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Sheldon, Sally (2016) *British Abortion Law: Speaking from the Past to Govern the Future*. The Modern Law Review, 79 (2). pp. 283-316. ISSN 1468-2230.

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Title Page: British abortion law: speaking from the past to govern the future

Abstract:

This paper analyses the poor alignment of the aging statutory framework and modern understandings of medical best practice in the context of abortion services. With a particular focus on medical abortion, it assesses the significant challenges that the gulf between the two poses for clinicians, service providers, regulators and the courts. Law is said to be at its most effective where there is a shared regulatory community that accepts and endorses the values that underpin it. It is suggested that the example of abortion law provides a marked example of what happens when legal norms once justified by broadly shared moral understandings, concerns for patient safety and requirements of best practice are now either unsupported by or, indeed, sit in opposition to such concerns.

Key words:

Abortion Act (1967), medical abortion, statutory interpretation, termination of pregnancy, regulation of medical practice.

British abortion law: speaking from the past to govern the future

Sally Sheldon

‘Written norms have two central features which make them particularly problematic regulatory instruments: their temporal aspect - they speak from the past or present but purport to govern the future - and their linguistic aspect: they are linguistic structures which require interpretation. How they will ‘work’ depends on the interpretation they receive.’¹

INTRODUCTION

When the abortion pill, mifepristone then commonly known as RU486, was first licensed for use in the late 1980s, it was heralded as the ‘pill that changes everything’,² with predictions that it could ‘end the abortion wars’.³ The grounds for excitement were clear. A method permitting early abortions to be carried out safely and effectively using pills might transform abortion into a procedure which required only the most minimal of skills and facilities to administer, raising possibilities for abortions to take place with little supervision in a wider variety of healthcare settings and, perhaps, even in the woman’s own home. This, it was predicted to the delight of some commentators and the horror of others, might lead to a profound shift both in political debates regarding abortion and in the

¹ J. Black (2002) ‘Regulatory Conversations’ 29(1) JLS 163, 172

² *Time Magazine*, cover, June 14 1993.

³ L. Lader, *RU486: the Pill that Could End the Abortion Wars and Why American Women Don’t Have it* (Reading Massachusetts: Addison-Wesley, 1992).

development and enforcement of law. One US lawyer went as far as to suggest that the ‘seemingly intractable’ abortion debate was approaching an ‘unceremonious solution’, as the ‘energy presently devoted to influencing political and legal institutions ultimately will subside in the face of [this] new technological reality’.⁴

With the benefit of twenty-five years of hindsight, of course, this prediction looks hopelessly far-fetched. While medical abortion (a term used to describe any termination of pregnancy provoked using drugs) has become widely available across much of the world, it is undeniable that significant energy remains devoted to fighting the ‘abortion wars’. Indeed, a series of pitched battles in the USA are currently focused precisely on issues relating to access to medical abortion.⁵ At the time of writing, five US states have introduced legislation to require that medical abortion be provided according to an outdated protocol that is known to have higher rates of side effects and to be less acceptable to women.⁶ Two require that women must be counselled that it is possible to ‘reverse’ the abortion if

⁴ L.A. Cole, ‘The End of the Abortion Debate’ (1989) 138 *Uni of Penn Law Rev* 217.

⁵ US states enacted 51 new abortion restrictions in the first 6 months of 2015, with medical abortion a major focus of this activity: Guttmacher Institute, *Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2015* (1 July 2015) <http://www.guttmacher.org/media/inthenews/2015/07/01/index.html>; Guttmacher Institute, *State Policies in Brief as of July 1, 2015: Medication Abortion*, http://www.guttmacher.org/statecenter/spibs/spib_MA.pdf (each last accessed 17 October 2015).

⁶ While doctors often prescribe ‘off label’ where there is a solid medical evidence base to suggest that this is appropriate, these states require physicians to prescribe abortion drugs according to the Food and Drug Administration (FDA) label for mifepristone that was approved in 2000. This ignores the fact that newer regimens are known to be more effective at higher gestations, cause fewer side-effects, and require less medication and fewer visits to the provider, making them more cost-effective, *ibid*.

she changes her mind after taking mifepristone (the first drug used in a medical abortion), despite the lack of clinical evidence to support the effectiveness or safety of such a 'treatment'.⁷

In the UK, opposition to medical abortion has been far more muted. The UK was one of the first countries to license mifepristone and, since then, a gradual revolution in abortion care has meant that today over half of reported induced abortions are provoked using drugs.⁸ Used in combination with a second drug, misoprostol, mifepristone has been shown to be safe, very effective, highly acceptable to women, and requiring little by way of specialist skills or facilities to administer.⁹ However, while

⁷ The law in one of the states concerned, Arizona, is currently subject to legal challenge and is not being enforced, see n 5 above. A systematic review of the medical evidence in support of such advice found just one publication, a case series of only six women in whom 'abortion reversal' had been attempted. Four of the six women continued their pregnancy after the 'treatment' (which involves the administration of a large dose of hormones), a continuing pregnancy rate compatible with that seen in other studies where a woman changes her mind about proceeding with the termination after taking mifepristone and receives no further treatment. See, D. Grossman, K. White, L. Harris, M. Reeves, P.D. Blumenthal, B. Winikoff, and D.A. Grimes (2015) 'Continuing Pregnancy after Mifepristone and "Reversal" of First-Trimester Medical Abortion: a Systematic Review' *Contraception*, available online first at [http://www.contraceptionjournal.org/article/S0010-7824\(15\)00226-7/pdf](http://www.contraceptionjournal.org/article/S0010-7824(15)00226-7/pdf) (last accessed 17 October 2015).

⁸ Department of Health, *Abortion Statistics, England and Wales: 2014* (June 2015); ISD Scotland, *Abortion Statistics. Year ending 31 December 2014* (May 2015). See generally, S. Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto, 1997), chapter 7 on the licensing process.

⁹ A. Templeton and D.A. Grimes 'A Request for Abortion' (2011) 365 *The New England Journal of Medicine* 2198. In the UK, medical abortion typically involves the sequential administration of mifepristone (an antiprogestin, which acts to block the progesterone receptors causing the uterine lining to break down and increasing the sensitivity of the uterus to prostaglandins) followed by misoprostol (a prostaglandin analogue, which induces

political opposition to abortion is less vociferous on this side of the Atlantic, it has proved similarly intractable, being clearly visible in the retention of clinically unjustified legal restrictions on service provision. Over three decades ago our highest domestic court noted that the development of medical abortion ‘invites, and indeed merits, the attention of Parliament.’¹⁰ Yet while the technology has continued to develop apace since this comment was made, such attention has been lacking, leaving relevant laws steeped in the clinical beliefs and the practices of far earlier times.¹¹ Moreover, the development of medical abortion techniques offers just one example, albeit a particularly powerful one, of the significant changes that have occurred since our abortion laws were passed. Notably, along with other technological advances, this period has also witnessed significant changes in how we see the respective ethical rights and responsibilities of doctor and patient, and the moral values that should inform clinical practice.

There is an important, ongoing ethical debate regarding how a woman’s rights to autonomy, equality and reproductive health should be balanced against the moral respect due to the developing embryo or foetus.¹² This paper does not seek to engage directly with it. Rather, taking seriously the broad

uterine contractions that expel the contents of the womb). See RCOG, *The Care of Women Requesting Induced Abortion (Evidence-based Clinical Guideline No. 7)* (London: RCOG, 2011), for guidance regarding best practice.

¹⁰ Lord Wilberforce, *RCN v DHSS* [1981] 1 All ER 545, 566, commenting on second trimester prostaglandin inductions. See below for detailed discussion of this case.

¹¹ The only changes made to the Abortion Act since its enactment were a small number of amendments in 1990, see generally, Sheldon n 8 above, chapter 6. One of these amendments, s 1(3A) is discussed further below, n 150 and accompanying text.

¹² For an introduction to the voluminous literature, see: J. Finnis, M. Cohen, T. Nagel, T.F. Scanlon *The Rights and Wrongs of Abortion: A Philosophy & Public Affairs Reader* (New Jersey: Princeton University Press, 1974); and

purposes that are said to inform British abortion legislation, it analyses the poor alignment between the aging statutory framework and contemporary clinical understandings of best practice in abortion services, assessing the significant challenges that the gulf between the two poses for clinicians, service providers and regulators. Law is said to be at its most effective where there is a shared regulatory community that accepts and endorses its terms.¹³ Abortion law provides a marked example of what happens where this does not exist. Here, legal requirements once justified by broadly shared moral understandings, concerns for patient safety and requirements of best practice continue unsupported by or, indeed, in opposition to such concerns. In what follows, I briefly outline the law regulating abortion in Britain. I then consider three such points of significant tension, which are inherent in the formal requirements that abortion decisions must be made by two doctors rather than the pregnant woman herself; that abortions must be performed by a doctor; and that they must be performed on NHS or licensed premises.

A BRIEF OVERVIEW OF THE CURRENT LAW

The law governing abortion is the oldest extant statutory framework governing any specific medical procedure in the UK,¹⁴ with the political sensitivity of abortion having contributed to the reluctance of

M. Tooley, C. Wolf-Devine, P.E. Devine, A. M. Jaggar, *Abortion: Three Perspectives* (Oxford: Oxford University Press, 2009).

¹³ Black, n 1 above, 178.

¹⁴ The entire statutory framework for abortion is contained within the first four of the 270 pages of statutes extracted in the chronologically ordered A.E. Morris and M.A. Jones (eds) *Blackstone's Statutes on Medical Law*, (Oxford: Oxford University Press, 5th ed, 2007). For an excellent discussion of the historical development of the

successive governments to contemplate reform.¹⁵ 'Unlawful procurement of miscarriage' is illegal by virtue of a statute passed at the midpoint of the reign of Queen Victoria, the Offences Against the Person Act 1861. This offence may be committed either by a pregnant woman herself or by a third party.¹⁶ A second criminal offence prohibits the unlawful supply of poison, 'other noxious thing', or any instrument or thing whatsoever, knowing that these will be used unlawfully to procure a miscarriage.¹⁷ Finally, the offence of 'concealment of birth' offers a means of prosecuting women where abortion or infanticide is suspected but cannot be proven.¹⁸ These prohibitions are the product of a time when, in the words of one leading judge, 'our society was only on the brink of the beginnings

law, see J. Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (Cambridge: Cambridge University Press, 1988).

¹⁵ S Sheldon (2015) 'The Decriminalisation of Abortion: an Argument for Modernisation, *Oxford Journal of Legal Studies*, available online first:

<http://ojls.oxfordjournals.org/content/early/2015/09/28/ojls.gqv026.full?keytype=ref&ijkey=bSmwstASzyuZ3cJ> (last accessed 17 October 2015).

¹⁶ s 58. The latter may be guilty of an offence whether or not the woman had actually been pregnant. The 1861 Act applies to England, Wales and Northern Ireland, with a similarly framed common law offence in Scotland, see G.H. Gordon, *The Criminal Law of Scotland* (Edinburgh: W. Green & Son, 1967).

¹⁷ s 59.

¹⁸ s 60. For a compelling critique of this provision, see G. Williams, *The Sanctity of Life and the Criminal Law* (London: Faber and Faber, 1958).

of the modern world', and 'in matters sexual [was] almost unimaginably different from ours'.¹⁹ The available sanctions reflect the punitive moral norms of Victorian Britain, with unlawful procurement of miscarriage punishable by life imprisonment (the most onerous sentence for abortion foreseen anywhere in Europe),²⁰ a sentence that potentially applies from the moment of implantation, some six to twelve days after fertilisation.²¹ A further, heavily overlapping offence is created by the Infant Life Preservation Act (1929), which similarly foresees a potential life sentence where someone kills a 'child' who is 'capable of being born alive'.²² The Law Commission has recently targeted the 1861 Act for reform, noting that it is widely recognised as being outdated. However the abortion offences are excluded from the review.²³

¹⁹ *R (Smeaton) v SS Health and Others* [2002] EWHC 610 (Admin), 332, per Munby J, who has since gone on to become President of the Family Division of the High Court and a member of the Court of Appeal.

²⁰ For a comparative review of European laws, see K. Nebel and S. Hurka 'Abortion: Finding the Impossible Compromise', in C. Knill, C. Adam and S. Hurka (eds), *On the Road to Permissiveness? Change and Convergence of Moral Regulation in Europe* (Oxford: Oxford University Press, 2015).

²¹ On the problems that this creates, see S. Sheldon (2015) 'The Regulatory Cliff Edge between Contraception and Abortion: the Legal and Moral Significance of Implantation' *Journal of Medical Ethics*, available online first at: <http://jme.bmj.com/content/early/2015/06/17/medethics-2015-102712.full.pdf+html?sid=8c443f5a-94e0-4345-a1a9-91708fb26abe> (last accessed 17 October 2015).

