From the UK Abortion Act 1967 to the present: the woman's decision-making journey

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ABSTRACT: The aim of this paper is to analyse the relationship between women's empowerment on the issue of abortion and their need for a supportive and informed deliberative process in the UK scenario. The UK Abortion Act 1967 and current proposals to change the law on abortion, though starting from different places, seem not to properly tackle the complexity behind the woman's decision-making process. The paper focuses on the two most relevant factors, timing and reasons, involved in the woman's deliberative process concerning termination of pregnancy, pointing out the strengths and weaknesses in the law and medical guidelines when it comes to safeguarding this process. From the 1960s to the present the British Medical Association (BMA) and the Royal College of Obstetricians and Gynaecologists (RCOG) – two of the main stakeholders – have shown a clear shift in their approach to the law on abortion and related policies from a more medical approach to a wider focus on women's personal choice. Nonetheless this shift – which has been reflected in new legislative proposals to amend the Abortion Act 1967 – should not compromise recognition of women's need to receive the social and medical support they deserve during a challenging and possibly life changing process.

KEYWORDS: Abortion; clinical guidelines; decriminalization; deliberative process; woman's autonomy

SUMMARY: 1. Introduction – 2. Gestional limit – 3. The requirement for two doctors' signature – 4. Home abortions and telemedicine – 5. Social factors and fetal anomalies – 6. Women's autonomy or women in vacuum? – 7. Conclusion.

1. Introduction

With the abortion debate taking centre stage again in the international media, this paper seeks to analyse whether the UK Abortion Act 1967 and proposals to amend it address women's need for empowerment in the reproductive decision-making process.
The first two sections tackle the main criteria when it comes to termination of pregnancy: stage of gestation and compliance with the reasons enshrined in the 1967 Act. Within the decision-making process, both factors might be seen either as burdensome constraints or as a way (sometimes limited) of ensuring that the woman takes her best possible decision in accordance with her personal

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circumstances. The third section will focus in particular on the advent of telemedicine and its recent implementation in the policy of home abortion, drawing attention to the (overlooked) risks involved in making the process to obtain an abortion smoother and swifter. The last two sections, then, engage with the reasons behind the decision to terminate a pregnancy highlighting the wide spectrum they encompass, from personal issues to serious fetal anomalies, and the need to consider the woman as a part of a large *team* pre, during and post her deliberative process. The vagueness of the law in this respect makes it, on the one hand, easier to match the reasons put forward for seeking an abortion with one of the criteria listed in the 1967 Act; but, on the other hand, it can allow important factors such as concerns, fears and doubts to be swept under the carpet.

The procedure for obtaining an abortion in England, Wales and Scotland[1] is currently regulated by the Abortion Act 1967 further amended by the Human Fertilisation and Embryology Act 1990. Under the Abortion Act a termination of pregnancy can be lawfully performed if two registered medical practitioners agree in good faith that one of the following criteria is met:[2]

(a) that the pregnancy has not exceeded its twenty-four 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.[3]

Since 1999 the UK's new devolved system has certainly impacted on abortion policies because abortion has been regarded as a devolved matter in England, Scotland[4] and Northern Ireland, though not in Wales.

When it comes to terminating a pregnancy, two factors are most relevant in the decision-making process protecting both the woman's health and prenatal life: gestational age at the time of the abortion and the motivation for the abortion. The woman, who can be considered the centre of this process, is supposed to be supported throughout this journey by what the BMA calls a 'team'.

> "In fact the BMA, in one of its latest reports on the Abortion Act 1967, stated that in 1981 the courts confirmed that abortion was a procedure carried out by a multi-disciplinary team, and that whilst the doctor should accept overall responsibility for all treatment with regard to a termination of pregnancy,

[1] For the purposes of this paper the author will not mention how abortions are currently regulated in Northern Ireland, Jersey, Guernsey and the Isle of Man.
[2] Procuring and performing an abortion illegally is considered a statutory crime in England and Wales under the Offences Against the Person Act 1861 and the Infant Life Preservation Act 1929, and a common law crime in Scotland.
[3] The Abortion Act 1967, including all amendments known to be in force at the time of writing. The entire text of the Act 1967 is available at https://www.legislation.gov.uk/ukpga/1967/87/contents [accessed 28 June 2022].
[4] The Scotland Act 1998 established the Scottish Parliament, but abortion became a devolved matter thanks to the Scotland Act 2016.

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they do not need to personally conduct every stage of the procedure, and can rely on information gathered by other members of their team in forming their opinion".[5]

A question arises: who are the team members?
The immediate answer might be the 'medical team' composed of doctors, midwives, and nurses. However, before the procedure takes place there is a decision-making process in which a wider group is expected to play a relevant role.
The 'team' might be seen as including, at least, the pregnant woman and anyone with input to her decision (such as her partner,[6] friends, family), though it is possible that she took the decision alone. In this case, the medical team should be aware that the woman may need to discuss the reasons that brought her to take the decision in a wider medical setting (perhaps including a counsellor) to assess if she is genuinely persuaded that this is the best choice for her.
There are many different reasons why a pregnant woman may decide to terminate her pregnancy, *e.g.*, financial constraints, lack of employment, her partner's opposition to continuing the pregnancy, the sex of the fetus,[7] fetal anomaly, the fact that the woman feels that her family is complete as it is.[8]
Let us now analyse in turn the most relevant factors involved in obtaining a lawful termination of pregnancy.

