects of an abortion, it is clear from *Montgomery* that doctors must disclose any material risks to enable their patients to make informed decisions.[123] As this applies to all medical procedures, it is unnecessary to make it a specific requirement in abortion legislation (as it is in France, for example[124]). This shows that doctors (or other medical professionals) would still have a significant role to play under a system of abortion on request in ensuring patient informedness, as well as competence and voluntariness.[125] However, this role would be more

unknown or even non-existent' (*Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102 and 116. See also: *King's College Hospital NHS Foundation Trust v C* [2015] EWCOP 83, [2015] 11 WLUK 797); and it would result in the patient's death (*Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 120-1). The ECtHR has adopted a similar approach where competent adults wish to refuse blood transfusions on religious grounds (*Jehovah's Witnesses of Moscow v Russia* App no 302/02 (ECtHR, 22 November 2010) para 136). The law also allows individuals to refuse treatment in advance through 'Advance Decisions' under the Mental Capacity Act 2005, s24-s26.

[118] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [2006] QB 273 [31].

[119] British Pregnancy Advisory Service (n 25).

[120] *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67, [2014] AC 591 [33].

[121] The current law acknowledges this. Although s1(1)(a) of the Abortion Act 1967 frames the issue as a medical one (by referring to physical/mental health), s1(2) of the same Act allows doctors to take account of 'the woman's actual or foreseeable environment' (ie. socio-economic factors).

[122] Sheldon (n 80) 4.

[123] *Montgomery v Lanarkshire Health Board* (n 107) [87].

[124] Art L2212-3 CSP.

[125] These are the key requirements for consent to be valid.

in line with their role in other medical contexts - rather than a decision making role. Crucially though, their role would both facilitate and support patient autonomy.

One final point to note on the autonomy argument for abortion on request is that the ECtHR seem to have given some weight to personal autonomy when making decisions in other contexts. Although the ECtHR has briefly mentioned autonomy in the judgments of abortion cases,[126] Scott has criticised the Court for 'underplaying' its importance and instead focussing on physical/psychological integrity.[127] Both Scott[128] and Fenwick[129] compare this with the approach taken by the ECtHR in the end of life decision making context. They claim that the ECtHR has, in that context, 'recognised'[130] and/or 'considered'[131] personal autonomy. Both cite *Pretty v United Kingdom*[132] as an example.[133] In this case, the ECtHR held that Article 8 ECHR encompasses personal autonomy.[134] The ECtHR's discussion of autonomy in relation to assisted dying,[135] seems to have been significant to the finding of an interference with Article 8 ECHR.[136] However, the ECtHR ultimately found that this could be justified as necessary in the interests of democratic society for the protection of the rights of others, and rejected the applicant's claim.[137]

In conclusion, the shift from medical paternalism to respect for patient autonomy seems to have been recognised by the courts and the ECtHR has also given some weight to personal autonomy in the assisted dying context. Therefore it appears outdated and inconsistent to not allow women to make their own abortion decisions. This conclusion may also have implications for the law regulating abortions after 24 weeks, as it is not limited to s1(1)(a) of the Abortion Act 1967 specifically in the way that Scott's human rights argument is. However, it is this section that is the focus of this paper, so any further implications will not be considered here.

[126] *A, B and C v Ireland* (n 52) para 216.
[127] Scott (n 49) 10; Rosamund Scott, 'Reproductive Health: Morals, Margins and Rights' (2018) 81 MLR 422, 447-8.
[128] Scott (n 49) 10.
[129] Fenwick (n 56) 274.
[130] Scott (n 49) 10.
[131] Fenwick (n 56) 274.
[132] 2002-III 155.
[133] Scott (n 49) 10; Fenwick (n 56) 274.
[134] *Pretty v United Kingdom* (n 132) para 61.
[135] ibid, paras 61-67.
[136] ibid, para 67.
[137] ibid, paras 76-78.

3C: De facto abortion on request

One response to the two arguments considered above (at 3A and 3B) might be that abortion on request already exists de facto, as Denning MR noted obiter in a case from 1981.[138] Although the criminalisation of abortion impacts women's access in some important respects, this paper has also acknowledged that it is likely that a woman seeking an abortion under s1(1)(a) of the Abortion Act 1967 would probably be able to get one,[139] and that the NHS website/professional guidance explicitly states that the abortion decision is the woman's alone.[140]

Scott herself acknowledges that her conclusion (that the interference with Article 8 ECHR by s1(1)(a) of the Abortion Act 1967, as it applies to the first trimester,[141] cannot be justified) is 'surprising.'[142] Nevertheless, the human rights argument shows that de facto abortion on request does not prevent an unjustified interference, because s1(1)(a) of the Abortion Act 1967 imposes a needless legal hurdle. Further, the fact that almost all women will satisfy s1(1)(a) of the Abortion Act 1967 is central to the claim that any attempt at justification will fail at the necessary stage of analysis.