²² s 1.

²³ Law Commission (2014) *Reform of Offences against the Person. A Scoping Consultation Paper* (Consultation Paper No 217).

Today, these offences under the 1861 and 1929 Acts are charged very rarely and then typically in the context of assaults on pregnant women which result in miscarriage of a wanted pregnancy rather than in the context of consensual abortion.²⁴ The legislation nonetheless retains a significant role in delineating the boundaries within which lawful abortion services may be offered.

For many years, the onerous provisions of the 1861 Act coexisted with large numbers of clandestine, illegal abortions, resulting in significant maternal mortality and morbidity.²⁵ In 1967, the Abortion Act was passed to address the situation of women left to attempt to end their pregnancies either alone or in the back streets. It applies in England, Wales and Scotland, but not Northern Ireland.²⁶ The Act

²⁴ See generally, Sheldon (2015), above n 15. For a rare example of the prosecution of a woman charged with ending her own (very advanced) pregnancy, see *R v Catt* [2013] EWCA Crim 1187. Two charges have also recently been brought under s.59, with the latter having resulted in a conviction. However it is too early to say whether this can be seen as the beginning of a trend towards a greater prosecution of this offence. See A. Erwin, 'Belfast Woman will go on Trial for Helping her Daughter to have a Medical Abortion', *Belfast Telegraph* (19 June 2015); Medicines and Healthcare Products Regulatory Agency, 'Woman Sentenced to 27 Months for Selling Abortion Pills Illegally' (press release, 26 June 2015). A conviction under s.59 was overturned on appeal in *R v Ahmed* [2010] EWCA Crim 1949, where the offence was not made out on the facts despite an 'appalling' attempt to procure a non-consensual abortion.

²⁵ See generally, Keown, n 14 above, Sheldon, n 8 above, Williams n 18 above.

²⁶ Northern Ireland has one of the most restrictive abortion laws in Europe, with women either travelling to access abortion services in England, or ending pregnancies illegally using medical abortion drugs sourced online. See generally F. Bloomer and K. O'Dowd 'Restricted Access to Abortion in the Republic of Ireland and Northern Ireland: Exploring Abortion Tourism and Barriers to Legal Reform' (2014) 16(4) *Culture, Health & Sexuality: an International Journal for Research, Intervention and Care* 366.

is said to be underpinned by two broad parliamentary purposes: ‘to broaden the grounds upon which abortions may be lawfully obtained’ and ‘to ensure that the abortion is carried out with all proper skill and in hygienic conditions’²⁷ or, more succinctly, to provide that ‘socially acceptable abortions should be carried out under the safest conditions attainable.’²⁸ It carves out a therapeutic exception to the serious criminal offences enacted by the 1861 Act, allowing for terminations deemed appropriate by two doctors to be performed under strict medical control.²⁹ Specifically, two doctors must certify in good faith that the woman meets one of a range of conditions set out in the Abortion Act, framed broadly so as to allow for the exercise of significant clinical discretion; the termination must be performed by a doctor; and it must be done on NHS or other approved premises.³⁰

In what follows, I consider the interpretation and application of statutory text that has not been substantially revised for almost five decades, to regulate an area of clinical practice that has evolved

²⁷ *RCN*, n 10 above, 567, cited approvingly in *Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland)* [2014] UKSC 68 at [27], with Lady Hale suggesting that the 1967 Act also had a further purpose: ‘to provide such a service within the NHS, as well as in approved clinics in the private or voluntary sectors’.

²⁸ *RCN*, *ibid*, 575.

²⁹ Since its amendment in 1990, the Abortion Act also offers a defence to prosecution under the Infant Life Preservation Act (1929), see s 5(1).

³⁰ Except in the case of emergencies, where the need for a second opinion and the restrictions on place of treatment do not apply, see s 1(4).

very significantly over that same period.³¹ I discuss in detail each of the three provisions noted above, assessing how it works fifty years on in a context of very different clinical realities; and I explore some of the ways that those charged with interpreting the law have sought to reconcile it with the competing norms of best medical practice. I conclude that these three provisions now exist in significant tension with the broad purposes of providing for ‘socially acceptable abortions’ to be ‘carried out under the safest conditions attainable.’ Further, while clinicians, service providers and regulators have laboured to work around the law’s deficiencies, the widening divergence between the aging statutory framework, on the one hand, and contemporary clinical practice and ethical norms, on the other, creates unjustified restrictions on the provision of a high quality, modern abortion service. This, I conclude, raises a compelling case for statutory reform.

TWO REGISTERED MEDICAL PRACTITIONERS MUST BE ‘OF THE OPINION, FORMED IN GOOD FAITH...’

Other than in an emergency situation, abortion in Britain is lawful only when it is deemed, in the good faith opinion of two doctors, to fall within one of the grounds set out in s.1(1) of the Abortion Act.

1. (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 –

³¹ The small number of changes introduced to the Abortion Act in 1990 left untouched the broad structure of the Act and those provisions enforcing medical control of abortion that form the focus of this paper. For an overview of the reforms, see J. Murphy, ‘Cosmetics, Eugenics and Ambivalence: the Revision of the Abortion Act 1967’ (1991) JSWFL 375; and Sheldon, n 8 above, chapter 6.

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

In Parliament, a powerful justification for the introduction of the Act was that it would bring abortion out of the back streets, where it had resulted in serious maternal mortality and morbidity, allowing doctors to take control of a woman's situation. Doctors were to be accorded broad discretion in determining when a termination would be appropriate and, in other cases, to offer the kind of persuasion and support that would enable a woman to continue with her pregnancy.³² As David Owen told Parliament:

[i]f we allow abortion to become lawful under certain conditions, a woman will go to her doctor and discuss with him the problems which arise ... he may well be able to offer that support which is necessary for her to continue to full term and successfully to have a child.³³

³² For example, Steel, HC Deb vol 732 col 1076 22 July 1966; HC Deb vol 750 col 1348 13 July 1967; Dunwoody, HC Deb vol 732 col 1096 22 July 1966. See generally, Sheldon *ibid* 24-7; Keown, n 14 above, chapter 5.

³³ Owen, HC Deb vol 732, col 1116 22 July 1966.

The need for a second medical signature was intended as a check on rogue doctors, as well as offering protection to the doctor himself. The Act's sponsor, David Steel, emphasised that, '[w]e want to stamp out the back street abortions, but it is not the intention of the Promoters of the Bill to leave a wide open door for abortion on request'.³⁴

Early Implementation of the Abortion Act

At the time that the Act was passed, the medical profession, like Parliament, was strongly convinced that doctors were best placed to decide whether an abortion was justified. While there were important differences between the major medical bodies regarding the detail of reform, all stood firmly behind the view that the decision of whether to end a pregnancy belonged to two doctors,³⁵ with the pregnant woman entitled merely to 'state her case'.³⁶ A range of accounts published in the years following the Act's introduction revealed how doctors understood their role as gatekeepers to legal abortion. While some individual doctors, particularly those who worked in the private sector, immediately adopted a permissive interpretation of the law,³⁷ others did not. At one hospital, over a six month period, 120 of the 170 requests for terminations made were refused.³⁸ Another study

³⁴ Steel, HC Deb vol 732 col 1075 22 July 1966.

³⁵ See Keown, n 14 above, S. McGuinness and M. Thomson, 'Medicine and Abortion Law Reform: Complicating the Professions' (2015) *Med L Rev* 177; S.J. MacIntyre, 'The Medical Profession and the 1967 Abortion Act in Britain' (1973) 7 *Soc Sci Med* 121-34.

³⁶ MacIntyre, *ibid* 131.

³⁷ Keown, n 14 above, chapter 5.

³⁸ T.L.T. Lewis 'The Abortion Act' (1969) 5638(1) *BMJ*, 241, 242. Numbers of abortion refusals are not collected centrally.

described how some doctors worked hard to persuade women to continue with their pregnancies, with many favouring marriage as the best 'solution'. As one doctor in this study explained:

[t]he majority of girls, those I've known since they were children, I manage to persuade them to get married. Girls from outside town, those I haven't seen previously - they're more difficult to persuade. Occasionally, girls do come in demanding termination but most can be talked out of it.³⁹

Some doctors confirmed that they had deliberately acted to create delay, so that the woman would fall outside the legal timeframe for access to abortion.⁴⁰ Women reported that they had been subject to what they perceived as overly intrusive questioning,⁴¹ and moralizing, judgmental treatment at the hands of their GPs.⁴² Significantly, in some parts of the country, it was virtually impossible to access abortion services within the NHS, as senior doctors refused to provide them within their hospitals.⁴³

³⁹ S.J. MacIntyre *Single and Pregnant* (London: Croom Helm, 1979), 75-6.

⁴⁰ D. Cossey, *Abortion and Conscientious Objection* (London: Birth Control Trust, 1982), 9; C. Francome, *Abortion Practice in Britain and the United States* (London: Allen and Unwin, 1986), 55.

⁴¹ MacIntyre (1977) n 39 above.

⁴² See generally, L. Francke, *The Ambivalence of Abortion* (Harmondsworth: Penguin, 1980); A. Neustatter and G. Newson, *Mixed Feelings: The Experience of Abortion* (London, Sydney and New Hampshire: Pluto, 1986); D. Winn *Experiences of Abortion* (London: Macdonald Optima, 1988); V. Davies, *Abortion and Afterwards* (Bath: Ashgrove Press, 1991).

⁴³ Subsequently, for many years the proportion of terminations funded by the NHS settled at around, or just under, the 50% mark. From 1992 onwards, however, the percentage of NHS funded terminations rose steadily from 57% in 1992 to nearly 98% today. Over that same period, regional variation in the availability of NHS

One research project brought together a group of doctors to consider the cases of women who had come to them requesting abortions from 1967-73.⁴⁴ While this study was designed to explore a particular therapeutic model and draws on the experience of just sixteen doctors,⁴⁵ it nonetheless provides an interesting insight into how the doctor's role in this context was understood at the time, with the 'first business of a doctor' being 'neither to accede willingly nor to reject niggardly'.⁴⁶ Group members had struggled to reach a decision when faced with a woman requesting abortion.

As they saw it, if they were too liberal and the woman was allowed to have an abortion, they might inhibit that side of her which was maturing. On the other hand, if they were too restrictive, they had no real knowledge of what sort of future the unborn child might have and whether they might be making unreasonable demands on an unsupported mother [...] It was also felt by many, particularly, by the women members of the Seminar, that the patient should have some say over what should happen to her body, i.e. that she should have some liberty in her choice. However, it was considered by the majority that this freedom could not be accepted absolutely, because there were doubts in the doctors'

funding has been greatly reduced: Department of Health, n 8. On the role played by NHS reorganisation in driving this change, see Sheldon, n 8 above, 56-8. On the significance of the growing numbers of NHS-funded abortions provided by non-NHS providers, see nn 50 and 62 and accompanying text, below.

⁴⁴ D. Tunnadine and R. Green *Unwanted Pregnancy - Accident or Illness?* (Oxford: Oxford University Press, 1978) 15.

⁴⁵ The study considered 147 case studies. It was influenced by the work of the psychoanalyst, Dr Michael Balint, in seeking to understand the 'whole person' of the patients in all of their physical, mental and emotional aspects. *Ibid.*

⁴⁶ J.S. Norell, 'Foreword' in *ibid*, vii, vii. Norell was then Dean of Studies at the Royal College of General Practitioners.

minds as to whether a woman in such a predicament would know what was in her best interests. In other words, she might get what she wanted, but not what she needed.⁴⁷

Later the authors dismiss the case for 'abortion on demand', noting that 'the decision is the doctor's alone' though he must 'take note' of the woman's wishes.⁴⁸

The medical profession is a large and heterogeneous body and its members will inevitably hold a wide range of views on abortion and on the women who seek to end pregnancies. Nonetheless, the medical paternalism implicit in the claims that to be forced to continue with a pregnancy might help a woman to 'mature' and that women facing unwanted pregnancies are not the best judges of their own best interests would undoubtedly be very widely perceived as an unacceptable anachronism today.

Current Implementation: from Medical Paternalism to Patient Autonomy

Modern abortion practice looks very different from that of the 1960s and 1970s.⁴⁹ Abortion services are now firmly established as a routine part of mainstream NHS provision, albeit with a substantial proportion of those services provided under NHS contract by the independent charitable sector.⁵⁰

⁴⁷ *ibid*, 4.

⁴⁸ *ibid*, 118.

⁴⁹ See Keown, above n 14, chapter 5, for an excellent, detailed account of how interpretation of the Abortion Act evolved over the 15 years following its introduction, tracing a significant relaxation in doctors' attitudes.