2. Gestational limit

Medically speaking, the development of pregnancy is counted from the first day of the woman's last menstrual period (LMP) to the following 40 weeks. The first trimester (5 to 12 weeks' gestation) is considered the earliest phase of pregnancy and, from a medical perspective, the safest time to carry out an abortion. At this stage abortion can be performed both by a medical and by a surgical procedure. In general, beyond 20 weeks or after the fetus is viable the procedure for terminating a pregnancy is called a later abortion. During the second trimester the abortion is usually done surgically while in the third trimester abortions involve inducing labour.
In the two decades following the Abortion Act 1967, medical progress clearly challenged the wording of the Act itself. In particular, the Human Fertilisation and Embryology Act 1990 brought amendments

[5] The Law and Ethics of Abortion. BMA views (November 2014, updated October 2018), 7. Available at https://www.bma.org.uk/-/media/files/pdfs/employment%20advice/ethics/the-law-and-ethics-of-abortion-2018.pdf?la=en [accessed 08/07/2021]. See also UK: Royal College of Nursing of the United Kingdom v Department of Health and Social Security [1981] 2 WLR 279.
[6] See DJ. Costescu, JA. Lamont, *Understanding the Pregnancy Decision-Making Process Among Couples Seeking Induced Abortion* in *Journal of Obstetrics and Gynaecology Canada*, 35, 10, 2013, 899-904.
[7] The BMA believes that is normally unethical to terminate a pregnancy on the basis of fetal sex alone, except in the case of severe sex-linked disorders. […] Doctors may come to the conclusion, in a particular case, that the effects on the physical or mental health of the pregnant woman of having a child of a particular gender would be so severe as to provide legal and ethical justification for a termination. (See *The Law and Ethics of Abortion. BMA views*, November 2014, updated October 2018, 8). See also E. Lee, *Construction abortion as a social problem: "Sex selection" and the British abortion debate*, in *Feminism & Psychology*, 27, 1, 2017, 15-33.
[8] For a more comprehensive view of the reasons why a woman could seek an abortion see L. Hoggart, *Moral dilemmas and abortion decision-making: Lessons learnt from abortion research in England and Wales*, in *Global Public Health*, 14, 1, 2019, 1-8.

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to the abortion law. The most relevant change was the reduction of the upper time limit for obtaining an abortion (on ground (a)) from 28 weeks' gestation to 24 weeks. The reason for this change was improved survival rates for new-born babies at 24 weeks.

Thirty years later the survival rate for 24-week-old infants had risen to 60% while 22-week-old babies now have a 10% chance of survival. This fact has been flagged many times to Parliament with the aim of reducing the current time limit for abortion. In the meantime, the RCOG has updated its guidelines. In fact, it recommends feticide, a procedure to stop the fetal heart, before carrying out an abortion at more than 22 weeks' gestation.[9]

> "Failure to perform feticide could result in live birth and survival, an outcome that contradicts the intention of abortion. In such situations, the child should receive the neonatal support and intensive care that is in the child's best interest and its condition managed within published guidance for neonatal practice".[10]

However, the BMA in its recent report underlines that the fetus's viability is only one of the factors to take into account in considering the abortion time limit. Some fetal anomalies become evident only around 20 weeks of pregnancy. Hence the BMA emphasizes the need "that women are given the time to make the right decision for them, whether to continue or end a much-wanted pregnancy in the second or third trimester, when a diagnosis of a serious or fatal fetal abnormality is made".[11]

Hence it is possible to depict two different scenarios when it comes to abortion decisions in terms of gestational age and timing: A. the woman is at an early stage of her pregnancy (first trimester). At this stage the health professionals she will encounter on her journey would normally encourage her to finalise her decision as quickly as possible. In fact, carrying out an abortion before 12 weeks of pregnancy is considered a safer medical procedure. B. the woman is at a later stage of her pregnancy (20 plus weeks). Health professionals should assume that the pregnancy has become "unwanted" at a later stage (even if the woman may still describe it as a "wanted" pregnancy)[12] because other factors have entered into the decision-making process such as a fetal anomaly, a complication in the mother's health, some life event making the pregnancy less feasible etc. At this stage, an abortion is permitted by the law in a reduced number of circumstances and in general carries more risk of complications for the woman. However, time becomes less constraining in the decision-making process because there is the general assumption that the pregnancy was originally wanted and consequently that its termination should be carefully pondered. It is recommended that patients are not rushed into their decision: they might need second opinions and consultations with counsellors can be recommended.

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[9] See ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, *'Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales'* (May 2010). Available at https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf [accessed 08/07/2021].

[10] ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, *'Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales'* (May 2010), 9. Available at https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf [accessed 08/07/2021].

[11] BRITISH MEDICAL ASSOCIATION, *'The Law and Ethics of Abortion. BMA views (September 2020 – post-ARM update)'*: 6. Available at https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf [accessed 11/05/2021].

[12] For an in-depth analysis on the termination of wanted pregnancy see also DP. SULLINS, *Affective and Substance Abuse Disorders Following Abortion by Pregnancy Intention in the United States: A Longitudinal Cohort Study* in *Medicina,* 55, 741, 2019.

