Thesis' Title: 'Informed consent to abortion: reframing the first medical encounter with a registered-medical-practitioner'

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Abstract

Though the Abortion Act 1967 was passed over 50 years ago, the ethical and political questions that spur from abortion are far from settled. This project focuses on the neglected issue of the first medical encounter between registered-medical practitioners (RMPs) and women considering abortion and analyses the RMPs' informative role. It is contended that the focus on how the decision-making process unfolds during the first medical encounter has been undermined and deserves more attention. The thesis supplies a novel interpretation of the informed consent framework based on the 2015 landmark decision of *Montgomery v Lanarkshire Health Board*[1] which set out two key principles to govern informed consent in mainstream medicine: partnership and autonomy. This thesis explores how adherence to these principles can be achieved in the context of the first medical encounter with a RMP and abortion. It argues for a novel and additional focus on the valuable contribution that RMPs can bring to informed decision-making that safeguards women's authentic autonomy. The project proposes a shift in the abortion debate in England and Wales, recommending changes that will enhance the emphasis on partnership and authentic autonomy in the first medical encounter with an RMP.

[1] [2015] UKSC 11

‘Informed consent to abortion:

reframing the first medical encounter with

a registered-medical-practitioner’

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Table of Contents

List of abbreviations

AA, Abortion Act 1967

BMA, British Medical Association

BPAS, British Pregnancy Advisory Centre

CIW, Care Inspectorate Wales

CQC, Care Quality Commission

DHSC, Department of Health and Social Care

DHSS, Department of Health and Social Security

ECHR, European Convention on Human Rights

FSRH, Faculty of Sexual and Reproductive Healthcare

GMC, General Medical Council

HFEA, Human Fertilisation and Embryology Authority

ILPA, Infant Life Preservation Act 1929

MCA, Mental Capacity Act 2005

NHS, National Health Service

NICE, National Institute for health and Care Excellence

OAPA, Offence against the Person Act 1861

PG, professional guidelines

RMP, registered-medical practitioner

RCOG, Royal College of Obstetricians and Gynaecologists

RCGP, Royal College of General Practitioners

RCPsych, Royal College of Psychiatrists

RCM, Royal College of Midwifery

RCN, Royal College of Nurses

List of cases

Parkinson v St James and Seacroft University Hospital NHS Trust [2001] EWCA Civ 530

Paton v BPAS [1978] QB 276

Paton v UK [1981] 3 EHRR

Pearce v United Bristol Healthcare NHS Trust [1999] ECC 167

Planned Parenthood v Casey 505 US 833 (1992)

Pretty v UK (2346/02)

R v Bourne 3 ALL ER [1938] 615

R v (Christian Concern) v SSHSC [2020] EWCA Civ 1329

R v Newton and Stungo Crim. L.R. [1958] 469

R v Smith [1959] 2 (QB) 35

Re AB (Termination of pregnancy) [2019] EWCA Civ 1215

Re T (adult: refusal of medical treatment) [1992] 4 ALL ER 649

Roe v. Wade 410 U.S. 113 (1973)

Royal College of Nursing v Department of Health and Social Security [1981] AC 800

Shaw v Kovac and University Hospitals of Leicester NHS Trust [2017] EWCA Civ 1028

Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] AC 871

Spencer v Hillingdon [2015] EWHC 1058 (QB)

Thefaut v Johnston [2017] EWHC 497 (QB)

Webster v. Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62

Worrall v Dr Helena Antoniadou [2016] EWCA Civ 1219

Wyatt v Curtis [2003] EWCA Civ 1779.

List of Legislations, Bills, Reports

Abortion Act 1967

Abortion Bill [HL] proposal 2019-2021

Abortion (Disability Equality) Bill (HL Bill 95)

Abortion (Cleft Lip, Cleft Palate and Clubfoot) Bill 2019-21

European Convention on Human Rights 1950

Human Rights Act 1998

Human Fertilisation and Embryology Act 2008

Human Fertilisation and Embryology (Welfare of Women) Bill (HC Bill 189) 2017-2019

Human Tissue Act 2004

Infant Life Preservation Act 1929

Mental Capacity Act 2005

Offence against the Person Act 1861

Report of the Committee on the Working of the Abortion Act (Lane Committee), 1974.

Rawlinson Report, Physical and Psychosocial effects of abortion on women, 1994.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11.

The Convention for the Protection of Human Rights and Dignity of the Human Being (Oviedo Convention), 1997

State of Utaha, Abortion Law, as amended in 2018, online available at: https://le.utah.gov/xcode/Title76/Chapter7/76-7-P3.html (accessed 21st October 2020)

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Alla mia famiglia,
Per avermi aiutato a Sperare contro ogni Speranza
in un Amore che non delude.

Chapter 1

Introduction

An overview of the thesis' structure, research questions, methodology and contribution to knowledge

1. Introduction

The introductory Chapter offers an overview of the research project. It sheds light on three aspects of the thesis: 1) the research questions and structure 2) the methodology and approach and 3) its original contribution to knowledge. Chapter 2 will then analyse the current scenario concerning the decision-making process in the abortion context of the first medical encounter with registered medical practitioners (RMPs). It will contend that the doctrinal and normative framework in England and Wales give limited weight to the decision-making process. This will then form the basis of the argument for the need of a change in approach.

This Chapter starts with an overview of the research questions around which this thesis is structured and the methodology chosen. It then delves into an analysis of the geographical approach adopted and offers reasons for it. In the context of the law in England and Wales it claims that a revised ethical and legal approach is needed to fill gaps in the law and professional guidelines regarding information provision. It then analyses a novel approach to the abortion debate: it shows that the abortion issue has been mostly framed as a question of 'who makes this choice?' or of 'what is this choice about?', which neglects what will be claimed to be the key aspect of the decision-making process. A 'how-approach' is put forward which considers 'how is the choice made?'. The term 'how' has been chosen because is a short and direct way to communicate the standpoint of this project and contrasts with the traditional focus on who (decides) and what (can be decided).

The subsequent section explains that this thesis is proposing to look at abortion from a specific angle: the decision-making process in the context of the first medical encounter with a RMP and the relevance of medical support as a tool to pursue a woman centred approach.[2] Subsequent chapters will show that the 'how-approach' will

[2] With the term 'women' this thesis means adult persons with legal capacity to consent or refuse a medical treatment, capable of becoming pregnant either naturally, because biologically fertile, or through artificial means, as it is per the case of IVF. I am aware of two existent debates: the first concerning trans-gender pregnancies and the second artificial wombs. As per the former it deals with the possibility of trans-gender patients to become pregnant: this thesis does not delve into this issue, but only acknowledges that a debate on informed consent has the potential to be extended to all those who are facing an unplanned pregnancy and considering abortion. As per the latter, that is to say the impact of artificial wombs on

reflect the informed consent (IC) case-law and in particular principles of partnership and autonomy extrapolated and adapted from the Supreme Court judgment in *Montgomery v Lanarkshire Health Board ('Montgomery')*.[3]

2. Research question and thesis structure

Traditionally the abortion debate in England and Wales has focused on the status of the fetus and the decisions available to pregnant women. The thesis will claim that the debate has become polarised and political and that it has neglected the crucial component of the decision-making process. Whereas in other aspects of healthcare law the informed consent process has received increasing attention and been the subject of much litigation, it is argued here that abortion law has fallen behind. Abortion, as Foster claimed, seems to 'exists on an island, unconnected with the general rules relating to informed consent'.[4] This thesis contends that the process of decision-making has been undermined in England and Wales and explores why that has come about, why change is important and how it can be achieved.

The thesis explores three central research questions through desk-based research:

Question 1: How far is the approach taken in relation to the common law in England and Wales on IC mirrored in abortion law and professional guidelines? This question is explored in Chapter 2. Chapter 2 argues that in the context of the first medical encounter in abortion decisions in England and Wales, the decision-making process has been neglected. This is relevant and worthy of analysis because it neglects principles of partnership and autonomy that will be claimed to be crucial in the context of informed consent. It also risks producing a '*domino effect'* whereby subsequent and additional forms of informative support (e.g. subsequent medical encounters, availability

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pregnancies, this thesis acknowledges that the future of this scientific advancements might open up the possibility to carry a fetus outside women's body and that this will change how 'pregnancy' and the concept of embodiment have been framed thus far. Chapter 5 will briefly mention the issue of artificial wombs as a possible future alternative to abortion that, when and if becomes available, should be prospected by RMPs. Ultimately this thesis, recognises the potential for future research on the tie between abortion and artificial wombs, yet it is not focusing on this debate. Both transgender pregnancies and artificial wombs have the potential to change how we conceive pregnancies as related to gender-discourses and hence also the issue of abortion. The issue of so called 'degendering' reproduction has been also discussed by E Jackson (E Jackson, 'Degendering reproduction?' (2008) *Medical Law Review*, vol. 11, 346) where she explores the potential of artificial wombs (ectogenesis) and IVF to disassociate the reproductive discourse as tied primarily to women alone. I am not focusing on the issue of de-gendering reproduction in my thesis, while recognising that there is potential for further future research in this context.

[3] [2015] UKSC 11

[4] C Foster, 'Does the English Law on Abortion affront Human dignity' (2016), *The New Bioethics,* vol. 22(3), 162, 182.

of counselling services, forms of ongoing care) can also be negatively impacted, because women would have learned about them through the IC process.

Chapter 2 will ground the need to facilitate a change in approach. It will claim that there is a need to provide support during the first medical encounter, and that this cannot be sufficiently tackled if the focus rests either on a discussion on the role of the decision-maker or fetal interest in isolation. In this context registered-medical-practitioners (RMPs) will be claimed to have a positive and key role. Ultimately, it will be argued that a focus on the decision-making process has been neglected and a change in approach is needed.

Question 2: Why is a focus on the decision-making process important in the context of abortion and the first medical encounter? This question is explored in Chapters 3 and 4 which constitute the theoretical framework of this thesis and proposes a novel 'how-approach'. Building upon the positive role that RMPs can exercise during the first medical encounter, it will extrapolate and reinterpret from the informed consent (IC) case-law positive principles that can help shape the law and professional guidelines on abortion. It will propose the principle of partnership (Chapter 3) and authentic autonomy (Chapter 4) as two relevant principles for this research context. Chapter 3 will reflect upon the principle of partnership and will propose as a way forward a model of revised medicalisation. This model builds firstly upon a rational non-interventional paternalism discourse as proposed by Savulescu[5], for its focus on the importance of balancing both RMPs and patients' expertise; and secondly on the supported decision-making model set out in the 2020 General Medical Council (GMC) guidelines on consent[6], for its focus on clinicians' advisory role. This proposed model will focus on the importance of communication, dialogue and informative support as key requirements for a more fruitful medical encounter. Chapter 4 will then reflect upon the principle of autonomy and propose a thick concept of authentic autonomy. This approach claims that women's autonomy is not built on a recognition of their agency alone, but also on an understanding and minimisation of possible decisional vulnerabilities (e.g. risk of patients' abandonment) together with a recognition of the

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[5] J Savulescu, 'Rational non interventional paternalism: why doctors ought to make judgments of what is best for their patients' (1995), *Journal of Medical Ethics*, vol. 21, 327.

[6] GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), online available at: https://www.gmc-uk.org/-/media/documents/updated-decision-making-and-consent-guidance-english-09_11_20_pdf-84176092.pdf?la=en&hash=4FC9D08017C5DAAD20801F04E34E616BCE060AAF (accessed 21st October 2020); this was preceded by the 2018 draft guideline: GMC, 'Decision making and consent, supporting patient choices about health and care, Draft guidance', (2018), online available at:: https://www.gmc-uk.org/-/media/gmc-site-images/ethical-guidance/related-pdf-items/consent-draft-guidance/consent-draft-guidance.pdf?la=en&hash=E85F0DD8C7033541BF51F1C619EF992B1A45A188 (accessed 21st October 2020).

plurality of interests at stake in the abortion context (e.g. women's health, fetus' interests, prospective father's interest). Together these principles will form the framework upon which a change in approach will be suggested for the context of abortion and the first medical encounter in England and Wales.

Question 3: What approach is needed to support the decision-making process in abortion in England and Wales? This question is explored in Chapters 5 and 6 of this thesis. Chapter 5 analyses the legal implications of a process of revised medicalisation for the context of abortion and the first medical encounter in light of the 'how-approach'. It explores two contexts: the Abortion Act 1967 (AA) and the law of negligence. As far as the AA is concerned, it will suggest the inclusion of a consent clause as the optimal tool to value the approach proposed in a criminal law framework. In light of the proposed legal changes, it will then explore the context of the law of negligence. It will offer ways in which courts can better clarify the meaning of the materiality test of information disclosure, this will help both minimising the inherent limitations of the law of negligence, while safeguarding the principles of partnership and authentic autonomy in the context of abortion. Chapter 6 will then focus on the policy implications of the approach proposed. It will offer a thorough consideration of current professional guidelines that govern the first medical encounter in the abortion context, and propose ways in which such guidelines can be amended so as to better safeguard the 'how-approach'. In particular, clarity on the content of the disclosure process, together with the importance of minimising the widespread reduction of clinical involvement, are suggested as crucial ways to safeguard authentic autonomy and partnership during the first medical encounter.

In Chapter 7 the conclusions of this work will be addressed. It will be claimed that the current abortion context in England and Wales neglects a focus on the decision-making process in the context the first medical encounter with an RMP. In light of the IC literature, which highlights the positive role that RMPs can and should exercise during the decision-making process, it has been claimed that this context should be governed by the principle of partnership and authentic autonomy (which I term the 'how-approach'). The first medical encounter, as the first link in a chain of support, is hence a key moment for this approach to be brought forward. This has led to a reflection on possible considerations for revision within the AA, the law of negligence and professional guidelines concerning abortion and informed consent. Ultimately, this thesis suggests possible legal and policy changes in approach so as to trigger a process of revised medicalisation which values and safeguards the relevant principles of authentic autonomy and partnership.

3. Methodology

This desk-based research project adopts literature-based methods to address the questions raised, critically engaging with relevant literature in the fields of informed consent and abortion. It also explores relevant statistics to analyse the impact/target of women requesting abortion services and to tackle how to effectively adopt an informed-consent based approach.

In addition to accessing library and online materials, I made several requests for additional information including:

a) Archive information from relevant public bodies concerning pre-Abortion Act and post-Abortion Act documents (e.g. Royal College of Psychiatrics[7], Parliamentary documents[8]);

b) Freedom of information requests: 1) to the NHS resolution[9], concerning the extent of negligence claims involving informed consent and abortion beyond the remit of wrongful birth cases. No data was held; 2) to the Department of Health and Social Care[10] (DHSC) concerning the number of doctors exercising their right to conscientious objection. No data was held.

The purpose of this thesis is to undertake desk-based analysis to address the questions raised. These questions have also the potential to be further substantiated and tested. Firstly, through the use of empirical work to shed a light on the medical practice and women's needs in the context of abortion and the first medical encounter. Secondly, the focus on the first medical encounter has the potential to be further expanded with a reflection on the interaction with wider forms of medical (e.g. the role exercised by medical staff, including nurses) and non-medical support (e.g. counselling services). These are aspects that are of crucial relevance and will form part of future research projects. The aim of the current analysis is to provide the theoretical background upon which future research paths can be developed.

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[7] Royal college of Psychiatrists, *Response to the Rawlinson Report on the physical & psychosocial effects of abortion*, Press Release, 1994.

[8] *Report of the Committee on the Working of the Abortion Act*, 1974, vol.1, Cmnd 5579, 94-96, para 288-295, when addressing the relevance of disclosure of information and access to counselling services for pregnant women considering an abortion; *Rawlinson Report*, *Physical and Psychosocial effects of abortion on women*, 1994, 1-30, this is a private report on the physical and psychosocial effects of abortion on women.

[9] The request was made on 17th June 2019 and I received a reply on 12th July 2019. They were unable to answer my request. In particular, in their response they said: 'although NHS Resolution may hold some information relating to claims such as these, due to the way claims are recorded on our claims database, we will not be able to identify such specific cases' (July 2019, FOI_3806).

[10] The request was made on 17th January 2019 and I received a response from DHSC on 9TH February 2019. I was then redirected to NHS digital enquires, but they replied saying that they 'do not hold this information'. They were also unable to assist me in finding out this information.

4. Geographical context

This research project adopts a narrow geographical focus: it analyses the legal and ethical framework concerning the first medical encounter for abortion in England and Wales. This thesis does not consider the Scottish context in any detail. It is true that the Abortion Act 1967 also applies in Scotland, and what will be shown to be the key judgment in an informed consent (IC) context, that is to say *Montgomery*, originated as a Scottish case that was brought to the Supreme Court. However, there are significant legislative differences in the abortion context that mitigate against a focus on Scotland for the purposes of this thesis. What will be later shown to be key background legislations -the Offence Against the Person Act 1861 (OAPA) and the Infant Life Preservation Act 1929 (ILPA) - do not apply in Scotland. This difference in broader legal scenarios offers a general reason why Scotland is not included in the chosen research context.

The key reason for this geographical approach also stands in a claim made in Chapter 5 and 6 that legal experts and policy makers should develop a revised ethical and legal approach in England and Wales. In light of recent and positive legal developments within the domestic IC case-law, which emphasizes the necessity to safeguard patients' decision-making process in partnership with RMPs, this research project asks how this could affect the broader ethical and legal landscape concerning the first medical encounter in this geographical context. It will hence derive positive principles from the IC context that will help shape this discourse.

This approach will not exclude *a priori* the possibility to transversally apply some of the considerations outlined also across the devolved nations of the UK and/or in other countries. Whilst the thesis is tailored to the England and Wales context to enable detailed consideration of case law and professional guidelines, the findings and principles have the potential to be relevant to the UK at large and other countries that are considering revising their legal and ethical landscape in the context of abortion and the first medical encounter.

5. Legal context

The legal framework surrounding abortion is comprised of three interlinked pieces of legislation:

(1) The Offence Against the Person Act 1861[11] (OAPA), frames a criminal offence to unlawfully procure an abortion. In particular, according to s. 58, a pregnant woman who intentionally procures an abortion to herself or a third party shall be guilty of felony. Furthermore, according to s. 59 it is a criminal offence, namely misdemeanour, to indirectly collaborate into an unlawful abortion, procuring or suppling drugs or other noxious thing.

(2) the Infant Life (Preservation) Act 1929[12] (ILPA), frames a criminal offence for the destruction of a child capable of being born alive. In particular, according to s. 1 the criminal offence of felony arises when someone intentionally 'destroy the life of a child capable of being born alive', that is to say causes the death of a viable child. In 1990, s. 37 (4)[13] Human Fertilisation and Embryology Act 1990 amended s. 5(1) of the Abortion Act, whereby no crime is committed under the ILPA by a registered-medical practitioner (RMP) who terminates pregnancy in accordance with the provision of the Abortion Act.

(3) the Abortion Act 1967 (AA), sets out a list of legal defences to the offences listed above for an abortion to be legally carried out in England and Wales. According to s.1, abortion is legal when (1) procured by a registered-medical-practitioner (2) two registered-medical-practitioners 'are of the opinion formed in good faith'[14] that the circumstances follow under one of the listed defences.

The AA sets up three main legal defences:

1) Risk to women's health: according to s.1(1)(a) when a pregnancy 'has not exceeded its twenty-fourth week[15] 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 women or any existing children of her family'. Furthermore, according to s. 1(2) account may be taken of the women's actual or reasonably foreseeable environment as a ground for a legal abortion. This sets the so called 'social ground' defence for a legal abortion.

2) Risk of grave permanent injury and risk to life: according to s.1(1)(b) an

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[11] ss. 58-59.

[12] ss. 1(1)-1(2).

[13] 'No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act.'

[14] The involvement of two RMPs is not required only in case of emergency (s.1(1)(4) AA).

[15] The Court of Appeal, in *British Pregnancy Advisory Service, R (on the application of) v The Secretary of State for Health and Social Care* [2020] EWCA Civ 355 (10 March 2020) has recently determined the meaning of 'the pregnancy has not exceeded its twenty-fourth week' in section 1(1)(a) Abortion Act 1967, holding that it is when the women is 24 weeks + 0 days pregnant, rather than, as argued by the appellants, 24 + 1.

abortion can be legally carry out when it 'is necessary to prevent grave permanent injury to the physical or mental health of the pregnant women'; or s. 1(1)(c) 'that the continuance of the pregnancy would involve risk to the life of the pregnant women, greater than if the pregnancy were terminated'.

3) Fetal abnormality: according to s. 1(1)(d) a further legal defence arises when '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'.

6. An overview of the approach chosen: the first medical encounter, the IC literature and the 'how-approach'

This research project focuses on a specific aspect of the abortion debate: the ethical and legal considerations surrounding the first medical encounter and the informative process that starts in this context. It hence looks at the decision-making process in the context of the first moment in time where RMPs and women meet. Following sections will explain in turn the meaning of 1) the first medical encounter 2) the 'how-approach', namely the approach proposed by this thesis, and will distinguish it from a pure 'how-question', as a general focus on the decision-making process in the abortion context. This analysis will be aimed at clarifying and offering a preliminary justification of key aspects of this thesis' analysis.

6.1 The first medical encounter: a definition

By the term first medical encounter this thesis means the first encounter between a woman and one of the two registered-medical practitioners (RMPs), as per s. 1(1) AA. It is not a statutory requirement for either of the two RMPs to have personally seen or examined a woman, although RMPs remain in charge of the procedure throughout.[16] Yet, this narrow focus is based on the understanding that the first encounter with an RMPs is a key link in the chain of support that can be offered to women in the abortion context. Crucially, as it will be argued later in this Chapter and in Chapter 2, its relevance has been neglected, triggering 'a *domino*' negative effect on the decision-making process.

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[16] See on this point *R v (Christian Concern) v SSHSC* at [35-39] [2020] EWCA Civ 1329, making reference to the judgment in *Royal College of Nursing v Department of Health and Social Security* [1981] AC 800.

When an unplanned pregnancy arises, women seeking a legal abortion in England and Wales are required, in line with the AA, to receive medical approval from two-RMPs.[17] Those clinicians are asked to assess in good faith that one of the conditions listed in the Act is satisfied. This first encounter with an RMP can either happen in an NHS facility, or more likely as statistics show,[18] in a private abortion clinic. These contexts, or class of places, although necessarily different, whereby the latter is characterized by the practice of abortion related services alone, and the former has a wider spectrum of medical activities, are both subject to the same legal- and policy-framework and are worthy of analysis.[19]

A narrow approach on the first medical encounter does not exclude focus on forms of complementary and subsequent medical (e.g. nurses) and non-medical support (e.g. through counselling sessions). It is possible, for instance, that prior to an encounter with an RMP, an encounter with a GP has already happened. Although this is rare, in light of the use of self-referral practices whereby women self-refer themselves straightforwardly to an abortion facility, this is still a theoretical possibility. It is also more likely that previous abortion-related encounters have happened especially when a serious risk of a fetal abnormality arises. Furthermore, the proposed approach does not exclude the subsequent involvement of wider medical professional, like nurses, or social workers and counsellors. The existence of both prior and subsequent forms of support is not in this sense excluded, however, it will be claimed that a process of reframing the wider medical involvement is built upon an analysis of the role of the RMP as first link

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[17] s. 1(1)(a) AA.

[18] DHSC, 'Abortion statistics, England and Wales: 2019', (June 2020), online available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf (accessed 21st October 2020),9.

[19] Both contexts are subject to the same legal (i.e. Abortion Act 1967) and policy-framework (i.e. generalized and specialist professional guidelines). As far as the Care quality commission is concerned, the independent regulator of health and social care in England, it should be outlined that: 1) Regulation 20, applies to both NHS and Non-NHS facilities and sets the regulatory requirements to abortion for providers; see CQC, 'Regulation 20: requirements relating to termination of pregnancies', (2009), online available at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-requirements-relating-termination (accessed 21st October 2020) 2) Regulation 11, broadly regulating the consent standards applies to both NHS and non-NHS providers; see CQC, 'Regulation 11: need for consent', (2014), online available at https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent (accessed 21st October 2020). 3) The inspection frameworks are outlined in two different documents, yet the standards required specifically concerning consent process are convergent, see for NHS Acute hospitals, that is to say NHS abortion providers: CQC, 'Inspection framework: NHS acute hospitals', (2018), online available at :https://www.cqc.org.uk/sites/default/files/20180706_9001228_Additional_service_Gynaecology_and_Termination_of_Pregnancy_framework_v2.pdf (accessed 21st October 2020) E6, 36; CQC: The inspection framework for non-NHS abortion providers, that is to say private abortion clinics is outlined in: CQC, 'Inspection framework: independent acute hospitals (and single specialties) termination of pregnancy', (2020), online available at: https://www.cqc.org.uk/sites/default/files/20191219_IH_TOP_inspection_framework_v6.pdf (accessed 21st October 2020) E6, 31. It should be noted that the Care Inspectorate Wales, the independent regulator of health and social care in Wales, does not set any inspection framework specifically for termination of pregnancy providers. See on this point: CIW, 'Who we inspect', online available at: https://careinspectorate.wales/providing-a-care-service/our-inspections (accessed 21st October 2020).

in the chain of support.

The first medical encounter with an RMP is here framed as the foundation, without which the structure of the whole decision-making process is at risk of being jeopardised. This thesis hence analyses how the first encounter should unfold so as to best safeguard what will be later shown to be the 'how-approach' and concepts of partnership and authentic autonomy in this context.