⁵⁰ 67% of abortion services in England and Wales were provided by independent providers in 2014, with 98% of these operating under NHS contract, see Department of Health, n 8 above. In Scotland, abortions are provided within the NHS to approximately 18 weeks of gestation, after which point women travel to England for services, largely to independent sector providers, see C. Purcell, S. Cameron, L. Caird, G. Flett, G. Laird, C. Melville and L. M. McDaid 'Access to and Experience of Later Abortion: Accounts from Women in Scotland' (2014) 46(2) *Perspectives on Sexual and Reproductive Health* 101–108.

Numbers have stabilised at around 200,000 terminations per year, representing an abortion rate broadly in line with that seen in other Western countries and one which has been subject to a modest decline over the last few years.⁵¹ There is liberal access to abortion services within earlier pregnancy, when the large majority of terminations occur.⁵² In a very significant shift from the account provided above, contemporary doctors are likely to frame abortion decisions as properly belonging to pregnant women.⁵³ While doctors may continue to form their own moral judgments regarding the validity of a woman's reasons for seeking abortions,⁵⁴ it appears rare for this to lead to a refusal of access to services. Active dissuasion would also appear far less common.

⁵¹ 15.9 resident women in England and Wales per 1000 aged 15-44. This is the lowest rate for 16 years, Department of Health, *ibid*. The rate for Scotland is 11.2 resident women per 1000, see ISD, n 8 above. Globally, the age standardised abortion rate stood at around 28 per 1000 in 2008, with 24 per 1000 in developed countries or 17 per 1000 with Eastern Europe excluded, see G. Sedgh, S. Singh, I.H. Shah, E. Ahman, S.K. Henshaw, A. Bankole, 'Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008' (2012) 379 (9816) *Lancet* 625.

⁵² 92% of abortions for women resident in England and Wales were carried out at under 13 weeks' gestation, Department of Health, *ibid*.

⁵³ S.M. Beynon-Jones 'Timing is Everything: the Demarcation of Later Abortions in Scotland' (2012) 42(1) *Soc Stud Sci* 53.

⁵⁴ Beynon-Jones describes how Scottish health professionals involved in abortion provision construct 'stratified' expectations about women's reproductive decision-making, with youth, age, parity and class mobilised as criteria through which to distinguish 'types' of patient whose requests for abortion are deemed particularly understandable or particularly problematic: S.M. Beynon-Jones 'Expecting Motherhood? Stratifying Reproduction in 21st-century Scottish Abortion Practice' (2012) 47(3) *Sociology* 509.

The overwhelming majority of legal terminations are performed on the basis of the first ground of the Abortion Act.⁵⁵ This permits an abortion to be authorised where two doctors form a good faith view that being forced to continue an unwanted pregnancy would be likely to pose a greater risk to a woman's mental or physical health than would a termination. Modern abortion procedures are very considerably safer than carrying a pregnancy to term and, thus, in all cases there is a solid evidence base on which a doctor may reach a good faith determination that an early termination is indicated, as, statistically, posing a far lower risk to a woman's physical health than continuing the pregnancy. While the so-called 'statistical argument' has been known for some decades,⁵⁶ it has gained more force as the medical evidence base has developed over the lifetime of the Act. One study carried out in the early years of the Abortion Act's operation, found that within a sample of 1,317 women admitted for abortion, there had been one death and a morbidity rate of 16.8% (16,800 per 100,000).⁵⁷

⁵⁵ In 2014, 98% of abortions for English and Welsh resident women were carried out on the basis of s 1(1)(a) alone: Department of Health, n 8, 46.

⁵⁶ On the 'statistical argument', see Keown, n 14 above, 128-30, referencing G. Williams, *Textbook of Criminal Law* (London: Stevens, 2nd ed, 1983) 299.

⁵⁷ S. Sood 'Some Operative and Postoperative Hazards of Legal Termination of Pregnancy' (1971) 5782(4) *BMJ* 270 (30 October), discussing patients admitted for NHS abortions from 1967-1970. Sood reports a morbidity rate of 16.8%, with 'morbidity' defined to exclude urinary tract infection. The following complications were most common: genital infection, chest infection, re-evacuation or perforation of the uterus and haemorrhage. Sood notes the following maternal death rates for legal abortions performed in 1970: 8.4/10,000 for abortions carried out by hysterotomy; 12.6/10,000 for abortion by hysterectomy; 2.2/10,000 by vacuum aspiration and 0.9/10,000 for all other methods, including dilatation and curettage, at 270, citing the Chief Medical Officer's Annual Report. Tunnadine and Green note that in 1967 it was thought that there was an increased risk, if only a small one, in performing an abortion rather than allowing a pregnancy to continue to term, above n 44, 2.

Today, one would expect to see a death rate of 0.32 per 100,000 women admitted for abortion (compared to 11.39 per 100,000 women who carry a pregnancy to term),⁵⁸ with just 100-200 per 100,000 suffering major complications that might require hospital care.⁵⁹

Further, changes to the structure of NHS funding introduced in the early 1990s made it impossible for senior doctors to block access to NHS funding for abortions simply by refusing to see them performed in 'their' hospitals.⁶⁰ Today, regional disparities in the availability of NHS funding have largely evaporated and, with the very notable exception of Northern Irish women, almost all UK resident women seeking abortion will access state-funded services.⁶¹

While the text of the Abortion Act has survived largely unchanged since 1967, abortion decisions are thus made within a radically different medical and institutional context and the reality of access to services in the first twenty-four weeks of pregnancy suggests that, in its interpretation, current regulation has evolved considerably. It has been significant in this process that two-thirds of abortions are now performed by specialist charitable service providers that operate with an explicitly pro-choice

⁵⁸ Centre for Maternal and Child Enquiries (CMACE) *Saving Mothers' Lives. Reviewing Maternal Deaths to make Motherhood Safer: 2006–2008* (2011) 118 BJOG (Suppl 1:1) 203.

⁵⁹ RCOG, n 9 above, 39s, citing a very small risk of haemorrhage, sepsis and uterine perforation.

⁶⁰ See Sheldon, n 8 above.

⁶¹ *R (A and B) v Secretary of State for Health* [2014] EWHC 1364 (Admin). For resident English and Welsh women, 98% of abortions are NHS-funded. Some regional disparity nonetheless persists in how early women are able to access services, with 89% of terminations in North Staffordshire but only 54% of those in the Vale of Glamorgan occurring at under 10 weeks: Department of Health, n 8 above.

mandate.⁶² This means that the majority of women who access abortion services will today do so within a supportive, non-judgmental environment. Further, those healthcare professionals who have a conscientious objection to abortion have a statutorily entrenched right to opt out of service provision, leaving this work to colleagues who do not share their views.⁶³

The development of this permissive approach has not, however, gone unchallenged. As well as offering an important target for criticism outside of legal arena, occasional *obiter* references from the courts have suggested the law is now ‘wrongly, liberally construed in practice so as to make abortion available essentially on demand prior to 24 weeks with the approval of registered medical practitioners,’⁶⁴ or that it is interpreted ‘so loosely that abortion has become obtainable virtually on demand.’⁶⁵ A former Health Secretary went still further. Responding to allegations that abortions had been authorised purely on the basis of a preference regarding the sex of the future child, Andrew Lansley berated the doctors involved as ‘people engaging in a culture of both ignoring the law and trying to give themselves the right to say that although Parliament may have said this, we believe in abortion on demand.’⁶⁶

⁶² See n 43 above. For the aims of the two major charitable providers of abortion services, see <http://www.bpas.org/bpasabout/values>; <http://www.mariestopes.org.uk/aboutmariestopesuk> (each last accessed 17 October 2015).

⁶³ s 4, Abortion Act. See *Doogan*, n 27 above, for recent consideration of this provision.

⁶⁴ *R v Sarah Louise Catt*, Sentencing Remarks (17 September 2012) at [15].

⁶⁵ Denning MR, *RCN*, n 10 above, 554.

In support of such criticisms, it should be recalled that the Parliament that passed the 1967 Act was explicitly told that there was no intention to introduce abortion 'on request'.⁶⁷ However, Parliament also clearly intended that the statute should leave broad scope for the exercise of clinical discretion, with doctors charged with determining which abortions were 'socially acceptable' within the general grounds laid down in the Abortion Act. It is this broad discretion that has permitted evolution in interpretation of the Abortion Act and the resulting liberal access to abortion.⁶⁸ While the two judges cited above can thus coherently criticise a 'loose' or 'liberal' interpretation of the law (as, presumably, one that is contrary to their own moral views on abortion), Lansley fundamentally misunderstands the operation of the law when he speaks of doctors 'ignoring' it. Interpretation of statutory norms is neither fixed nor determinate but rather arises from shifting, contextually derived understandings and shared world views.⁶⁹ In this specific context, evolving interpretations of the legislation have served to track not just broader shifts in moral attitudes to abortion,⁷⁰ and the medical evidence base

⁶⁶ Cited in R. Winnett, C. Newell and H. Watt, 'One in Five Abortion Clinics Breaks Law', *Telegraph* (22 March 2012).

⁶⁷ See n 34 and accompanying text, above.

⁶⁸ Keown, n 14 above, 137.

⁶⁹ J. Black (1997) 'New Institutionalism and Naturalism in Socio-Legal Analysis: Institutional Approaches to Regulatory Decision Making' 19 *Law & Policy* 51, 52.

⁷⁰ In a representative sample of 953 adults, over half supported the view that 'a woman should not have to continue with her pregnancy if she wants an abortion' (15% very strongly agreed, 12% strongly agreed, 27% agreed and 17% disagreed). A second question, asked in the same survey, provided an even stronger response (perhaps reflecting a restrictive view of the appropriate role of government in this context): when asked to select the statement that best reflected their views, only 17% selected the statement that 'the Government has a

described above, but also an evolution in the ethical values that inform the doctor/patient relationship. These values have shifted definitively away from the paternalism that informed the vision of doctors' role at the time of the Abortion Act's introduction.

Today, the importance of respecting patient autonomy pervades the professional guidance available to doctors. The GMC tells doctors that they have a duty to 'work in partnership with patients':

Listen to, and respond to, their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care.⁷¹

It advises that '[t]he doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.'⁷² Pregnant women are

responsibility to reduce the number of abortions', compared to the 70% who chose the statement that 'it's a woman's right to choose whether or not to have an abortion and the Government should not interfere.' Ipsos MORI (2011) *Public Attitudes towards Abortion*, <https://www.ipsos-mori.com/researchpublications/researcharchive/2854/Public-Attitudes-towards-Abortion.aspx>. A second poll found that a similarly high proportion of those who identified as Christian (63%) agreed that, within the legal time limit, an adult woman with an unwanted pregnancy should be able to have an abortion if she wants one, compared to 20% against. See Ipsos MORI for Richard Dawkins Foundation for Reason and Science (UK), *Religious and Social Attitudes of UK Christians in 2011*, <https://www.ipsos-mori.com/researchpublications/researcharchive/2921/Religious-and-Social-Attitudes-of-UK-Christians-in-2011.aspx> (each last accessed 17 October 2015).

⁷¹ General Medical Council, *Good Medical Practice* (London, GMC: 2013), inside cover.

⁷² General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (London, GMC: London, GMC: 2008) at [5].

not an exception to this principle, with NICE guidelines regarding the provision of Caesarean section procedures stating that women 'should be offered evidence-based information and support to enable them to make informed decisions about childbirth.'⁷³ The importance of respecting autonomy in the abortion context, as in others, is implicit in the detailed RCOG guidance on the information of risks and side effects that doctors should offer their patients in order to ensure that the decision to terminate a pregnancy is properly informed;⁷⁴ and explicit in guidance offered by the Royal College of General Practitioners:

While the opinion and feelings of others will often form part of the picture for each woman, the [abortion] decision remains hers. It is important that the woman acknowledges the implications and responsibility of the decision.⁷⁵

The marked shift from a historical emphasis on the doctor's duty of beneficence in medical decision-making towards a more pronounced focus on patient autonomy, has been matched by a

⁷³ National Institute for Health and Care Excellence, *Caesarean Section: Clinical Guideline CG132* (London, NICE, 2011). The Guidelines also provide that: '[a] pregnant woman is entitled to decline the offer of treatment such as CS, even when the treatment would clearly benefit her or her baby's health. Refusal of treatment needs to be one of the woman's options' (1.1.2.3).

⁷⁴ RCOG, n 9 above.