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What is often missing in these two scenarios, and is highly relevant to the woman's deliberative process, is the perspective/stake of the fetus in the decision. Time is not just the woman's ally in the decision-making process but there is also the prenatal interest in continuing life. Early medical abortions are praised for their safety and naturalness since they can be perceived as no more than a kind of menstrual regulation.[13] Then a later stage is envisaged when the fetus is seen as similar to a new born baby. At that stage of gestation in many countries including the UK the criteria for obtaining an abortion are consistently narrower. However, issues such as fetal pain,[14] post abortion fetal survival etc. should be more openly addressed, in order to protect both prenatal life and the patient's need to know all the factors involved in her decision. Otherwise, we cannot truly call the woman's choice an informed decision.

3. The requirement for two doctors' signatures

One of the most contested requirements for abortion is the need for two doctors' signatures on a form – the HSA1 form – confirming that the termination complies with the terms of the Abortion Act 1967. However, in case of emergency this condition is waived. The question is whether this requirement is just a burdensome duty to ensure legal compliance with the procedure for terminating pregnancy in order to protect the physicians from legal disputes or if it benefits the patient as well. In 2012 the then Health Secretary ordered an inspection of all abortion providers in England, which found that in 14 out of 249 abortion clinics pre-signing of forms was commonplace.[15] Even though this conduct was vehemently condemned, the inspection highlighted how little consideration is now given to this important step in the woman's decision-making journey.
Before the inspection took place, in 2007 the House of Commons appointed the Science and Technology Committee to examine the evidence on scientific and medical progress since the last amendment of the law in 1990 and the 1967 Act. The evidence brought by medical bodies was focused on the "demedicalization" of the law on abortion[16]. In fact, among the report's findings there was a "widespread concern that the requirement for two signatures delays access to abortion service"[17]. In particular, the RCOG highlighted the potential difficulty in finding two doctors to agree to sign the certificate, even though such delays could help the woman seeking an abortion to think through her decision. The BMA took the argument against the need for two doctors' signatures a step further, stating that

> "[T]he Abortion Act 1967 should be amended so that first trimester abortion (abortions up to 13 weeks) is available on the same basis of informed consent as other treatment, and therefore without the need for two doctors' signatures, and without the need to meet specified medical criteria. From a clinical

[13] See MM. Laufaurie *et al*, *Women's perspectives on medical abortion in Mexico, Colombia, Ecuador and Peru: A qualitative study* in *Reproductive Health Matters* 13(26), 2005, 75-83.
[14] See SW. Derbyshire, JC. Bockmann, *Reconsidering fetal pain* in *Journal of Medical Ethics* 46, 2005, 3-6.
[15] Z. Kmietowicz, *Pre-signing of forms found in 14 out of 249 abortion clinics in England* in *British Medical Journal* 345, 2012, e4784.
[16] See F. Amery, *Beyond Pro-life and Pro-choice. The Changing Politics of Abortion in Britain*, Bristol, 2020, 130-132.
[17] HC Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967. Twelfth Report of Session 2006-07*, HC 1045-I, 33.

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> perspective abortion is better carried out early in pregnancy. Given the relative risks of early abortion compared with pregnancy and childbirth, virtually all women seeking an abortion in the first trimester will meet the current criteria for abortion. The proposed amendment would help ensure that women seeking abortion are not exposed to delays, and consequently to later, more costly and higher risk procedures".[18]

However, the BMA in its written evidence only apparently shifted the focus of the law on abortion from a medical perspective to the woman's right to choose. In fact, even though the BMA aimed to "de-medicalize" the practice of abortion, when it came to the removal of two doctors' signatures to consent to early terminations, it compared abortion to standard medical procedures where the patient needs only to sign her informed consent (casting the matter again in a medical framework).[19]
Yet, the Government dismissed this recommendation, asserting that

> "The requirement for two doctors' signatures was believed necessary when the Abortion Act 1967 was passed, to ensure that the provisions in the 1967 Act were being observed and to safeguard women. The decision to require two doctors' signatures was based on professional opinion at the time. […] Current evidence does not indicate that the requirement for two doctors' signatures is causing delay".[20]

Again, women's needs are cast in medical terms rather than including the need for women to have their deliberative process safeguarded.
The BMA reinforced this position also in its latest report on the ethics of abortion published in 2020. In fact, the BMA emphasised the criticisms voiced in the 2007 report, claiming that the agreement of two medical practitioners would make "current abortion law increasingly out of step with the emphasis on patient autonomy elsewhere in medicine".[21]
However, it is worth noting the reason why this clause had originally been inserted in the Abortion Act 1967. In 1971, a few years after the Act came into force, Parliament appointed an interdisciplinary committee, called the Lane Committee, in order to produce a detailed report on the strengths and weaknesses of abortion law reform to date. The 1967 Act saw a powerful alliance between medical bodies, in particular the RCOG and the BMA, and the Government on the need to create a law aimed at preventing medico-legal issues in clinical practice.[22] This meant that the idea of "abortion on demand" was not welcome in the Act because it would have left women in a social and medical vacuum