6.2 From the how-question to the 'how-approach'

The perspective embraced is labelled the 'how-approach'. In order to understand the meaning attached to the proposed approach, a preliminary distinction should be made here between the 'how-question' and the proposed 'how-approach'. The how-question deals with how a decision about abortion is reached. It encompasses both the process concerning circumstances where the pregnancy is 'unplanned' or 'not welcomed' from the moment in which it is discovered[20], and/or circumstances where there is a later change in perspective due to previously unknown events, as it is for instance in the case of a diagnosis of fetal abnormality. The latter, the 'how-approach', constitutes the particular way in which this thesis proposes to answer the how-question. This approach will be built upon two key principles, namely partnership and authentic autonomy, as derived and re-interpreted from the IC case law, which will be shown to be in need to be better reflected in the first medical encounter concerning abortion.

6.2.1 The how-question and the informed consent (IC) literature

The how-question asks 'how a decision concerning an abortion unfolds'. This question is predominantly derived here from the IC scholarship for what will be shown to be its focus on disclosure of information and decision-making dynamics between

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[20] The phenomenon of unplanned pregnancies is also statistically significant, in the latest 2018 report, in England 45% of pregnancies were unplanned or ambivalent. See on this point: Public Health England, 'Health matters: reproductive health and pregnancy planning', (2018), online available at: https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning#resources (accessed 21st October 2020) This data can be also combined with conception statistic (i.e. data which gathers both childbirth and abortion notification) showing that in 2018 the conception rate has decreased for the 11th year in a row, with a percentage of conception resulting in abortions constantly increasing. See the latest release: Office for National Statistics, 'Conceptions in England and Wales, Main points', (2020),online available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018, (accessed 21st October 2020).

patients and clinicians. It should be clarified at the outset that in law reference to the decision-making process inevitably includes the safeguarding of 'valid consent' and 'informed consent' as two separate, yet interrelated, key legal aspects. They are 'separate' because they set, amongst others, different standard of disclosure. Crucially, a failure to obtain a *valid* consent can result in criminal assault and a battery, whereas a failure to obtain *informed* consent can result in negligence.[21] Yet they can be 'interrelated' because the former (valid consent), with its narrow standard of disclosure, can constitute the basis for the safeguarding or the neglect of the latter (IC) which requires more extensive information disclosure. The focus of this thesis is on IC. A reflection on how to strengthen the consent process will be included in subsequent chapters in so far as this can serve as a baseline for the safeguarding of IC and of the 'how-approach'.

IC is a crucial concept in healthcare ethics whereby clinicians embark on a partnership process of information disclosure aimed at fostering an autonomous patient decision. Faden and Beauchamp[22] have claimed that IC has two distinct and general uses, the first claims that it is a 'form of autonomous authorisation by a patient or subject'[23] whereby a clinician is protected from liability, the second amounts to a series of rules and policy governing the IC process itself. It can be stated that ultimately IC is at the same time a 'safety net' for medical professionals, but also a 'process' oriented, amongst others, towards equipping the patients so as to better safeguard their autonomy.[24]

Beauchamp and Childress[25] have framed IC as a series of key legal requirements.[26] Firstly, they claim that two preconditions need to be in place, namely that the patient has competence and that the decision is voluntary. The same authors also break down the information elements: the disclosure of information in line with a legal standard, the recommendation of a plan and a process that fosters understanding. Altogether this

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[21] It should be clarified that the safeguarding of the former (valid consent) does not necessarily coincide with the latter (informed consent). As Cave has also clarified, 'Informed consent is not necessarily valid (if it is not voluntary or capacitous) and consent that is valid is not necessarily adequately informed. This flows from the different informational thresholds that apply in battery and negligence.' See on this point: E Cave, 'Valid Consent' (2020), *Journal of Medical Ethics*,0, 1. See also later Chapter 2 on tort law approaches, section 4. This thesis focuses on how to strengthen the IC process in the context of abortion. In this respect, it will explore 1) how the safeguarding of a valid consent within the Abortion Act can be ameliorated (as the baseline approach); 2) how the safeguarding of informed consent can be strengthened in common law and professional guidelines. See also on this point Chapter 5.

[22] R R Faden, T L Beauchamp, *A history and theory of informed consent*, (New York: Oxford University Press, 1986) 274-283.

[23] TL Beauchamp J L Childress, *Principles of Biomedical Ethics*, (Oxford: Oxford University Press, 2019) 119.

[24] Later Chapters will indeed clarify how these principles of partnership and autonomy can inform the chosen field of research.

[25] TL Beauchamp J L Childress, *Principles of Biomedical Ethics*, (Oxford: Oxford University Press, 2019) 120.

[26] In the England and Wales scenario these can be summed up in the requirements of legal capacity as enshrined in the Mental Capacity Act 2005, ss.1-3.

process is aimed at, not only authorising a legal medical intervention on someone's body, but also helping the patient reaching a final personal decision.

The reason behind a focus on the 'how-question' lies in a contended neglect[27] of this question from the political, doctrinal and normative debates surrounding abortion. The political debate has predominantly directed its attention to either an analysis of women as decision-makers, that will be later phrased as the 'who-question', or to an abortion as the termination of unborn life, that will be phrased as the 'what-question'. Crucially little weight has been given to a how-question, that is to say to the decision-making process. The doctrinal and normative debates, it will be argued, have also neglected this question. Chapter 2, in this respect, will claim that the AA, as the main legislative tool in this context, although recognising the involvement of medical professional during the first encounter[28], gives insufficient weight to this approach. A pervasive political and normative movement to reduce medical involvement in abortion decision-making also undermines their contribution.[29] Wider legal tools derived from the law of tort can only partially limit this phenomenon. Additionally, professional guidelines are but a starting point for this phenomenon to be tackled.

The importance of addressing the how-question also well fits the claim purported by the National Institute for health and Care Excellence Guidelines (NICE) 2019 on Abortion Care that 'improving information provision would benefit all women who are having an abortion'.[30] This has led NICE 2019 to provide recommendations 'that could apply to everyone'.[31] In other words, an information-oriented discourse can benefit women regardless of the reasons that might draw them towards an abortion. However, the argument set out here goes beyond a focus on those who end up having an abortion to also encompass those who face an unplanned pregnancy and decide, after the first medical encounter, not to have an abortion. This is because it is contended that an analysis of the decision-making process with its focus on the first medical encounter should apply prospectively to women deciding between pregnancy and abortion rather than retrospectively to those who choose abortion.

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[27] For a further analysis see Chapter 2, section 3.

[28] s. 1 (1)(a) AA.

[29] See below section 6.2.3, and Chapter 2 for an account of a process of de-medicalisation (section 3).

[30] NICE, 'Abortion Care', (2019), online available at: https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693 (accessed 21st October 2020) 30. See also: NICE, 'Abortion Care (2019), [B] Information needs of women undergoing an abortion', online available at: https://www.nice.org.uk/guidance/ng140/evidence/b-information-needs-of-women-undergoing-an-abortion-pdf-6905052974 (accessed 21st October 2020).

[31] NICE, 'Abortion Care', (2019), 30.

6.2.2 The 'how-approach'

The 'how-approach' is the proposed response to the how-question outlined by this thesis. This will be thoroughly unpacked in Chapters 3 and 4 where it will be claimed that the response lies in two principles: partnership and authentic autonomy. The former will call for an approach oriented towards dialogue, communication and support between women and RMPs which will seek to strike a balance between clinical expertise and patients' needs and values. The latter, authentic autonomy, will highlight the crucial relevance of the time spent in an information-sharing process for the safeguarding of women's autonomy as this offers the opportunity to be supported during the decision-making process.

As will be shown in Chapter 2, common law in England and Wales has been slow to embrace ethical principles on the importance of patient autonomy and partnership when information is disclosed in the context of medical decision-making more widely. It has neglected a how-question as a general focus on the decision-making process. However, since the Supreme Court decision of *Montgomery* in 2015, a patient-centred approach has been more firmly adopted. It is argued that abortion has not kept up with these developments and a change in approach is needed.

The key point that this project derives from the IC literature is hence the relevance of patients and RMPs as partners working together the process of medical consent. This also implies that the decision-making process is oriented towards both information disclosure and facilitating understanding of the information as key preconditions for IC. Chapters 5 and 6 will then unpack the implications of the chosen approach for the context of England and Wales, suggesting legal and policy-changes to further safeguard this process.

6.2.3 The 'how-approach' and the role of RMPs

The 'how-approach' is an expression of a form of revised medicalisation of the abortion context, that is to say of the desire of reshaping and not reducing the involvement of clinicians. The first time that women and RMPs meet is of crucial relevance for a disclosure process to unfold and for the safeguarding of the principles of partnership and authentic autonomy. The first encounter is hence a foundational moment for the 'how-approach' to be safeguarded. This approach also entails the proposal of a revised medicalisation between women and RMPs. This is a contentious claim given developing arguments prevalent at the time of writing for the progressive

reduction of medical involvement[32], and a current push towards rapidity of the process and self-referral practices.[33] It is hence important to clarify the multifaceted nature of decision-making surrounding abortion and set out the rationale behind the proposed approach.

The decision-making process[34] concerning abortion involves a variety of interconnected components which merge medical and non-medical aspects. Starting from the medical component, abortion is a medical intervention that terminates an existent pregnancy which is inevitably associated with the importance of outlining connected medical risks, benefits and possible alternatives. However, the reasons affecting the decision-making process are not solely medical. Research has shown that factors influencing the outcome of an unplanned pregnancy are often multifaceted[35] and can vary depending on age[36], stage of pregnancy[37], pregnancy circumstances and broader socio-economic factors. Biggs et al. [38] in a US-study isolated 35 possible themes that led

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[32] See on this point: Sheldon S, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016), *The Modern Law Review*, 79 (2), 283. Sheldon S, 'How can a state control swallowing? The home use of abortion pills in Ireland' (2016), *Reproductive Health Matters,* vol. 24 (48), 90. For a wider analysis of the challenges purported by a process of reduction of medical involvement (de-medicalisation) see Chapter 2, section 3.2.

[33] This means that women can bypass the involvement of GPs, and self-refer themselves to an abortion clinic without a prior GP- encounter/referral.

[34] For a further analysis of the decision-making process concerning abortion see: S Rowlands, 'The decision to opt for abortion' (2008), *J Fam Plann Reprod Health Care*, vol. 34 (3), 175, where she unpacks five steps that characterise the decision-making process, namely '1) the acknowledgement of the pregnancy; 2) formulation of options: to continue the pregnancy and keep the baby, to continue the pregnancy and offer the baby for adoption or to undergo abortion; 3) selection of continuation of the pregnancy or abortion by a balancing exercise; 4) commitment to the chosen outcome; 5) adherence to the decision'. See also: Kero in her reflection on the variety of psychosocial factors in women requesting abortion: A Kero, 'Psychosocial factors in women requesting abortion', in: S Rowlands, *Abortion care,* (Cambridge: Cambridge University Press, 2014) 34-40; Brauer et al. in an empirical study on the variety of experiences faced by women with an unintended pregnancy in the Netherlands, showing a different degree of complexity and difficulties during the decision-making process which can also affect the aftermath of the decision itself. M Brauer, J van Ditzhuijzen, H Boeije, C van Nijnatten, 'Understanding decision-making and decision difficulty in women with an unintended pregnancy in the Netherlands' (2019), *Qualitative Health Research*, vol. 29(8), 1084.

[35] See for a broad account of women's reasons for seeking an abortion: S Chae, S Dessi, M Crowell, G Sedgh, 'Reasons why women have induced abortions: a synthesis of findings from 14 countries' (2017), *Contraception*, vol.96, 233, 234-236; E Coast, A H Norris, A M Moore, E Freeman, 'Trajectories of women's abortion-related care: a conceptual framework' (2018), *Social Science & Medicine*, vol. 200,199, 202-205.

[36] See on under-18 abortion experience: E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283, 286, 289-296.

[37] See on factors influencing second trimester abortion in England and Wales: R Ingham, E Lee, S J Clements, N Stone, 'Reasons for Second Trimester abortions in England and Wales' (2008), *Reproductive Health Matters*, vol.16, 18.

[38] M A Biggs, H Gould, D G Foster, 'Understanding why women seek abortion in the US' (2013), *BMC Women's Health*, vol.13(29), 1, 6. For a further wider analysis of decision-making factors see: J Pereira, R Pires, M C Canavarro, 'Decision-making trajectories leading to termination of an unplanned pregnancy: specificities among adolescent and adult women' (2019), *Journal of Reproductive and Infant Psychology*, vol. 37(3), 242, 248, 251. This empirical study showed in particular that adult women more frequently 'not considering pregnancy continuation, concealed the decision from their family and reported economic reasons for abortion; or considering its continuation but were pressured into abortion by their partners' Pereira et al., *above*, 242. The decision-making process and the consent process appear to be more complex when a suspect of fetal abnormality arises. A 2018-empirical study on patient's perception of prenatal diagnosis of fetal cardiac pathology and the reason to continue or terminate a pregnancy highlighted the greater complexity of the decision-making process and the importance of seeking informed consent in a timely manner. See: G A Tayeh, J M Joaunnic, F Manson et al, 'Complexity

women towards the decision to abort which he then categorized under a final set of 11 overarching themes which are here summarized: 1) not financially prepared, 2) not the right time for a baby, 3) partner related reasons (e.g. poor or lack of a relationship), 4) need to focus on other children, 5) interferes with future opportunity (e.g. work or education related), 6) not emotionally or mentally prepared, 7) health related reasons (e.g. concerns for her own health or the health of the fetus) 8) want a better life for the baby than she could provide, 9) not independent or mature enough for a baby, 10) influences from family or friends, 11) don't want a baby or place a baby for adoption. It is clear that many of these rationales are not medical in nature.

Furthermore, Kumar in an empirical study on 21 women in the London area who had undergone an abortion, highlighted factors like 'inability to care for a child (for financial reasons or because they felt too young to provide a stable environment), commitment to finishing their education, or lack of family and partner support'.[39] This approach is also supported by a 2011-Australian empirical research study on women's abortion experience which found that many women perceive abortion as a possible difficult 'solution' to a 'problem'. According to this study the nature of the problem lies in the pregnancy itself and in the challenges arising from it. The challenges that women can experience are, according to this study, 'related to themselves [women], the potential child, existing children, their sexual partners and other significant relationships, and economic constraints'.[40] These studies indicate that an unwanted pregnancy usually has a highly personal component, because, for example, it happens at the wrong time or in the wrong circumstances, like the absence of a stable relationship, that affects women's willingness to take responsibility for a child.

It is hence well-possible that some of the questions that women can face specifically in the first medical encounter are also not strictly medical and can be future-related: do I want to be a parent? Or do I want to be a parent of 'this child'? For some women, what is at stake when it comes to an unplanned pregnancy is crucially the long-term responsibility connected to the raising of a child in general, or to a 'specific' child when it comes to a child carrying the risk of disabilities. Abortion is in this scenario perceived to be a potential solution to a parenting problem. An alternative set of questions are: can I be a parent? can I be a parent for this child? If the former questions

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of consenting for medical termination of pregnancy: prospective and longitudinal study in Paris' (2018), *BMC Medical Ethics*, vol. 19(33), 1.

[39] U Kumar, 'Decision-making and referral prior to abortion: a qualitative study of women's experiences' (2004), *Journal of Family Planning and Reproductive Health Care*, vol.30 (1), 51, 52.

[40] M Kirkman, H Rowe, A Hardiman, D Rosenthal, 'Abortion is a difficult solution to a problem: a discursive analysis of interviews with women considering undergoing abortion in Australia' (2011), *Women's Studies International Forum,* vol. 34, 121, 124.

rest merely on the willingness or not to embrace the long-term responsibility connected to childbirth, for which abortion appears to be, as the 2011-study was suggesting a 'solution', this alternative set of questions puts more emphasis on the 'capability' of parenting in general or parenting a child with a disability. The 'parenting questions' might involve, to only list some, lack of financial resources, wrong timing because of age or existence of other children, but also lack of information and/or stereotypies concerning the raising of a child with a disability.

On a closer analysis, these questions, that can be broadly phrased as 'social questions', are strictly interconnected with the medical ones. The questions of 'parenting' are closely related to, for instance, an analysis of the nature and the impact that an abortion can have on the health and well-being of women and also considering possible alternatives to it. It is therefore possible that some women might ask themselves whether they are willing or not to take the responsibility connected with an abortion and whether there are any possible alternatives that they can brainstorm. In this sense, the broader social relevance of these questions, does not exclude clinical involvement, yet it requires, as it will be claimed below, that the encounter is adapted to take account of the breadth of the issues at stake.

Furthermore, for some women, abortion will not be a 'neutral' or 'morally-free' option. They might consider that abortion would have moral implications since it terminates fetal life. For them abortion may not be an 'easy' option and when presenting for the first medical encounter, they will require space, time and support to negotiate a challenging situation. They might need to further consider alternative opportunities that can fit not only their unplanned pregnancy circumstances, but also their moral view point.[41]

The difficulties in answering these questions, which merge medical, social and moral aspects, are often exacerbated by further broader circumstances. Take for example the lack of a stable relationship and hence of a partner support, which 2019 Abortion statistics in England and Wales[42] have clearly reported to be a common-trait for most

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[41] A 2019 empirical study led by L Hoggart [L Hoggart, 'Moral dilemmas and abortion decision-making: lessons learnt from abortion research in England and Wales (2019), *Global Public Health*, vol.14(1), 1] on young women and their moral dilemmas concerning the abortion decision-making in England and Wales, highlighted the complexity of the decision-making process, where moral and personal (autonomy-related) components are often intertwined. Individual and moral understanding together with considerations of personal autonomy are hence closely interconnected. In Hoggart's perspective this leads to moral relativism. This thesis is drawing upon this work only to show the various factor influencing the decision-making process that inevitably affect the content and modality of the first medical encounter.

[42]2019 England and Wales abortion statistics show that '81% of abortions in 2019 were for women whose marital status was given as single, a proportion that has remained roughly constant for the last 10 years. 52% were to women who were single with partner'. DHSC, 'Abortion statistics, England and Wales: 2019', (June 2020), online available at:

women seeking an abortion, or the existence of abusive/ instable-relationship with their partners. These are some of the circumstances that can negatively impact on women's decision-making and contribute to the feeling of lack of support and abandonment.[43]

Given the interconnection between the medical, social and moral components, the temptation might be to consider the involvement of medical professionals as irrelevant or limited in this context. In other words, if women's needs are to be taken seriously, it might be argued that medical professionals are not best placed to address social questions and issues that women might have through an information disclosure process. Critics of the medicalised approach proposed in this thesis might hence argue that abortion is best expressed and is empirically experienced as a private matter[44] whereby women reach a decision before an encounter with medical professional through discussion with those 'who are emotionally close to them'.[45] This issue will be addressed in Chapter 2, where the push towards reduction of medical involvement will be unpacked. It represents a tension that cannot be easily solved, yet forms of revised medicalisation will be suggested as a possible way forward.

As will be developed in Chapters 3 and 4, the response in this thesis is that there are unacceptable risks to considering abortion as a purely private matter. Firstly, there is the risk that this understanding would lead towards delays in accessing support[46] where it is needed. Secondly, it can also undermine the positive advisory role that medical professional can play, which I will argue is especially relevant to the first medical encounter. The role of medical professional, as will be clarified through the thesis, is not

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf , (accessed 21st October 2020) 7-8.

[43] It should be clarified that the possible negative impact on women's wellbeing of poor relationship and social support in general is not associated only with pregnancies ending in abortions, but also in those ending in childbirth. See on this point a 2017 research study: K Barton, M Redshaw, MA Quigley, C Carson, 'Unplanned pregnancy and subsequent psychological distress in partnered women: a cross-sectional study of the role of relationship quality and wider social support' (2017), *BMC Pregnancy Childbirth,* vol. 17(1), 44. This study suggests more broadly that both during and after the pregnancy, whether it result or not in an abortion, the existence of forms of support is vital.

[44] See on this point: E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283, 295; P Baraitser, S Morton, H Massil, 'Decision-making and referral prior to abortion: a qualitative study of women's experiences' (2004), *Journal of Family Planning and Reproductive Health Care*, vol. 1, 5.

[45] E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283, 290.

[46] Lee and Ingham have conducted a research study that explores the reasons for late term abortions (E Lee, R Ingham, 'Why do women present late for induced abortion' (2010), *Best practice & research clinical obstetrics and gynaecology*, vol.24, 479). They claim that 'delays' might be due also to personal concerns that women might have about abortion. This study suggests, amongst others, that: 'All women of reproductive age should be made aware they do not have to have reached a definite decision to discuss the possibility of abortion with a provider', Lee, Ingham, *above*, 487. This ultimately shows possible drawbacks of framing the decision-making process as entirely private since it can negatively impact also on the time of gestation and possible delays in reaching out for advice.

to scrutinize women's reasoning or to reach a 'shared' in the sense of a mutually agreed decision between them, but to offer the opportunity of professional support based on its risks and benefits, and possible alternatives (e.g. childbirth, adoption, fetal surgery).

This project hence provides a different approach. It acknowledges the broadness of the factors influencing the decision-making process, however it does not consider the reduction of medical involvement as the way forward. It highlights that clinical questions inevitably are interconnected with wider factors, but this should not be a reason to reduce their involvement, but to recalibrate better ways in which the parties can dialogue with one another. It hence focuses on the positive role that medical professional can and should play with the provision of informative support during the first medical encounter. In this vein, the first medical encounter is understood to be of key relevance because it can both ensure that scientifically accurate and relevant information is shared, while also opening up to wider forms of support, when needed (e.g. counselling services).[47]

The 'how-approach' can hence contribute to the creation of what Coast et al., when providing a broad framework for the abortion context, phrased as a 'knowledge environment'[48] where the availability of good quality information can positively operate also through the support of medical professional. This can lead to different outcomes in different circumstances. For instance, with those who already had made a decision, this might further substantiate their standpoints, for those who instead experience decisional vulnerabilities (e.g. lack of support, lack of awareness, feeling of being 'without a choice', sense of isolation-loneliness[49]) it can offer the opportunity of reflection and advice during the decision-making process.

Additionally, this approach will not exclude, yet it will encourage, any further form of non-medical support (e.g. counselling services). The latter, however, will not constitute the focus of this work.

Ultimately, the decision-making process as unfolding in the first medical

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[47] It should be clarified that this does not overlook the possibility of violent relationships between doctor and patients, yet is seeks to minimise these circumstances offering a revised approach.

[48] E Coast, A H Norris, A M Moore, E Freeman, 'Trajectories of women's abortion-related care: a conceptual framework' (2018), *Social Science & Medicine*, vol.200, 199, 206. It should be also clarified that knowledge is here framed not only as an understanding of the law on abortion in general its policies and services, [see on this point J Erdman, 'The global abortion policies database: knowledge as a health intervention' (2017), *BMJ*, vol 8, 1] but, as Chapters 5 and 6 will clarify, also on connected risks and possible alternatives.

[49] See for instance a Norwich-study on women who are ambivalent on abortion and their experience of a sense of loneliness: M Kjelsvik, R J Tveit Sekse, A Litleré Moi, E M Aasen,C A Chesla & E Gjengedal, 'Women's experiences when unsure about whether or not to have an abortion in the first trimester' (2018), *Health Care for Women International*, vol.39(7), 784, 793.

encounter is a key moment. Here the relevance of forms of support can find a timely space: since the earliest stages women will be offered the opportunity to have a space for reflection and support in a medical context. This is also because the 'how-approach' will claim that the ability to reach a personal decision stands not merely in the availability of a decision-making role or into an analysis of the content of the medical intervention in question and of its possible risks/benefits/alternatives, but crucially also in the weight given to what 'lays in between' that is to say the decision-making process here framed in a clinical context. The existence of a multifaceted nature of the decision-making process crucially does not call for a reduced medicalisation, but for a *revised* medicalisation.

6.2.4 The 'how-approach': further broader justifications

A key advantage purported by the application of the 'how-approach' to the context of abortion is the desire to put women and their interests at the heart of the medical encounter. Through its focus on the decision-making process and the relevance of partnership, this project aims to foster opportunities of giving voice to women, their unplanned pregnancies, and hence the existence of a growing fetus, while also offering the opportunity of external forms of medical support. Women are therefore valued not as 'empty-decision makers', but instead are offered the opportunity of support in the context of their decision-making process.

A focus on the decision-making process has also the potential to operate as an additional aspect that can account for women's interest understood in a broader relational sense. As it will be shown in the upcoming Chapters, the issue of the decision-making process has often been neglected by mainstream political and legal approaches. This alternative approach has conversely the benefit to foster an understanding of women which includes in the reflection any competing interests that might be affected directly or indirectly by their decision, for example existing children, partners, the father and the fetus. This does not mean delving into the discussion of whether legal status should be granted to fathers or the fetus, or that they have a right to be considered. Conversely, this means that this approach is further ethically justified and justifiable in light of the broader impact that the choice can have on the affected parties.

The 'how-approach' offers the opportunity of a space for an evaluative exercise facilitated by medical professionals as part of the decision-making process around abortion. It values women's interests understood in a wide sense, giving voice to the broader circumstances that might both impact and be impacted by their decisions.