⁷⁵ Royal College of General Practitioners, *RCGP Position Statement on Abortion* (London, RCGP, 2012). http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/_media/Files/Policy/A-Z-policy/RCGP_Position_Statement_on_Abortion.ashx (last accessed 17 October 2015).

corresponding development in the relevant legal standards.⁷⁶ An illustration of the distance that has been travelled was recently and powerfully provided in *Montgomery*.⁷⁷ Previously, it had been accepted that a doctor might lawfully omit to warn a patient of the risks involved in a proposed treatment, provided always that such an omission was accepted as proper by a responsible body of medical opinion.⁷⁸ Rejecting the professional practice test in this context, a seven judge Supreme Court was unanimous in holding that the paternalistic vision that underpinned it had long ‘ceased to reflect the reality and complexity of the way in which healthcare services are provided’, with patients ‘now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession.’⁷⁹ As the leading judgment recognised, ‘social and legal developments ... point away from a model of the relationship between the doctor and patient based upon medical paternalism’:⁸⁰

What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors [...] treats them so far as possible as adults who are capable of understanding

⁷⁶ For a sustained critique of this trend, see C. Foster, *Choosing Life, Choosing Death: the Tyranny of Autonomy in Medical Ethics and Law* (Oxford: Hart, 2009).

⁷⁷ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. For a compelling early analysis of the tension between abortion legislation and the increasingly strong commitment to patient autonomy in medical law, see E. Jackson ‘Abortion, Autonomy and Prenatal Diagnosis’ (2000) 9 SLS 467.

⁷⁸ *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] UKHL 1.

⁷⁹ *Montgomery*, n 77 above, at [75].

⁸⁰ *ibid*, at [81].

that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.⁸¹

Again, it is clear from *Montgomery*, which turned upon a woman's right to make an informed choice between a vaginal and Caesarean delivery, that pregnant women are not to be treated as a legal exception to the principle of respect for patient autonomy. This is so even in those situations where treatment decisions will have a significant impact on fetal health or survival: a competent pregnant woman has an absolute right to refuse even those medical interventions that her doctors deem essential to save her own life and that of a full term fetus.⁸² The fact of being pregnant:

does not diminish [a woman's] entitlement to decide whether or not to undergo medical treatment [...] Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.⁸³

Finally, it has also been suggested that current legal requirements regarding the need for two doctors to authorise a termination are importantly out of line with the UK's obligations under human rights law.⁸⁴

⁸¹ *ibid.*

⁸² *George's Healthcare NHS Trust v S* [1988] 3 WLR 936; *Re MB (Caesarean Section)* [1997] EWCA Civ 1361.

⁸³ *George's, ibid*, 957.

⁸⁴ R. Scott, 'Risks, Reasons, and Rights: the European Convention on Human Rights and English Abortion Law' (forthcoming) *Med L Rev*. Scott argues that to make access to lawful abortion within early pregnancy conditional on fulfilment of the terms of s 1(1)(a) is an unjustified interference with a woman's private life under Article 8 of the European Convention on Human Rights. She also raises concerns regarding the lack of a system of formal review in the event that doctors decide not to grant a termination.

Clearly, evolutions in jurisprudence and professional guidelines cannot overrule statutory provisions, however anomalous the requirements of the Abortion Act might appear in the context of modern medical law.⁸⁵ But this broader context of medical practice and the ethical norms which guide it will inevitably and entirely appropriately influence how doctors interpret the terms of the Abortion Act. Indeed, while a conscientious objector has a legal right to opt out of providing abortion services,⁸⁶ the doctor who sees his or her role as involving dissuasion, cajolement, prevarication or refusal to provide information in order to block or delay access to abortion services requested within the legal time limits would today potentially stand in serious breach of the above professional guidance and, following *Montgomery*, the law of negligence.

Further, it cannot be assumed that taking a liberal interpretation of the law is obviously subversive of its intended purpose. While Parliament did not intend to legislate for ‘abortion on request’, it did intend that the ‘great social responsibility’ of determining what abortions would be permitted within the broad terms of the legislation should be placed firmly ‘on the shoulders of the medical profession’,⁸⁷ deliberately providing for local, contingent decision-making. Five decades on, when doctors take a permissive view of who should be granted access to abortion services within the terms

⁸⁵ See Jackson, n 77 above.

⁸⁶ s 4(1), Abortion Act 1967.

⁸⁷ *R v Smith* [1974] 1 All ER 376 (CA): ‘the legality of an abortion depends on the opinion of the doctor. It has introduced the safeguard of two opinions: but, if they are formed in good faith by the time the operation is undertaken, the abortion is lawful. Thus a great social responsibility is firmly placed by the law on the shoulders of the medical profession’, per Scarman LJ, 381. The existence of wide medical discretion in this context has been more recently confirmed in *Re SB (a Patient; Capacity to Consent to Termination)* [2013] EWHC 1417 (COP) and *Re X (a Child)* [2014] EWHC 1871 (Fam).

of the legislation, this serves to recognise, first, 'the statistical argument' regarding the relatively greater clinical risks of continued pregnancy compared to termination; second, the significant shifts in medical practice towards respect for patient autonomy; and, third, contemporary ethical views on abortion which, over the five decades since the Act was passed, have shifted firmly towards a more permissive stance.⁸⁸ As such, where a doctor believes in good faith that a 'socially acceptable' abortion is rendered such purely on the basis that a woman has made an informed decision that she does not wish to continue with a pregnancy, he or she has a solid legal basis for authorising a termination.

Ongoing Challenges for Regulation

This conclusion nonetheless sits in clear tension with a legal framework that requires abortion decisions to be made by two doctors, raising an important issue regarding the ongoing role played by this requirement in the context of modern abortion services. This issue was at the heart of recent controversy regarding the revelation that some doctors were 'pre-signing' the HSA1 forms, which provide formal notification that a termination has been authorised, without having first considered any information relating to the specific pregnant woman to be treated. Concerned about this practice, then Health Secretary Andrew Lansley, ordered the Care Quality Commission (CQC) to carry out a spontaneous, mass inspection of abortion clinics. Early leaked accounts reported a 'scandal' that around one fifth of inspected clinics were breaking the law by pre-signing forms, with many said to be likely to be stripped of the licences permitting them to offer abortions.⁸⁹ This was not born out in the

⁸⁸ See n 70 above.

⁸⁹ Winnett et al, n 66 above.

final report issued by the CQC, which cited pre-signing at just 14 (6%) of 249 inspected clinics, all of which were NHS Trusts, and none of which were found to have provided poor care to their patients.⁹⁰

The legality of 'pre-signing' is moot.⁹¹ The Abortion Act requires doctors to provide notification that an abortion has been authorised but makes no specific provision for when certification should take place, beyond the requirement that doctors must form an opinion in 'good faith'. Statutory Regulations provide that any certificate of an opinion must be given before the termination takes place but are silent on the question of it should be signed.⁹² However, the controversy surrounding pre-signing is interesting for the broader issue perceived to be at stake: the accusation that the doctors involved were 'rubber stamping' the forms and abdicating the decision-making role foreseen for them in the 1967 Act.⁹³

Concerns regarding pre-signing were one factor in the Department of Health's decision to issue further *Guidance in Relation to Requirements of the Abortion Act 1967*.⁹⁴ The Guidance offers a restrictive

⁹⁰ Care Quality Commission, 'Findings of Termination of Pregnancy Inspections Published', Press Release (London: CQC, 2012). <http://www.cqc.org.uk/content/findings-termination-pregnancy-inspections-published> (last accessed 17 October 2015).

⁹¹ See generally D. Flower, 'Certifying Abortions: the Signing of HSA1 Forms' in *bpas, Britain's Abortion Law: What it Says and Why*, 22; Barbara Hewson 'The Public is Being Misled about Pre-signed Abortion Certificates' (2012) Sol Jo (16 April).

⁹² Abortion Regulations 1991 (S.I. No. 1991/499).

⁹³ S. Wollaston 'Abortion Law is no longer Fit for Purpose' *Guardian* (24 April 2014); Department of Health, *Guidance in Relation to Requirements of the Abortion Act 1967* (London: Department of Health, 2014) at [20].

⁹⁴ Department of Health, *ibid*.

reading of requirements regarding doctors' decision-making. First, it finds pre-signing of forms (without subsequent consideration of any information relating to the woman) to be incompatible with the requirements of the Abortion Act.⁹⁵ Pre-signing is said to call 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.⁹⁶ The Guidance also advises that a doctor must make an individual assessment of the woman requesting an abortion, rather than relying on the assessment of other members of the multi-disciplinary healthcare team.⁹⁷ Finally, it notes that, whilst not strictly legally required, it is nonetheless 'good practice' for at least one of the doctors who authorises an abortion to see the pregnant woman in person.⁹⁸

The claim that a doctor must be able to turn his or her mind to a specific woman's circumstances in order to form a 'good faith' determination is said to reflect Parliament's intention that each doctor should consider the woman's individual circumstances.⁹⁹ Such a reading gains support from the general schema of the Act: the fact that each individual request for abortion must be judged to fit within one of four broad grounds implies that an individualised assessment is required, as does the

⁹⁵ *ibid*, at [17].

⁹⁶ *ibid*.

⁹⁷ *ibid*, at [12], [20] and [21].

⁹⁸ *ibid*, at [6].

⁹⁹ Flower, n 91 above.

recognition that the two doctors may find that different grounds are met.¹⁰⁰ The fact that the HSA1 form requires the name and address of the woman to be listed also points in this direction.¹⁰¹

However, while the concept of 'good faith' clearly place limits on how a doctor's judgment may be reached,¹⁰² it is not self-evident that either a literal or purposive interpretation of the Act requires an individualised assessment. Here, it is noteworthy that the legislation specifically allowed broad scope for clinical discretion, leaving the question of how a decision should be reached to the doctors involved. It is arguable that a 'good faith' opinion that abortion is justifiable in all cases could be reached on the basis of the relative risks to a women's mental or physical health (for the latter, relying on the 'statistical argument' set out above).¹⁰³

Further, even assuming that the Guidance is correct to assert that an individual assessment of a woman's case by two doctors was intended by Parliament, it might be argued that any such intention on this specific issue would have been grounded in the broader belief that this scrutiny was necessary to meet the over-arching purposes of the legislation. Yet there is no reason to believe that the goal of ensuring that 'socially acceptable abortions should be carried out under the safest conditions attainable'¹⁰⁴ is furthered by the restrictive interpretation of the law offered in the Guidance. Notably, there is no indication that the Government intends to reinforce the doctor's gatekeeper role as a means of restricting access to services and reducing numbers of abortions. There is nothing in the

¹⁰⁰ *ibid.*

¹⁰¹ Guidance, n 93 above.

¹⁰² *Smith*, n 87 above.

¹⁰³ Flower, n 91 above, 25; on the 'statistical argument' see generally n 56 and accompanying text above.

¹⁰⁴ *RCN*, n 10 above, 575.

Guidance that would suggest a desire to return to the era where the doctor's proper function was understood as managing a woman's pregnancy in the sense of refusing to allow her to make key decisions about it: indeed, the need for the provision of impartial information to women is explicitly recognised.¹⁰⁵ Further, the Guidance makes no suggestion that greater scrutiny might serve to improve abortion services, either in terms of the safety or support of women seeking terminations, or in ensuring that abortion decisions are well informed, non-coerced and carefully considered. And, as noted above, the CQC inspection into pre-signing found no evidence of poor care to patients. Yet if these broad policy arguments are not to be invoked in favour of a tighter level of medical control, then a restrictive interpretation of the doctors' role within the regulatory structure appears to be asserted as an end in its own right.

Neither is it clear why a face to face assessment should be thought 'good practice' in this context while, in others, doctors are encouraged to work collaboratively as part of a multi-disciplinary team and to rely on information gathered and assessments made by their colleagues.¹⁰⁶ In the abortion context, an increasingly significant role has come to be played by nurses and counsellors, who should be appropriately skilled in ensuring that a woman's decision is firm, considered and non-coerced, and in identifying any exceptional medical circumstances that would require the specialist input of a doctor. As will be discussed in more detail below, the importance of multi-disciplinary team working

¹⁰⁵ Department of Health, n 93 above, at [32] provides that '[p]atients should be able expect impartial advice from the NHS and CCGs.'

¹⁰⁶ See GMC (2013), n 71 above, s 35, providing that '[y]ou must work collaboratively with colleagues, respect their skills and contributions'. It is noteworthy that there was some inconsistency in the interpretation of the law taken in recent CQC inspections, with some inspectors seeing it as a breach of the rules for a doctor to sign a HSA1 form without seeing a woman's records, while others did not. Flower, n 91 above, 26, argues that it is 'simply not for the regulator to prescribe how any individual doctor reaches his decision in good faith.'

has been elsewhere emphasised by the Department of Health and accepted in judicial interpretation of the Act, provided that a doctor remains in overall control of the abortion procedure.¹⁰⁷

Maintaining compliance with regulation entails building a shared view of what that regulation means, with a stable and effective regulatory system achieved only where there is broad acceptance of the values that underpin the regulatory norms.¹⁰⁸ In seeking to impose a more restrictive reading of the legislation by simple assertion, with limited reference to the purposes underpinning it, the Government here fails to address the issues that would tend to a culture of ‘rubber stamping’. Rather, in a broader context of evidence-based medicine where protocols are developed on the basis of clinical need, it risks reinforcing a view of certification paperwork as an anomalous, bureaucratic measure, required merely to comply with legal requirements. More generally, the above analysis highlights the scope for disagreement regarding the appropriate interpretation of the law. The lack of clarity is a particularly egregious failing in a law backed by such onerous criminal sanction.