[18] HC SCIENCE AND TECHNOLOGY COMMITTEE, *Written Evidence. BMA.* Available at https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045we13.htm [accessed 26 March 2021].
[19] The Royal College of Nurses (RCN) reported in its written evidence to the HC 1045-I that "There is no other medical or surgical procedure which requires the consent of a medical practitioner or the signature of two doctors before it is carried out."
[20] Government Response to the Report from the House of Commons Science and Technology Committee on the Scientific Developments Relating to the Abortion Act 1967 (November 2007). Available at https://www.gov.uk/government/publications/government-response-to-the-report-from-the-science-and-technology-committee-scientific-developments-relating-to-the-abortion-act-1967 [accessed 26 Mar 2021].
[21] BRITISH MEDICAL ASSOCIATION, *The Law and Ethics of Abortion. BMA views (September 2020 – post-ARM update)*: 9. Available at https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf [accessed 8 July 2021].
[22] See D HALFMANN, *Historical Priorities and the Responses of Doctors' Associations to Abortion Reform Proposals in Britain and the United States, 1960-1973* in *Social Problem,* 50, 4, 2003, 574-578. See also BMA-RCOG, *Medical Termination of Pregnancy Bill: Views of the British Medical and the Royal College of Obstetricians and Gynaecologists* in *British Medical Journal* 2, 1966, 1649-1650.

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and without the necessary support to sustain their decision to terminate their pregnancy. In fact, the Lane Report stressed that

> "Some of those who favour a liberal abortion policy, whether or not abortion on demand, tend in our opinion to underestimate the complexities of these situations and the risk of morbidity following the operation. […] patients should always be told of the possible risk of complications".[23]

The Report emphasised that its position was in line with a holistic view of the patient, comprising physical, mental and social aspects of her situation, and stated that the doctors "should continue to exercise their clinical judgment after making an assessment of the woman's health and situation rather than be restricted to ensuring that she was medically fit to undergo abortion".[24]

4. Home abortions and telemedicine

Abortions performed during the first 12 weeks of pregnancy are the most common and can be classified as early abortions. There are two ways to perform them: surgical and medical. At the time when the Abortion Act 1967 entered into force only surgical abortions could take place and, for this reason, only premises where surgical terminations were permissible could be licensed. In the late 1980s medical abortions were introduced thanks to the development of the so-called "abortion pill" or "RU-486" by a French pharmaceutical company called Roussel-Uclaf. In October 1988 the French Government granted its approval of this drug, followed by Great Britain in July 1991 and Sweden in September 1992. However, the French pharmaceutical company's executives – the Roussel-Uclaf's German parent company Hoechst A.G.– blocked any further expansion in availability of the abortion pill until the retirement in April 1994 of its chairman Wolfgang Hilger, who was personally opposed to abortion.[25] Since then, medical abortion has become a widely-used method, with an increased number of women opting for it and with the highest figures occurring during the Covid-19 pandemic.[26]

Early medical abortion can be safely performed on the woman during the first 10 weeks of gestation. Hence a timing decision is considered particularly important. Ideally a medical abortion should, it is believed, be performed around 6/7 weeks of pregnancy because there is more risk of retained products in the uterus once the pregnancy is more advanced. Two pills, called mifepristone and misoprostol, are administered at two different times and, originally, both were taken in an approved place

[23] Report of the Committee on the Working of the Abortion Act, Vol. I Report. (Her Majesty's Stationery Office: London, 1974), 55.

[24] Ibid, 64-65.

[25]See L. LADER, *RU-486, Made in America* in *The New York Times*, 17 March 1994. Available at https://www.nytimes.com/1994/03/17/opinion/ru486-made-in-america.html [accessed 8 July 2021].
See R. ALTA CHARO, *A Political History of RU-486* in *Institute of Medicine, Biomedical Politics*, Washington DC, 1991, 43-98.

[26] In 2021 87% of the abortions in England and Wales were medically induced. The latest national abortion statistics for England and Wales are available at https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021 [accessed 28 June 2022]. In contrast in Scotland 99% of terminations were medical and of these 53% of pregnant women took both pills at home. The latest abortion statistics for Scotland are available at https://publichealthscotland.scot/publications/termination-of-pregnancy-statistics/termination-of-pregnancy-statistics-year-ending-december-2021/ [accessed 28 June 2022]

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and in front of a healthcare professional. In 2018 the Government in England – shortly after followed by Wales and Scotland – approved the pregnant woman's permanent address as a class of place to undertake the second stage of treatment. This means that while Mifepristone had to be taken at the clinic the second pill, Misoprostol, could now be taken at home.[27] It is worth noting that a study carried out by the RCOG found that where the patient is able to choose the method of terminating her pregnancy (either surgical or medical) medical abortion is related to more complications.