7. The 'how-approach' and the contribution to knowledge

The need for a change including a clearer 'how-approach' in the context of the first medical encounter is novel and constitutes an original contribution to the academic debate in this field. The novelty of the approach proposed claims that legal developments in other areas of healthcare law supporting informed choice, as expressed in the Supreme Court judgment *Montgomery v Lanarkshire Health Board*[50], are not sufficiently reflected in abortion laws and professional guidelines.[51] This judgment has enshrined the right of every patient to IC establishing that every decision concerning a medical intervention should be the result of a patient-tailored process of information disclosure. In other words, this judgment has highlighted the key relevance of what I will claim to be the 'how-approach' in the medical arena. Aspects of this novel argument were published in 2020 in *Medical Law International*.[52]

Drawing upon recent legal developments in the field of IC, giving weight to principles of partnership and autonomy, this thesis will argue that legal developments promoting patient's autonomy are relevant to the context of abortion and have so far been neglected. A change of approach is recommended.[53] It is argued that only through an accurate, truthful and flexible information process in partnership with clinicians, women can be safeguarded in the exercise of their authentically autonomous choices.[54]

There is therefore a need to move towards a more comprehensive approach that accounts both for the patients' decision-making role and the content of the choice, through weight given to a fruitful partnership with medical professionals during the first medical encounter. This approach lays down an 'ought to be' perspective, namely what ought to be done in the given research context, while recognising that political obstacles might well arise rendering it more aspirational than a practical solution.

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[50] [2015] UKSC 11

[51] See Chapter 2 sections 3-5.

[52] E Cave, C Milo, 'Informing Patients: the Bolam Legacy' (2020), *Medical Law International*, 0, 1.

[53] For a critical approach on this point see for instance: S Lee, 'Abortion in Northern Ireland: the twilight zone', in: A Furedi, *The Abortion Law in Northern Ireland*, (Family Planning Association, 1995) 25-26, 37; C F Stychin, 'Body talk: rethinking autonomy, commodification and the embodied legal self', in: S Sheldon, M Thomson, *Feminist Perspectives on Health Care Law* (Cavendish Publishing Limited, London: 1998) 223-227.

[54] For a further reflection on autonomy see Chapter 4.

8. Conclusion

Chapter 1 constitutes the Introduction of this work. It has highlighted the approach, structure and contribution to knowledge. This research project acknowledges the existence of multifaceted components in making a decision about abortion and aims to focus and work specifically on the positive contribution RMPs can make starting from the first encounter with relevant women.

Through a 7-Chapter structure, this thesis will show that the how-question has been given insufficient weight (Chapters 2-4) and that policy makers and law makers should devote more attention to a proposed 'how-approach' (Chapters 5-7) if positive principles of partnership and authentic autonomy want to be safeguarded. Chapter 2, to which we now turn, clarifies how principles of partnership and autonomy, as derived and adapted from the IC-case law, can shape the abortion debate. In particular, it claims that greater focus is needed on how the decision-making process unfolds in the context of abortion, and how medical professionals can provide valuable support.

Part 1

Part 1 of this thesis, containing Chapter 2, addressees the first research question, namely, how far is the approach taken in relation to the common law in England and Wales on informed consent (IC) mirrored in abortion law and professional guidelines? Chapter 2, will explore the *status quo* concerning abortion and the safeguarding of the decision-making process as it unfolds during the first medical encounter between women and a registered-medical practitioner (RMP). It will show that limited weight is devoted to the decision-making process in the context of the Abortion Act 1967 (AA), tort law and professional guidelines. Part 2, comprising Chapters 3 and 4, will then build upon these considerations to extrapolate and adapt relevant principles from the Supreme Court judgment in *Montgomery*. In light of these principles, the current state of art will be deemed problematic and considerations for revisions explored in Part 3 (Chapters 5 and 6).

Chapter 2

Abortion decision-making in England and Wales

What is the current political, doctrinal and normative approach concerning informed consent and abortion in England and Wales?

1. Introduction

This Chapter argues that the current abortion framework gives insufficient weight to the decision-making process, or the 'how-question', as I phrase it: the common law position on informed consent (IC) in England and Wales is not mirrored sufficiently in abortion law and professional guidelines. It claims that the political, doctrinal and normative legal dimension have neglected a focus on the decision-making process (the 'how-question'). This will form the baseline for the proposition of a novel theoretical framework (Chapters 3 and 4), which I have phrased as a 'how-approach', and an analysis of considerations for revisions (Chapter 5 and 6) which embrace the proposed theoretical framework.

2. The neglected 'how-question' in the political abortion debate

The abortion debate in England and Wales has been characterised by a polarised nature which, I shall argue, has neglected the question of how women are supported in making abortion decision. The polarised nature of the debate can be understood through an analysis of the questions that abortion campaigners and opponents have traditionally tried to answer. The former, abortion campaigners, have focused on a 'who-question', namely a focus on the decision-maker; the latter, abortion opponents, have focused on a 'what-question', namely a focus on the fetus. In this polarised scenario, the 'how-question' that is to say a focus on the decision-making process, I shall claim, has been neglected.

Ultimately, it is not the intention here to take a position on the political debate on abortion, but rather to demonstrate that the polarised nature of the debate in England and Wales has led to the neglect the question of how women are supported in making abortion decisions. Though oversimplified, this reflection sets out the main thrust of abortion debates to serve as a starting point for an argument for a change in approach that incorporates the decision-making process and the relevance of what in the next Chapters will be heralded important principles of partnership and authentic autonomy.

Whilst this change of approach will not attempt to solve the much-contested issue of the legal status of the fetus or the existence or not of a right to abortion[55], it will establish the importance of an additional and neglected perspective that will be shown to be important, whatever the political perspective on abortion.

2.1 Deficiencies in an exclusively 'who-question'[56]

Abortion campaigners (sometimes referred to in political circles as 'pro-choice' advocates) have traditionally focused on women as '*the*' decision-maker and hence focussed predominantly on the question of 'who makes this choice'. It will be argued in this section that emphasis on the right of women to decide has led to a neglect of the support she might need in making the decision. I label this the 'who question approach' since its focus on who decides, emphasising women's unfettered right to choose, whilst limiting relevance for acknowledgement of potential vulnerability and the positive contribution of medical support in the decision-making process.

In a who-question, a key role is attributed to women's decision-making capabilities. This concept is mostly understood here as an expression of women's rights to self-determination.[57] Women should hence be offered the chance to 'self-determine' their own course of treatment, in this case to make a decision concerning an abortion. A who-question hence values the right of every woman to 'choose' as an 'end in itself'. It echoes the will-theory of rights[58] which holds that law should give expression to human will and gives rights-holders the choice of whether to insist on their rights or waive

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[55] Chapter 5, will go back to this point claiming that the proposed 'how-approach' does not frame IC as coupled with the existence of a right to abortion and a process of de-criminalisation, see section 2.1.

[56] See for a doctrinal account of what I have phrased here as the 'who-question': J Thomson, 'A defense of Abortion' (1971), *Philosophy and Public Affairs*, vol. 1(1), 47; A Furedi, *The moral case for abortion*, (London, Palgrave Macmillan, 2016) 121-142; S Sheldon, *Beyond Control: Medical Power, Women and Abortion Law* (London: Pluto Press,1997) 49-74; M Tooley , 'In defense of abortion and infanticide', in: J Feinberg, *The problem of abortion* (Belmont, Wadsworth Publishing Company: 2nd ed, 1984) 120-134; J F Reiman , 'Asymmetric value and abortion, with a reply to Don Marquis, in: RM Baird, ER Stuart, *The ethics of abortion* (New York: Prometheus Books, 3rd edition, 2001) 328-342. This approach can also echo what Coggon and Miola phrased as a libertarian view of healthcare law in the context of decision-making. See on this point: J Coggon, J Miola, 'Autonomy, liberty and medical decision-making' (2011), *Cambridge Law Journal*, vol.70(3),523-547.

[57] See on this point: A Maclean, *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 11-22; R Young, 'Autonomy and the Inner self', in: J Christman, *The inner citadel*, (New York: Oxford University Press, 2nd ed, 2014) 77-88. This understanding echoes also what Coggon understood to be a 'current desire autonomy', see on this point: J Coggon, 'Varied and Principled Understandings of Autonomy in English law: Justifiable Inconsistency or Blinkered Moralism?' (2007), *Health Care Anal*, vol.15(3),235-255. For a further analysis of autonomy see Chapter 4.

[58] For an overview on this point: H L A Hart, 'Are there any natural rights?' (1955), *Philosophical review*, vol.64 (2), 175. This is distinguished from an interest theory approach which places a major weight on the interests behind the protection of any claim-right. This can reflect what has been also phrased as difference between right-theory approaches and duty-based approaches, although these labels are also interpreted with some degree of flexibility. See also: S Pattinson, *Medical Law and Ethics* (London: Sweet & Maxwell, 6th ed, 2020) 7-10.

them. This theorisation of autonomy unpacks the value behind an understanding of autonomy as self-determination and supports the need to give an intrinsic value[59], to women's individual agency and hence their decision-making role in the abortion context. Autonomy in this context is, therefore, a 'status'.[60] It is valued in itself as a decision-making role, without necessarily due focus on the decision-making process and how the choice is reached.

Pro-choice advocate, Furedi argued that: 'the point is that life is full of decisions and it is who makes them that matters'.[61] The claim is that, because abortion is 'one of the choices' that many women face in their daily lives, it should be fully protected. In this vein, the legalisation of abortion[62] is perceived to be a reply to women's request to be in control over their reproductive choices.[63] Ultimately, women's choice to have an abortion has been considered by abortion advocates to be private[64] and personal. In this sense, in line with an interpretation of Article 8 of the European Convention on Human Rights (ECHR) and the Human Rights Act 1998, a reproductive choice of legally capable women to have or not an abortion, is understood as an expression of women's own perspective, needs, circumstances, and values, and thus of their right to privacy and respect for their personal life.[65]

This approach can be summed up with the idea that abortion is a choice for the women alone to make. A choice matters *per se* and considerations beyond it are largely perceived as undue limitations placed upon women's decision-making role. The choice to have or not have an abortion, according to this line of reasoning, is private and belongs to women alone. In this vein, abortion should always be legitimate and legal,

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[59] See: A Maclean, *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 23-29.

[60] C Mackenzie, 'Feminist innovation in philosophy: Relational autonomy and social justice' (2019), *Women's studies international forum*, vol.72, 144.

[61] A Furedi, *The moral case for abortion*, (London: Palgrave MacMillan, 2016) 141.

[62] See for an analysis of the legalisation of Abortion in England and Wales and the path from legalisation to 2019: S Sheldon 'The Abortion Act (1967): a biography' (2019), *Legal Studies,* vol. 39, 18.

[63] See also on the point of reproductive autonomy: G Dworkin, *Life's Dominion* (London: Harper Collins, 1993) 148; J Harris, 'Rights and reproductive choice', in: J Harris, S Holm, *The future of Human reproduction* (Oxford: Clarendon Press,1998) 34-37; M Simms, 'Abortion: the Myth of the Golden Age', in: B Hutter and G Williams, *Controlling Women: the Normal and the Deviant*, (London: Croom Helm, 1981) 183.

[64] See on this point: O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press,2009) 53-57; D S Warren, and L D Brandeis, 'The Right to Privacy' (1890), *Harvard Law Review*, vol. IV, 193; E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283-304.

[65] See for instance on this point: E Jackson, *Regulating reproduction*, (Oxford and Portland: Hart Publishing, 2001), 71-111; V Greenwood and J Young, *Abortion in Demand* (London: Pluto press,1976) 127-140; E Lee, *Abortion law and politics today* (London: Macmillan LTD, 1998) 76-94.

with no need to place any weight on women's reasons and circumstances[66] or subject her to clinical involvement.

However, an exploration of the who-question, as the aspiring principle for the legalisation of abortion, shows the existence of a stance that risks being overly narrow and potentially internally inconsistent. Pro-choice advocates focus on an understanding of autonomy that emphasizes the value of women's decision-making role[67], but the risk of this approach is to reduce emphasis on how the decision is made. If the fetus is understood as lacking a legal status and women have an unfettered right to abortion, this can limit the potential to accommodate support in the decision-making process. Abortion becomes a question of women's right alone which can render any evaluative exercise, which includes an interest-oriented discourse, as an undue limitation of what is perceived as an absolute right. This flows from the view that rights are connected to agency and fetuses are not agents. Both the relevance of clinicians' advisory role in the decision-making process and possible decisional vulnerabilities of women risk being undermined.

2.2 Deficiencies in an exclusively what-question

The political pro-life movement[68] opposes the legalisation of abortion which it frames as a medical intervention that terminates the life of a human being (i.e., fetus).[69] From this perspective, the focus is on the question of 'what is an abortion?'. The lack of a focus on women's decision-making authority results from the weight given to the protection of unborn life.[70]

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[66] A Furedi, *The moral case for abortion*, (London: Palgrave MacMillan Press ltd, 2016) 141.

[67] This focus on women's agency implies that a fetus has no legal status. See on this point: M A Warren, 'On the moral and legal status of abortion' (1973), *Monist*, vol.57, 43-61.

[68] See for instance: J Finnis, 'The rights and wrongs of Abortion: A reply to Judith Thomson' (1973), *Philosophy & Public Affairs*, vol.2 (2), 117-145; H J Gensler, 'An appeal for consistency', in: R M Baird, E R Stuart, *The ethics of abortion* (Prometheus Books, New York, 3rd edition, 2001) 280-294; D Marquis, 'Why abortion is immoral', in: R M Baird, E R Stuart, *The ethics of abortion* (Prometheus Books, New York, 3rd edition, 2001) 309-327; J Keown, *The Law and the ethics of Medicine: Essays on the inviolability of Human Life*, (Oxford University Press, 2012) 3-22, 88-107.

[69] M L Condic, 'When does human life begins' (2008), *Westchester Institute White Paper Series*, vol.1(1), online available at: https://bdfund.org/wp-content/uploads/2016/05/wi_whitepaper_life_print.pdf (accessed 21st October 2020); M L Condic, 'Life: Defining the Beginning by the End' (2003), *First Things,* vol. 133, 50-54.

[70] See for instance: J Finnis, 'The rights and wrongs of Abortion: A reply to Judith Thomson' (1973), *Philosophy & Public Affairs,* vol.2 (2), 117-145; D Marquis, 'Why abortion is immoral' (1989), *The Journal of Philosophy*, 86(4), 183-202; J Keown, 'The Law and the ethics of Medicine: Essays on the inviolability of Human Life' (Oxford: Oxford University Press, 2012) 3-231; H J Gensler, 'An appeal for consistency', in: R M Baird R M, E R Stuart, *The ethics of abortion* (Prometheus Books, New York, 3rd edition, 2001) 280-294; C Kaczor, *The ethics of abortion : women's rights, human life, and the question of justice* (Abingdon:

Abortion in this sense is perceived as morally impermissible.[71] The mother and the child are two different human beings, yet bound in a relationship of interdependence. The existence of a tie between women and unborn children is generally considered to be the ground for the existence of a moral duty of care[72] owed by the mother towards an unborn child. The moral impermissibility of an abortion hence comes from a recognition that the mother's act can deliberatively affect the life of the fetus. Given that life, in a scientific sense, begins at the moment of conception[73], every act that interferes with it is not only immoral, but should, from the pro-life perspective, also be illegal.

This approach can be summed up in the following circular statement 'a life is always life'.[74] Life matters in itself since the moment of its beginning, namely conception, and every act that interferes with it is neither morally nor legally acceptable. It follows that, in this account, fetuses are given a full moral and legal status from the moment of conception.[75]

Routledge, 2015) 13-210; C Foster, 'Does the English Law on Abortion Affront Human Dignity?' (2016), *The New Bioethics*, vol. 22 (3), 162-184.

[71] J Finnis, 'The rights and wrongs of Abortion: A reply to Judith Thomson' (1973), *Philosophy & Public Affairs,* vol.2 (2), 144-145; M A Warren, 'On the Moral and Legal Status of Abortion', in: L Gruen, G E Panichas, (Ed.) *Sex, Morality and the law* (New York: Routledge,1997) 302. See also on this point: J Keown*, The Law and ethics of medicine: essays on the inviolability of human life* (Oxford: Oxford University Press, 2012)109-234; G Bradley, 'Life's Dominion: a review essay' (1993), *Notre Dame Law Review*, vol. 69, 329; J W Dellapenna*, Dispelling the Myths of Abortion History,* (Carolina Academic press, 2006) 1005-1007; G Williams, *The sanctity of life and the criminal law* (London: Faber & Faber, 1958) 139-176.

[72]For a critical analysis on this point: R Scott, 'Maternal duties toward the unborn? Soundings from the law of tort' (2000), *Medical Law Review*, vol.8, 1.

[73] M L Condic, 'When does human life begins' (2008), *Westchester Institute White Paper Series*, vol.1(1), online available at: https://bdfund.org/wp-content/uploads/2016/05/wi_whitepaper_life_print.pdf (accessed 21st October 2020); M L Condic, 'Life: Defining the Beginning by the End' (2003), *First Things,* vol. 133, 50-54.

[74] For a critical perspective of this point and the concept of 'personhood' see: W B Bondeson, J R Englehardt, S F Spicker, D H Winship, *Abortion and the Status of the Fetus* (Dordrecht: Reidel D, 1983)107-226.

[75] The attribution of a full moral and legal status to a fetus is conventionally assigned by pro-lifers at the moment of conception (see on this point, for instance, J Finnis 'The rights and wrongs of abortion' (1973), *Philosophy and Public Affairs,* vol.2(2), 117. Other viewpoints assign full-status at different stages:

1. After 14-days, a fetus becomes a 'person' when the primitive streak appears (see for instance, J McMahan, *The Ethics of Killing* (Oxford: Oxford University Press, 2002) 267-278.
2. At quickening, a fetus becomes a person when the mother can feel the fetus moving inside her (see for instance R Gillon, 'Is there 'a new ethics of abortion'?' (2001), *Journal of Medical Ethics,* vol.27(2), 885.
3. At viability, when the fetus is capable of existing independently of the mother (see for instance, D Jensen, 'Birth, meaningful viability and abortion' (2015), *Journal of Medical Ethics*, vol.41(6), 460; S Lee, H Ralston, E Drey, et al 'Fetal pain' (2005), *Journal of the American Medical Association,* vol. 294, 947.
4. At sentience, when the fetus develops sentience or is capable of sensation or desires (see for instance B Steinbock, *Life Before Birth* (Oxford: Oxford University Press, 1992) 36-42.
5. At birth, when the fetus becomes an entirely separate entity from the mother (see on this point, A Burin, 'Beyond pragmatism: Defending the 'bright line' of birth' (2014), *Medical Law Review,* vol. 22, 494.

Crucially, like the pro-choice approach, the pro-life approach can also risk neglecting a focus on the decision-making process, and hence the how-question. If abortion is immoral, any focus on the process and on an understanding of the impact and responsibilities connected with this choice can become irrelevant.

2.3 Going beyond the who-approach and what-approach

It has been argued that the who-question and the what-question have a tendency to neglect the question of how the decision is made. This is not to deny that the focus on decision-making could not be better accommodated as part of the legal and political debate. On the contrary: it will be argued that this can and should be achieved. Nor does it argue that there have not been attempts to improve the situation.

There have been political attempts to amend the AA which were focused also on improving, at least indirectly, the consent process. Two illustrative examples are given. The first example focuses on attempts to amend the AA in its provision of abortion for substantial risk of a serious fetal abnormality without time limit.[76] This political debate has given voice to the desire to better equip prospective parents with relevant information before a decision about abortion, following a diagnosis/or prognosis of a serious fetal abnormality. This is evident in the Abortion (Disability Equality) Bill (2016-2017) proposal[77]of full and accurate information disclosure concerning all available options, including bringing the fetus to term, and the availability of family support groups.[78] A further example is the Health and Social Care Bill (2010) (HSC). It proposed

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6. Until some time after birth, someone in this view is not a person until they are a rational and self-conscious being (see on this point P Singer, *Writings on an ethical life* (New York: Ecco Press, 2000) 165-185.

[76] s.1(1)(d). An abortion on the grounds of disabilities can also be theoretically framed under the broad formulation of s.1(1)(a).

[77] The Abortion and Disability Bill 2016-2017, was proposed by Lord Shinkwin. He pointed out that the current stance of the AA allowing abortion for fetal abnormality with no-time limit was discriminatory against people with disabilities. This debate has put forward the proposal of a reform of the AA whose aim as stated during the first-reading at the House of Lords, was 'to make provision for disability equality and for the provision of balanced information in respect of abortions'. See: Parliament UK, 'Abortion (Disability Equality) Bill (HL)', (11 July 2017), vol.783, first reading, online available at: https://hansard.parliament.uk/lords/2017-07-11/debates/852B3614-2DFA-4C74-B81E-D8F4C07AE637/Abortion(DisabilityEquality)Bill(HL) (accessed 21st October 2020). See also the full-text of the Bill at: Parliament UK, 'Abortion (Disability Equality) Bill (HL Bill 95)', online available at: https://publicationsectionparliament.uk/pa/bills/lbill/2016-2017/0095/lbill_2016-20170095_en_2.htm#l1g1 (accessed 21st October 2020)

[78] ' In section 1, after subsection (2) insert—

'(2A)Before a termination is proceeded with under section 1(1)(d)—

(a)the parents of that child must be given full and accurate

information regarding all options following a prenatal

that women accessing abortion should be offered an independent counselling session.[79] This counselling session would be provided by organisations other than abortion private clinics which were claimed to have a vested financial interest in the pursuit of abortion. The HSC Bill proposal was claimed to be a tool to further enhance the decision-making process in the abortion context, because it offered women the support they needed should they wish not to opt for an abortion. Both the Disability Equality Bill and the HSC Bill proposals showed consideration of the how-question: the Disability Equality Bill with its emphasis placed on a more thorough information sharing, and the HSC Bill proposal with its focus on the provision of support outside and beyond abortion private clinics.

Although these political proposals gave weight to the decision-making process, they are not free from challenges, and evidently have not been successfully transcribed into law. Clearly, informed consent was not the core aim. In the case of the Disability Equality Bill, the core aim was to tackle the potential discrimination against fetuses carrying a risk of a substantial abnormality. The aim to enhance informed consent, was only secondary. The HSC Bill looked more closely at information provision but only through the perspective of counselling services. In this context, there was no broader reflection on informed consent within a clinical setting, and hence the relevance of the medical encounter for the safeguard of the decision-making process. Both these political proposals ultimately rested either on a specific ambit (i.e. serious fetal abnormality) or on a specific form of support (i.e. counselling services). It is therefore contented that these Bills failed to recognise the broader relevance of the first medical encounter with an RMP for the decision-making process.

2.4 Conclusion

This simplified overview of the political debate has highlighted that the polarised and politicalised nature of the debate about who can make decisions and whether the act involves ending the life of a person has resulted in the squeezing out of a consideration

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diagnosis of disability, including the keeping of that child, and

(b)this information must include information from disability

family support groups and organisations led and controlled by

disabled persons' Parliament UK, 'Abortion (Disability Equality) Bill (HL Bill 95)', online available at: https://publicationsectionparliament.uk/pa/bills/lbill/2016-2017/0095/lbill_2016-20170095_en_2.htm#l1g1 (accessed 21st October 2020).

[79] For a critical analysis on this point see: S Halliday, 'Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life' (2016), *Contemporary issues in law*, vol.13(4), 287, 288.

about the decision-making process itself. This is problematic if it entails that IC is neglected in this context. An additional important consideration is that if the political questions surrounding abortion rest exclusively on an opposition between, on one hand, the decision-maker (the who question), and on the other the act (the what question), then this results in a stark, and often irreconcilable, opposition. A focus on the neglected issue of the decision-making process can reduce the polarised nature of the debate.

3. The neglected how-question in the Abortion Act 1967

Building on the above overview concerning the lack of a due weight given to the decision-making process in aspects of the political debate, this section highlights ways in which this phenomenon is reflected at a doctrinal level. Two sources of law will be considered: the primary legislation that governs abortion – in particular the Abortion Act 1967 (AA) – and the common law on IC. The section will go on to consider professional guidelines, which are a form of 'soft' law, in that they fill in gaps in the law in accordance with legal principles. It is contended that cumulatively, these measures go some way toward addressing issues of decision-making process[80], but that they leave significant gaps that need to be addressed.

3.1 The AA: a gradualist approach

The AA endorses a gradualist perspective. This position[81] acknowledges women's agency, yet limits it in light of the progressive relevance to be attributed to the interests of the fetus. Abortion is, in this perspective, not solely a question of women's right to self-determination, but also accommodates the gradually growing relevance of the interests of the fetus. The most common approach, is to ascribe the fetus proportional status:[82] the moral status of the fetus progressively increases with gestational development.

In Britain, as Pattinson points out:

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[80] On the difference between valid consent and IC, see Chapter 1 section 6.2.1. and below on tort law approaches section 4.

[81] For an account of the gradualist view see: W Quinn, 'Abortion: identity and loss' (1984), *Philosophy and Public Affairs,* vol.13(1), 24; J Feinberg, *Freedom and Fulfilment* (Princeton: Princeton University Press, 1994) 37-75; K Greasley, *Arguments about abortion* (Oxford: Oxford University Press, 2017)147.

[82] S Pattinson, *Medical Law and Ethics* (London: Sweet & Maxwell, 6th ed, 2020) 236-237.

> 'before implantation the fetus can be lawfully destroyed without relying upon any of the grounds in the abortion legislation (and if created outside the body must be destroyed unless both gamete donors consent to its storage or use), the legal ground for abortion are more restrictive after 24-weeks and legal personality is only obtained at birth.'[83]

This approach attempts to accommodate both[84] the relevance attributed to women's rights and fetal interests. Yet, it recognizes that the former trumps the latter until a specific moment in time. Women's right to seek a legal abortion hence stops where the attribution of a legal status to the fetus is attributed, that is to say at birth.