On other occasions, far from advocating a restrictive reading of the legislation, the Department of Health has accepted a broad, purposive interpretation of the Abortion Act that seeks to avoid the imposition of clinically unjustified restrictions on good practice. However, as will be seen next, while taking a purposive interpretation of the Act may paper over the cracks in the regulatory framework, it cannot address the underlying tensions that are causing them to appear.

¹⁰⁷ RCN, n 10 above.

¹⁰⁸ S. Picciotto ‘Constructing Compliance: Game Playing, Tax Law, and the Regulatory State’ (2007) 29 *Law & Policy* 11, 18.

A PREGNANCY MUST BE 'TERMINATED BY A REGISTERED MEDICAL PRACTITIONER'

In order for an abortion to be lawful, a second requirement of the Abortion Act must also be met: the pregnancy must be 'terminated by a registered medical practitioner.'¹⁰⁹ This provision reflected the desire to take abortions out of the backstreets, ensuring that they would be performed safely by appropriately skilled professionals.¹¹⁰ In 1967, legal abortions were far riskier, technically more demanding procedures 'done by surgical methods', with the 'knife with the cutting edge' of necessity 'operated by a registered medical practitioner'.¹¹¹ In the years immediately following the introduction of the Act, however, a far safer, technically less demanding means of performing early abortions – by vacuum aspiration – quickly became widespread, already rendering the need for the skilled hand of a doctor less self-evident.¹¹² Today, medical abortion accounts for over half of all legal abortions

¹⁰⁹ s 1(1).

¹¹⁰ Lord Denning MR suggests that it was also deemed necessary to protect nurses, who he assumes to be young, vulnerable and opposed to abortion, by requiring those doctors minded to prescribe abortions to be prepared to carry them out themselves. He notes: 'I can quite understand that many nurses dislike having anything to do with these abortions. It is a soul-destroying task. The nurses are young women who are dedicated by their profession and training to do all they can to preserve life. Yet here they are called on to destroy it.' RCN, n 10 above, 555.

¹¹¹ *ibid*, 554. While Lord Denning restricts his remarks here to the second trimester terminations at issue in the case before him, the same radical changes in abortion technology are equally marked at other stages of gestation.

¹¹² Vacuum aspiration involves gentle suction to remove the foetus from the womb and is used until approximately fifteen weeks of pregnancy. It typically takes less than five minutes. It was introduced to much of the English-speaking world by D. Kerslake and D. Casey 'Abortion induced by means of uterine aspiration'

performed in the UK, with most of the other half provided by vacuum aspiration, and less than one in twenty relying on more technically demanding methods.¹¹³ Here, I consider three different abortion procedures, each of which raises important questions as to how this provision should be interpreted in the light of evolving medical technologies.

Second Trimester Medical Abortion by Prostaglandin Infusion: *RCN v DHSS* (1981)

By the early 1980s, it was accepted practice for second trimester medical terminations using prostaglandins (drugs that cause uterine contractions) to be conducted largely by nursing staff. The doctor would insert a catheter into the womb, leaving nurses or midwives to attach it to a pump, add the necessary prostaglandin infusion, switch the pump on, monitor the patient's vital signs, adjust the flow of the drug, and add fresh supplies as necessary over the 18-30 hours that it might take for a miscarriage to occur. While the doctor would be available to be called if necessary, he or she would not routinely be present on the ward.¹¹⁴

Department of Health Guidance asserting the legality of this procedure was challenged by the Royal College of Nursing, which was concerned regarding the potential legal liability of its members in the event that the Guidance was incorrect. The issue that came before the courts in *RCN* was thus the

(1967) *Obstetrics and Gynecology* 30. By 1969 one third of all terminations in England and Wales were performed this way, see: M. Potts, P. Diggory, J. Peel, *Abortion* (Cambridge: Cambridge University Press, 1977) 183.

¹¹³ Medical abortions accounted for 51% of the total number of abortions performed in England and Wales in 2014 and 80% of those performed in Scotland, see Department of Health and ISD, n 8 above.

¹¹⁴ See *RCN* n 10 above, 821.

following: where the only steps that directly cause an abortion are carried out by a nurse or midwife, is the pregnancy 'terminated by a registered medical practitioner'?¹¹⁵

The courts' response was finely balanced.¹¹⁶ However, a slim majority in the House of Lords accepted the Department of Health's broad, purposive interpretation of the Abortion Act, reading the requirement that a pregnancy be terminated by a registered medical practitioner to mean that a doctor 'should accept responsibility' for all stages of treatment for the termination of pregnancy, without necessarily needing to carry out specific actions him or herself.¹¹⁷ Lord Diplock explained:

The particular method to be used should be decided by the doctor in charge of the treatment for termination of the pregnancy; he should carry out any physical acts, forming part of the treatment, that in accordance with accepted medical practice are done only by qualified medical practitioners, and should give specific instructions as to the carrying out of such parts of the treatment as in accordance with accepted medical practice are carried out by nurses or other members of the hospital staff without medical qualifications. To each of them, the doctor, or his substitute, should be available to be consulted or called on for assistance from beginning to end of the treatment.¹¹⁸

This broad reading of the provision allowed the then existing medical practice to be maintained.

¹¹⁵ *ibid.*

¹¹⁶ Woolf J (at first instance) and Lords Diplock, Keith and Roskill (in the House of Lords) concluded in favour of the Department's position. Lord Denning MR, Brightman LJ and Sir George Baker P (in the Court of Appeal) and Lords Wilberforce and Edmund-Davies (in the HL) found against, offering a more restrictive reading of the Act.

¹¹⁷ *RCN* n 10 above, per Lord Diplock, 569. See further, Lord Keith, 575; Lord Roskill, 577.

¹¹⁸ *ibid*, Lord Diplock, 569-70.

Early Medical Abortion

While the *RCN* case concerned second trimester inductions, it has assumed particular contemporary significance with regard to early medical abortion. This was foreseen by Woolf J, at first instance.

No doubt the time is not far ahead when a pregnancy can be terminated merely by the patient taking a pill. If in such circumstances the doctor, having examined the patient, decides that it is a case where in accordance with s.1 the pregnancy should be terminated, and he complies with the other conditions of s.1, then the fact that the pill may be handed to the patient by the nurse rather than the doctor so that the patient can take the pill will not mean that the treatment is not that of the doctor.¹¹⁹

While prescient regarding future developments in medical science, however, the legal issue is less clear cut than Woolf J here assumes. A contrary interpretation is offered by the authoritative legal commentators, Ian Kennedy and Andrew Grubb, who query whether terminations would be lawful where drugs are prescribed by a doctor, dispensed by a pharmacist but self-administered by a woman.

Legally, the situation is analogous to a case where a doctor provides the means (eg pills) for a patient to kill himself. It is the patient who commits suicide. The doctor is guilty of assisting suicide, if anything. It cannot be said that he is guilty of murder since the law regards the patient's own actions as the cause of death. *Mutatis mutandis*, here the woman causes her own termination. The provisions of the Abortion Act would not be complied with.¹²⁰

Distinguishing *RCN*, Kennedy and Grubb suggest that a doctor's 'responsibility' for the patient during an early medical abortion does not involve the 'right to control those who acted on his behalf in a professional capacity.'¹²¹ It rather intends a relationship that is 'neither one of control nor one where

¹¹⁹ *ibid*, 553.

¹²⁰ I. Kennedy and A. Grubb, *Medical Law: Text and Materials* (London: Butterworths, 3rd ed, 2000) 1478.

¹²¹ *ibid*, 1479.

the patient (in administering the drug to herself) can be said to act on the doctor's behalf or be in his charge.¹²² A woman does not, as does a nurse, act 'in a ministerial capacity' for the doctor.¹²³ Kennedy and Grubb conclude that it is unlikely that a future court would further expand the meaning of the 1967 Act to cover this situation.¹²⁴

In their analysis, Kennedy and Grubb assume that the misoprostol used in the second stage of an early medical abortion is administered by a nurse.¹²⁵ As such, they raise a concern only with regard to what they estimate to be around 3% of cases, where a woman's miscarriage is provoked by (self-administered) mifepristone alone, with no need for the second (nurse-administered) stage of the treatment.¹²⁶ Today, however, misoprostol tablets are typically inserted by the woman herself.¹²⁷ This remains true not just for the early abortions discussed by Kennedy and Grubb but also for many of those performed later in pregnancy, where the preferred treatment regime has evolved significantly

¹²² *ibid.*

¹²³ Lord Keith, *RCN*, n 10 above, 575.

¹²⁴ Kennedy and Grubb, n 120 above.

¹²⁵ *ibid.*, 1478.

¹²⁶ *ibid.*

¹²⁷ A healthcare professional – typically a nurse – would only insert the tablets in rare cases, for example where a woman is uncomfortable in touching her own genitals. Personal communication, Dr Patricia A. Lohr, Medical Director, bpas.

from that described in *RCN*.¹²⁸ It should further be noted that the physical involvement of the doctor under such protocols is likely to be even more minimal than that described in *RCN*, with no ‘hands on’ involvement and, other than prescribing drugs and giving instruction, no role in ‘initiating’ treatment.¹²⁹

If Kennedy and Grubb’s analysis is correct, then, its implications are significant. Given that, *ex hypothesi*, the woman would be held to have terminated her own pregnancy, it would mean that the large majority of medical abortions performed in the first trimester of pregnancy, and many of those performed later, would potentially constitute serious criminal offences. It seems unlikely that the public interest threshold for a prosecution would be met in the context of otherwise lawful terminations performed with due regard to patient safety. However, if a court were persuaded to issue a declaration that abortions provided under these protocols are unlawful, this would have a very significant effect in restricting the way in which medical terminations might be offered. The lack of clarity on this point is thus troubling, particularly given how finely balanced were the judgments in *RCN*.

¹²⁸ This will generally involve mifepristone followed by misoprostol at three-hourly intervals, RCOG, n 9 above. In British clinics, the mifepristone and first dose of misoprostol is typically self-administered by the patient, with subsequent doses of misoprostol either self-administered or inserted by a nurse, Lohr, *ibid*.

¹²⁹ While a requirement of ‘initiation’ does not figure in the language of the House of Lords judgments in *RCN*, the Department of Health Guidance notes a requirement that the doctor ‘personally decides upon *and initiates* the process of medical induction and takes responsibility for it throughout the termination’, n 93 above, at [29], *my italics*. While it is possible that this represents a further deliberately restrictive reading of the legislation, it may simply be that this language is an unconsidered hangover from an earlier iteration of the Guidance, drafted specifically with the then contemporary practice regarding late medical inductions at dispute in *RCN* (where a doctor would have inserted the catheter into the womb) in mind.

On balance, it is likely that the courts would refuse Kennedy and Grubb's analysis of the law, preferring to take a broad, common sense reading of the Abortion Act. This would avoid an interpretation that would be highly disruptive to the organisation of current, safe accepted practice.¹³⁰ It would also avoid the absurdity of legally requiring a health professional to place tablets in a woman's mouth or vagina rather than allowing her so to place them herself. While the only judicial *dicta* on this point emanates from the lower courts, it is significant that it assumes the legality of this practice.¹³¹ Finally, it is also noteworthy that no query was raised regarding the legality of 'self-administration' of abortion drugs in a far more recent case, despite the repeated use of that term in written submissions to the Court.¹³²

Vacuum Aspiration

However, the analysis cannot stop there. If the absurdity of a legal requirement that would require a doctor (or another healthcare professional acting under her or his guidance) to place tablets inside a woman's body is likely to be avoided by a common sense, purposive interpretation of the relevant statutory provision, then the same approach should also pertain with regard to other kinds of abortion method. For example, vacuum aspiration is an extremely safe and technically undemanding

¹³⁰ Lord Denning MR countenanced such an outcome with equanimity in *RCN*: '[if the doctor] is not allowed to leave it to the nurses, the result will be *either* that there will be fewer abortions *or* that the doctor will have to use the surgical method with its extra hazards. This may be so. But I do not think that this warrants us departing from the statute', *RCN*, n 10, 557 (emphasis in original). Today, the fact that abortion is today broadly accepted as a part of mainstream health services is likely to incline a contemporary court to be less dismissive of risks to women's health and the disruption of good clinical practice.