> "Medical abortion with mifepristone and misoprostol is associated with a longer duration of bleeding, more pain and gastrointestinal adverse effects, and a higher likelihood of being incomplete than vacuum aspiration under general anaesthetic up to 14 weeks of gestation. One partially randomised preference trial […] found that rates of unplanned or emergency admissions were higher after medical than surgical procedures (4.2% and 0.7%, respectively), mainly owing to retained products of conception. Overall complications were also more frequent in the medical group (5.0% and 2.6%, respectively)".[28]

In 2020 a further relaxation of UK law on medical abortion was temporarily granted during the Covid-19 pandemic to allow pregnant women to take both abortion pills at home thanks to the introduction of telemedicine.[29] In fact, the situation encouraged a change from in person to remote consultation where, after a clinical assessment, both medications are dispatched directly to the patient's home address. Both the BMA and the RCOG have been adamant in wanting this arrangement made permanent to shorten waiting times and make the abortion procedure smoother.[30] In March 2022 the House of Commons voted by 215 to 188 to make telemedicine for early abortion permanent in England, forcing the Government to abandon its plan to end the temporary scheme by the end of August 2022.[31] However, this change in the law raises controversies, in particular regarding the decision-making process and women's health and safety. In fact, one of the major drawbacks envisaged by the removal of in person consultations and the fact that patients can terminate their pregnancy in their home is a lack of human contact with a third party who can walk the woman through a clear decision-making process. This element becomes even more important when the patient experiences critical social factors. The National Institute for Health and Care Excellence (NICE) offers clear guidelines for healthcare providers to coordinate a care program for pregnant women with complex social factors. In fact, it suggests that "some women may need extra [support] because of their personal circumstances, such as problems

[27] See DEPARTMENT OF HEALTH AND SOCIAL CARE, *The Abortion Act 1967-Approval of Class of Places*, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf [accessed 8 July 2021].

[28] RCOG, *The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline* 7, 2011, 34. Available at https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf [accessed 8 July 2021].

[29] See I. BERTINI, *New UK Government guidelines on medical abortion during the COVID-19 emergency*, in JME Blog 15 April 2020. Available at https://blogs.bmj.com/medical-ethics/2020/04/15/new-uk-government-guidelines-on-medical-abortion-during-the-covid-19-emergency/ [accessed 8 July 2021].

[30] See I. BERTINI, *The first-year anniversary of the application of telemedicine to early medical abortions in UK*, in JME Blog 4 April 2021. Available at https://blogs.bmj.com/medical-ethics/2021/04/04/the-first-year-anniversary-of-the-application-of-telemedicine-to-early-medical-abortions-in-uk/ [accessed 8 July 2021].

[31] In February 2022 the Welsh Government and in May 2022 the Scottish Government made permanent the use of telemedicine for early medical abortion thus making permanent the use of both pills at home.

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with alcohol or drugs, or because they have a violent partner or family member".[32] It also emphasizes the importance of in-person appointments because they can offer the best opportunity for the woman to disclose difficult situations to a third person. Alongside these elements, it must be remembered that, from the perspective of health and safety, complications such as later than expected gestational age and undetected ectopic pregnancy are hard to rule out completely without in person consultations.[33]

5. Social factors and fetal anomalies

During the years before the Abortion Act 1967 came into force both the "social clause" and the clause permitting abortion of a fetus with serious anomalies were issues much debated within the Parliament. Specifically, in the early 1960s the Thalidomide scandal raised the question whether it was possible under the law to abort a fetus with serious anomalies. In fact, in those years medical practitioners were prescribing a new drug, Thalidomide, which mainly prevented sickness in pregnant women. Unfortunately, this drug was later associated with serious fetal anomalies and it was withdrawn from the market. However, this was not the first time that issues of eugenics arose within the abortion debate. In fact, back in February 1938, Stella Brown, one of the most prominent abortion reform campaigners, became a member of the Eugenics Society probably hoping for an alliance with the Abortion Law Reform Association (ALRA).

Accusations of eugenics were also levelled against the first Private Member's draft Bill on abortion presented by Lord Silkin in 1965. As Hansard reports show, it comprehended both fetal anomalies and social issues as new grounds for obtaining an abortion.[34]

The second reading before the House of Lords saw much scepticism about the draft Bill. In particular Viscount Dilhorne raised many concerns about the meaning of the "social clause": assessing the terms of this clause could not fall within a medical practitioner's competence. He also argued that it was very

[32] NICE, *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* (2010) 22 September. Available at https://www.nice.org.uk/guidance/cg110/ifp/chapter/About-this-information [accessed 8 July 2021].

[33] See ARA. AIKEN *ET AL*, *Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study*, in *British Journal of Obstetricians and Gynaecologists* 128, 2021, 1464-1474.

[34] The principal clauses were:

It shall be lawful for a register medical practitioner to terminate pregnancy in good faith

In the belief that if the pregnancy were allowed to continue there would be a grave risk of the patient's death or of serious injury to her physical or mental health resulting either from giving birth to the child or from the strain of caring for it, or

In the belief that if the pregnancy were allowed to continue there would be a grave risk of the child being born grossly deformed or with other serious physical or mental abnormality, or

In the belief that the health of the patient or the social condition (including conditions of her existing children) make her unsuitable to assume the legal and moral responsibility for caring for a child or another child, as the case may be, or

In the belief that the patient became pregnant as the result of intercourse which was an offence under section one to eleven inclusive of the Sexual Offences act 1956 or that the patient is a person of unsound mind.

A termination under paragraph (c) or (d) of section 1 of this Act shall not be performed after the end of the 16th week of pregnancy.

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unlikely that performing abortions in those circumstances could be the appropriate answer to social and economic issues, in particular, with the advent of the Welfare State.[35]

In 1966 Lord Silkin introduced a second Bill in order to address the criticisms of his first one.[36] The main changes were the removal of the "social clause" and the clause related to termination following sexual assault; the Bill also introduced a requirement that two doctors assess the legality of the abortion procedure and that the abortion procedure should be performed in an NHS hospital or in an approved place.