Thus, it is clear that a gradualist approach is aimed at widening and balancing the interests of both women and fetuses. It is therefore pertinent to explore whether and how far this approach leads to a recognition of the relevance of the decision-making process (the how-question). In order to provide an answer to this question, the next section will start with an exploration of the legal context when AA was legalised to unpack possible historical reasons behind the current approach, to then move to an analysis of how the AA has been translated in medical practice.

3.2 The AA context of medicalisation

The AA does not make explicit the requirement to engage in a process of IC prior to choosing abortion. One possible explanation for this is that the Act was conceived in

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[83]S Pattinson, *Medical Law and Ethics* (London: Sweet & Maxwell, 6th ed, 2020) 239.

[84] The AA places some relevance to the role played by women's self-determination, although it might be claimed to be limited at least in its theoretical formulation. In particular, s. 1(1), places little weight to an understanding of autonomy as self-determination when it states: 1) the existence of legal defenses, which limit the time-frame and circumstances upon which an abortion can be legally carry out; 2) the medical control over the decision, which places the final authorisation for a legal abortion not on women but on RMPs. Some supporters of a will-theory approach consider the current approach of the AA unsatisfactory because it fails to grant women's right to be a self-determined agent. However, although formally leaving the final choice in RMPs' hands, the wideness of the defences listed in practice places little obstacle to women's self-determination. Some aspects of the theoretical formulation of the AA also reflects what Coggon has called 'ideal desire autonomy.' (See: J Coggon, 'Varied and Principled Understandings of Autonomy in English law: Justifiable Inconsistency or Blinkered Moralism?' (2007), *Health Care Anal*, vol.15(3),235). This approach gives key relevance not merely to what women may want, but to what a women *should want* in the abortion context. Hence from this perspective, women, as 'responsible-decision maker' consider the reasons for acting in accordance with objective standards of value as determined at the State level. In this sense, the AA can be considered to be an expression also of an ideal desire autonomy when it sets out the existence of legal defenses for an abortion to be legally carried out. This is perceived to be justified by the need to protect women's health and wellbeing interests together with a gradualist account of fetal interests. The AA hence places a crucial weight not on the right to an abortion per se, as it is in a pure will-theory approach, but balances it with a focus on the function that such right wants to protect, in this case women's well-being and fetal interests. This has to be contrasted with the 'law in practice' where a right to abortion can be claimed to exist. See on this point: E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283, 287. See also: E Lee, 'Tensions in the regulation of Abortion in Britain' (2003), *Journal of Law and Society*, vol.30(4), 532.

an era where great emphasis was placed on deference to the medical profession and on medical paternalism. In a leading negligence case from 1957, *Bolam v Friern Hospital Management Committee,*[85] the court held that a doctor was not negligent in failing to provide a patient undergoing electro convulsive therapy with relaxant drugs. Accordingly, in this context the clinician is considered to have a strong decision-making power with regard to medical interventions. This was made evident in the criteria for an evaluation of clinicians' standard of care. In *Bolam*, it was held that a clinician 'is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art[86]'(so called-*Bolam* test). This case demonstrates a level of deference to clinicians on matters of reasonableness in the law of negligence. However, its relevance extends far beyond negligence. Brazier and Miola have argued that a *Bolamisation*[87] of healthcare law occurred from the 1960s. There is evidence that the AA is caught up in that era of deference and paternalism insofar as it does not expressly facilitate a balancing exercise between the clinical contribution and patients' autonomy.

A related contextual issue flows from the historical role played by medical professionals at the time of the legalisation of abortion. The AA was influenced by feminist groups, but also by medical professionals,[88] who argued firstly that legislation needed to address the potential for abortions to be performed by unskilled personnel, thereby putting women at serious risk to their health and life. They called for a protection of professional autonomy with the aim of advancing standards of safety through their professional dominance in the field of reproductive medicine.[89] Secondly, they sought clearer legal dispositions to guide medical practice in this field and avoid risk of legal prosecution.[90] In other words, although medical professionals faced little risks of prosecution[91], they sought clarity and legal certainty to overcome any fear of prosecution in their daily practice.

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[85] [1957] 1 WLR 582.

[86] *Bolam* at [587].

[87] M Brazier, J Miola, 'Bye Bye Bolam: A medical litigation revolution?' (2000), *Medical Law Review*, vol.8, 85.

[88] J Keown, *Abortion, Doctors and the Law*, (Cambridge: Cambridge University Press, 1988) 22-23, 84-98; S McGuinness, M Thomson, 'Medicine and abortion law: complicating the reforming profession' (2015), *Medical Law Review*, vol. 23(2), 177.

[89] S Sheldon, *Beyond Control: Medical Power, Women and Abortion Law* (London: Pluto Press,1997) 17-18.

[90] See: S Sheldon, *Beyond Control: Medical Power, Women and Abortion Law* (London: Pluto Press,1997) 18, where Sheldon argues that despite the very little real risk of prosecution, medical professionals perceived legal protection as fragile and ambiguous. The High Court case of *R v Bourne* ALL ER [1938] 615, although clarified the position of the law, was perceived by many practitioners as ambiguous. Medical professionals particularly perceived to be difficult to determine whether the pregnancy was terminated in good faith and feared grave consequences. For these reasons many medical professionals were, according to Sheldon, reluctant to carry out abortions for fear of prosecution.

[91] S Sheldon, *Beyond Control: Medical Power, Women and Abortion Law* (London: Pluto Press,1997)18.

Ultimately, both the phenomenon of *Bolamisation* and the strong influence of medical professionals exercised at the time of the legalisation can be offered as possible explanations for medicalised stance of the AA. This, I would argue, contributed to a lack of due emphasis on decision-making process.

However, on a closer analysis, it is clear that, although the AA medicalises abortion by requiring the agreement of two RMPs acting in good faith,[92] this does not necessarily entail a paternalistic approach in practice. As we shall see in the next subsection, this approach still triggers certain decision-making related duties. Some scholars have argued that the AA is a strong example of medical deference, in so far as it places too much power into the medical professionals' hands.[93] It is contended here that it is not the involvement of medical professional *per se* that is problematic, not even the fact that the ultimate decision rests with them. Instead, the deferential approach that was adopted is the problem. In other words, whilst the AA did not compel a process-driven approach that facilitated autonomous decision making, it did not prevent it either. Medical deference was problematic, and remains so to some extent, but this flows not from medicalisation *per se* (that is to say, from the involvement of medical professional). Instead, medical deference flows from a paternalistic ethos that dominated that historical period. However, medicalisation can be reconciled, as it will be claimed, with a focus on the decision-making process.

3.3 Focus on decision-making process flowing from medicalisation of abortion

As referred to above, the very involvement of RMPs in the abortion process involves some level of focus on decision-making process. This subsection explores the nature of this involvement and sets out certain deficiencies. Though it is not made explicit in the Act that a consent process is required, consent is nonetheless a necessary corollary that flows from the fact that abortion is a medical intervention. This comes from the broader legal framework[94] which requires that no medical treatment is pursued without the consent of the patient. Furthermore, the Act refers to the requirement for

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[92] s. 1(1) (a) AA.

[93] See for instance on this point: J Erdman, framing the Abortion Act as a form of medicalisation which invest RMPs of a 'moral authority' in the context of abortion. J Erdman, 'Moral Authority in English and American Abortion Law', in: S H Williams, *Constituting Equality: Gender Equality and Comparative Constitutional Law,* (Cambridge: Cambridge University Press, 2009) 107,114,117. Contrast this with Mason, who argued that that this is only a *façade*, and that the law in practice is now more relaxed. See J K Mason, 'Voluntary and involuntary termination of pregnancy', in: J K Mason, *The Trouble Pregnancy, legal wrongs and rights in reproduction* (Cambridge: Cambridge University Press, 2009) 29-30.

[94] As it will be further clarified later section 4.1, this is also related with the avoidance of liability in battery.

medical professionals to act in good faith, which can be interpreted as to collaboration between the parties before a final decision is reached. However, it will be argued that, notwithstanding that the AA leaves the 'door-open' for a focus on the decision-making process, this is in many ways insufficient because the consent process is in practice[95] often replaced with simple assent.

The AA relies on the requirement of good faith.[96] It asks RMPs to certify in good faith that the requirements of the Act are met. Though it is not a statutory requirement for either of the two RMPs to have personally seen or examined a women, RMPs remain in charge of the procedure throughout.[97] RMPs need to sign 'notification forms', namely HSA1-HSA2-HSA4, so as to fulfil the requirement of the Abortion Regulations 1991.[98] It might be assumed that the good faith requirement imports a process-driven approach to the AA, but in fact, as I will claim through this section, it is of limited value in this regard.[99] Section 1(1) AA requires RMPs to consider whether the circumstances of the case fit with the legal defences listed in the Act. The current legal interpretation of the good faith requirement calls RMPs to form an *honest* opinion, that the statutory grounds are satisfied. BPAS in its 2013 briefing paper[100] clearly summarize the point:

'To show that an opinion has been formed 'in good faith' does not mean that authorising an abortion must be the 'right' course of action, simply that the doctor has not been dishonest or negligent in forming that opinion. What makes an abortion lawful is the doctor's opinion that there are lawful grounds for the procedure, rather than the fact that those grounds exist.' [101]

One implication of the current interpretation of the good faith requirement is therefore that it gives wide discretion to RMPs and constitutes an often easy-to-be-met threshold.

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[95] This thesis is not making empirical claims, but it is using reference to medical practices/malpractices as an additional point that strengthens the need for a change in approach.

[96] s. 1(1) AA.

[97] See on this point *R v (Christian Concern) v SSHSC* at [35-39] [2020] EWCA Civ 1329 making reference to the judgment in *Royal College of Nursing v Department of Health and Social Security* [1981] AC 800.

[98] SI 1991/499. See regulations 3-4. For an overview of the required forms and respective guidance see: DHSC, 'Abortion notification for England and Wales', (2013), online available at: https://www.gov.uk/government/publications/abortion-notification-forms-for-england-and-wales (accessed 21st October 2020).

[99] See S Pattinson, *Medical Law and Ethics* (London: Sweet & Maxwell, 6th ed, 2020) arguing that 'in view of the rarity of past prosecutions and, as we shall see, the ease with which a doctor can plausibly claim that the grounds for abortion are satisfied, prosecution is highly unlikely', 244.

[100] BPAS, 'Britain's abortion law, what is says and why', (2013), online available at: http://www.reproductivereview.org/images/uploads/Britains_abortion_law.pdf (accessed 21st October 2020).

[101] BPAS, 'Britain's abortion law, what is says and why', (2013), *above*, 6.

A further implication flows from the fact that any challenge to RMPs' good faith under the AA would be subject to the wide discretion of the jury.[102] In *R v Smith*[103] the court of Appeal held that: 'the question of good faith is an essentially one for the jury to determine on the totality of evidence'.[104] In this one-and-only case, a clinician was found to be acting in 'bad faith' because of the quality of the encounter itself which felt below the standards of a reasonable and genuine belief on the medical side. The clinician, amongst others, asked for money to speed up the abortion process, while also falsifying the notification form and without involving the second RMP. The good faith requirement, and hence also its future evolution, suffers the limitation of the wide discretionary power of the jury. The wide discretion also indicates, as Pattinson suggests[105], difficulty for women to hold RMPs liable for a failure to act in good faith.

Though the opportunities to hold RMPs to account in court for lack of good faith face practical limitations, medical malpractices challenging the application of this requirement have been evidenced by the DHSC in 2014[106] and the Care Quality Commission in 2016.[107] On examination of these challenges, it is clear that the good faith requirement is sometimes poorly upheld. The 2014 Guidance of the DHSC[108]noted that:

> 'Practices have come to light recently which call into question whether doctors have acted in accordance with their legal obligations under the Abortion Act. These practices include the signing of HSA1 forms [109] by doctors before a woman has been referred, and doctors signing forms relying solely on decisions made

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[102] *R v Smith* [1959] 2 QB 35, this is the only judgment on the issue of good faith post-Abortion Act 1967. It should be clarified that prior to the enactment of the AA two further cases of criminal liability under the Offence Against the Person Act s. 58 are recorded: *R v Bourne* 3 All ER [1938] 615, and *R v Newton and Stungo* Crim. L.R. [1958] 469.

[103] [1959] 2 QB 35.

[104] *R v Smith* at [381].

[105] S Pattinson, *Medical Law and Ethics* (London: Sweet and Maxwell, 6th edition, 2020) 244.

[106] DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), online available at: https://assetsectionpublishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/313459/20140509_-_Abortion_Guidance_Document.pdf (accessed 21st October 2020).

[107] CQC, 'The Care Quality Commission (CQC) has published the reports of its inspections of Marie Stopes International from earlier this year', 20th December 2016, available online at: https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-reports-marie-stopes-international (accessed 21st October 2020).

[108] DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), *above.*

[109] HSA1 forms are referred to as 'grounds for carrying out an abortion' forms. For an overview of the required forms and respective guidance see: DHSC, 'Abortion notification for England and Wales', online available at: https://www.gov.uk/government/publications/abortion-notification-forms-for-england-and-wales (accessed 21st October 2020). It should be clarified here that these forms are relevant firstly to avoid liability in criminal law on the side of doctors. However, I am also claiming that they are relevant for the consent process. The consent process should be intertwined with a process of exploring whether the legal defences as required by the AA are met, and hence with the signing of notification forms. This is because a consent process cannot be considered to be delayed to a later stage, once these legal requirements have been fulfilled. A net division between notification and consent process can undermine the positive advisory role of medical experts in this field which is set as the baseline for what will be claimed to be a partnership oriented approach.

about the woman in question by other doctors or members of the multi-disciplinary team without any other information.' [110]

In particular:

> 'In February 2012, CQC inspectors identified a number of cases where signatures on HSA1 certificates predated the referral and assessment of women in a clinic. For example, one woman was referred to the clinic on 20 December and assessed on the 22 December. The certificate reflected that a doctor at the clinic had seen the women and signed the form on 22 December. However, the signature of the second doctor, also a practitioner at the clinic, was dated 19 December. Therefore, on the information provided, the second doctor had certified the abortion before being assigned the case, and before having any opportunity to consider the clinical files or other specific information to the women'.[111]

This evidence suggests that, in practice, there are many instances where the good faith of RMPs could be called into question. It was often the second RMP who was found to have pre-signed notification forms, without having an actual meeting with women. They were also breaching the legal requirement of two registered medical practitioners and signing consent forms relying on their colleagues' assessments. While many here would say that these practices are irrelevant for a reflection on the first medical encounter, I would claim that this in fact has the potential to jeopardise also the first encounter with an RMP. This is because it frames the contribution of medical professional in general as progressively irrelevant and with it misses the importance of RMPs' contribution within the decision-making process.

The DHSC in this sense highlighted that:

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

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[110] DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), *above,* 6.

[111] DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), *above,* 7.

> they have formed themselves in good faith rather than relying solely on a colleague's opinion, however trusted that colleague's judgement may be. DH considers the signing of forms without consideration of any information relating to the women to be incompatible with the requirements of the Abortion Act'.[112]

This questionable practice of pre-signed notification forms is therefore relevant evidence of both a potential breach of the requirement of good faith, and also of a broader neglect of a focus on the decision-making process. With regard to the latter, opportunities are lost to provide valuable support during the decision-making process. Sheldon[113] has questioned the illegality of this practice considering that the wideness of the formulation of the AA might not necessarily require that a medical 'scrutiny' is actually achieved in daily medical practice, and neither, she opines, should it. To this point it can be objected that the law in its formulation, although using broad terms, should set the scene for a meaningful involvement of RMPs. Also, the law should not trivialize the consent process and abdicate to the positive contribution of the clinician.

The DHSC has confirmed that the practice of pre-signed notification forms is potentially subject to legal challenge and has made efforts to limit its occurrence. In 2014, it issued guidance clarifying that the good faith requirement entails that 'form HSA1 must be completed, signed and dated by two RMPs before an abortion is performed'.[114] On the same line of reasoning, the British Medical Association[115] opined that the pre-signed notification forms practice will raise questions about whether the decision was in good faith.

Even if it is assumed that the issue with pre-signed notification forms is resolved, there remain potential additional problems with the good faith requirement. The DHSC has specified that, though it is good practice for at least one of the certifying RMPs to see the women, it is also clear that it is not a legal requirement to do so.[116] This is

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[112] DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), *above,* 8.

[113] S Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016), *The Modern Law Review*, 79 (2),283, 297-300. See also: S Sheldon, 'The Abortion Act (1967): a biography' (2019), *Legal Studies*, vol. 39, 18, 27-28.

[114] DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), *above,* 6. In 2014 the DHSC also specified that abortion certifications need to be in place, so as to provide a legal check that malpractices do not occur again. After the 2014 report no further documents have been produced by the DHSC on this topic.

[115] BMA, 'The law and Ethics of Abortion', (2018), online available at: https://www.bma.org.uk/-/media/files/pdfs/employment%20advice/ethics/the-law-and-ethics-of-abortion-2018.pdf?la=en (accessed 21st October 2020) 7. However, the BMA also said that in some, although exceptional circumstances, this practice could sit along the good faith requirement. The BMA suggested that in the first trimester the requirement of two RMPs should be also removed. This also reflecting a desire to de-medicalise abortion.

[116] 'Although there is no legal requirement for at least one of the certifying doctors to have seen the pregnant woman before reaching a decision about a termination, the Department's view is that it is good practice for this to be the case', above DHSC, 'Guidance in Relation to Requirements of the Abortion Act 1967', (2014), *above*, 5, para 6.

potentially problematic because it can further undermine the point of medical-encounters themselves, especially of the first medical encounter, which is oriented towards building a meaningful decision-making process seeking partnership and support between the parties.

However, it cannot necessarily be assumed that the clarifications will be followed and that pre-signed notification forms are a thing of the past. Two years after clarifying advice was issued, in 2016, an investigation held at Marie Stopes International abortion facilities in England raised concerns about patient consent and the respect of the requirement of good faith. The Care Quality commission (CQC), which monitors, inspects, and regulates health and social care services, highlighted in this respect that:

> 'Clinicians were reportedly bulk-signing HSA1 forms, which meant that they did not necessarily have access to all relevant information or sufficient time to review it before authorising a termination. Also, there was no process in place for ensuring HSA4 forms[117] were submitted to the Department of Health within the legal timeframe of 14 days.'[118]

The above-mentioned report led the CQC issuing warning notices to Marie Stopes International and the temporary suspensions of their service.

On the basis of the 2014 and 2016 events, it can be claimed that although the literal formulation of the AA might leave the 'door open' for a legal protection of the decision-making process through the requirement of good faith, empirical evidence suggests that medical practice has not adequately and universally embraced this opportunity.

What the current doctrinal framework fails to achieve is to give due weight to the decision-making process during the first medical encounter. It underplays the importance of the dynamics surrounding the consent process in the context of abortion in a manner that is out of sync with recognition of the importance of IC in relation to other medical interventions. Whilst the AA does not prevent an IC process, neither does it literally or has it been interpreted to require one.[119] The contribution of clinicians has

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[117] HSA4 forms are referred to as 'abortion notification' forms. For an overview of the required forms and respective guidance see: DHSC, 'Abortion notification for England and Wales', (2013), online available at: https://www.gov.uk/government/publications/abortion-notification-forms-for-england-and-wales (accessed 21st October 2020).

[118] CQC, 'CQC publishes inspection reports on Marie Stopes International', (20th December 2016), online available at: https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-reports-marie-stopes-international (accessed 21st October 2020)

[119] The issue of the lack of weight given to the decision-making process, and hence to IC, has been also recently evidenced in another reproductive context, concerning the use of medications (hormone pregnancy test and sodium valproate) and

been progressively emptied, the consent process has been reduced to a formality, and with it, the basis for the safeguarding of IC.[120] This analysis ultimately highlights that relevant questions that should be asked about abortion are not only 'who' and 'what', but also and more crucially 'how' a decision is made. Building upon this, Chapters 3 and 4 will show that the concept of partnership and autonomy, as derived and revised from the IC case law, can be utilized to form a better balance between medical support and patient autonomy.

3.4 Current challenges to the AA approach: the de-medicalisation debate

The previous section has highlighted that the current approach of the AA is an example of an *unsatisfactory* medicalisation that takes too little consideration of the decision-making process. To this extent, it will be added that the current political and academic debate has exacerbated the neglect of the decision-making process through the advocacy of a process of 'de-medicalisation'.[121] It will be argued that the resolution of the unsatisfactory medicalisation is not to de-medicalise, as this risks losing a key support mechanism. Instead, the nature of the medicalisation needs to be changed: a revised medicalisation will be proposed.

The de-medicalisation[122] debate has mostly focused its attention on the need to reduce the involvement of RMPs in the abortion context. The meaning attached to

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medical devices (pelvic mesh implants). In this Report it was highlighted, amongst others, that patients lacked knowledge concerning both the nature and the risk associated to these medications and medical devices. See on this point: The independent medicine and medical devices, 'First do no harm. The report of the independent medicines and medical devices safety review', (2020), online available at: https://slingthemesh.files.wordpress.com/2020/07/first-do-no-harm-report-2020.pdf (accessed 21st October 2020).

[120] This is because, as said above, IC does not coincide with the protection of a valid consent yet the two are strictly interconnected.

[121] See on this point: E Lee, S Sheldon, and J Macvarish, 'The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revised' (2018), *Social Science and Medicine*, vol. 212, 26; S Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016), *The Modern Law Review*, vol. 79 (2), 283-316; S Sheldon, 'The law of abortion and the politics of medicalisation', in: J Bridgemen S Millns (eds) *Law and body politics : regulating the female body* (Aldershot, Dartmouth, 1995) 105-124.

[122] A further related concept is the one of de-professionalisation of abortion. This concept considers a stronger involvement of RMPs widely understood, namely not only general medical practitioners or medical specialists, but also trained nurses and further staff into the abortion procedure. This is mostly evident in the context of surgical abortion, where the medicalised nature of the AA has been challenged under the claim that the involvement of a broader team of professionals can offer a valid way forward to the current medicalised status quo. The proposal of a de-professionalisation is put forward by S Sheldon, 'British abortion law speaking from the past to govern the future' (2016), *The Modern Law Review*, 283, 304-307. This has found further support in: P A Lohr, J Lord and S Rowlands, 'How would decriminalisation affect women's health', in: S Sheldon K Wellings, *Decriminalising Abortion in UK* (Bristol, Policy press, 2020) 52- 53.

Notably the House of Lords supported this move towards de-professionalisation in *Royal College of Nursing v Department of Health and Social Security [1981] AC 800*. The majority held that the focus is on safe administration of the procedure, in terms of proper skills and hygiene conditions and it did not require the involvement of doctors in every part of the procedure.

medicalisation is contested. Conrad[123] believes that de-medicalisation can only be associated with the complete move beyond the use of medical terms for a specific issue. In line with this conception, it is more accurate to speak about degrees of de-medicalisation or a process of de-medicalisation, rather than de-medicalisation altogether when it comes to the abortion context.

Looking at the abortion debate in England and Wales it can be claimed that the process of de-medicalisation is expression of a desire to respond to medical 'control' with an increased process of self-management of the abortion procedure. This implies a progressive reduction of RMPs' involvement and, as Dalton[124] argues, also a stronger emphasis on women's right to fully control their bodies. In this context, the role of medical professionals, as framed by the AA, is considered to be 'out of date'.

The de-medicalisation agenda has already impacted on abortion services. Expression of this desire to reduce the involvement of medical professionals and to increase self-management of abortion is apparent in the legalisation of 'home' as a class of places where an abortion can be administered (this is the so called 'home-abortion'). When a pregnancy does not exceed 9 weeks and 6 days, 'home abortion' involves two medications: misoprostol and mifepristone, taken in succession. In late 2018, the DHSC[125] approved the home use of mifepristone, whereas the use of misoprostol, the first pill, was to be still taken under medical supervision in licensed facilities. Later, during the COVID-19 pandemic, the temporarily home use[126] of both abortifacients was

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Lord Diplock also stated that: 'The requirements of the subsection are satisfied when the treatment for termination of a pregnancy is one prescribed by a registered medical practitioner carried out in accordance with this direction of which a registered medical practitioner remains in charge throughout' [821]. See also on this point: S Sheldon, G Davis, J O Neill, C Parker, 'The Abortion Act (1967): a biography' (2019), *Legal Studies*, vol 39, 18,24-25. See also Herring, raising further issues concerning the interpretation of the home use of the drug RU-486 and the requirement of the Abortion Act as interpreted by the *Royal College of Nursing v Department of Health and Social Security* case. See: J Herring, *Medical Law and Ethics* (Oxford: Oxford University Press, 7th edition, 2018) 311.

123 P Conrad, 'Medicalisation and social control' (1992), *Annu. Rev. Sociol.*, vol.18, 209, 224-226.

124 A F Dalton, 'Moms, Midwives, and MDs: a mixed-methods study of the medicalisation and de-medicalisation of childbirth' (2009), Phd dissertation submitted to Duke University.

125 DHSC, 'Approval of home use for the second stage of early medical abortion', (14 January 2019), online 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 21 October 2020); BBC News, 'Abortion pill can be taken at home in England, under new plan', (25 August 2018), online available at: https://www.bbc.com/news/health-45295398 (accessed 21st October 2020) ; DHSC, 'Government confirms plans to approve the home-use of early abortion pills', (25th August 2018), online available at:https://www.gov.uk/government/news/government-confirms-plans-to-approve-the-home-use-of-early-abortion-pills (accessed 21st October 2020); The British Medical Journal NEWS, 'The UK government has announced that women in England will now be legally allowed to take the second early medical abortion pill, misoprostol, at home', (2018), online available at: https://www.bmj.com/content/362/bmj.k3675, (accessed 21st October 2020); for an overview of the situation in UK see: Taylor RB, Wilson ALM, 'UK Abortion Law: Reform proposals, private members' bills, devolution and the role of the courts' (2019), *The Modern Law Review*, vol, 82(1), 71, 97-98.