¹³¹ Woolf J, n 119 above.

¹³² *BPAS v SS for Health* [2011] EWHC 235 (Admin).

procedure, which accounts for just under half of abortions performed in England and Wales.¹³³ Currently, all vacuum aspiration procedures are performed by doctors, as this has been assumed to be necessary to meet the requirement that a pregnancy be 'terminated by a registered medical practitioner'. The House of Commons Science & Technology Committee proceeded on this assumption in its review of the Abortion Act.¹³⁴ Likewise, the Faculty of Sexual and Reproductive Health currently restricts training in vacuum aspiration to doctors, citing *RCN* as authority for its belief that '[b]y current law, nurses and midwives are unable to perform abortion procedures'.¹³⁵

However, following *RCN* and subject always to the clinical safety of such a move, it is far from clear why vacuum aspirations might not be legally performed by an appropriately trained and skilled nurse acting as part of a multi-disciplinary team that includes a doctor.¹³⁶ The doctor's role in deciding upon treatment and giving any necessary, specific instructions as to how it should be carried out would be exactly the same. Further, as for a medical abortion, the doctor or her substitute would be available

¹³³ Department of Health, n 8 above.

¹³⁴ House of Commons Science and Technology Committee (S&TC) *Scientific Developments Relating to the Abortion Act 1967 (Twelfth Report of Session 2006-7) Volume 1*, HC 1045-1 (2007) 108-9.

¹³⁵ Although they can 'provide the medication prescribed by the doctor for medical abortions and assist in the provision of surgical procedures'. Faculty of Sexual and Reproductive Health of the Royal College of Obstetricians and Gynaecologists, *Syllabus and Logbook for the Certificate in Abortion Care of the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists* (London: FRSA, undated, <http://www.fsrh.org/pdfs/AbortionCareLogbook.pdf>), 4 (last accessed 17 October 2015).

¹³⁶ See V. Argent and L. Pavey 'Can Nurses Legally Perform Surgical Induced Abortion?' (2007) 33(2) *J Fam Plann Reprod Health Care* 79.

to be consulted or called on for assistance from beginning to end of the treatment. While it might appear a greater stretch of the statutory language to interpret medical direction and oversight as sufficient to constitute 'performance' of a hands on, surgical procedure (rather than the handing over of drugs), it should be recalled that, on its facts, *RCN* was also concerned with the performance of physical acts.

In *RCN*, Lord Roskill is silent regarding the issue of hands on involvement of the doctor, rather reasoning that the legal requirement is met when the 'entirety of the treatment for the termination of pregnancy and [the nurse's] participation in it is at all times under the control of the doctor even though the doctor is not present throughout the entirety of the treatment.'¹³⁷ Lord Keith notes merely that the doctor must 'personally [perform] essential parts of it which are such as to necessitate the application of his particular skill',¹³⁸ implicitly accepting that this question should be resolved with regard to a current medical evidence base. Lord Diplock likewise notes that 'the doctor need not do everything with his own hands', rather emphasising that the treatment must be 'carried out in accordance with his directions' and that a doctor must remain 'in charge throughout.'¹³⁹ Each of these readings would appear to support the legality of permitting appropriately trained nurses and midwives to perform vacuum aspirations.

The Supreme Court has also more recently summarised *RCN* as providing that the statutory requirement is met:

¹³⁷ *RCN*, n 10 above, 577.

¹³⁸ *ibid*, 575, providing always that he should have 'responsibility for the whole process'.

¹³⁹ *ibid*.

when [the abortion] was a team effort carried out under [the doctor's] direction, with the doctor performing those tasks that are reserved to a doctor and the nurses and others carrying out those tasks which they are qualified to perform.¹⁴⁰

The opposition in the final sentence might be taken to imply that 'reserved to a doctor' is appropriately understood as meaning those tasks which the doctor alone is qualified to perform. Alternatively, it might be understood as referring to those aspects of treatment that are legally reserved to a doctor, such as certification requirements and the right to prescribe certain drugs (including the mifepristone and misoprostol used in a medical abortion).¹⁴¹ Significantly, however, the Court did not read the Abortion Act as requiring that a doctor perform any specific physical tasks.

Do vacuum aspirations fall within those tasks that nurses and midwives are 'qualified to perform'? First, they would clearly require appropriate training.¹⁴² Further, a British pilot might be considered desirable before any innovation in practice is rolled out more generally. However, extensive international evidence suggests that this development would be safe.¹⁴³ While in 1967 it was

¹⁴⁰ *Doogan*, n 27 above, at [9], per Lady Hale.

¹⁴¹ s 58, Medicines Act (1968).

¹⁴² This would require an extension of the training programme noted above, n 135.

¹⁴³ The World Health Organisation recommends that vacuum aspiration can be safely provided by associate clinicians, midwives, and nurses. See WHO (2015) *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception*, http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/ (last accessed 17 October 2015) describing how, in many parts of the world, vacuum aspirations are already offered by midlevel providers, with similar safety records to those enjoyed by doctors. See further T.A. Weitz, D. Taylor, S. Desai, U.D. Upadhyay, J. Waldman, M.F. Battistelli, E.A. Drey, 'Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants under a California Legal Waiver' (2013) 103(3) *Am J Public Health* 454; I.K. Warriner, O. Meirik, M. Hoffman, C. Morroni, J. Harries, N.T.

uncommon for these staff to perform surgical procedures, today they perform a range of complex procedures including colposcopies and hysteroscopies.¹⁴⁴ They also fit contraceptive coils, which is said to require about the same level of skill as vacuum aspiration.¹⁴⁵ Whether they might conduct other kinds of procedures would turn on the question of safety and, on this basis, later surgical procedures may continue to require the skilled hand of an experienced doctor.¹⁴⁶ It seems reasonable to suggest, however, that these questions are best answered through robust scrutiny of the contemporary medical evidence.

My Huong, N.D. Vy, A.H. Seuc 'Rates of Complication in First-Trimester Manual Vacuum Aspiration Abortion Done by Doctors and Mid-Level Providers in South Africa and Vietnam: a Randomised Controlled Equivalence Trial' (2006) 368 (9551) *Lancet* (Dec 2) 1965; T.D. Ngo, M.H. Park, C. Free 'Safety and Effectiveness of Termination Services Performed by Doctors versus Midlevel Providers: a Systematic Review and Analysis' (2013) 5 *Int J Women's Health* 9. Having reviewed the evidence, the House of Commons Science and Technology Committee recommended that, subject to usual training and professional standards, nurses and midwives should be permitted to carry out early surgical abortions, finding that this would not compromise patient safety or quality of care: S&TC, n 134 above, at [108].

¹⁴⁴ See generally Argent and Pavey, n 136 above.

¹⁴⁵ S&TC, n 134 above.

¹⁴⁶ Although this is an assumption of empirical fact, which should equally be subject to testing against the evidence. It is noteworthy that one meta-analysis of six studies found that clinical officers and doctors did not differ significantly in key outcomes for caesarean section: A. Wilson, D. Lissauer, S. Thangaratinam, K.S. Khan, C. MacArthur, A. Coomarasamy 'A comparison of clinical officers with medical doctors on outcomes of caesarean section in the developing world: meta-analysis of controlled studies' (2011) 342 *BMJ* d2600.

While the above analysis presents a clear challenge to the current, received interpretation of the law in practice, it does nothing more than to follow to its logical conclusion the broad, purposive approach of the House of Lords in *RCN*. Notably, recognising that appropriately trained midlevel providers could lawfully offer vacuum aspirations would have no impact on the first of those purposes (broadening the grounds under which abortions are available) and should be permitted only if it can be demonstrated not to offend against the second (ensuring that abortions are performed safely and hygienically).¹⁴⁷ There is nothing inherently unsafe about permitting a woman to put tablets into her own mouth or vagina, rather than allowing a healthcare professional so to place them. Likewise, if vacuum aspirations can be safely and effectively performed by appropriately trained and skilled non-doctors, then there appears to be no good reason against accommodating this practice within the existing statutory framework. In the light of such a broad reading, however, given a general expectation within health care that specific tasks should be undertaken only by those with the requisite skills and training, the statutory requirement that a termination be performed by a registered medical practitioner appears largely redundant.

ANY 'TREATMENT FOR THE TERMINATION OF PREGNANCY' MUST BE CARRIED OUT ON NHS PREMISES OR IN ANOTHER APPROVED PLACE

Finally, the Abortion Act places restrictions on where terminations may be lawfully performed.¹⁴⁸ This provision was crafted to ensure that services were offered openly, only in those locations with the facilities necessary for their safe performance. Five decades on, the goal of discouraging clandestine

¹⁴⁷ Indeed, once an abortion has been authorised, it is arguable that it is only the second of these purposes that has any relevance. However, this argument was implicitly rejected by the Court in *BPAS*, n 132 above. See below for further discussion.

¹⁴⁸ s 1(3), as amended 1990.

terminations has been largely achieved through the provision of high-quality, NHS-funded services.¹⁴⁹ Further, many abortion services rely heavily on early medical abortion, which can generally be performed safely with no need for specialist facilities (provided that appropriate aftercare can be accessed in the rare event of serious complications). Indeed, in anticipation of such developments, the Abortion Act was amended in 1990 specifically to provide a power for the Secretary of State for Health to approve a ‘class of places’ (for example, GPs’ surgeries) for the termination of pregnancy using drugs.¹⁵⁰ Twenty-five years on, this power has never been used.

Home Use of Misoprostol: BPAS v Secretary of State for Health (2011)

The place of provision requirement was at the heart of a legal challenge brought by BPAS, Britain’s largest charitable abortion provider.¹⁵¹ Faced with the refusal of successive governments to make use of the power to license a broader ‘class of places’ for early medical abortion, BPAS argued that such an extension was, in any case, unnecessary. It suggested that the term ‘treatment’ within the Abortion Act should be understood to mean only prescription and supply of a drug, in the sense that a doctor might treat a migraine merely by prescribing medication rather than by actually administering it.¹⁵² As such, it claimed, while prescription must take place on approved premises, a woman might take

¹⁴⁹ Occasional press reports suggest that a small number of illegal medical abortions take place outside licensed healthcare services in Britain, see eg H. Rumbelow, ‘The Woman Who Offers Abortions on the High Seas’ *The Times*, 2 *Supplement* (22 October 2014). In Northern Ireland, this is far more common, see Bloomer and O’Dowd, n 26 above.

¹⁵⁰ s 1(3A), see generally Sheldon, n 8 above, chapter 7.

¹⁵¹ *BPAS*, n 132 above.

¹⁵² *BPAS*, Skeleton Argument on Behalf of the Claimant, at [35], on file with the author.

mifepristone, the first drug used in a medical abortion, in the clinic and take away the second, misoprostol, for later use at home.¹⁵³

BPAS's argument played heavily on the common sense intuition that the more restrictive interpretation of the 'place of provision' requirement – requiring a woman to return to the clinic in order to take the misoprostol on approved premises before, in many cases, leaving immediately in order to arrive home before her miscarriage began – offended against common sense. BPAS also emphasised the significant shifts in abortion technologies and practice that had occurred both since 1967 and, indeed, since the Abortion Act was amended in 1990.¹⁵⁴ Clinical evidence was advanced from a number of other countries to demonstrate the safety, effectiveness and acceptability of home use. BPAS suggested that once women have understood the simple treatment regime involved (in terms of quantities and frequency of administration), they are not in need of supervision while they take the drugs.¹⁵⁵ Indeed, those women who use misoprostol to ensure the completion of a

¹⁵³ *ibid.*

¹⁵⁴ In 1990, British clinics performed early medical abortions using mifepristone in combination with gemeprost, a prostaglandin analogue known to have unpleasant side effects and to require storage at less than 10 degrees Celsius until warming 30 minutes prior to use. This suggested a clinical need for use of the drugs to be supervised in the clinic. This changed with the introduction of misoprostol, when '[e]arly medical abortion was transformed from a painful, unpleasant, resource-intensive and costly procedure into what it is today: a procedure that still involves pain and bleeding, but which can be reasonably well managed and controlled'. See generally, J. Bristow, 'Misoprostol and the Transformation of the 'Abortion Pill,' *Abortion Review* (26 January 2011), <http://www.abortionreview.org/index.php/site/article/908/> (last accessed 17 October 2015).