It is also worth noting that the new wording of the Bill expressly included, as grounds for obtaining a legal abortion, physical and mental anomalies of the fetus, which could deprive the child of "any prospect of reasonable enjoyment of life", and the mother's own physical or mental inadequacies. The idea behind these clauses was, on the one hand, that the mother's mental and physical disabilities and diseases were likely to be inherited by the fetus; on the other hand, there was an assumption that, in the case of disability in the mother, it was better to prevent the birth of a child than to support the family in raising him or her. Eventually this Bill passed on 7th March 1966, but since the Government called for a general election, it did not go further.

Lord Silkin felt quite confident in reintroducing his Bill to the new Parliament on 10th May 1966. While he emphasized the need to insert again the "social clause,"[37] the House of Lords was more focused on the issue of eugenics comprehended in the Bill's first clause. The risk envisaged was twofold: on the one hand, the doctors at that time could only presume the risk of fetal anomalies without certainty with the consequence that the relaxation of the law on this point would have permitted a healthy fetus to be aborted. On the other hand, there was no definition of the word "defective" in relation to the

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[35] See Hansard Report, Abortion Bill HL, 30 November 1965, Vol. 270. Available at https://bit.ly/3NPnxzy [accessed 8 July 2021].

[36] Below you can find the revised clause 1 of the Abortion Bill:

Subject to the provisions of this Act it shall be lawful for a registered medical practitioner, after obtaining a concurring opinion from a second registered medical practitioner, to terminate a pregnancy, provided that such two registered medical practitioners certify in writing that in their opinion the termination of the pregnancy is necessary on the ground that –

The continuance of the pregnancy would involve serious risk to the life or grave injury to the health whether physical or mental of the pregnant woman whether before at or after the birth of the child; or

The child if born would be likely to suffer from such *physical or mental abnormalities* as to deprive it of any prospect of *reasonable enjoyment of life*; or

The pregnant woman is or will be *physically or mentally inadequate* to be the mother of a child or of another child as the case may be; or

The pregnant woman is a *defective* or became pregnant when under the age of sixteen or as the result of rape or of intercourse which was an offence under section 128 of the Mental Health Act 1959 or section 97 of the Mental Health (Scotland) Act 1960 (relating to sexual intercourse with patients).

[37] Hansard Report, Abortion Bill HL, 10 May 1966, Vol. 274. Available at https://hansard.parliament.uk/Lords/1966-05-10/debates/b52a0e38-e64c-4c32-8387-e45b1e0ffa6c/AbortionBillHl?highlight=lord%20silkin%20abortion#contribution-d818ba8a-44e1-4546-942a-b8a699a41599. Lord Silkin in his introduction states "what I am groping for, and I hope I shall eventually reach something which will be acceptable, is the case of the prospective mother who really is unable to cope with having a child, or another child, whether she has too many already or whether, for physical or other reasons, she cannot cope, but about whom it cannot be said that her life would be endangered or that there would be serious injury to her health".

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woman's health. Consequently, inserting eugenic provisions in the Bill would have produced a more permissive law on abortion without tackling the social elements involved.
In May 1966 the ALRA found a sponsor in the House of Commons, David Steel MP, who could introduce Lord Silkin's bill on abortion in the more important House and with greater chances of success. Steel, in agreement with the ALRA, insisted that the new Bill should have been broader in its scope.[38] However, after some negotiations with the RCOG and the BMA the social grounds were repealed (namely the indications for mental disability, economic hardship, rape, pregnancy below the age of 16), but the reference to the risk to the psychological and physical health of the mother was retained. This meant that doctors could perform "therapeutic" abortions. As Simms notes, "The BMA constantly emphasised the importance of leaving the individual doctor free and unfettered to exercise his independent judgment. […]. Even in cases of sexual assault, the BMA was not prepared to see any pressure put on doctors to terminate".[39] This was not due to a lack of empathy on the part of clinicians but was the best way to preserve the medical body from entering into a field where it did not have any competence. For instance, it could not be left to the doctor alone to prove that a pregnancy had occurred after an act of violence. The Royal Medico-Psychological Association (RMPA), in its practical recommendations on the Abortion Law, maintained a more open approach towards the social circumstances that could lead a woman to seek an abortion. However, the RMPA highlighted that any decisions connected to the social environment should be taken in accordance with a social worker.[40] Moreover it pointed out that

> "[D]octors would not wish a situation to be created by law which would encroach upon their independence in matters requiring professional and ethical judgment. Spelling out in detail when a doctor should or should not have the right to induce abortion, even if the legislation is cast in permissive terms, would have the effect of introducing an element of coercion in the sense that in each defined situation the patient might reasonably expect the doctor to acquiesce, and the role of the surgeon or gynaecologist would be reduced to that of a technician carrying out an objectionable task"[41].