126 The home use of both abortifacient was firstly temporarily allowed by the Government on 24th March, than in a u-turn this disposition was then removed. See news coverage: The Independent, 'Coronavirus: department of health says temporary changes to abortion law were 'published in error',(24th March 2020), online available at:

allowed, provided that an e-consultation between the parties had happened, unless circumstances require otherwise (e.g., in suspected or confirmed COVID-19 cases and in need for face-to-face consultation/deferring an abortion).

The rationale for the 2018 and the COVID-19 changes have been explored recently in *R v (Christian Concern) v SSHSC.*[127] In this case, the appellant sought judicial review of the 2020 legal changes alleging that the decision was *ultra vires* and contrary to the legislative purpose of the AA 1967. In rejecting both claims, the Court of Appeal considered the justifications for both the 2018 and 2020 legal changes. In relation to the 2020 change the aim was to 'broaden the access of a woman to a legal termination of pregnancy'.[128] The 2020 change responded to the difficulty in accessing abortion services due to the extraordinary lockdown measures, forcing both women and doctors to 'stay at home'.[129] If women were in self-isolation, it would have been difficult and potentially also risky for them to physically get to the clinic for the first medical encounter. This led to the push towards the further reduction of medical involvement and its substitution with telemedicine tools. The 2018 changes were based on the developments in medical science and practice and hence the 'safety'[130] of a medical abortion.[131] When it comes to early term medical abortion, the starting point is that, unless circumstances show

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https://www.independent.co.uk/life-style/health-and-families/coronavirus-abortion-law-change-department-of-health-a9420116.html (accessed 21st October 2020). The Government claimed that this information was published in error: see UK Government, online available at: https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion (accessed 21ST October 2020). The measure was then approved on 30th March. See: DHSC, 'The Abortion Act 1967- Approval of a class of places', (30th March 2020), online available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf (accessed 21st October 2020). The same decision was then passed also in Wales and Scotland. See: Welsh Government, 'Wales approves home abortions during Coronavirus crisis', (31st March 2020), available at: https://gov.wales/wales-approves-home-abortions-during-coronavirus-crisis (accessed 21st October 2020); Scottish Government, 'Abortion – COVID-19 – Approval For Mifepristone To Be Taken At Home And Other Contingency Measures', (31st March 2020), online available at: https://www.sehd.scot.nhs.uk/cmo/CMO(2020)09.pdf (accessed 21st October 2020). For an analysis of relevant guidelines in this context see: RCOG, 'Coronavirus (COVID-19) infection and abortion care', (2020), 31ST July 2020, online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-COVID-19-infection-and-abortion-care.pdf (accessed 21st October 2020) It should be noted that the first version of this guidance was issued before the new regimen concerning the home use of abortifacient in England Wales and Scotland, on 31st March 2020 and then updated on 1st April 2020.

[127] [2020] EWCA Civ 1329.

[128] *R v (Christian Concern)* [at 40].

[129] See on this point the British pregnancy Advisory service (BPAS), advocating for a change in the legal landscape to allow the home use also of the first abortifacient (i.e. misoprostol). BPAS, 'Home use of misoprostol', (2020) online available at: https://www.bpas.org/get-involved/campaigns/briefings/home-use-of-abortion-drugs/ (accessed 21st October 2020).

[130] S Sheldon, 'How can a state control swallowing? The home use of abortion pills in Ireland' (2016), *Reproductive Health Matters,* vol. 24 (48), 90, 94-95; see also J N Erdman et al. framing this point, amongst others, as a question of 'harm reduction': J N Erdman, K Jelinska, S Yanow, 'Understanding of self-managed abortion as health inequity, harm reduction and social change' (2018), *Reproductive Health Matters*, vol. 26(54), 13,14.

[131] *R v (Christian Concern)* at [42-48].

otherwise[132], the self-administration of the abortifacients is contended to be a safe medical intervention, safe enough to render medical involvement unnecessary.[133] The 2018 changes in the context of early medical abortion, allowing for the home use of the second abortifacient, was also the result of stories of miscarriages occurring on the journey home from the clinic where both pills were taken.[134] It was additionally recognizable that the 2018 and 2020 move towards de-medicalisation have also been triggered by a desire to place a stronger weight on women's right to autonomy as 'control' over their bodies,[135] to reduce delays[136]and to and to avoid 'pathologising' the procedure.

In response, I would argue that whilst the 2020 changes were an exceptional response to the COVID-19 crisis, the focus on safety, control, and delay risks a slippery slope to de-medicalisation. Though the endorsed process does not exclude altogether the existence of a first medical encounter with an RMP, at least under the pre-pandemic regulation, it risks jeopardising its relevance and shrinking the role of clinicians to mere

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[132] It should be clarified that this point is not uncontested: there is still an ongoing debate amongst scholars on the safety of early term medical abortions. Some argue that the use of mifepristone and misoprostol is still connected with potential side effects in particular risks of failed abortion in cases of women who had previous terminations or a previous live birth, risks of serious infection although low, risks of uterine rupture and hemorrhage. See on this point: H Hamoda, 'Medical and surgical options for induced abortion in first trimester' (2010), *Best Practice & research clinical obstetrics and gynaecology*, vol.24, 503, 508. This research study considers this treatment to be effective, yet it points out the existence of possible side-effects. Also exploring the possible side-effects of medical abortions: P W Ashok, A Templeton et al., 'Factors affecting the outcome of early medical abortion: a review of 4132 consecutive case' (2002), *BJOG: An international journal of obstetrics and gynaecology*, vol.109, 1281. Also, a further research study that describes the complications that, although uncommon, can occur: R Hausknecht 'Mifepristone and misoprostol for early medical abortion: 18 months experience in the United States' (2003), *Contraceptio*n, vol.67, 463. Also on this Fisher et al. describing possibilities of serious infection connected with medical abortion: M Fisher, J Bhatnagar,J Guarner, S Reagan et al., 'Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion' (2005), *The New England Journal of Medicine*, vol. 1(353), 2352. See also for a general overview: B Kruse, S Poppema, M D Creinin, P Maureen, 'Management of side effects and complications in medical abortion' (2000), *Am J Obstetric and Gynecol*, vol.183, s63. Complications are also more frequent when it comes to second trimester medical abortions, see on this point: D Grossman, K Blanchard, P Blumenthal, 'Complications after second trimester surgical and medical abortion' (2008), *Reproductive Health Matters*, vol. 16 (3), 173.

[133] S Sheldon' British abortion law speaking from the past to govern the future' (2016), *The Modern Law Review*, vol. 79 (2), 283, 307-312.

[134]See example of news coverage on this topic: The independent, 'I had to risk miscarrying in a taxi after taking an abortion pill. Women should be allowed to take it at home', (2 April 2018), online available at: https://www.independent.co.uk/voices/abortion-pill-home-england-mifepristone-misoprostol-campaign-jeremy-hunt-a8284796.html, (accessed 21st October 2020); BBC, 'Women in England should be allowed to have abortions at home', (29 May 2018), https://www.bbc.co.uk/news/newsbeat-44241069 (accessed 21st October 2020). Also see on this point K Greasley, 'Commentary: Medical Abortion and the 'golden rule' of statutory interpretation' (2011), *Medical Law Review*, 314. She critically commented on the judgment in *BPAS v the Secretary of State for Health* [2011] EWCH 235, calling for a change in approach which allowed the home use of the second abortion pill to avoid miscarriage occurring on the way and also unnecessary trip back to the clinic.

[135] S Sheldon, 'British abortion law speaking from the past to govern the future' (2016), *Modern Law Review*, vol. 79 (2), 283. See also in support of this approach: P A Lohr, J Lord and S Rowlands, 'How would decriminalisation affect women's health', in: S Sheldon, K Wellings, *Decriminalising Abortion in UK* (Bristol, Policy press, 2020) 48-52.

[136] See on this point an empirical study conducted in Britain on access barrier to abortion services in early pregnancy as a justification for 'home-abortion': R A Aiken, K A Guthrie, M Schellekens, J Trussel, R Gomperts, 'Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain' (2018), *Contraception*, vol 97, 177.

deliverer of a service. This is because the progressive push towards de-medicalisation, can risk sending the message that the involvement of clinicians is of little, if any, value in the abortion context, and should be progressively reduced. This agenda is hence problematic because rather than framing women and RMPs as partners, it frames RMPs as intruders, in opposition to women.

Given the acceptance by the Court of Appeal of a process that allows an early term medical abortion to take place at home, emphasis should be placed on preventing a further slide towards de-medicalisation. There is a risk that pressure will be exerted to maintain the new COVID-19 measures as a new *status quo*. But extraordinary measures necessary in times of pandemic emergency should not be used in 'ordinary' circumstances. A full home use without the opportunity of a first face-to-face medical encounter in non-pandemic circumstances, would risk reiterating the negative message that the intervention of medical professionals is only an obstacle to access-related concerns. The relevance of a fruitful partnership between women and RMPs to safeguard the decision-making process should be acknowledged and dispositions concerning the relevance of at least one face-to-face meetings should be restored, once the pandemic is contained.

It is already the case that a physical meeting between the RMP and woman is not a statutory requirement[137] of the AA. Continuing the trajectory of the 2018 and 2020 legal changes, together with the questionable practice of pre-signed notification forms, risk jeopardising the effectiveness of the encounter with RMPs, in terms of what will be shown, in Chapters 3 and 4, to be the key principles of partnership and authentic autonomy. De-medicalisation undermines partnership because it risks missing the relevance of the medical encounter and of the RMPs advisory role. It undermines authentic autonomy, (a thick conception of autonomy), because it risks framing women considering abortion as mere 'consumers' of an abortion service, instead of responding to women's individual and particular needs and values in the decision-making process. A process of de-medicalisation has the potential to undermine the importance of both partnership and authentic autonomy.

The following sections argue that the common law on IC minimizes to some extent the impact of de-medicalisation. However, it can only go so far. A revised

[137] In this sense de-medicalisation is not contrary to the objective of the AA. An encounter with and RMP can be in fact replaced by forms of telemedicine and wider professional involvement (e.g. nurses, midwives), while the RMP still takes responsibility of the procedure. See on this point *R v (Christian Concern)* at [39, 42] and above footnote on de-professionalisation (above footnote n.122). What is contended here is that de-medicalisation sends a broader negative message concerning the relevance of medical involvement.

medicalisation is required in order to facilitate a 'how-approach' based on authentic autonomy and partnership that will be proposed in Part 2 of the thesis.

4. Limited relevance of the law of tort in the abortion context

The limited weight given to the decision-making process in the context of abortion and the first medical encounter should be put into a broader legal context. This section will further substantiate it through an account of tort law approaches[138] concerning the law of battery and negligence. It will be showed that battery is of limited application in this context. The law of negligence, on the other hand, has greater relevance, particularly post the Supreme Court judgment in *Montgomery v Lanarkshire Health Board.*[139] It is proposed however that *Montgomery*'s application outside the medical mainstream realm is not straightforward.[140] Also, in the abortion context, *Montgomery* is not a panacea. Subsequent sections will then analyse the interconnection between the 'how-question' and relevant professional guidance.

4.1 Trespass to the person: battery

The regulation of a patient decision-making process finds indirect legal relevance within the law of tort. The first referral point is the domestic law of trespass to the person. The questions that this section will unpack are: what is the relevance of the law of trespass to the person within the context of the decision-making process concerning abortion? Does it resolve the above-mentioned neglect of the decision-making process in sum or in part? It will be claimed that the domestic law of trespass to the person can help tackling this phenomenon, but is of limited application.

The most relevant trespass to the person tort in this context is the tort of battery. Liability arises every time there is a direct and intentional application of force from one person to another without the latter's consent.[141] It positively requires that, within the

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[138] See for an overview of the challenges arising from the law of tort and consent: E Jackson, 'Informed consent and the impotence of tort', in: S A M McLean, (ed.) *First Do No Harm: Law, Ethics and Healthcare. Applied legal philosophy* (Aldershot: Ashgate Publishing, 2006), 273-286; A Maclean*, Autonomy, Informed Consent and Medical Law*, (Oxford: Oxford University Press, 2009) 191-213.

[139] [2015] UKSC 11

[140] E Cave, 'Valid consent' (2020), *Journal of Medical Ethics*, 0, 1.

[141] *Collins v Wilcock* [1984] 1 WLR 1172

medical context, before any medical intervention is put into place, the requirements for a valid consent are satisfied. These can be broadly identified[142] as: patients' capacity, disclosure of broad information, voluntariness of the decision and compliance with public policy. The first, patients' capacity, concerns the mental status of the patient, requiring, as derived indirectly from the Mental Capacity Act 2005 (MCA), a two-stage test for incapacity that evidences (1) the lack of an 'impairment or disturbance of the mind or brain'[143] and (2) the ability of the patient to understand, retain, use or weigh, communicate the medical information relevant to the decision.[144] The law of battery also safeguards the voluntariness of the decision, requiring it to be free from undue influence, that it is to say from certain third parties pressure and/or coercion. When it comes to information disclosure, however, to meet the requirement for a valid consent, the law of battery requires only the provision of general and broad information[145] which can provide only an overview of the intervention in question. It does not ask for any extra or more detailed information sharing. Battery can be a useful legal tool to protect against abortion without a valid consent[146], but it is of limited application to protect the patient, more widely, from uninformed abortion. This is because, as argued by Cave, 'informed consent is not necessarily valid (if it is not voluntary or capacitous) and consent that is valid is not necessarily adequately informed. This flows from the different informational thresholds that apply in battery and negligence.'[147] Valid consent and informed consent are crucially not the same thing in law as they do not set the same threshold of information disclosure.

It is true that trespass can broadly help safeguard a more personal decision of the patient, given that it is 'actionable per se'. In other words, claimants do not have to prove actual damage as part of their claim, but it is the violation per se that grounds their claim. However, the elective nature of abortion, whereby it is more likely to be sought because of women's requests, although framed within the parameters of the AA, rather than a medical diagnosis[148] (as it is in the case of risk to life, or serious fetal abnormality),

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[142] Mental Capacity Act (MCA 2005) ss. 2-3.

[143] MCA 2005 s 2(1).

[144] See MCA 2005 section 3(1).

[145] *Chatterson v Gerson* (1981) 1 ALL ER 257, whereby for a patient to have capacity in law only needs to understand 'in broad terms' the nature of the procedure, that is to say only central aspects of the medical procedure.

[146]This can be contrasted with recent attempts of the Court of protection to 'force abortion' on women with learning disabilities (*AN NHS FOUNDATION TRUST vs AB & ORS* [2019] EWCOP 26). This was then reversed by the Court of Appeal in *Re AB (Termination of pregnancy)* [2019] EWCA Civ 1215.

[147] E Cave, 'Valid consent' (2020), *Journal of Medical Ethics*, 0, 1, 4.

[148] This does not include the cases of abortion in a context of emergency.

makes a claim in battery unlikely.

In summary, the law of battery requires a valid consent to abortion and protects voluntary decision-making, but it is of limited application in supporting a fruitful decision-making process in the context of abortion and the first medical encounter. This is mostly because the information requirement has a low threshold and requires only the disclosure of broad information.

4.2 Negligence

Having analysed the limited impact that the law of battery can have in tackling any perceived gaps in protection of the decision-making process set out in the AA, this section analyses how far the 'how-question' has been tackled by the domestic law of negligence in the context of abortion. It will be claimed that the law of negligence plays an important role, but is insufficient. It is not merely a direct application of the law of negligence that should be pursued in this context. This section will provide a first overview of the landmark Supreme Court judgment in *Montgomery* and explore challenges and potentials for the abortion context. Chapters 3 and 4 will then expand this reflection to show that positive principles can and should be derived from *Montgomery*. These principles, it will be claimed, should further shape the legal and ethical landscape in England and Wales surrounding the first medical encounter and the abortion context.

The 2015 Supreme Court judgment in *Montgomery* is the key reference point for a discourse concerning IC. [149] This judgment, delivered with the agreement of 7 judges, was a case concerning negligence liability for failure to disclose risks related to natural birth to a diabetic pregnant woman. The new-born suffered brain damage as a result of shoulder dystocia happening during natural delivery, a risk of which the patient was not warned. The judgment followed in the footstep of previous professional guidelines, particularly the GMC guidelines on consent 2008[150], and marked, as it will be shown below, an evolutionary path of domestic case-law. It enshrined the right of every patient to informed consent, in the mainstream medicine context, that is to say the right to receive information concerning risks, benefits, and reasonable alternatives to the proposed treatment that are needed in order to make an informed choice.

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[149] This judgment was delivered by an agreement of all 7 judges, with the two leading judgments of Lord Keer and Reed and supporting judgment of Lady Hale.

[150] GMC, 'Consent: patients and doctors making decisions together', (2008), available at: https://www.gmc-uk.org/static/documents/content/Consent_-_English_0617.pdf (accessed 21st October 2020).

A clear difference with the law of battery can be outlined: the law of negligence, to which *Montgomery* refers, does not require only the disclosure of broad information, but a more extensive disclosure.[151] Through a new test of negligence liability, the materiality test of disclosure[152], medical professionals are called to consider, when embarking into the disclosure process, both clinical considerations and patient-centred approach. The test of negligence liability, sets out the relevance of 'objective' information as well as more 'subjective' information, that is to say patient-sensitive information.[153] It further positively supports the need to start an informative process, which aims to foster understanding[154]of the information provided. The informative process is, in this sense, not a pre-fixed and one-off event. It is a process which both medical professional and patients should embark on in partnership, taking into account the needs and wishes of the patient.

This case, with its focus on the decision-making process, has a strong potential to operate beyond the mainstream medicine context and hence also within the first medical encounter and abortion. *Montgomery* could hence trigger a series of questions in the abortion context: has the RMP warned women of the physical and psychological risks related to an abortion? Has the RMP engaged in a discussion on alternatives, such as adoption? The tie between *Montgomery* and abortion appears to be particularly relevant in light also of the recent case of *Mordel v Royal Berkshire NHS Foundation Trust.* [155] In this wrongful birth case, which applied the *Montgomery* ruling, the claimant was granted damages for a breach of the IC process by the clinician. She claimed that had she known about the possibility of her child having Down's Syndrome she would have pursued an abortion. Although the question of abortion did not expressly arise in the circumstances of the case, but only as a 'hindsight' approach, it can be used to show that a link between *Montgomery* and abortion is gaining support at the common law level. In this case, the court held that there was a failure within the informative process which, in line with *Montgomery,* had to imply that a space for a more extensive dialogue had to be found, one

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[151] *Montgomery* at [75]

[152] *Montgomery* at [85]

[153] The importance of both 'objective' and more 'subjective' elements to be disclosed in the IC process in light of *Montgomery* has been stressed also in a 2017 article by Fulford, Herring et al. See on this point: J Herring, K M W Fullford et al., 'Elbow room for best practice? Montgomery, patient's values, and balanced decision-making in person-centred clinical care' (2017), *Medical Law Review*, vol. 25 (4), 582. For a throughout analysis of this see also Chapter 3, particularly section 3.

[154] *Montgomery* at [90]

[155] [2019] EWHC 2591 (QB). A further post-*Montgomery* wrongful birth case is *NHX v Barts Health NHS Trust [2020] EWHC 828 (*QB). The fact of the case concern antenatal counselling and risk related to vaginal delivery. The baby suffered cerebral palsy during delivery. The judge found that there should have been a discussion about using continuous fetal motoring, instead of intermittent auscultation (which was part of the birth plan) and had this been done the baby would have had mild rather than severe brain damage.

that goes beyond a mere 'yes or no' approach.

It is hence apparent that *Montgomery* calls for a positive reconsideration of the informative role of clinicians within the abortion context. This has the potential to help tackling the neglected focus given to the decision-making process and hence of RMPs contribution in this context. However, it should be acknowledged that, in practice, legal protection in abortion cases has focussed on wrongful birth cases.[156] To date, common law support is limited to those cases in which women 'regret' not being made aware of specific information concerning the fetus that would have encouraged them to pursue an abortion. There is no specific case law concerning the failure to provide IC per se in the abortion context[157], that is to say, beyond a wrongful birth case. This might be associated, as it will be further explored below, to the general challenges related to the law of negligence. Crucially, this implies that those who pursued an abortion and later on perceived the existence of an informative gap are hence left without the prospect of redress. This is a key challenge that offers a first justification for what will be later shown to be the importance of using the law of negligence as a starting point for a change in approach and not as the end of the conversation.

Having considered the problem of directly applying *Montgomery* in cases of abortion, it is also relevant to turn to the more general limitations of the law of negligence.[158]These challenges affect, as it will be claimed, also the possibility to rely on it as 'the' solution to the phenomenon explained above. As far as the law of negligence is concerned, this is not actionable *per se* and requires that an actual harm arises as a result of the breach of duty. In this sense, liability does not arise for a failure to protect the decision-making process per se, but only when this is reflected in an actual harm. It should be also added to this point that to date courts have been also reluctant to grant damages[159] for a failure to satisfy the right to IC per se. This is also related with the difficulty in establishing a causal link between the breach of IC and the harm arising from it. Take, as an example, the risk of subsequent pre-term birth as triggered by an

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[156] The issue of informed consent and abortion has also arisen in the context of the duty of confidentiality and medical professional duty to disclose information concerning a hereditary disease. In the 2020 judgment in *ABC v St George's Healthcare NHS Trust and SW London and St George's Mental Health NHS Trust and another* [2020] EWHC 455 it was held that the test to be applied was still *Bolam,* and that the threshold set to protect the duty of patients' confidentiality was particularly hard to cross.

[157] A freedom of information request was made to NHS resolution and no data on this was found (response received on 12th July 2019).

[158] For a wide analysis of the limitations of *Montgomery* as related to both mainstream medicine and abortion see Chapter 3-4.

[159] See on this point *Shaw v Kovac and University Hospitals of Leicester NHS Trust* [2017] EWCA Civ 1028, at [4], [64-65].

abortion.[160] The existence of a clear factual and legal causation link between failures within the IC process and the possible long-term harm, is hard to be satisfied.

This thesis will hence seek to extrapolate from the IC doctrine and from the Supreme Court judgment in *Montgomery*, two principles: RMP-women partnership[161] and women's autonomy.[162] It will explore their remit, limitations and theoretical underpinning and propose how they might be reinterpreted and applied in the abortion context. The proposed principled-approach seeks to value the decision-making process surrounding the first medical encounter concerning abortion in England and Wales. In this vein, it should be clarified also that the law of negligence, would still amount to a positive, yet partial view of the problem in question. This is so even in a future scenario in which it may/may not become actionable per se and damages for failure to satisfy the right to IC granted. What this thesis will show is that IC brings forth both ethical and legal considerations that need to be reframed and applied beyond the law of negligence spectrum. This is because the sensitivity and complexity of the issue of abortion, one which involves issues concerning women, fetus, and perspective parents in general, cannot be fully reduced to a claim in negligence only, whether this is successful or not.

In summary, a principled-approach has the potential to operate as a positive development for stronger weight to be given to the decision-making process in a reframed medical encounter in the abortion context.

5. How far do professional guidelines address the how-question?

Having explored the limited focus on the how-question in the context of the AA and the law of tort, this section will address the final ambit of analysis, namely the context of professional guidelines (PG) on consent. This reflection will further substantiate the above analysis, arguing that PG, can help limiting the lack of focus on the 'how-approach', but do not currently provide a sufficient solution. Chapter 6 will set out what is required to fully address the problem.

When referring to PG, it should be firstly recognised that these are non-legally binding documents. A breach of their requirement is hence 'weaker' in strength

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[160]See on this point: RCOG, 'The Care of women requesting induced abortion', (2011), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf , (accessed 21st October 2020) 5.12.

[161] See Chapter 3.

[162] See Chapter 4.

compared to a legally binding or hard-law tool (such as the AA or the common law on IC). This does not mean that they are free from internal and disciplinary consequences. A breach of the General Medical Council (GMC) guidelines on consent is, for instance, potentially associated with disciplinary measures that range from warnings to being struck off the medical professional register.

When it comes to the RMPs-women relationship, the GMC 2020 guidelines on consent[163], together with the National Institute for Health and Care Excellence (NICE) and Royal College of Obstetrician and Gynaecologists (RCOG) relevant guidelines[164] all positively emphasize the need for partnership, collaboration, and information disclosure. They all *prima facie* positively embrace IC and strive towards a fruitful medical encounter. The 2019 NICE guidelines on Abortion Care, for instance, explicitly clarifies that:

> 'Healthcare professionals should ensure that women have the information they need to make decisions and to give consent in line with General Medical Council guidance and the 2015 *Montgomery* ruling.'[165]

NICE 2019 further highlights that an information-oriented approach would benefit 'all women who are having an abortion'.[166] It also clarifies that this is a line of approach that will well fit women beyond the reason why they are seeking an abortion, whether for instance this is for a fetal abnormality or for personal reasons.