¹⁵⁵ See further, T.D. Ngo, M.H. Park, H. Shakur, C. Free 'Comparative Effectiveness, Safety and Acceptability of Medical Abortion at Home and in a Clinic: a Systematic Review' (2011) 89(5) *Bulletin of the World Health*

spontaneous miscarriage already commonly take the drug at home.¹⁵⁶ Finally, it noted that home use is preferred by many women, partly for the convenience of eliminating the need for a second visit to a clinic and partly for avoiding the risk of miscarriage during the journey home.¹⁵⁷ There was thus ‘no sensible reason why Parliament would wish to prevent women who have met the criteria of the 1967 Act and wish to take the misoprostol safely at home, from doing so.’¹⁵⁸ BPAS argued that the first purpose of the Abortion Act (broadening the grounds on which abortions might lawfully be offered) was irrelevant to the interpretation of the specific provision under dispute, which concerned not *whether* but *how* abortions might be performed. The place of provision requirement, it suggested, should thus be interpreted merely with reference to the second purpose of the Act: to ensure that abortions are performed safely.

While accepting that the international data offered a *prima facie* case for the safety of home use,¹⁵⁹ the Government responded that a pilot study would be necessary before it could be adopted in Britain (finding no apparent irony in advancing this argument when such a study was blocked only by its own refusal to approve a broader ‘class of places’).¹⁶⁰ However, it relied primarily on the first purpose of

Organization 360; C. Shannon and B. Winikoff ‘How Much Supervision is Necessary for Women Taking Mifepristone and Misoprostol for Early Medical Abortion?’ (2008) 4(2) *Women’s Health* 107-11.

¹⁵⁶ See S&TC, n 134 above, at [105a].

¹⁵⁷ BPAS, n 132 above, at [12].

¹⁵⁸ BPAS, Supplementary Skeleton Argument on Behalf of the Claimant, at [8], on file with the author.

¹⁵⁹ BPAS, Skeleton Argument for the Secretary of State, at [20], on file with the author.

the Abortion Act in opposing BPAS's claim, arguing that the widening of access to abortion envisaged in the Act was not without limits and the power to licence a broader 'class of places' had been deliberately left as a matter for political control. Thus, if the Court were to issue the declaration sought by BPAS, '[i]t would represent, in a highly controversial area, a very significant shift of responsibility from the democratically elected and accountable Secretary of State to the medical profession.'¹⁶¹ Further, the Act had been specifically amended in 1990, not to permit the provision of abortion anywhere safe to do so, but rather to allow a future government 'to react to further changes in medical science' and 'to approve a wider range of place, including potentially the home'.¹⁶²

The Court preferred the Government's reading of the law, finding that the words 'any treatment for the termination of pregnancy' must include not just the prescription but also the administration of an abortion drug, which should, therefore, take place on approved premises. This is a plausible interpretation (particularly given the amendment introduced in 1990), which offers a literal reading

¹⁶⁰ *ibid*, at [21], [22]. A small study (of 49 women) has, in fact, already been done in Scotland, in apparent ignorance that it was in breach of the law: H. Hamoda, P.W. Ashok, G.M.M. Flett, A. Templeton (2005) 'Home Self-Administration of Misoprostol for Medical Abortion up to 56 days' Gestation' 31(3) *Jo Fam Plann and Reprod Health Care* 189. Home self-administration of misoprostol for medical abortion up to 56 days' gestation was found to be acceptable to the women in the study, although this needed to be further assessed in the context of a randomised trial.

¹⁶¹ *ibid*, at [39].

¹⁶² *ibid*, at [32]. The fact that s 1(3A) refers directly to the 'use' of such medicines as may be specified, reserving powers of approval to the Health Secretary, was seen to provide significant weight to the Government's reading of the statute, *ibid*, at [30].

of the provision.¹⁶³ However, eschewing the broad, purposive approach adopted in *RCN*, it leaves unaddressed the question of what exactly is ‘politically sensitive’ about home use of misoprostol in the context of a safe, legally authorised abortion. In making this claim, it is noteworthy that the Government did not rely on the kinds of arguments advanced in early pro-life campaigns against the licensing of mifepristone: that abortion services should not be made too ‘convenient’ for women, or that abortion drugs risk ‘trivialising’ abortion, making it ‘like taking an aspirin’, and potentially leading to a relaxation of attitudes towards abortion.¹⁶⁴ Neither did it suggest that early abortion could not be successfully managed by women at home.¹⁶⁵ Nor, indeed, were these kinds of arguments relied upon by the leading pro-life charity that intervened in the case: SPUC rather disputed the evidence regarding the safety of the drugs and raised concerns that taking a very narrow reading of the term

¹⁶³ For a critique of the narrow interpretation adopted here, see K. Greasley, ‘Medical Abortion and the ‘Golden Rule’ of Statutory Interpretation. *BPAS v the Secretary of State for Health*’ (2011) 19(2) *Med L Rev* 314.

¹⁶⁴ See generally, Sheldon n 8 above, 130. A minority of S&TC members expressed the concern that home use ‘could, in all probability lead to an increase in the number of women seeking abortion due to a more relaxed attitude developing towards contraception on behalf of the young and sexually active’. S&TC, n 134 above, 77.

¹⁶⁵ I. Knight, ‘Brutal Truth of DIY Abortion’ *The Sunday Times* (14 October 2007), characterises home use of misoprostol as ‘a brutality too far’, suggesting that it involves ‘chucking pills at women and expecting them to go home, cramp and bleed until the thing is done and then - what? Flush the loo?’ This account appears to have been written in ignorance of the substantial evidence that women find home use highly acceptable, see: Ngo et al, n 140 above; Y. Swica, E. Chong, T. Middleton, L. Prine, M. Gold, C.A. Schreiber, B. Winikoff ‘Acceptability of Home Use of Mifepristone for Medical Abortion’ (2013) 88 *Contraception* 122; P.A. Lohr, J. Wade, L. Riley, A. Fitzgibbon, A. Furedi ‘Women’s Opinions on the Home Management of Early Medical Abortion in the UK’ (2010) 36(1) *J Fam Plann Reprod Health Care* 21.

‘treatment’ in this context might also have the effect of restricting the scope of conscientious objection rights under the Act.¹⁶⁶

While this is inevitably speculative, what seems more likely is that the Government simply felt there to be too great a political cost to opening up any aspect of abortion for public debate and scrutiny, in a context where it appears to be assumed that providers can ‘work around the deficiencies’ of the Act.¹⁶⁷ Indeed, the need for ‘caution’ in a politically sensitive area has been cited by a former Health Secretary as a reason against permitting home use.¹⁶⁸ However, if a judicial review of the Government’s refusal to exercise its power to license a ‘broader class of places’ in line with its authority to react to further changes in medical science were to be sought, its decision would need to be justified by more than vague references to ‘political sensitivity’.¹⁶⁹ And it is difficult to construct a

¹⁶⁶ *BPAS*, Written Representations on behalf of SPUC, on file with the author, at [8].

¹⁶⁷ The CEO of BPAS, reports that ‘[m]inisters and officials at the Department of Health have repeatedly said to us that they see no need to change the law because it is possible to “work around” its deficiencies. This is not good enough. The law as it stands undermines the delivery of safe, evidence-based abortion services.’ A. Furedi ‘A Shocking Betrayal of Women’s Rights’, *Spiked* (28 October 2008), <http://www.spiked-online.com/index.php?/site/article/5845/> (last accessed 17 October 2015).

¹⁶⁸ Dawn Primarolo confirmed that there were no clinical or scientific reasons against home use, explaining rather that ‘the Department [of Health] over the years has progressed very cautiously ... because of the very strongly held views with regard to abortion.’ House of Commons Science and Technology Committee (S&TC), *Scientific Developments Relating to the Abortion Act 1967 (Twelfth Report of Session 2006-7) Volume 2*, HC 1045-II (2007), Ev 48.

¹⁶⁹ If such a review were to be sought, it is noteworthy that the *BPAS* court accepted that women’s homes could constitute ‘a class of places’ within the terms of the Act, *BPAS*, n 132 above, at [32].

coherent defence of the refusal to allow for a British trial designed to inform a decision to license a 'broader class of places' that does not rely on punitive attitudes towards women seeking abortion, ignorance of trials that have established the safety and acceptability of home use elsewhere, or some combination of the two.¹⁷⁰

Whatever the rationale for the Government's reluctance to use its power under s.1(3A), the result is that service providers and clinicians are left to attempt to work as best they can within the restrictions imposed by the existing legal framework, with this provision offering a further example of what happens when regulation becomes significantly out of line with the dictates of best clinical practice. Again, the broad purpose underpinning this provision (ensuring safety) is not obviously furthered by the specific mechanism intended to operationalise it (restrictions on place of provision). On the contrary, as is considered next, the resulting tensions have played out in the adoption of a range of treatment protocols that attempt to balance safety, efficacy and convenience for women, with the impact of the legal provision clearly cutting against these concerns.

Early Medical Abortion in Practice: a Range of Regimens

As noted earlier, in the UK, medical abortion involves the sequential administration of two drugs: mifepristone and misoprostol. Trials have established that the drugs are clinically most effective when used 24-72 hours apart, with a slight decline with a 72 hour interval.¹⁷¹ In jurisdictions where no place

¹⁷⁰ The S&TC concluded that there was no evidence relating to safety, effectiveness or patient acceptability that should deter Parliament from passing regulations to enable women to enable women who choose to do so from taking the second stage of an early medical abortion at home, n 134 above, at [123]. A properly conducted trial and broadening of access under s 1(3A) would appear to meet both of the substantive concerns expressed in SPUC's submission to the Court.

¹⁷¹ E.G. Raymond, C. Shannon, M.A. Weaver, B. Winikoff 'First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: a Systematic Review' (2013) 87(1) *Contraception* 26; E.A. Schaff, S.L. Fielding, C.

of provision restrictions apply, providers are able to explain this to the woman, giving her the drugs to take home so that she can time usage to maximise their efficacy and her chances of achieving a miscarriage at the time most convenient and acceptable to her (perhaps when her children are absent, when her partner or a friend is able to be with her, or avoiding the need to book time off work). If the only considerations for how a lawful abortion may be provided are patient safety, clinical effectiveness and acceptability to the woman, this is a highly attractive way of delivering an abortion service.

In the British context, however, home use is blocked by the legal restriction discussed above. This has led service providers to offer a range of options as they negotiate the tension between the best interests of their patients and the regulatory framework. Evidence based medicine is typically used to optimise clinical treatment and decision making, establishing the best possible protocol that, other things being equal, should then replace others. Here, however, it has been used to introduce a range of regimens designed to achieve the optimal balance between efficacy and acceptability to the individual woman concerned, within the context of a clinically ungrounded, legal constraint on best practice.

For example, British clinics have offered a same day early medical abortion service, with misoprostol administered after the maximum delay compatible with regular opening hours (6-8 hours after the mifepristone). While known to be slightly less effective than the longer delay (achieving a complete

Westhoff, C. Ellertson, S.H. Eisinger, L.S. Stadalius, L. Fuller 'Vaginal Misoprostol Administered 1, 2, or 3 Days after Mifepristone for Early Medical Abortion: a Randomized Trial' (2000) 284(15) *JAMA* 1948; E.A. Schaff, S.L. Fielding, C. Westhoff 'Randomized Trial of Oral versus Vaginal Misoprostol at One Day after Mifepristone for Early Medical Abortion' (2001) 64 *Contraception* 81; L. Wedisinghe and D. Elsandabesee 'Flexible Mifepristone and Misoprostol Administration Interval for First-Trimester Medical Termination' (2010) 81(4) *Contraception* 269. The RCOG recommends a 24-48 hour interval, n 9 above, recommendation 7.19.

abortion in 96% as opposed to 98% of cases),¹⁷² this nonetheless remains a very effective treatment protocol and, importantly, one that allows a woman to access abortion care as a day service. A further alternative foresees the near simultaneous administration of the two drugs, with misoprostol taken 15 minutes after the mifepristone. This is not as effective as when the medicines are given 24 hours apart, but still offers a 95% chance of complete abortion, albeit with a marginally greater risk of side effects.¹⁷³ However, these negatives are set against the highly attractive features of this protocol for many women, particularly those who will need to travel some distance or to rearrange work or childcare commitments to attend a clinic. It appears that, even having been informed of the decreased chance of success and increased rate of side effects, a sizeable proportion of women prefer this regime, accepting the possibility that a further trip to the clinic might be necessary to complete the abortion in the event that the initial treatment fails, against the certainty of two visits required for a protocol requiring a longer delay in administration.¹⁷⁴

The development of these options shows clinics navigating the tension between statutory requirements and the norms of best clinical practice, in a way that allows them to optimise the treatment choices available to women. Above, I noted the importance that the regulatory community

¹⁷² Raymond et al, *ibid*.

¹⁷³ M.D. Creinin, C.A. Schreiber, P. Bednarek, H. Lintu, M.S. Wagner, L.A. Meyn, Medical Abortion at the Same Time (MAST) Study Trial Group, 'Mifepristone and Misoprostol Administered Simultaneously versus 24 Hours Apart for Abortion: a Randomized Controlled Trial' (2007) 109(4) *Obstet Gynecol* 885. Same time administration was found to result in a higher incidence of nausea, diarrhoea, and chills.