[38] Revised Clause (1) of the Medical Termination Pregnancy Bill (15th June 1966):
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 that practitioner and another registered medical practitioner are of the opinion, formed in good faith
That the continuance of the pregnancy would involve serious risk to the life or of grave injury to the health, whether physical or mental, of the pregnant woman whether before, at or after the birth of the child; or
That there is substantial risk if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; or
That the pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be; or
That the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape.
[39] M. SIMMS, *Abortion Law and Medical Freedom*, in *The British Journal of Criminology* 14, 2, 1974, 124.
[40] See *The Royal Medico-Psychological Association's Memorandum on Therapeutic Abortion* in *The British Journal of Psychiatry* 12, 491, 1966, 1072.
[41] *Ibid*, 1071.

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However, the final wording of the Abortion Act 1967 did not prevent access to abortion for social reasons. In fact, the "woman's mental and physical health" became the umbrella clause under which the social and environmental reasons fell.

The most recent attempts to change the current abortion law have been two Private Members' Bills, the HC Bill 276 (Abortion Bill 2017-2019), presented by Diana Johnson, and more recently, the HL Bill 31 (Abortion Bill 2019-2021), introduced by Baroness Barker. Both bills' main focus has been the decriminalization of consensual abortions up to 24 weeks gestation and the creation of a specific criminal offence for non-consensual terminations. The strong emphasis on consent clearly reflects a greater stress on the decision-making process that brings a woman to choose to terminate her pregnancy. However, the fact that both bills aim to decriminalize abortion by removing the requirement for certification by two doctors, and by treating abortion procedures like any standard medical procedure raises real concerns over how in practice women will be supported in their decision-making process.

In fact, the definition of "coerced abortion" can be very wide. Of course, there are cases where a pregnant woman is directly threatened by her partner or her family, who want her to get an abortion for various reasons such as extramarital conception, fetal sex, an absolute refusal to become a parent, but those circumstances are not the most common. The majority of women who seek an abortion are women who may see themselves as making a choice, but who do not perceive that their pregnancy is compatible with their present circumstances. They may have just started a new job, they are not in a stable relationship, they are experiencing financial hardship, they strongly believe that the sex of the fetus may undermine their family stability because of their cultural background etc. Women in these circumstances might perceive abortion as the only way of avoiding a possible deterioration of their current situation. These women can experience such internal and external pressure that they may feel "forced" to terminate their pregnancies.

The law as it stands, whether or not Baroness Barker's Bill passes, entrenches these situations since it does not tackle either from a social or legal angle the underlying problems that bring a pregnant woman to choose an abortion. Writing from a pro-choice perspective, Goldbeck-Wood reflects,

> "To avoid brutalisation, abortion should not be offered on a conveyor belt but through a reflective process. We will not achieve this by criminalising abortion, overpowering women's autonomy over their bodies, or pretending that healthcare practitioners, politicians, or religious leaders can know what is best for individuals. Rather we need structures and processes which support shared conscientious reflection".[42]

In fact, to ensure consent, patients need a supporting environment to guarantee that there is no coercion and that women's wider socio-economic conditions are not forcing them into consenting to a measure they would otherwise resist.

All these factors also play a huge role in the deliberative process where fetal anomalies are detected, combined with the need for more time to get a second medical opinion, to establish which anomalies are permanent and which can be partially/totally resolved before or after birth, and for socio-medical plans to allow the family to think about their future with a disabled child. In fact, when it comes to

[42] S. GOLDBECK-WOOD, *Reflection is Protection in Abortion Care – An Essay by Sandy Goldbeck-Wood,* in *The British Medical Journal,* 359, 2017, j5275.

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fetal anomalies, the BMA recommends that women are not rushed into making a decision, advising that

> "Doctors faced with a potential late abortion for serious fetal abnormality should be aware that women should be given information and time to understand the nature and severity of fetal abnormality, and should be offered specialised counselling where appropriate, in order to assist them in reaching an informed decision about how to proceed".[43]

In these circumstances the BMA clearly emphasises the importance of time. On the one hand, the woman needs time to understand issues related to the fetus: further tests might be needed to assess the nature of the anomaly, whether it can be resolved after birth or is permanent, so that the woman can then make up her mind. On the other hand, it is necessary to point out that more time to reflect means a higher gestational age which brings other issues in the case of abortion such as a risk of more complications for the mother, the fact that the fetus may be capable of surviving outside the womb etc. It is in fact permissible to terminate a pregnancy up to birth for fetal anomalies.
In June 2020 Fiona Bruce introduced the Abortion Bill 131 2019-21 to exclude cleft lip, cleft palate and clubfoot as qualifying fetal anomalies for termination of pregnancy under section 1 (1)(d) of the Abortion Act 1967. It is well known that those anomalies are treatable after birth and unfortunately the Abortion Act 1967 does not offer more details apart from the phrase "becoming seriously handicapped" to describe the fetal anomalies that make an abortion permissible under ground (d).

6. Women's autonomy or women in a vacuum?

The RCOG states that

> "All women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications. Clinic staff must be sensitive to the different stages of decision making those individual women have reached and must be able to identify those who may require additional support and counselling. These may include young women, women with mental health problems, women with poor social support and where there is evidence of coercion. This help should be tailored to age, comprehension and social circumstances".[44]

It is evident that a decision regarding termination should be seen as a team process where the woman has to be placed at the centre, so she can make the best possible decision that reflects her innermost interests. However, the present time has seen a common trend among States – exacerbated by the global pandemic – to make this process faceless and swift, in another word, efficient. For this reason, the new policies surrounding the regulation of medical abortion have encouraged women's "self-

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[43]BMA, *The Law and Ethics of Abortion. BMA views,* September 2020 – post-ARM update, (2020), 8. Available at https://www.bma.org.uk/media/3307/bma-view-on-the-law-and-ethics-of-abortion-sept-2020.pdf [accessed 8 July 2021].