The formulation provided by PG has the potential to operate positively on the first medical encounter. PG can set up what information clinicians should both (i) be aware of and hence disclose during this assessment, and (ii) provide the modality of disclosure. In this sense, for instance NICE 2019, in its information provision section concerning abortion, has a great potential to guide the IC process. It puts forwards a

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[163]GMC, 'Decision Making and consent, working with doctors, working for patients', (2020) online available at: https://www.gmc-uk.org/-/media/documents/updated-decision-making-and-consent-guidance-english-09_11_20_pdf-84176092.pdf?la=en&hash=4FC9D08017C5DAAD20801F04E34E616BCE060AAF (accessed 21st October 2020)

[164] General Medical Council, 'Seeking patients' consent: the ethical considerations',(1998), online available at: http://www.gmc-uk.org/Seeking_patients_consent_The_ethical_considerationsectionpdf_25417085.pdf, (accessed 21st October 2020); -- Good medical practice (1998), online available at: http://www.gmc-uk.org/good_medical_practice_july_1998.pdf_25416527.pdf, (accessed 21st October 2020); ---, 'Consent: patients and doctors making decisions together', (2008)online available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent (accessed 21st October 2020);NICE, 'Caesarean section' (2012), online available at: https://www.nice.org.uk/guidance/cg132/Chapter/1-guidance#women-centred-care-2 (accessed 21st October 2020); NICE, 'Decision-making and mental capacity', (2018), online available at: https://www.nice.org.uk/guidance/indevelopment/gid-ng10009, (accessed 21st October 2020). RCOG, 'The Care of women requesting induced abortion, evidence-based clinical guidance', number 7, (2011), online available at: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-abortion-care.pdf (accessed 21st October 2020); NICE, 'Abortion Care', (2019) online available at: https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693 (accessed 21st October 2020) .

[165] NICE, 'Abortion Care', (2019), *above*, 8.

[166] NICE, 'Abortion Care', (2019), *above,* 30.

women-centred model which is based on two key assumptions. The first is that *Montgomery*, as it has been also highlighted above, is of key relevance in this context and also that women experience an informative desire in the abortion context. When it comes to the disclosure of risks NICE 2019[167] follows in the footstep of RCOG 2011[168] and 2015,[169] and unpacks the possible physical risks connected to abortion, whether this is through a surgical or a medical abortion. It adds to previous PG, in light of the 2018 legalisation of so called early term 'home abortion', the need to make clear the opportunity of post-abortion support, especially for those women who are opting for a medical abortion at home, that is to say when part of the procedure happens in an unsupervised setting. When it comes to the risks of psychological sequelae[170], NICE 2019 does not delve specifically into this issue, but makes reference to other relevant professional guidelines. It is hence necessary to go back to RCOG 2011 to have a clearer picture on this point. RCOG 2011 stated that:

> 'Women with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy.'[171]

However, the issue of information disclosure is not free from challenges within the current PG. Taking as an example the issue of risk disclosure, a throughout look at PG shows that there is not a consistent approach across them. For instance, NICE 2019 does not refer to the existence of risk factors for the issue of psychological sequelae, or risk of pre-term birth for future pregnancies. These deficiencies, looked from the medical perspective, can trigger the possibility of non-disclosure and hence can jeopardise the disclosure process itself. If it is true that *Montgomery* required the calibration of the disclosure process in light of the circumstances of the case, clinicians should be offered the tools to enter into the first encounter with the 'knowledge-package' needed for the situation at stake, limiting the possibility of unknown risks on their side.

The challenges related to lack of a consistent approach across PG can be further substantiated. When it comes to a process of disclosure of alternative options, the issue appears to be often neglected. The disclosure of pregnancy options is not expressly

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[167] NICE, 'Abortion Care', (2019), *above,* 11-21.

[168] RCOG, 'The Care of women requesting induced abortion, evidence-based clinical guidance', (2011), *above,* 5.1-5.6.

[169] RCOG, 'Best Practice in comprehensive abortion care', (2015), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf (accessed 21st October 2020)

[170] RCOG, 'The Care of women requesting induced abortion, evidence-based clinical guidance', (2011), *above*, 5.6.

[171] RCOG, 'The Care of women requesting induced abortion, evidence-based clinical guidance', (2011), *above*, 5.14.

highlighted in the most recent guidelines in NICE 2019.[172] RCOG 2011[173], on the other hand, suggests that medical professionals offer the opportunity of a conversation on pregnancy options. However, this is considered only as a *suggested* practice, rather than an aspect of RMPs informative legal duties, as should arguably be required in light of *Montgomer*y. Further on the disclosure of alternatives, the opportunity of pursuing 'no treatment' is also neglected. Though this requirement is clear in the most recent GMC 2020 guidelines on consent,[174] it does not appear to be sufficiently clear in more specific PG in the context of abortion. For example, NICE 2019 does not refer to the possibility to cancel the abortion appointment or to delay it. This is conversely something that it is possible to find in RCOG 2011[175] and 2020.[176]

A further crucial challenge is related to the role attributed to clinicians. Looking closely at relevant PG, it appears that they mirror the push towards de-medicalisation as unpacked and criticized above. This is exemplified by the push towards self-referral practices[177], whereby women are encouraged to skip the encounter with their GP and refer themselves directly to an abortion facility. These practices do not exclude a first medical encounter with an RMP, but they can contribute to a slippery slope that exacerbates the wider de-medicalisation of abortion, which I have argued is problematic.

Ultimately, this thesis welcomes the desire of relevant PG to start an IC-oriented approach in the abortion field, while highlighting existent challenges. Possible ways to tackle them will be offered in Chapter 6. Overall, it will be claimed that women facing an unplanned pregnancy and considering an abortion deserve a first medical encounter, which is partnership-oriented and safeguards authentic autonomy. This is also because RMPs are to be framed as the first link in a chain of support and neglecting the relevance of this link has inevitable negative '*domino effects*'.[178] There is hence the need to

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[172] NICE, 'Abortion Care', (2019), *above*.

[173] RCOG, 'The Care of women requesting induced abortion, evidence-based clinical guidance', (2011), *above* 4.14.

[174] A discussion around the possibility of 'taking no action' is included as a core principle around decision making and consent. Particularly principle four says: 'Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action' GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), *above* ,7 ; this was already suggested within the 2018 by GMC draft guideline:. See: GMC, 'Decision-making and consent, supporting patient choices about health and care, Draft guidance', (2018), *above,* at 25, p.11-12.

[175] RCOG, 'The Care of Women requesting induced abortion',(2011), *above* ,4.25.

[176] RCOG 2020, in the specific context of the COVID-19 pandemic, clarifies that: 'If a woman has symptoms, or has tested positive, a risk assessment should be undertaken to determine if the abortion can be safely deferred for the isolation time recommended by PHE'. See: RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), *above*, 19.

[177] See on this point: NICE, 'Abortion Care', (2019), *above,* 25.

[178] This issue is tied also to the one of counselling services. To date the offer is considered to be optional by PG, as it will be pointed out in Chapter 6. Counselling is offered only to those specific patients who are perceived to have need for an 'extra' support. The challenge that this thesis is embracing is to rediscover the importance of the first link in the chain of support, namely the relevance of the first medical encounter, so as to also better trigger and understand the importance of additional

reconsider RMPs' involvement in this field and to 'be there' for women, not imposing any point of view, but offering space and time for medical support before any final decision is reached.

6. Conclusion

Chapter 2 has argued that the relevance of the decision-making process in the context of the woman's first medical encounter when considering an abortion, has been underemphasised in both the political, doctrinal and normative legal dimensions. The political debate has given significant weight to the 'who' and 'what' questions, neglecting emphasis to the decision-making process (i.e., the how-question). The doctrinal and normative framework in England and Wales also reflect this problem: the AA does not prevent focus on the decision-making process, yet it does not endorse it. The broader legal context mitigates, but does not resolve this problem: the law of tort (and the law of negligence in particular) is a useful starting point, but not the end of the conversation.

The Chapter has hence tackled the first research question, namely how far is the approach taken in relation to the common law in England and Wales on IC mirrored in abortion law and professional guidelines? It has identified the current scenario upon which this thesis is built, that is to say the neglect of the how-question in the abortion context. Chapters 3 and 4 will set out a theoretical framework (a new 'how-approach'), in light of which changes to the status quo will be then proposed.

forms of support (e.g. counselling). Chapter 6 will also point out that during the first medical encounter RMPs should signpost the availability of such services, see section 3.2.

Part 2

Part 1 has explored the phenomenon upon which this thesis is built, namely the neglected focus on the decision-making process (i.e., the how-question) in the context of abortion and the first medical encounter. Part 2, which comprises Chapters 3 and 4, will address the following research question[179]: why is a focus on the decision-making process important in the context of abortion? It will extrapolate and adapt from IC case law (and *Montgomery* in particular) two principles: partnership (Chapter 3) and authentic autonomy (Chapter 4). It will argue that these principles should guide the first medical encounter in the abortion context (i.e., the 'how-approach'). A novel formulation of these principles will guide the solution to the problem identified in Part 1 regarding the lack of attention to the how question in the context of abortion. Part 3 will propose revisions of the abortion legal and ethical framework in England and Wales.

[179] Question n 2, see Chapter 1 at section 2.

Chapter 3

The principle of partnership

Deriving and adapting the *Montgomery* principle of partnership to fit the context of abortion and the first medical encounter in England and Wales

1. Introduction

Building upon the phenomenon explored in Part 1, that is to say the insufficient focus on the decision-making process in the abortion debate, Chapter 3 will suggest that a model of revised, not reduced, medicalisation, is a way forward for the first medical encounter in the abortion context. This consideration is based upon the idea that issues related to abortion have not only an elective, but also a medical connotation. This is neither exclusively because of the nature of the medical intervention itself; nor is it solely because of information that doctors can disclose in this context. But also because of the positive advisory role that doctors can play. This Chapter, therefore, claims that the law and professional guidelines pertaining to the first medical encounter should reflect the principle of partnership, derived, and adapted from the *Montgomery* judgment: namely, the idea that patients and clinicians work together towards a final decision. This will neither imply a dichotomy between, on the one hand, women as 'the' decision-makers[180], and on the other hand, the fetal life[181], as 'the' counterpart of that choice. Nor will it imply an antagonism between clinicians and women. Conversely, through an opportunity of better collaboration between women and RMPs, which devotes increased weight to the decision-making process, a more balanced approach to partnership in abortion than the one currently reflected in law and professional guidelines will be sought.

[180] For an analysis of key literature in this field see for instance: J Thomson, 'A defense of Abortion' (1971), *Philosophy and Public Affairs*, vol. 1(1), 47; A Furedi, *The moral case for abortion*, (Palgrave Macmillan, London: 2016) 9-140; S Sheldon, *Beyond control: Medical Power, Women and Abortion Law* (London: Pluto Press, 1997) 1-74.

[181] For an analysis of key literature in this field see for instance: J Finnis, 'The rights and wrongs of Abortion: A reply to Judith Thomson' (1973), *Philosophy & Public Affairs*, vol.2 (2), 117; J Keown, *The Law and the ethics of Medicine: Essays on the inviolability of Human Life* (Oxford: Oxford University Press, 2012) 3-20; 88-108.

2. The principle of partnership as a key principle behind the growth of an informed consent approach

The principle of partnership builds upon and expands positive lessons that can be learned from the IC doctrine and case-law. This section first explores the growth of the domestic IC literature through the lenses of the RMP-patient partnership. Through an historical overview of key domestic law of negligence cases, with a particular attention paid to the most recent Supreme Court judgment in *Montgomery*, it will be argued that legal developments of the doctrine of IC, in both law and ethics, have gradually challenged a paternalistic view of healthcare law. They have also highlighted the importance of patients' involvement coupled with the development of a relationship between patients and clinicians. This analysis will not serve the aim of offering the law of negligence as a potential solution to the problematic phenomenon that Chapter 2 has exposed (i.e., the neglected how-question). Conversely, in deriving from the phenomenon, this Chapter will develop a theory of partnership as a starting point for a revised medicalisation in the abortion context. Chapter 4 will then analyse a further principle behind the IC literature: autonomy. It will propose a revised consideration of autonomy that better suits the abortion context. Together, Chapters 3 and 4 outline the approach proposed by this thesis for the decision-making process in the context of abortion and the first medical encounter: the 'how-approach'.

2.1 The historical journey of the law of negligence from a doctor-centred approach to the growth of IC and a patient-centred approach

2.1.1 From Bolam to Chester

The historical standard of negligence liability adopted in *Bolam v Friern Hospital Management Committee*[182] reflected and perpetuated a paternalistic stance. Recalling the analysis provided in Chapter 2[183], the paternalist stance of *Bolam* is clearly shown by the standard of information disclosure laid down in this case[184] whereby both risk assessment and treatment options, were focused on medical expertise and assessment alone.

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[182] [1957] 1 WLR 582.

[183] See Chapter 2 at 3.2.

[184] *Bolam* at [121].

The will to gradually move from a paternalistic stance towards a more patient-centred approach[185] is found in the subsequent negligence case in *Sidaway v Board of Governors of the Bethlem Royal Hospital* .[186]In this case Lord Scarman proposed that the standard of care should be assessed from a reasonable patient perspective: 'the test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person would be likely to attach significance to the risk ...'.[187] However, the majority held that a patient was entitled to receive only the amount of information that a responsible body of medical opinion considered relevant. The implication was that disclosure of information (or, as Lord Diplock termed it, 'advice') was considered an aspect of treatment and diagnosis, and thus a matter of clinical judgement.

In *Bolitho v City and Hackney Health Authority*,[188] in a medical treatment (as opposed to information disclosure) context, Lord Browne-Wilkinson questioned the idea of general and undisputed reliability of medical opinion and stated that before accepting a medical opinion as responsible, the mere presence of a number of medical experts sharing a genuine opinion was not in itself conclusive. [189] This judgment represented a challenge to the *Bolam*-standard and reasserted its boundaries in treatment and diagnosis cases. Post-*Bolitho*, judges must also scrutinise the logical foundation of medical opinion and must be satisfied that clinicians have directed their minds to the potential evidence in support or against it. The case represents a limitation on the extensive scope of *Bolam*, though it does not relate to risk disclosure: the test, as expressed by Lord Brown-Wilkinson, is applicable only to diagnosis and intervention.[190]

Another relevant step is evident in the *Pearce* case.[191] In a risk-disclosure context, Lord Woolf proposed an adaptation to *Sidaway*: clinicians were called to disclose 'significant risk which would affect the judgment of a reasonable patient'.[192] Such information-sharing would have allowed the patient to 'determine for him or herself as to what course he or she should adopt'.[193] This position reflects a more balanced doctor-patient relationship.[194] However, the judgment only went so far. With regard to the

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[185] See also: M Brazier 'Patient Autonomy and Consent to Treatment: The Role of the Law' (1987), *Legal Studies*, vol.7, 168; M Jones, 'Informed Consent and Other Fairy Stories' (1999), *Medical Law Review* vol. 7(2), 103.

[186] [1985] AC 871

[187] *Sidaway* at [889-890]

[188] [1997] 3 WLR 1151

[189] *Bolam* at [242].

[190] J Keown, 'Reining in the Bolam Test' (1998), *Cambridge Law Journal*, vol.57, 248-250.

[191] *Pearce v United Bristol Healthcare NHS Trust* [1999] ECC 167.

[192] *Pearce* at [21].

[193] *Pearce* at [21].

[194] For a further analysis of the principle of autonomy see Chapter 4.

meaning of 'significant risk', Lord Woolf said it was significant if it could affect the judgement of a reasonable patient. On the facts of *Pearce*, he concluded that the 'very small risk' in question was not significant. The patient's individual values and preferences were given little consideration. Thus, while the language used by the Court of Appeal was suggestive of a movement away from the precedents of the past and towards a more collaborative approach, and while 'the doctor, in determining what to tell a patient, has to take into account all the relevant considerations[195],' the focus remained somewhat detached from the particular patient.

A step towards a refinement of the *Pearce* occurred in *Wyatt v Curtis*.[196] Sedley LJ reconsidered Lord Woolf's approach in *Pearce* explaining that a significant risk should be assessed from the patient's perspective. He acknowledged that the doctor's perspective and the patient's perspective could differ. RMPs could consider a small risk as irrelevant and not enough to be disclosed, while patients could still perceive such a risk as relevant to their decision and therefore conclude that this risk should be disclosed.

Subsequently in *Chester v Afshar*[197] (a case largely on causation in relation to negligent medical treatment) the House of Lords recognized the need to involve patients through the legal endorsement of patients' right to know significant risks to the proposed intervention. In this vein, Lord Hope, following the decision in *Chappel v Hart*[198], emphasized that the function of the law should be the protection of patients' right to choose. He also stated that: 'if it is to fulfil that function it must ensure that the duty to inform is respected by the clinician'.[199] In *Chester*, the lack of information provided amounted to a loss of opportunities to both consider and perhaps take an alternative course of action (e.g., whether to have the surgery or not, or whether to have it at a different time by the same or another surgeon).

More fundamentally, this case rested upon a rejection of a doctor-centred approach and the gradual establishment of a partnership-based approach, though this theoretical foundation was not explicitly stated. Evidence of this approach can be hinted from the judgment where Lord Steyn[200] rejected a doctor-centred stance and stated that patients have a right to be informed of risks related to a surgery, even if small in magnitude**.** He specifically embraced the language of IC, noting that the court was the final arbiter. He also approved Lord Woolf's remark in *Pearce* that if there was a

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[195] *Pearce* at [23]

[196] [2003] EWCA Civ 1779.

[197] [2004] UKHL 41.

[198] [1998] HCA 55

[199] *Chester* at [56]

[200] *Chester* at [11-27].

significant risk, affecting the judgment of a reasonable patient, then it would be, in the normal course of action, the responsibility of a doctor to inform the patient of that risk.

Overall, pre-*Montgomery* case law evolved to give new and additional relevance to a patient-centred approach. Yet, the precise nature of the proposed partnership and the appropriate balance between the medical control and patients' autonomy remained unclear.

2.1.2 The Montgomery case: cementing the importance of a partnership approach in the law of negligence

The move towards a more partnership-oriented approach in the law of negligence has been more clearly endorsed in recent years by a landmark and transformative Supreme Court case: *Montgomery v Lanarkshire Health Board.*[201] This section will describe the changes brought by the *Montgomery* case focusing on the principle of partnership. It will analyse its potential, but also set out both general limitations and difficulties in applying it in the context of abortion. The ultimate aim is to explore the current legal understanding of the RMP-patient relationship in negligence and to offer a further legal justification for a revised theorisation of it to best fit the abortion context and the first medical encounter.

The Supreme Court judgment in *Montgomery* has cemented a move away from paternalism and towards the partnership approach. The novelty of the *Montgomery* approach lies, in this sense, in both complementing the precedent of the past, and moving further on the journey outlined above. This judgment distinguishes between the assessment of risks and benefits, which still forms part of the medical expertise according to the *Bolam*-standard, and the information-sharing, which can be shaped according to patients' values and preferences.[202] This reflects the view that patients are no longer regarded as mere 'passive recipients' of RMP's advice, but are instead conceived as rights-holders.[203]

According to Lord Kerr and Lord Reed:

> '[…] instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing

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[201] [2015] UKSC 11.

[202] *Montgomery* at [82-83]. See also on this point: A M Farrell, M Brazier M, 'Not so new directions in the law of consent? Examining Montgomery v Lanarkshire' (2015), *Journal of Medical Ethics*, vol. 42, 85, 86.

[203] 'One development which is particularly significant in the present context is that patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession.' *Montgomery* at [75].

> outcome), treats them so far as possible as adults who are capable of understanding 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.'[204]

Additionally, they point out that:

> 'The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended intervention, and of any reasonable alternative or variant interventions. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.'[205]

The test of information disclosure, the materiality test, is structured around two limbs.[206] The first limb focuses on the disclosure of what a reasonable person in the patients' position would want to know and implies the relevance of an objective medical component. The second limb focuses on the particular patients' needs and, in circumstances where it is reasonable for the doctor to be aware of them, requires the disclosure of more subjective information. The materiality test, in its two limbs, implies that both an objective medical component and a more subjective and hence patient-oriented aspect should be taken into account when disclosing information. It is hence both a question of doctors' expertise and patients' needs.[207] Additionally, information disclosure is no longer focused on the magnitude of risks[208] arising, nor on the patient proactively asking questions.[209] There is a desire to limit the risk of a priori exclusion of material information from the medical side. The duty to obtain IC is strictly and clearly tied with a partnership approach between the parties, since it is only when a collaboration between RMPs and patients is sought that both medical expertise and patients' needs and values can be balanced.[210]

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[204] *Montgomery* at [81].

[205] *Montgomery* at [87].

[206] See for an interpretation of the materiality test: M Dunn, K W M Fulford, J Herring, A Handa, 'Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Intervention' (2019), *Health Care Analysis*, vol.27, 110.

[207] It should be specified that the two components do not carry the same weight. The second limb is relevant only when it is reasonable for clinicians to be aware of more subjective circumstances.

[208] *Montgomery* at [89].

[209] *Montgomery* at [73].

[210] *Montgomery* at [77-78; 81; 90].

Some commentators[211] challenge the novelty of the *Montgomery* approach considering it to be a mere *reiteration* of what already stated at the soft-law level in the GMC guidance on consent and the NICE guidelines.[212] A move towards a new model for consent which emphasizes patients' contribution was already brought by PG and pre-*Montgomery* case law. Ultimately, this line of reasoning considers the *Montgomery* approach as a mere 'echo' of the soft-law regulation and case law.

In this vein, it appears to be right to say that the *Montgomery* case should not be considered in isolation, and this is something that Lords Kerr and Reed recognized within the judgment itself.[213] The decision should indeed be placed within the context of a gradual evolution of the healthcare practice, as expressed in pre-*Montgomery* case law and soft-law regulation. This gradual evolution was also prepared by further legal and social aspects. On a purely legal level, the *Montgomery* case is the predictable outcome of a change in the healthcare law context [214]both at the national and international levels. However, it is also indicative of wider social changes. Domestic case law of negligence, as outlined in the previous sections, coupled with the enactment of the Human Rights Act 1998, have gradually prepared the basis for a new understanding of the doctor-patient relationship. The context in which the *Montgomery* case was delivered was also one in which patients could easily access medical information, via, for instance, the use of online platforms (e.g., Google).[215] Patients are no longer to be framed as 'empty-recipients' of medical advice, but as persons whose voices need to be heard. For these reasons, it might be a too reductionist approach to consider *Montgomery* as a mere symbolic judgment.

Montgomery has marked a crucial step in the move to a patient-centred partnership.[216]Pre-*Montgomery* case law and GMC guidelines were expressions of a desire

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211 A Farrell A Brazier M, 'Not so new directions in the law of consent? Examining Montgomery v Lanarkshire health Board' (2016), *Journal of Medical Ethics*, vol. 42, 85; C Foster, 'The last word on consent? Montgomery is the belated obituary, not the death knell, of medical paternalism' (2015), *New Law Journal* , vol.165, 8. See also: M Campbell , 'Montgomery v Lanarkshire Health Board' (2015), *Common Law World Review*, vol.44 (3), 222; S W Chan, E Tulloch, E S Cooper, A Smith, W Wojcik, J E Norman, 'Montgomery and informed consent: where are we now?' (2017), *BMJ*, 357:j2224; M Lamb , 'Montgomery: a symbolic or substantive change to the law?' (2017), *North East Law Review,* vol.5, 25; C P McGrath,' 'Trust me, I'm a patient…':disclosure standards and the patient's right to decide' (2015), *Cambridge Law Journal*, vol. 74(2), 211.

212 GMC, 'Consent: patients and doctors making decision together', (2008), online available at: https://www.gmc-uk.org/static/documents/content/Consent_-_English_0617.pdf (accessed 21 October 2020) see especially para 5 ; NICE, 'Caesarean section' (2012), online available at: https://www.nice.org.uk/guidance/cg132/Chapter/1-guidance#woman-centred-care-2, (accessed 21 October 2020).

213 *Montgomery* at [81]

214 See also: M Campbell, 'Montgomery v Lanarkshire Health Board' (2015), *Common Law World Review*, vol.44 (3), 222.

215See on this point: H L Dreyfus, S E Dreyfus, *Mind over machine: the power of human intuition and expertise in the era of the computer* (Oxford: Blackwell, 1986) 16-52, 101-120; E Reid, 'Montgomery v Lanarkshire Health Board and the Rights of the Reasonable Patient' (2015), *Edinburgh Law Review*, vol.19(3), 360. See also *Montgomery* at [76].

216 T Elliot, 'Case Comment: A break with the past? Or more of the same? (2015), *P.N.*, vol. 31(3), 190; E Reid, 'Montgomery v Lanarkshire Health Board and the Rights of the Reasonable Patient' (2015), *Edinburgh Law Review*, vol.19(3),

to give more space to patients' view in the medical context. *Montgomery* is a response to that need, clearly expressed via: 1) the provision of a new test of disclosure, which balances the clinical contribution and patient voice[217], 2) the acknowledged relevance attributed to dialogue and advice between the parties and the importance of reaching a shared decision.[218] *Montgomery*, in this sense, was a clear expression of a desire to cement a partnership-oriented approach.

Applied in the abortion context, it is apparent that women have a right to receive relevant information on risks and reasonable alternatives and their understanding should be fostered, so as to lead them towards a meaningful choice. This rejects the idea that women make a solo decision which RMPs implement; just as it rejects the idea that RMPs decide without any reasonable attempt to find out the risks relevant to the individual patient.[219] In short, it rejects a purely *what* or *who* question approach, and demands consideration of the *how* question.