The suggestion that autonomy is already respected in practice arguably supports the argument for law reform, since this would resolve the discrepancy between the law and how it operates in practice. Lee calls this discrepancy the 'socio-legal gap.'[143] However, Sheldon asserts that 'it cannot be assumed that a liberal interpretation of the law is obviously subversive of its intended purpose.'[144] Indeed, it is clear from reading Parliamentary debates that the promoters of the Bill were looking to achieve something extremely permissive.[145] David Steel MP sought an overtly social ground for abortion when he said, 'We ought not to demand of the medical profession that they should slip these in under a general Clause relating to physical and mental health.'[146] Nevertheless, a social ground within a framework of two doctors' agreement is not the same as abortion on request. In fact, David Steel MP also stated expressly that, 'it is not the intention of the Promoters of the Bill to leave a wide open door for abortion on request.'[147] It would therefore appear be an exaggeration to suggest that

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[138] *Royal College of Nursing v Department of Health and Social Security* [1981] AC 800, 803.
[139] British Pregnancy Advisory Service (n 25).
[140] National Health Service (n 23); Royal College of General Practitioners (n 23).
[141] Although Scott's conclusion relates to first trimester abortions specifically, this paper has shown that it can be extended to all abortions performed under s1(1)(a) of the Abortion Act 1967.
[142] Scott (n 49) 31.
[143] Ellie Lee, 'Tensions in the regulation of abortion in Britain' (2003) 30 Journal of Law and Society 532, 533.
[144] Sheldon (n 22) 296.
[145] HC Deb 22 July 1966, vol 732, cols 1067-1165.
[146] ibid, col 1074.
[147] ibid, col 1075.

this could be encompassed by even the most generous interpretation of Parliament's intention. A survey of Parliament's intention may not even be warranted here, because the courts begin with a literal approach to statutory interpretation and the wording of the Abortion Act 1967 is clear. Therefore, the argument that we already have, *de facto*, abortion on request appears insufficient to undermine the two arguments for abortion on request discussed here.

Further, McCulloch and Weatherall have warned that de facto abortion on request is 'vulnerable' to change when not protected by law.[148] They suggest that the threat comes from the potential for 'both legislative and political challenges' to women's access to abortion.[149] McCulloch and Weatherall give the example of a case in New Zealand that was brought by a pro-life organisation who wanted a more restrictive regime imposed by the committee that oversees the doctors who approve abortions.[150] This reached the Supreme Court of New Zealand, but narrowly failed by a 3-2 ruling.[151] Although McCulloch and Weatherall were writing about the position in New Zealand (prior to the recent change in the law that provided for abortion on request up to 20 weeks),[152] abortion law in New Zealand at the time was very similar to the current law in England and Wales.[153] Another similarity was that a women seeking an abortion in New Zealand was likely to get one, because the overwhelming majority of requests were authorised.[154] Their argument supports the argument for law reform, because it suggests that access to abortion would be better protected by the law. Whilst there have not (yet) been any directly comparable attacks on access to abortion through the courts in England and Wales, the potential exists. Indeed, the Court of Appeal have recently granted permission[155] to hear a challenge by Christian Concern regarding the Health Secretary's decision to temporarily allow at-home abortions amidst the national lockdown due to the Covid-19 pandemic.[156]

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[148] Alison McCulloch and Ann Weatherall, 'The fragility of de facto abortion on demand in New Zealand Aotearoa' (2016) 27 Feminism and Psychology 92, 93.
[149] ibid, 96.
[150] ibid.
[151] *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2012] NZSC 68 (SC).
[152] *Contraception, Sterilisation, and Abortion Act* 1977 (as amended by the *Abortion Legislation Act* 2020) s10.
[153] It was a criminal offence to terminate a pregnancy (*Crimes Act* 1961, s182(1)) but abortion was allowed in a number of circumstances (*Crimes Act* 1961, s187A - now repealed) provided that two doctors approved the abortion (*Contraception, Sterilisation, and Abortion Act* 1977, s33 - now repealed).
[154] *Right to Life New Zealand Inc v Abortion Supervisory Committee* [2008] 2 NZLR 825 (HC) [5].
[155] *R (On the application of Christian Concern) v Secretary of State for Health and Social Care* [2020] EWHC 1546 (Admin), [2020] 5 WLUK 489.
[156] Department of Health and Social Care, 'The Abortion Act 1967 - Approval of a Class of Places' (30 March 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf> accessed 14 August 2020.

Conclusion

Although women in England and Wales can lawfully terminate their pregnancies in a range of circumstances, the criminalisation of abortion impacts their access to the procedure. Doctors act as gatekeepers (controlling women's access to abortion) and the stigmatisation of abortion may make the abortion process more emotionally challenging for women, or even dissuade them from accessing abortion services. Abortion on request would make it clear, in law, that abortion is the woman's own decision, by removing the two doctor requirement. It would also make abortion more acceptable by legalising abortion in a very broad way. On the basis of two arguments, this paper concludes that s1(1)(a) of the Abortion Act 1967 should be replaced by a provision making abortion available on request up to 24 weeks of pregnancy. The first of these arguments is that the interference with Article 8 ECHR by s1(1)(a) of the Abortion Act 1967 cannot be justified. Any attempt at justification most likely fails for want of a legitimate aim. Even if one can be found, the interference is not necessary because it imposes a needless legal hurdle. The second argument is that it appears outdated and inconsistent to not allow women to make their own abortion decisions. This is because the shift from paternalism to respect for patient autonomy seems to have been recognised by the courts, and the ECtHR has also given some weight to personal autonomy in the assisted dying context. That abortion on request already exists de facto fails to undermine these arguments, and - in any event - is problematic in its own right due to its vulnerability. Abortion on request is, therefore, a desirable response to the criminalisation of abortion in England and Wales.