¹⁷⁴ A service evaluation carried out at BPAS found that, following a detailed explanation of the relative merits of the two protocols, 42% (843 of 1,991) women opted for simultaneous administration. I am grateful to Dr Patricia A. Lohr, Medical Director BPAS, for sharing this finding.

accept the broad ethical values that underpin legislation, citing the concern that, where such acceptance is lacking, the law risks becoming treated as mere empty bureaucracy. Here, the legal requirement becomes something rather more pernicious than that: it operates as a clear constraint on the ability to offer a service that maximises both clinical effectiveness and acceptability to women.

Of course, it might be suggested that it is appropriate for non-clinical factors to be at play here. After all, the medical framework envisaged in the Abortion Act aimed simultaneously both to retain control over access to abortion services and to ensure that they were provided safely and openly. Yet unless it is believed that rendering access to abortion services more difficult or inconvenient for women is an effective and ethically acceptable means of influencing use of them, the 'place of provision' requirement can play no proper role in meeting the first purpose. It operates merely to shape the way in which lawful services can be offered. By virtue of the narrow interpretation preferred by the *BPAS* court and successive governments' refusal to license a broader class of places for home use, clinicians are prevented from offering best practice to patients undergoing lawfully authorised terminations. The practical impact of the law clearly cuts against the purpose of ensuring that abortions 'should be carried out under the safest conditions attainable'.¹⁷⁵

CONCLUSION

In order to mitigate the effects of the fact that law 'speaks from the past',¹⁷⁶ more modern statutes regulating morally controversial areas of clinical practice have sometimes established regulatory authorities empowered to issue codes of practice.¹⁷⁷ This offers a mechanism permitting regulation

¹⁷⁵ *RCN*, n 10 above, 575.

¹⁷⁶ Black, n 1 above.

¹⁷⁷ For example, the Human Fertilisation and Embryology Act (1990, as amended 2008) and the Human Tissue Act (2004).

to evolve in a controlled way, taking account of shifting moral views and scientific knowledge, within the broad principles entrenched in the statute. While such a mechanism is not provided by the Abortion Act, it has been seen that this does not mean that the law is static. Rather, how legal norms 'work' depends on their interpretation, a process that is necessarily dynamic and contingent, adapting to suit practical circumstances and local contexts, and informed by evolving knowledge, experience and values within the regulatory community.¹⁷⁸ Nonetheless, the need to keep abortion law current through interpretative work alone means that a highly anachronistic statutory framework is now stretched to breaking point through the need to read it in a way that respects modern clinical practice.

It has been seen above that a narrow, literal interpretation of the Abortion Act may restrict the provision of services in line with current best practice and cut against the purposes that led to its introduction; yet, taken to its logical conclusion, a broad, purposive interpretation risks undermining the existence of the disputed provisions altogether. Thus, while a purposive construction of the requirement that an abortion must be 'performed by a registered medical practitioner' has allowed medical practice to evolve in line with considerations of safety and common sense, followed to its logical conclusion, the approach would appear to entail that appropriately trained other healthcare professionals, operating as part of a multidisciplinary team, should also be permitted to offer any procedures that fall within their competence and are not legally reserved to doctors. Such an expansive reading would not offend against the broad purposes of the legislation. It would, however, tend to render the written provision essentially redundant given the general expectation (backed by legal and disciplinary sanctions) that any medical procedure offered within formal healthcare services should be performed only by those with the requisite skills and training.¹⁷⁹

¹⁷⁸ Black, n 1 above, 175. See further, S. Picciotto 'Introduction: Reconceptualizing Regulation in the Era of Globalization' (2002) 29(1) JLS 1, 9.

¹⁷⁹ See generally Sheldon, n 15 above, for discussion of the other kinds of sanctions that would apply here.

Alternatively, the Abortion Act might be more restrictively interpreted, saving a disputed provision from redundancy but only at the expense of allowing it to operate as a clinically unjustified, potentially disruptive impediment to the provision of safe, efficient and acceptable services. Such an effect can be seen in the narrow, literal reading of the 'place of provision' restriction offered in *BPAS*. The consequences of this interpretation are seen in the fact that women may risk miscarriage on their journey home from the clinic or, alternatively, opt for a less effective treatment protocol with a higher rate of side effects in order to work around the legal restriction. Here, a restrictive reading of the law ensures that the provision has some real impact on medical practice but this impact appears entirely negative when assessed against the Act's broad purpose of ensuring safety.

The need for two doctors to authorise an abortion is at the heart of the medical control envisaged in the Abortion Act and dispute regarding appropriate interpretation of this provision has been fierce. Notably, concerns have been expressed that the requirement for two doctors' signatures has become treated as a matter of 'rubber stamping'. For the Parliament of the late 1960s, the need for two doctors' opinions reflected a widespread belief, endorsed by professional bodies, that the abortion decision was properly seen as a medical one. The requirement for a second opinion was intended as an additional safeguard to ensure that the decision was made in good faith, to avoid the possibility that rogue doctors might seek to profit from vulnerable women, and to provide protection for the first doctor.¹⁸⁰ Over the five decades that have passed since the legislation was enacted, however, broad support for the idea that it should be doctors who decide whether an abortion is justified has ebbed

¹⁸⁰ For two recent accounts that highlight the complexity of the political processes leading to the introduction of the Abortion Act and, in particular, the role played by professional interests in shaping its terms, see M. Thomson, 'Abortion Law and Professional Boundaries' (2013) 22(2) SLS 191; and McGuinness and Thomson, n 35 above.

away, at least in earlier pregnancy when the overwhelming majority of abortions take place.¹⁸¹ It is significant here that doctors are now trained to take seriously the right to self-determination of their patients, with pregnant women not treated as an exception to that principle in any other context, and with this requirement backed by potential disciplinary and legal sanction. And while the vastly altered ethical landscape cannot overrule statutory requirements, it is to be expected that doctors should take account of the former in interpreting the latter. In this context, there seems little to justify the restrictive interpretation of the decision-making requirements espoused by the Department of Health. Further, accusations that doctors are ‘rubber stamping’ or only ‘creatively complying’ with the law are unhelpfully reductive. The essence of ‘creative compliance’ is ‘compliance with the letter of the law while totally undermining the policy behind the words’, so as to escape the intended impact of the law.¹⁸² In a context where the letter of the law has become so poorly aligned with its own policy drivers, however, the accusation simply makes no sense. Rather, when doctors take a permissive approach to their formal decision-making role under the Abortion Act, this is arguably supported by a purposive interpretation of the Act, ensuring that ‘socially acceptable abortions are performed safely’.¹⁸³ The result is nonetheless a badly confused legislative framework that offers poor guidance to the doctors charged with its interpretation. In taking a purposive interpretation of the law, what does it mean to suggest that doctors should *not* allow abortion on request but *should* allow those

¹⁸¹ In 2014, for women resident in England and Wales, 92% of terminations were carried out at under 13 weeks, only 2% at over twenty weeks, and one tenth of one percent after 24 weeks, Department of Health, n 8 above. See polling data, n 70 above.

¹⁸² D. McBarnet *When Compliance is not the Solution but the Problem: from Changes in Law to Changes in Attitude* (Centre for Tax System Integrity Working Paper No. 18, 2001).

¹⁸³ RCN, n 10 above.

abortions deemed 'socially acceptable', when a majority of the British public believe that an abortion is morally permissible purely on the basis that it is desired by the pregnant woman?¹⁸⁴

This complex and confused regulatory landscape illustrates both the elasticity of statutory language, with considerable regulatory evolution compatible with unchanging statutory text, and the limits to such elasticity. Negotiation of precisely where those limits lie is an important part of law-making and one that raises significant and highly complex issues of democracy.¹⁸⁵ In this context, an increasingly permissive interpretation of the law has supported the development of liberal access to abortion services. Within the first twenty-four weeks of pregnancy, in practical if not formal legal terms, this comes close to the 'abortion on request' that Parliament was specifically advised would not result from the Abortion Act. Yet this interpretation has also allowed the law to keep pace with evolving moral views in a context where appropriate opportunities for democratic debate of liberalising reform have been deliberately blocked. While numerous attempts to further restrict the availability of abortion over the years have been defeated,¹⁸⁶ there has been no opportunity to vote on the liberalisation of the law beyond the small number of primarily 'tidying' amendments agreed in 1990.

¹⁸⁴ n 70 above.

¹⁸⁵ Picciotto notes that questions of indeterminacy and formalism are fundamentally about democracy, since it concerns the processes for generating the authoritative meaning of laws, n 108 above.

¹⁸⁶ Keown, n 14 above; D. Paintin, *Abortion Law Reform in Britain 1964-2003* (Stratford-upon-Avon: BPAS, 2015).

A liberalising raft of amendments spearheaded by the Liberal Democrat MP, Evan Harris, was blocked by the Brown Government without being put to the vote in 2008.¹⁸⁷

As courts struggle to reconcile the requirements of this antiquated legal framework with the norms of contemporary medical practice, it is small wonder that abortion cases feature heavily in casebooks on statutory interpretation.¹⁸⁸ While once at the forefront of modernising reform, the Abortion Act has swung increasingly far adrift from clinical and professional ethical norms of best practice. Indeed, the mechanisms designed to operationalise the Act's concern with safeguarding women's health now actively cut against that concern. If the health argument for requiring strict supervision by doctors drops away (as is most evidently the case in the context of medical abortion), then an uneasy compromise regarding the need for medical control of abortion is disrupted. We are thus left to confront head on the question of whether doctor's role in the regulatory framework is justified by the need for gatekeepers to limit access to safe, legal abortion services to those women who are deemed to be deserving, with others left to travel, to access illegal services, or to continue with unwanted pregnancies.¹⁸⁹ While this paper has not sought directly to engage in the ethical debate regarding the morality of abortion, it has noted that as a matter of empirical fact, Britain has moved away from accepting such a role for doctors, rather gradually shifting to a position where abortion services are

¹⁸⁷ This was allegedly the quid pro quo necessary to secure the support of Northern Irish MPs for a controversial anti-terrorism measure. See generally S. Sheldon 'A Missed Opportunity to Reform an Outdated Piece of Legislation', (2009) 4 *Clinical Ethics* 3.

¹⁸⁸ eg C. Manchester and D. Salter, *Manchester and Salter on Exploring the Law: the Dynamics of Precedent and Statutory Interpretation* (Andover: Sweet & Maxwell, 4th ed, 2011).

¹⁸⁹ As is the case for women in Northern Ireland, where the Abortion Act does not apply. See: DHSSPNI; Bloomer and O'Dowd, n 26 above.

entrenched as an essential part of reproductive healthcare. In such a context, it is difficult to justify the ongoing restrictions imposed by the current law.

If the same broad purposes that had guided the Abortion Act – permitting socially acceptable abortions to take place in conditions of safety – were today allowed to guide the drafting of modern legislation, there is little doubt that this would result in a very different regulatory framework.¹⁹⁰ Indeed, given substantial popular support for the view that, at least before viability, abortion decisions should be left to the women who must live with their consequences,¹⁹¹ there is a strong argument that a new ‘abortion law’ might be no specific law at all.¹⁹² Rather, abortion services might simply be regulated by the same mass of general criminal, civil, administrative and disciplinary regulations that

¹⁹⁰ While the detail of such a law would require a different paper, the group of reforms coordinated by Evan Harris MP provide one model for how legislation governed merely by concerns for patient self-determination and best clinical practice might appear, see Sheldon, n 187 above for discussion.

¹⁹¹ While the first poll cited above, n 70, asked questions that were framed without reference to time limits, later terminations clearly do raise particular concerns for many people. YouGov asked 1,761 British adults in January 2012: ‘Currently, the legal time limit for abortion is 24 weeks. Leaving aside medical emergencies, which of these options do you favour?’ Only 5% favoured increasing the time limit, as compared to 34% who favoured retaining a 24 week limit, 37% who favoured reducing the time limit, 6% who favoured banning abortion altogether, and 17% who did not know. YouGov poll for the Sunday Times, http://cdn.yougov.com/cumulus_uploads/document/y4asheswh1/YG-Archives-Pol-ST-results-13-150112.pdf (last accessed 17 October 2015). In Sheldon, n 15 above, I also examine the question of post-viability terminations as offering a ‘hard case’ in any reform agenda.

¹⁹² See Sheldon, *ibid.*

govern all medical practice.¹⁹³ Regardless of the detail of any new abortion law, this paper has sought to demonstrate that reform is long overdue and that the existing statutory framework is no longer fit for purpose.

¹⁹³ See *ibid*, for consideration of this issue and the argument that dangerous or non-consensual practice might be effectively regulated through existing general legal provisions.