In light of this analysis, the existence of a problematic *status quo* outlined in Chapter 2 is revealed. There, it was argued that, in practice, RMPs may neglect the decision-making process, and hence consider IC to be satisfied without the meaningful engagement and discourse that *Montgomery* requires.[220] In other words, the *Montgomery* case offers strong legal support for a requirement to embrace a patient-sensitive and fact-sensitive approach,[221] while also valuing the existence of an objective medical component. This means that a determination of what constitutes a material risk[222] and reasonable alternatives includes both an objective medical appreciation and also the peculiarity of each woman and the circumstances involved. A standardized one-size-fits-all approach, which Chapter 2 argued can flow from current law and guidance, does not satisfy this requirement. Instead, a *Montgomery* compliant perspective would require RMPs to provide women considering an abortion with contextualized information concerning risk, benefits, and alternatives to an abortion.

360; Image P, 'After Bolam: what's the future for patient consent?' (2016), *The Lancet*, available online at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)32114-6/fulltext (accessed 21 October 2020)

[217] *Montgomery* at [87]

[218] *Montgomery* at [90]

[219] See also Lord Kerr and Lord Reed: 'An adult person of sound mind is entitled to decide which, if any, of the available forms of intervention to undergo, and her consent must be obtained before intervention interfering with her bodily integrity is undertaken' *Montgomery* at [87]. In other words, before any medical intervention is agreed, a dialogue between the parties should take place, one which gives due time and space to the patient's point of view.

[220]For an understanding of daily-medical practice and the widespread of a mere 'tick-boxes approach' see: P White, 'Consent after Montgomery: what next for healthcare professionals?' (2016), *Clinical Risk,* vol.22 (1-2), 33.

[221] *Montgomery* at [89].

[222] For a further analysis see Chapter 5 section 3.

The *Montgomery* case hence requires that RMPs place strong relevance on dialogue during the decision-making process of abortion. Expanding upon this point, Brannan et al,[223] claimed that, in the mainstream medicine context, there are a series of questions that clinicians should potentially ask themselves, when encountering a patient. These questions can also be relevant when a woman meets the RMP for the first time. They include (*inter alia*):

- Have I made the woman aware of the relevant risks regarding the proposed intervention?
- Have I informed her of any reasonable alternatives and their associated risks and benefits?
- Have I presented this information in a form that the woman can understand?

Following the *Montgomery* approach this would imply seeking a conversation, which will go beyond a mere appreciation of the magnitude of risks and the ability of women to expressly ask questions.[224] This approach gives due value to the actual medical and non-medical needs and circumstances of each woman, which affect her decision to have or not have an abortion. More fundamentally, it asks RMPs to place every woman at the heart of the conversation. In other words, RMPs should acknowledge that they are dealing with pregnant women, who, for a variety of reasons, are not perceiving a pregnancy as a welcomed event in their lives.

This section has argued that the *Montgomery* approach, in its novelty, offers a strong legal case for the existence of a principle of partnership, which puts at the core the relationship between RMPs and women. This judgment highlights that the current doctrinal and political scenario explored in Chapter 2 is problematic and should be reconsidered. The next section will analyse possible limitations of the principle of partnership as expressed within *Montgomery* to then propose a new understanding of it as a way forward.

2.1.3 The limitations of the Montgomery judgment: the Bolam legacy as a potential threat to the partnership approach in the abortion context

The existence of a partnership-oriented approach has, as it has been highlighted above, a strong potential to operate in the abortion context of the first medical

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[223]See, for instance, on the daily-practice implication of this approach: S Brannan, R Campbell, M Davies et al., 'The Supreme Court makes it clear that when it comes to informed consent, patients have a right to know' (2015), *Journal of Medical Ethics,* vol. 41, 429-430.

[224] *Montgomery* at [58, 73].

encounter. This section focuses on possible challenges that might arise. It outlines broader interpretative challenges existent within the *Montgomery* case, and claims that they are relevant not just for the mainstream medicine context, but also in the abortion arena. In particular, it will be claimed that there are applicative challenges that can arise in the abortion context. This section will ultimately argue that, to date, the relevance of the principle of partnership stands along blurred lines given 1) the still pervasive influence of the *Bolam*-approach, and hence a doctor-centred standard of disclosure, notwithstanding the significant progress made in *Montgomery*, and 2) the influence of a consumeristic approach. This reflection will ultimately form the basis for a reconsideration of the principle of partnership to best suit the abortion context.

Let us start with an exploration of broader interpretative challenges within *Montgomery,* which apply across the mainstream medicine context (i.e. traditional treatments such as in a hospital setting) and that can also impact on the abortion context. The major challenge stands in the existence of a tension between what I have phrased elsewhere together with Cave as the '*Montgomery* supremacy' and 'the *Bolam* legacy'.[225] In that paper, we argue that *Bolam* remains relevant to aspects of medical advice, and that the patient-centeredness enshrined in *Montgomery* is not uniformly applicable across all aspects of medicine.

With regard to the first claim, we outline four interpretative challenges that can provide evidence of this phenomenon. Firstly, there was initial uncertainty as to *Montgomery*'s effect on the relevance of the *Bolam* test in disclosure cases. In *Spencer v Hillingdon*[226]*,* the *Bolam* test was applied in the context of advice on post-operative risk subject to a *Montgomery* 'gloss'. Medical professionals needed to ask themselves the following question: 'would the ordinary sensible patient be justifiably aggrieved not to have been given the information at the heart of this case when fully appraised of the significance of it?'.[227] This interpretation was later rejected in *Thefaut v Johnston*[228]*,* where Green J clarified that *Montgomery* was not a variant of *Bolam.*

Secondly, *Bolam* is likely to have relevance in relation to the therapeutic exception, which might be employed by RMPs when they consider the disclosure of material information to be detrimental to the health of the patient. *Montgomery* played a relevant role in the recent Singapore court of appeal judgment in *Hii Chii Kok v OOI Peng Jin London Lucien (Hii).*[229] However, in the formulation of the reasonable consideration for a

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[225] E Cave C Milo, 'Informing patients: the Bolam legacy' (2020), *Medical Law International*, 0, 1, 14.

[226] [2015] EWHC 1058 (QB).

[227] *Spencer* [68].

[228] [2017] EWHC 497 (QB).

[229] [2017] SGCA 38.

waiver of information, and hence medical expertise, *Bolam* was held to be the referral point. Relying on an argument put forward by Cave, we claimed however that this issue did not need to be explored further. The relevance of this exception is dubious and unlikely to be relied upon in legal proceedings in the mainstream medicine context, and also, I would argue, in the abortion context.

Thirdly, the *Bolam* test has relevance in relation to constructive knowledge of risks associated with proposed treatment. The disclosure of material information implies that RMPs should know about these risks. However, if an information on risk is material, but the RMP was not aware of it, this opens the question as to the reasonableness of the RMP position, and how this ought to be judged. In *Duce v Worcester Acute Hospitals NHS Trust*[230]*,* a patient underwent a surgery to being relieved from a pre-existence pain, but was not told that a different pain could arise as a side effect of the surgery itself. The *Montgomery* test in these circumstances was spelled out in a two-part test[231]: the first part reflects on the RMP's awareness of the risks, the second part refers to the reasonableness of risks disclosure which is determined by the court. In light of *Duce* it therefore appears that *Bolam* and *Montgomery* will apply concurrently to different aspects of the disclosure issue. The issue at stake can also be reflected upon in the abortion context. Challenges related to constructive knowledge of risks can arise more prominently in the case of abortion for risk to health and life, as per s.1(1)(b) and (c), and serious fetal abnormality in s. 1(1)(d). This reflection is here used to show, not merely the limitations of a law of negligence approach, but the restrictions that might be placed on a partnership-oriented approach given that an assessment of constructive knowledge of risk partially falls within the *Bolam* test.

A fourth challenge that derives from *Montgomery* concerns the lack of a clear separation between selection of treatment options and disclosure of options. Following *Duce*, arguably the former might be assessed under *Bolam,* because it is a matter of clinical expertise*,* and the latter, under *Montgomery,* because it concerns the patient's supported choice. In *Bayley v George Eliot Hospital*[232] the claimant argued that she was not disclosed an alternative treatment that she would have funded privately. HHJ Worster acknowledged that patients, in line with *Montgomery*, need to be made aware of reasonable alternatives and variant treatments; however, in the circumstances of the case, the proposed alternative was not something that a surgeon would ought to be aware of at that time. In this sense, it seems that *Bolam* was relevant to the assessment of the

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[230] [2018] EWCA Civ. 1307

[231] *Duce* at [83-85]

[232] [2017] EWHC 3398 (QB)

reasonableness of the selection of alternatives. We have argued that it is likely that the two tests are going to sit alongside in assessing constructive knowledge of risk and reasonable alternative options and their communication to patients: *Bolam* remains relevant to aspects of medical advice, and the precise lines of division between the *Bolam* and *Montgomery* materiality tests are not yet clear. This issue creates an overlap between the two standards of disclosure.

A further related issue concerns differential diagnosis. When it comes to abortion for serious fetal abnormality, the disclosure of reasonable alternatives flows from the range of possible diagnoses which may be uncertain or unclear. Pre-*Montgomery* in *Mejklejohn v St George's Healthcare NHS Trust*[233], the duty to warn of alternatives was framed under *Bolam* and the majority in *Sidaway*. In my article together with Cave, we have clarified that in post-*Montgomery*, 'dialogue around differential diagnosis is required where it affects the range of alternative and their relatives risks and benefits' [p.19].[234] In the abortion context, disclosure of uncertainty as to the possible diagnosis following a test for serious fetal abnormality, as per s. 1(1)(d) AA, the possibility of an error in judgment on the side of medical professional and/or the limitation of the test and hence the risk of a misdiagnosis, is still likely to fall within the realm of *Bolam*. This is also likely to influence the information disclosure process and risk endorsing an unbalanced doctor-centred approach.

The tension between a '*Bolam* legacy' and a '*Montgomery* supremacy' is clear in the mainstream medicine context and also has relevance in the abortion context. In light of this, Chapter 5[235] will later claim that *Bolam* would still be framed as the right test in relation to matters of clinical expertise, as it is for instance in the case of formulation of treatment options. Yet, given the interconnection between clinical and elective aspects, which is particularly evident in the abortion context, upholding the principle of partnership will require more.[236] Beyond the tort law spectrum, partnership should be further enhanced through professional guidelines to better calibrate the disclosure process with patients' values and circumstances.

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[233] [2014] EWCA Civ 120 at 62.

[234] See: E Cave C Milo, 'Informing patients: the Bolam legacy' (2020), *Medical Law International*, 0, 1, 14, where we have justified this point based on GMC 2008 guidelines on consent, arguing that guidance are clearer on this point compared to the law.

[235] Chapter 5, section 3.2

[236] See for a wider analysis of the implications Chapter 5-6.

2.1.4 Partnership versus consumerism post-Montgomery

A crucial impact of the *Montgomery* approach is, as it has been clarified above, the push towards a recognition of the importance of partnership. The principle of partnership should inform not only the mainstream medicine context, but also the RMPs-women relationship in the context of abortion, specifically for the first medical encounter. Previous sections provided an overview of possible challenges purported by *Montgomery* and the impact of the *Bolam* legacy for a partnership approach to be pursued in the abortion context. They can be summarized in the lack of a clear line between the still pervasive influence of *Bolam* and the new partnership-oriented test. I am here focusing on an additional challenge, namely the risk of a consumeristic approach. This section reiterates that *Montgomery* constitutes a crucial starting point, while acknowledging the potential drawbacks purported by the way in which the judgment frames patients as consumers. It hence argues that, in the context of analysis, there is a need to seek a RMPs-women relationship that overcomes the risks of framing women as mere consumer of a service (i.e. abortion) through a clearer partnership based approach.

The *Montgomery* approach entails the growth of a RMPs-women relationship in line with what Fulford and others have labelled 'value-based clinical care'.[237] According to Herring, Fulford et.al[238], after *Montgomery*, clinical care will be influenced by the need to understand patients' own value-based system. When applied in the abortion context, this promotes the idea that support would be driven by the specific circumstances faced by women, which affect their choices (e.g. values, preferences, needs). In this sense, Herring, Fulford and others believe that *Montgomery* ultimately implies a *balanced* RMP-patient approach. RMPs are thus called to guide patients in their decision-making process, balancing a series of relevant elements, (e.g. value of a reasonable person in the patient's position and in particular, medical evidence influencing the decision), while never substituting them in their autonomous decisions.

However, the requirement of a balanced partnership-oriented approach is in stark contrast with a consumeristic consideration acknowledged in the judgment itself:

> 'patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely

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[237] K W M Fulford, E Peile, H Carroll, *Essential Values-Based Practice: Clinical Stories Linking Science with People,* (Cambridge: Cambridge University Press, 2012) 3-36;185-200.

[238] J Herring, K M W Fulford et al., 'Elbow room for best practice? Montgomery, patient's values, and balanced decision-making in person-centred clinical care' (2017), *Medical Law Review*, vol. 25 (4), 582.

> treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services.'[239]

Women, in this sense, are 'consumers' recipients of a service, exercising choices. Whilst this categorisation emphasises the need to hear women's voices and respect their choices, it also risks putting in opposition RMP's supportive role and women's autonomy.[240] Arvind and McMahon have rightly pointed out that *Montgomery* misses a crucial dimension of partnership, since it ends up emphasising patients' unilateral decisions, rather than a collaborative and dialogical approach.[241] Consumeristic models view a decision reached without advice and consultation as autonomous -- a conception I will challenge in Chapter 4. This assigns RMPs the limited role of putting into practice patients' expressed will.[242] Yet, building on the work of Goodrich[243], who carried out empirical research amongst UK patients, there are shortcomings in a consumeristic framework. Firstly, the categorisation of 'patients-consumers' is misguided, since patients face inevitable difficulty of having little or no choice at all when it comes to medical decisions. Legal and resource-constraint limitations are inevitably in place. This is because patients, in a public funded system, cannot ask to receive whatever treatment they wish if this is not medically justified. Secondly and equally relevant, is the consideration of the overall psychological situation which affects patients. They are generally in a position of vulnerability compared to the average consumer, since their psychological condition can often be marked by a feeling of discomfort and distress. This vulnerability is often exacerbated in the reproductive arena, where the reality of choice and hence the feeling of being 'without a real choice' [244], implies that a mere guarantee of a right to choose, as it will be further unpacked in the Chapter 4, is not necessarily enough for a personal decision to be reached, or at least, not enough for everyone. Take, as an example, the case of a pregnant woman in an abusive relationship,

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[239] *Montgomery* at [75].

[240] S W Chan, E Tulloch, E S Cooper, A Smith, W Wojcik, J E Norman, 'Montgomery and informed consent: where are we now?' (2017), *BMJ,* 357: j2224.

[241] T T Arvind, A M McMahon, 'Responsiveness and the role of rights in medical law: lessons from Montgomery' (2020), *Medical Law Review*, vol. 28(3) 445, 462.

[242] Further evidence of this approach is the case-law concerning the assessment of the best interest of patients who lack capacity which frames it more and more in line with a subjective perspective and less on the relevance also of an objective medical component. See: *Aintree University Hospitals Foundation Trust v James* [2013] UKSC 67, *Briggs v Briggs* [2016] EWCOP 48; *Salford Royal NHS Foundation Trust v Mrs P and Q* [2017] EWCOP 23 (Fam).

[243] J Goodrich, J Cornwell, 'Seeing the person in the patient', (2008) The King's fund, online available at: https://www.kingsfund.org.uk/publications/seeing-person-patient (accessed 21ST October 2020) 6-44.

[244] See, for instance, on the daily reality of medical choices concerning an abortion: S Lee, 'Abortion in Northern Ireland: the twilight zone', in A Furedi, *The Abortion Law in Northern Ireland*, (Family Planning Association, 1995) 25-26, 37; also on intimate partner violence as a strong risk factor for an abortion-decision see: C C Pallitto, J Garcia-Moreno, H A F M Jansen et al., 'Intimate partner violence, abortion and unintended pregnancy: results from WHO multi-country study on women's health and domestic violence' (2013), *Int J Gynecology Obstetrics*, vol. 120, 3-9.

who is likely to feel she has no choice but to have an abortion. She may, however, also equally welcome receiving advice and support during the medical encounter.

This phenomenon has crucial implications for abortion. If questions concerning abortion entail a medical intervention, this implies (1) that a RMPs-women relationship should be fostered, and (2) that a right to IC should be safeguarded. This should be applied to the first medical encounter, as the first link in a chain of support to be offered. Undermining or neglecting the importance of this first link can also have negative *'domino effects'* on further forms of medical care (e.g. counselling services). As it will be made further evident below, women should be placed at the heart of their relationship with RMPs, holding rights to receive information before any medical decision is taken. However, this should not be translated in a mere individualistic approach, whereby the contribution of the medical sector is considered to be intrinsically irrelevant. Rather, both contributions should be balanced: both medical advice and patients' voice matter.

The next section will show that, building upon the principle of partnership, and moving beyond the consumeristic approach, a new model of revised medicalisation should be sought for abortion. It should be clarified that this will not *a priori* exclude the possibility to extend it to other branches of healthcare law, or extend it beyond the first medical encounter, but it will mainly claim that the considerations outlined are clearly suited for the specific context of analysis.

3. The proposal of a re-framed understanding of the principle of partnership: from rational-non-interventional paternalism to supported decision-making

The analysis conducted so far has identified the existence of the principle of partnership to be derived from *Montgomery*, whilst also pointing to some of its general and specific limitations when applied in the abortion context. Building upon the neglect of a due weight given to the decision-making process in the abortion context (Chapter 2), this section proposes to re-frame the understanding of partnership. It will partially rely upon a model called rational-non interventional paternalism set out by Savulescu,[245]

[245] J Savulescu, 'Rational non interventional paternalism: why doctors ought to make judgments of what is best for their patients' (1995), *Journal of Medical Ethics*, vol. 21, 327. See also: C Charles, A Gafni, T Whelan, 'Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)' (1997), *Social Science and Medicine*, vol. 44(5), 681; J Savulescu, R W Momeyer, 'Should informed consent be based on rational beliefs?' (1997) *Journal of Medical Ethics*, vol. 123(5), 282; C Charles, A Gafni, T Whelan, 'Decision-making in the physician–patient encounter: Revisiting the shared decision-making model' (1999), *Social Science and Medicine,* vol. 49, 651; L Sandman, C Munthe, 'Shared decision-making, paternalism and patient choice' (2010), *Health Care Anal*, vol. 18, 69, 79-80; H Draper, T Sorrell, 'Patients' responsibilities in Medical Ethics' (2002) *Bioethics*, vol.16, 335, 348-349; A Maclean, 'Autonomy, consent and persuasion' (2006), *Eur J Health L*, vol.13, 321, 333. For a wider reflection on different theorisations of RMP-patient relationship, see for instance: E J

in so far as this offers a viable theoretical ground upon which to seek a balance between medical advice and patient contributions. Furthermore, it will propose to align this approach with a supported decision-making model, as recently proposed by the GMC guidelines on consent 2020[246], which will attribute key relevance to a fruitful collaboration between the parties. It will be argued that this approach is supported by doctrine and theory. It reflects the journey of the domestic law of negligence towards a collaborative approach between RMPs and patients. This model has also the benefit to recognize, on one hand, women's vulnerabilities in the context of sensitive decision-making processes like those related to abortion, and on the other, RMPs' role as advisors. This model, which is not currently sufficiently embraced by the abortion legal and ethical contexts in England and Wales, will seek to uphold women's rights as decision-makers and recognise their autonomy rights[247], whilst providing a suitable support structure in which medical advice can be fully utilised.

Before analysing a specific model which should inform the RMPs-women relationship in the abortion context, it is vital to start with an acknowledgement of the peculiar nature of medical judgements. The distinctive characteristic of medical decisions is their double-sided nature: they are, at the same time, based on objective and subjective grounds. The more objective nature of medical decisions is quite intuitive. It is science which provides to be the more objective ground on which medical decisions are and should be based. However, it is also true that medicine has an inevitable subjective component. This is due to two major reasons. (1) Medical diagnosis and hence medical decisions are future-related, and inevitably, therefore, not always fully predictable (e.g. patients' response to medical interventions can vary). This means that, even though patients expect to receive a fully certain and hence objective diagnosis on which to base a personal decision, this might not always be the case, since an inherent subjective component is present in the medical arena. (2) Medical decisions are characterized by their impact on the personal sphere and are often value-based (e.g. relevance of patient's values, needs, environment, socio-economic circumstances). This often has a series of implications. As far as RMPs are concerned, both the way in which they frame the information provided and the overall diagnosis might be influenced by their own value-system. As far as patients are concerned, this subjectivism might imply that the final

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Emanuel, & L L Emanuel, 'Four models of the physician-patient relationship' (1992), *Journal of the American Medical Association*, vol. 267(16), 2221.

246 GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), 17.

247 See on this point a 2018-empirical research emphasising the call for safeguarding women's decision-making role, while acknowledging the relevance, although limited, of medical professionals' contribution: E Lee, S Sheldon, J Macvarish, 'The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revised' (2018), *Social science and medicine*, vol. 212, 26.

medical decision varies according to their personal value-system, but also according to the influence of RMPs.

This double-sided nature of medicine (i.e. both objective and subjective), and in particular its subjective dimension, might appear to be a limitation of clinical reasoning and judgements. In other words, given the relevance of medical decisions, and also the impact they have on every patient, there should have been no room for any subjective dimension, and a fully objective and predictable advice should have been expected. However, Savulescu[248] reinforces the relevance of the double-sided nature of medicine. It is indeed a key characterisation of the medical sector where deep personal interests like those related to concepts like 'harm' and 'benefits' are at stake. In this sense, Savulescu emphasizes the unavoidability of a degree of subjectivism. In his opinion, a pure objective medicine is not only impossible, but also undesirable on patients' perspective, since this would mean denying the essence of this science where a tie with every patient's own reality and hence a certain degree of flexibility is undeniable (e.g. personal values, socio-economic circumstances, health-background etc.).

Whether or not a fully objective medicine is possible/impossible or desirable/undesirable, it might be agreed with Savulescu that a subjective dimension is often present in the medical context.[249] This is clear, I would suggest, in the context of abortion: to offer this medical intervention (i.e, the abortion service) inevitable carries a subjective connotation, for at least two reasons. (1) It can have a different impact on different women, given their health-history, both in a physical and psychological sense; (2) their final decision can be also influenced by their different value-systems and personal circumstances. The crucial question to address is hence not how to eliminate a subjective component. Instead, it is how to find a proper balance between both these dimensions (i.e., subjective and objective).[250] This double-sided connotation of medicine can turn out not to be a limitation of the clinical sector, but rather a strength, provided it

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[248] J Savelscu, 'Rational non interventional paternalism: why doctors ought to make judgements of what is best for their patients' (1995), *Journal of Medical Ethics*, vol. 21, 327; see also on the point of the inevitable subjective dimension of medicine and the need to avoid a 'neutral' approach: J Wyatt , 'Medical Paternalism and the Fetus' (2001), *Journal of Medical Ethics*, vol. 27(2), 15, 18. This can also reflect the model proposed by Sadman and Munthe of 'shared rational paternalism' where the final decision, although formalised by the RMPs, happens after a deliberation with the patient aimed at evaluating views and preferences. See: L Sandman, C Munthe, 'Shared decision-making, paternalism and patient choice' (2010), *HealthCare Analysis,* vol. 18, 60, 61-62.

[249] See also on this point Kennedy [I Kennedy, *The Unmasking of Medicine*, (London: Granada Publishing Limited, 1983) 81-130] reflecting not only on the subjective dimension of medical reasoning but also on its ethical nature inherent. He calls, amongst others, 1) for a medical education which acknowledges the ethical dimension of RMPs' judgement and hence equips future generations of medical professionals 2) for a partnership dimension between RMPs and patients.

[250] This also recalls Macintyre's question concerning the existence of a medical power and wondering how to use it: 'The crucial question concerns the use of this [medical] power, the competence of the profession to judge how this power should be used, and the knowledge base upon which decisions are made', S J Macintyre, 'The medical profession and the 1967 Abortion Act in Britain' (1973), *Social Science & Medicine*, vol.7, 132.

is used as a starting point for a nuanced and balanced understanding of the RMP-woman relationship in the abortion context.

Also relevant in the abortion context, specifically in the first medical encounter, is the model proposed by Savulescu: namely, rational-non-interventional paternalism. RMPs, in this model of soft-paternalism, are not 'mere fact-provider', but advisors.[251] Translated into the abortion context, this does not mean that RMPs should propose a biased and merely personal perspective[252] on the medical intervention in question. Rather, they should more broadly open a shared discussion on medical facts, women's values, and circumstances. In other words, they should balance their own medical expertise, their understanding of women's values and preferences, and the overall situation.

This model of RMP-woman relationship places weight on a dialogical component within the decision-making process. It is the dialogue that has to be rationally based, since it will ask both parties, RMPs and women, to be ready to provide 'reasons' for their points of view. RMPs are called to provide evidence for their clinical analysis and hence what they believe to be the best intervention option for women (e.g. risks, benefits and possible alternatives). At the same time, however, RMPs' perspective does not diminish or undermine women's role. Women are equally called upon to express their preferences, being as open as they desire to dialogue with RMPs.