[44] RCOG, *The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7*, 2011, 47. Available at https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf [accessed 8 July 2021].

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evaluation" and "self-management."[45] The same trend can be seen in the new legislative proposals where abortions before 24 weeks of pregnancy are compared to standard medical treatments which require only the patient's informed consent. This move makes social and medical support, and the protection of women's personal choice mutually exclusive in the deliberative process for abortion.
As Carter Snead noted in his recent publication – which addresses the key conflicts of US public bioethics including in the debate over the law on abortion – this view of the patient seeking an abortion is a myth and does not reflect reality. American laws and policies in this domain rely on the notion of atomised individual wills of those who freely construct their lives making either compromises or contentions with others they encounter on their path. Hence, the law on abortion serves the purpose of creating the conditions of freedom where self-determined individuals can freely and unforcedly pursue their chosen future in matters of parenthood and procreation.[46] Yet,

> "[Women] should indeed be free, as the Supreme Court, has written, to shape their own destinies, in accordance with their self-understanding and their spiritual imperatives, as they understand them. They should be free and uncoerced in matters of procreation and parenthood. […] What is missing? A serious consideration of *embodiment* and its meaning and consequences. […] Specifically, the Court is blind to the reality of vulnerability, dependence and natural limits that necessarily attend any problem or conflict involving embodied beings":[47]

Every citizen, including parents and children is, in fact, placed in a wider network of others that the Court dismisses, weakening "the ties of extended family, neighbours, fellow citizens, and the government to the pregnant woman because it isolates her in her suffering and vulnerability and ignores the obligations *of everyone* to come to the aid of women and families in crisis".[48]
It is now possible to bring the same considerations into the UK scenario. On many occasions both the RCOG and the BMA have introduced into their policies clauses that encourage a deeper understanding of the circumstances that bring a woman to decide to seek an abortion. Those policies are undoubtedly expected to be in line with the need to protect women's deliberative process. Healthcare providers have the duty to actively support a holistic view of medicine, which should place the patient within her net of relationships and social and medical circumstances to enable her to take the best-informed decision.

7. Conclusion

Ultimately the current law on abortion and related policies can make the women's decision-making journey surrounding termination of pregnancy a lonely one, unsupported and studded with blind spots in the deliberative process in many respects.

[45] See AL. CABELLO, AC. GAITAN, *Safe Abortion in Women's Hands: Autonomy and a Human Rights Approach to COVID-19 and Beyond*, in *Health and Human Rights Journal* 23, 1, 2021. Available https://www.hhrjournal.org/2021/02/perspective-safe-abortion-within-womens-reach-autonomy-and-a-human-rights-approach-to-covid-19-and-beyond/ [accessed 8 July 2021].
[46] See O. CARTER SNEAD, *What it Means to be Human. The Case for the Body in Public Bioethics*, Cambridge (MA), 2020, p. 6.
[47] SNEAD, *What it Means to be Human. The Case for the Body in Public Bioethics*, 170-171.
[48] SNEAD, *What it Means to be Human. The Case for the Body in Public Bioethics*, 176.

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Firstly, it has been noted that time is one of the main constraints in the decision-making process. On the one hand, when it comes to early abortions women are for medical reasons rushed into making their decisions, while for late abortions a pondered decision is recommended. However, if time is the woman's ally in the decision-making process this is not unrelated to the prenatal interest in continued life which also needs to be considered. In particular, when it comes to late abortions issues such as fetal pain and fetal survival should be more openly addressed to ensure that the woman's choice is an informed one.

Secondly, the common trend among stakeholders is to compare abortions before 24 weeks of pregnancy to standard medical treatments which require only the patient's informed consent. This results in the paradox that social and medical support, and the protection of the woman's personal choice become mutually exclusive in the deliberative process for abortion.

Third, the trend to offer home abortions as a smoother and quicker procedure, considerably limiting any human contact (and any in person health assessments) does not necessarily equate to a better service, in particular when patients are prisoners of unhealthy environments. In fact, the new policies surrounding the regulation of medical abortions have encouraged women's "self-evaluation" and "self-management" as the new frontier of health care. However, drawbacks can be significant compared to in person evaluations and health checks such as in regard to undetected ectopic pregnancies, retained material in the uterus and haemorrhage. Additionally, the lack of human contact can only deepen the trench around women's complex social and mental circumstances.

This hands-off approach can be even more detrimental when it comes to patients experiencing difficult social factors or carrying a pregnancy with a diagnosis of fetal anomaly. In these circumstances women need a supportive and caring environment in order to ensure their capacity for meaningful decision-making. Consequently, it is essential to enforce policy measures to prevent women's socio-economic factors from coercing them into consenting to a measure they would otherwise resist.

Women's reflective deliberation and consent alongside their autonomy will be certainly enhanced when they are placed in situations where they are properly listened to and cared for.

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