This dialogue will be 'non-interventional' since it will not deprive women of their capability of being decision-makers. Although formally in law the AA[253] leaves the ultimate decision on legality to RMPs, this will not reflect their own judgment in isolation, but will instead also assure that women's voices are heard. The ultimate aim of this model is to guarantee that the decision-making process concerning a medically sensitive and intimate decision, like the one concerning abortion, places due weight on both women's own perspectives and medical expertise. In doing so, this model fundamentally guarantees that women make an autonomous decision.[254]

Ultimately, the proposal of a nuanced partnership approach is here built upon Savulescu's model in so far as: 1) the advisory role of clinicians is recognized; b) the need

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[251] J Savulescu, 'The proper place of values in the delivery of medicine' (2007), *The American Journal of Bioethics*, vol 7 (12), 21. Contrast this with: R M Veatch, 'Abandoning Informed consent' (1995), *Hastings Center Report*, vol. 25, 5. See also: J Savulescu, 'Liberal rationalism and medical decision-making' (1997), *Bioethics*, vol. 11(2), 115.

[252] On a more general level it should be also recalled that RMPs can also decide not to engage at all in a first medical encounter concerning abortion if they decide to exercise their right to conscientious objections (s.4 AA).

[253] An analysis of the implications on the AA is provided in Chapter 5, section 2.

[254] The idea behind this concept is that it is not possible to be autonomous without a proper focus on how the decision-making process unfolds. It is hence key that a proper balance between RMPs' role and patients' right is sought. See also Chapter 4.

to consider patients as experts too is acknowledged. From 1) and 2) it follows the need to engage into a respectful dialogue. However, the approach proposed here is, also, different from Savulescu's. I do not claim that both parties should embark on a mutually persuasive approach, where each party 'argues on his/her favour'. This is because a mutually persuasive approach can risk building 'walls' between women and RMPs rather than 'bridges' of support. The wall is a confrontational approach. The bridge is, instead, a dialogue, which is rationally-based and which can potentially trigger an evaluative and personal exercise on the side of women before any final decision is made. The true essence of communication[255] becomes an ability of both parties to listen to each other. This can help provide the basis for a self-reflection exercise before a personal decision concerning abortion is taken.

In this sense, the proposed approach recognizes that both RMPs and women carry different, yet relevant expertise. Here I echo Savulescu and Coulter[256], while applying their considerations to the theme of abortion in this way: women are 'experts' too.[257] It is hence not only RMPs who know the best intervention option, but, also women, since they are carriers of personal and peculiar expertise (e.g. self-awareness of values and needs both medical and non-medical) that should be crucial in the medical decision-making process concerning an abortion.

In this proposed partnership framework, both parties will find the opportunity to work towards a decision that reflects a model of authentic autonomy that will be set out in Chapter 4. Authentic autonomy requires an understanding of the women's decision-making role in line with the promotion of her wellbeing.[258] It will show that an authentic autonomous approach fosters women's wellbeing and is consistent with a holistic account of the reality of women's choices. This approach values not only their decision-making role (the who question), and the meaning of the choice (the what question), but also provides a key role to the decision-making process and hence of wider interests involved (the 'how-approach').

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[255] See also on this point: K Taylor, 'Paternalism, participation and partnership- the evolution of patient centredness in the consultation' (2009), *Patient Education and Counselling*, vol. 74, 150; N Levy, 'Forced to be free? Increasing patient autonomy by constraining it' (2014), *Journal of Medical Ethics*, vol.40, 293; N C Manson and O O'Neill, *Rethinking informed consent in bioethics* (Cambridge: Cambridge University Press, 2007) 26-67.

[256] A Coulter, 'Paternalism or partnership' (1999), *BMJ*, vol. 319 (7212), 719.

[257]This can also recall what Wyatt framed as 'expert-expert' relationship as a way to understand the doctor-patient relationship in the abortion context, whereby both parties are considered experts. In this vein the doctor is expert in diagnostic information, treatment options and possibilities, the patient in aspects like family history, family roots, philosophy and way of life. See J Wyatt, 'Medical paternalism and the fetus' (2001) *Journal of Medical Ethics*, vol 27 (2), 15.

[258] See on the need to value autonomy and well-being although in a stronger subjective sense: M Dunn, K W M Fulford, J Herring, A Handa, 'Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Intervention' (2019), *Health Care Analysis*, vol.27, 110.

This position also reflects a 'clinical empathy' approach,[259] where weight is given to a dialogical aspect between the parties, minimising the risk of treating women as routine or standardised cases. Spending time with patients and providing truthful and contextualized information, providing wider opportunities of support can foster a reflective exercise that promotes an autonomous decision. In this sense, the relevance of a dialogical approach comes from the recognition that a mere:

> 'non-interference is, in fact, not benign, because the mental freedom to imagine one's own future often comes not from some process inside one's head, but from processes in the social world. It is through emotional communication starting in early infancy that we develop a sense of agency and efficacy, a life-long process.'[260]

The 'empathic' role of clinicians is justifiable because the ability to make a decision clearly does not come from a mere negative approach (i.e. non-interference), but from a fruitful communication[261] between the parties involved. This is further justifiable because at times the 'choice' of whether or not to have an abortion, can be marked by: 1) a degree of complexity[262], caused by the nature of gestation itself in which the interests of two-beings are at stake[263], namely the woman and the fetus, including also

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[259] J Halpern, *From detached concern to empathy: humanising medical practice* (Oxford: Oxford University Press, 2001) 67-94, this model is considered by Halpern in the context of the doctor-patient relationship in general. This is here used in relation to the specific abortion context. The importance of seeking an 'empathic' relationship is also highlighted by: A Kerasidou, K Baeroe, Z Berger, A E Caruso Brown, 'The need for empathetic healthcare systems' (2020), *Journal of Medical Ethics*, 0, 1; N Quist, 'The paradox of questions and answers: Possibilities for a doctor-patient relationship' (2003), *The Journal of Clinical Ethics*, vol. 14, 79. See also in a different yet interrelated context of unplanned pregnancies and the case of women who wish to continue their pregnancy, where the importance of empathy is also recognised: L Ayerbe, M Perez-Pinar, C Lopez del Burgo, E Burgueno, 'Continuation of unintended pregnancy' (2019), *The Linacre Quarterly*, vol. 86 (2-3),161,163.

[260] See J Halpern, *From detached concern to empathy: humanising medical practice* (Oxford: Oxford University Press, 2001) 116.

[261] See on the relevance of communication: O O'Neill , 'Ethics for Communication?' (2009), *European Journal of Philosophy,* vol. 17, 167-179; N C Manson and O O'Neill, *Rethinking informed consent in Bioethics* (Cambridge: Cambridge University Press, 2007) 26-96; on a critical point of Manson and O'Neill's approach and in particular on the lack of a tie between communication and relationality see: A Maclean, *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 226-259.

[262] P L Ukules, 'Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy' (2011), *American Journal of Law & Medicine,* vol. 37, 567, 578-588; 592-595

[263] On the relationship between fetal and maternal autonomy rights, see Karpin [J Karpin, 'Reimagining maternal selfhood: transgressing body boundaries and the law' (1994), *Australian Feminist Law Journal*, vol 2(36), 45,] who proposes to consider them not as competing but connected interests that needs to be understood in a relational perspective. See also: Mackenzie on relationship of connection and differentiation between women and fetus [C Mackenzie, 'Abortion and embodiment' (1992), *Australasian Journal of Philosophy*, vol. 70 (13), 136, 148-149]. See also in partial disagreement with this point C Pickles, endorsing J Seymour's perspective on the 'not-one-but-not two' approach. This approach claims that there is 'not one' identity (i.e., woman alone) but not even two different ones (women and fetus) involved in the abortion scenario. It accounts for a relational view of pregnancy that recognizes the existence of both women and fetus, while granting strong autonomy rights to the mother. See: C Pickles, 'Approaches to pregnancy under the law: a relational response to the current South African position and recent academic trends' (2014), *De Jure,* vol. 47(1), 20, 34-38.

concurrent third-parties interests (e.g., the father)[264]; 2) a degree of distress[265] that women might face, given the existence of a potential wide variety of circumstances impacting on their decision-making process (e.g. stigma[266], abusive relationships[267], fear of fetal abnormality[268]). Echoing here Halpern's[269] reflection, in complex contexts often affected by circumstances of distress, the ability of a patient's 'self-efficacy as well as their ability to imagine goals for the future'[270] can be crucially impaired. In this sense, communication and relationality are two sides of the same coin. There is no proper information disclosure, as it will also be shown also in Chapter 4, without a relational dimension between RMPs and women.

Partially disagreeing with O' Neill and Manson, which emphasise the relevance of communication *per se*[271], and following Maclean's approach, who values communication and relationality,[272] it becomes apparent that communication without relationality can end up in a form of 'abandonment'[273], which is the opposite of the way in which I have framed the principle of partnership. In other words, if an information disclosure was enough on its own (e.g. information provision and signature of a given form), women would have been ultimately left to their own responsibility, or worse, abandoned to their fate. Unless women expressly refuse an IC discourse[274], they should be accompanied in

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264 See a research study unpacking abortion as a possible solution, yet problematic and difficult: M Kirkman, H Rowe, A Hardiman, D Rosenthal, 'Abortion is a difficult solution to a problem: a discursive analysis of interviews with women considering undergoing abortion in Australia' (2011), *Women's Studies International Forum*, vol. 34, 121.

265 See on this point for instance: N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007) 141-160, for a further analysis see Chapter 4.

266 See an empirical study on the impact of abortion-related stigma as a factor affecting women's decision-making process: L Hoggart, V L Newton, 'How could this happen to me? Young women experiences of unintended pregnancy and abortion: key findings' (2015), The Open University, Milton Keynes, UK, online available at: http://oro.open.ac.uk/45139/1/MSI_quali-report_10-15_final_email.pdf (accessed 21 October 2020).

267 C C Pallitto, C Garcia-Moreno, HAFM Jansen, L Heise, M Ellsberg, C Watts 'Intimate partner violence, abortion, and unintended pregnancy: results from the WHO multi-country study on women's health and domestic violence' (2013), *Int J Gynecology Obstetrics*, vol. 120, 3; A J Taft, L F Watson, 'Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women' (2007), *Australian and New Zealand Journal of Public Health*, vol. 31(2), 135.

268 K C Jeon, L S Chen, P Goodson, 'Decision to abort after a prenatal diagnosis of sex chromosome abnormality: a systematic review of the literature' (2012), *Genetics in Medicine*, vol. 14(1), 27. See also a study emphasising the need for an informed-consent discourse in the fetal abnormality context: G Gorincour, S Tassy, A Payot, P Malzac et al., 'Decision-making in termination of pregnancy: A French perspective' [FRENCH TEXT] (2011), *Gyne´cologie Obste´trique & Fertilite´,* vol. 39, 198.

269 J Halpern, *From detached concern to empathy: humanising medical practice* (Oxford University Press, 2001) 67-94; J Halpern, H M Weinstein, 'Rehumanasing the other: empathy and reconciliation' (2004), *Human Rights Quarterly,* vol. 26, 561.

270 See J Halpern, *From detached concern to empathy: humanising medical practice* (Oxford: Oxford University Press, 2001),104.

271 N C Manson and O O'Neill, *Rethinking informed consent in Bioethics* (Cambridge: Cambridge University Press, 2007) 26-96.

272 A Maclean, *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 220-259.

273 A Maclean, 'Autonomy, Consent and Persuasion' (2006), *European Journal of Health Law*, vol. 13, 321-338.

274 *Montgomery* at [85].

their journey of decision-making by medical staff, while still receiving basic information.[275]

The proposed approach also echoes the GMC approach on decision-making and consent.[276] Building upon the 2008 guideline, the latest 2020 guideline[277] emphasizes that patients should be supported in their decision-making process through a fruitful and respectful relationship with medical staff, which takes the form of supported-decision-making. This model requires that RMPs listen and support women during their decision-making process, valuing them not merely as decision-makers, but also as someone in the path towards a personal decision. RMPs, as advisors with their medical expertise, should therefore guide women in their path, providing them with relevant information in line with medical expertise, balanced with needs and circumstances. RMPs are not called to a mutually agreed decision, but rather to be involved in the decision dynamics as advisors during the decision-making process.

Echoing also Cave's[278] work on shared decision making in the doctor-patient relationship, the approach proposed here can also reflect the desire to give 'more attention to the *dynamics* of decision-making, a better and more nuanced combination of patient preferences' and to balance 'professional expertise and the evidence-base'.[279] This also implies that high-level dynamics should be in place, namely those that do not seek to achieve mere information provision, but also an active participation of both parties, offering the space for reflection and advice.

Ultimately, in this line of reasoning, RMPs owe to every woman a deeper level of attention and interaction that goes well beyond a mere detached protection of a standardised and routine process. RMPs need to give time and space, in line with women's particular circumstances and needs, where a cooperative and hence dialogical relationship is pursued.

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[275] This also mean that the first medical encounter is a key, yet a starting point for an ongoing support to be offered, unless this is openly refused by the woman.

[276] This is purported in GMC 2008, GMC 2018 draft guideline and GMC 2020. See on this point: GMC, 'Consent: patients and doctors making decision together', (2008), online available at: https://www.gmc-uk.org/static/documents/content/Consent_-_English_0617.pdf (accessed 21 October 2020); GMC, 'Decision-making and consent: supporting patient choices about health and care, Draft guidance for consultation', October 2018, online available at: https://www.gmc-uk.org/-/media/gmc-site-images/ethical-guidance/related-pdf-items/consent-draft-guidance/consent-draft-guidance.pdf?la=en&hash=E85F0DD8C7033541BF51F1C619EF992B1A45A188 (accessed 21 October 2020); GMC, 'Decision Making and consent, working with doctors, working for patients', *above*, (2020).

[277] See particularly: GMC, 'Decision-making and consent: supporting patient choices about health and care, Draft guidance for consultation', (October 2018), 5; GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), 7,11, 17,39.

[278] E Cave, 'Selecting treatment options and choosing between them: delineating patient and professional autonomy in shared decision-making' (2020), *Health Care Analysis*, vol. 28, 4.

[279]E Cave, 'Selecting treatment options and choosing between them: delineating patient and professional autonomy in shared decision-making' (2020), *Health Care Analysis*, vol. 28, 4, 18.

This is because it has the potential to lead to a variety of possible benefits. Firstly, it fosters a relationship of mutual trust between RMPs and women in the context of abortion. Women, ultimately, will be more likely to perceive RMPs as trustworthy persons who are paying attention to their own individuality.[280] This might enhance not a mere 'blind trust'[281] as an unconditional paternalistic reliance on the medical sector, but a more genuine trust, where women see RMPs as fiduciary persons, advisors.[282] Secondly, this dialogical understanding can work positively on women's self-esteem and capability of being a decision maker. In other words, this approach can have positive 'therapeutic effect' and enhance women's capability to make any medical decision, strengthening her authentic autonomy.[283] Further, this model is beneficial insofar as it values every patient as a person.[284] Stewart[285] argues that the recognition of others' humanity allows us to discover our own authentic humanity. RMPs are indeed called to recognise the personhood behind every woman: she is someone deserving to be treated with dignity[286] and respect, not a mere routine case.

However, to engage into a more partnership-oriented approach might seem to place a strong obstacle to the rapidity of accessing abortion. As it has been clarified above in the section concerning the consumeristic challenge, access to the service and hence the desire to foster its rapidity, are but one side of the coin. If considered in isolation from the principle of partnership they can negatively affect the decision-making process and can risk leading towards patients' abandonment. This is because decisions following an unplanned pregnancy can be marked, at least for some women, by a degree of distress. In this sense, a reduction or exclusion of a relational dimension with RMPs is

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[280] See on a move towards greater attention to patients' needs: J Halpern, *From detached concern to empathy: humanising medical practice* (Oxford: Oxford University Press, 2001)10, 39-49; J Tamin, 'Can Informed Consent Apply to Information Disclosure? Moral and Practical Implications' (2013), *Clinical Ethics,* vol. 9(1), 1.

[281] See on this point: T L Beauchamp , 'Informed consent: its history, meaning and present challenges' (2011), *Cambr Quart Healthcare Ethics* ,vol. 20, 515; A R Dyer and S Bloch, 'Informed consent and the psychiatric patient' (1987), *Journal of Medical Ethics*, vol. 13, 12; M Brazier and M Lobjoit, 'Fiduciary relationship: an ethical approach and a legal concept?', in: R Bennett and CA Erin (eds) *HIV and AIDS Testing: Screening and Confidentiality* (Oxford: Oxford University Press, 1999) 187; I Kennedy, 'The fiduciary relationship and its application to doctors and patients', in: P Birks (ed), *Wrongs and remedies in the twenty-first century* (Oxford: Oxford University Press, 1996) 111–140.

[282] This also recalls the so called 'attachment' theory of doctor-patient relationship see: P Salmon, B Young, 'Dependence and Caring in Clinical Communication: The Relevance of Attachment and Other Theories' (2009), *Patient Education and Counseling*, vol. 74(3),331.

[283] See Chapter 4, section 3.

[284] See for instance: M Gregg Bloche, K P Quinn, 'Professionalism and personhood ', in: D C Thomasma, D N Weisstub, C Herve, *Personhood and Health Care* (Dordrecht: Kluwer Academic Publishers, 2001), 347-352.

[285] D Stewart, A Mickunas, *Exploring phenomenology. A guide to the field and its literature*, (Ohio University Press, 2nd edition, 1990)67.

[286] For a further analysis of the concept of dignity see also: C Foster, 'Putting dignity to work' (2012), *The Lancet,* vol. 379, 2043; R Macklin, 'Dignity is a useless concept' (2003), *BMJ,* vol. 327, 1419; E D Pellegrino, A Schulman, T Merrill, eds. *Human dignity and bioethics* (Notre Dame, IN: University of Notre Dame Press, 2009)297.

not necessarily beneficial[287] because it has the potential to result in women's abandonment.[288] The necessity to respect women's agency cannot mean abandoning them to their own fate, conversely there is a need to foster a relational dimension which provides them with due medical support in their decision-making process.

This issue will be further explored in Part 3 when the implications of this approach will be explored. At this stage, it is enough to say that the medical encounter should give stronger weight and value to the relationship with patients over access and broad time related concerns. These challenges, whether endemic to the administration of healthcare service, or related to the progress of the pregnancy, should never trump the importance of dialoguing and listening to patients' voice. Access alone if not tied with the opportunity of support and hence partnership risk leading to patients' abandonment.

The 'how-approach' proposed by this thesis, firstly built upon the concept of partnership, focuses on the advisory role of clinicians, values a rationally based dialogue with women, recognising the 'expertise' of both parties in a relational approach, and offers support in the decision-making process. This appears to be optimal for the abortion context of the first medical encounter. This model of revised medicalization of abortion strives for collaboration rather than opposition between the parties, while also opposing the reduction of clinical involvement, which may lead to abandonment. This is also tied to a reframed understanding of autonomy, as Chapter 4 will suggest. Considered together, Chapters 3 and 4 will stress the importance of reframing the way in which the first encounter between women and RMPs should be shaped in the abortion context in England and Wales.

4. Conclusion

Chapter 3 proffers an analysis of the first of the two principles proposed by this thesis as guiding principles for a new 'how-approach': the principle of partnership. Building upon the IC case law, it proposes a nuanced application to the context of abortion and the first medical encounter.

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[287] On a critical point see: S Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016), *The Modern Law Review,* vol. 79 (2), 283; S Sheldon, 'How can a state control swallowing? The home use of abortion pills in Ireland' (2016), *Reproductive Health Matters*, vol. 24 (48), 90; E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283.

[288] See on the concept of abandonment: A Maclean, 'Autonomy, Consent and Persuasion' (2006), *European Journal of Health Law*, vol. 13, 321; A Maclean, *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 220-259; R Heywood, 'Excessive Risk Disclosure: The Effects of the Law on Medical Practice' (2005), *Medical Law International*, vol. 7, 9; R Heywood, 'Re-thinking the Decision in Pearce' (2005), *Contemporary Issues* in *Law*, 264. Further analysis of this concept is provided in Ch 4.

It started with an analysis of the historical journey of the law of negligence towards the recognition of the relevance of the role of patients within the medical encounter and the gradual move towards a fruitful partnership with RMPs. It explored in particular the Supreme Court judgment in *Montgomery,* which championed patient choice, but also highlighted the relevance of dialogue and support between the parties. It has been argued that the application of the judgment is not free from challenges. This flows from the pervasive influence of the previous doctor-centred standard of information disclosure, phrased as a '*Bolam*-legacy'.[289] Also, certain aspects of the judgment take a consumeristic view, implying that it is the patient's perspective alone which has increasing value. Both these factors, the '*Bolam*-legacy' and a consumeristic view, I have suggested, can undermine partnership, either by over-emphasising medical control, or by over-emphasising patient choice. Hence it has been necessary in this Chapter to clarify the partnership model suggested in *Montgomery*.

To this end, this Chapter has proposed a revised medicalisation to be sought in the domestic abortion context. Building on work by Julian Savulescu, it has proposed a model of rational non-interventional paternalism, which sees both RMPs and patients as holding relevant expertise which should be carefully balanced. I have, however, adapted this model to better accommodate the supported decision-making approach, which reflects the new 2020 GMC guideline, emphasising the relevance of dialogue and communication as key aspects of the medical encounter.

The next Chapter will focus on the principle of autonomy and propose a redefinition in line with a thick understanding of autonomy. Together, Chapters 3 and 4 will constitute the theoretical framework upon which this thesis is built, and which will pave the way for the proposition of revisions to law and professional guidance in Part 3.

[289] E Cave, C Milo, (2020), *above.*

Chapter 4

The principle of authentic autonomy

Deriving and adapting the *Montgomery* principle of autonomy to suit the context of abortion and the first medical encounter in England and Wales.

1. Introduction

Two principles underlie the proposed 'how-approach' to a revised medicalisation of abortion. Chapter 3 considered the relevance of the principle of partnership, examining it in case law, in its doctrinal limitations, and proposing a particular theoretical conception. This Chapter considers the principle of autonomy in a similar fashion. Here too, an analysis of the judgment in *Montgomery* is provided. Also, the principle is critiqued and reinterpreted to best suit the context of abortion and the first medical encounter in England and Wales.

This Chapter argues that a thick conception of autonomy, referred to as 'authentic autonomy', should be promoted. This conception aims to protect meaningful choices based on relevant information, dialogue, and support from the RMP. Authentic autonomy (thick conception) will be differentiated from autonomy as self-determination (thin conception). The latter tends to emphasize women's choice alone, and in doing so, it can lose sight not only of women's vulnerabilities, but also of wider interests involved in the abortion context (including, for example, women's health-related interests and other stakeholders' interests, e.g., fetus' interests and father's interests). This Chapter will show that, when it comes to IC[290] and autonomy, recognition of the decision-making role, if not supported with the opportunity to gain relevant understanding and support during the decision-making process, is no more than an 'empty vessel'. Pure autonomy as self-determination promises empowerment and control over the reproductive arena, but it can, I suggest, result in a form of abandonment and lack of control. A nuanced understanding of autonomy – of 'authentic autonomy' – is, it is argued, required as justification for both the supportive role of RMPs and the 'how-approach'.

[290] This Chapter does not seek to consider autonomy as 'the' one and only principle. Foster was right in claiming that autonomy cannot be the sole principle to be praised. This Chapter is hence using a specific reflection on autonomy to highlight some of its inconsistencies and propose a possible change in conceptual approach. See on this point: C Foster, *Choosing life Choosing death: the tyranny of autonomy in medical ethics and law,* (London: Hart, 2009) 7-9.

2. The principle of autonomy

2.1 A definition

A lot of ink has been spilt on the meaning attached to the principle of autonomy. Before embarking on an analysis of the specific tie between IC, autonomy, and abortion, an overview of its content should be provided.

The word autonomy has a Greek origin, *autos-nomos*, and means the capacity of being self-ruled, of having mastery and control over one's own life. Going beyond the literal meaning, in his book on autonomy, Foster provides a broad conceptualisation of this principle under four different senses, which can here help understanding the existing doctrinal scenario.[291]

The first is a Kantian sense.[292] The Kantian approach to proper autonomy[293] means acting in accordance with the universal moral law. The autonomous will for Kant is rational and should obey the categorical imperative and this should be willed as universal. To act autonomously hence means, in a duty-based perspective, to freely opt to do what is right. The meaning and content of what constitute the universal law, however, is often difficult to specify. A duty-based conceptualisation has nevertheless the benefit of recognising that to be autonomous, at the very least, entails an account for wider interests, beyond mere individual agency. These wider interests are often other-related, and both impact and are impacted by someone's act. Foster also rightly points out that the limitation of this perspective is that it perceives the worth of human beings only in so far as they are decision-makers and attend to their life-plans, excluding or

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[291] C Foster, *Choosing life Choosing death: the tyranny of autonomy in medical ethics and law,* (London: Hart, 2009) 7-9. For a different conceptualisation of the existing debate, see: A Maclean, *Autonomy, Informed Consent and medical law* (Cambridge: Cambridge University Press, 2009) 9-29. Maclean distinguishes between the nature of autonomy and the value of autonomy. As far as the former is concerned, he considers: a) autonomy as self-determination, b) autonomy as rational self-determination, c) autonomy as moral rational self-determination. He then provides an account of the value of autonomy. Autonomy in this sense has both an intrinsic value, namely one that arises from its relationship with rationality and agency, and an instrumental value for the broader benefits that respecting an autonomous choice can achieve (e.g. well-being). Further relevant ways of theorising autonomy have been also provided by J Coggon in his account of ideal desire, best desire and current desire autonomy [J Coggon, 'Varied and Principled Understandings of Autonomy in English law: Justifiable Inconsistency or Blinkered Moralism?' (2007), *Health Care Anal*, vol.15(3),235] and Feinberg in his conceptualisation of autonomy as self-regulation [J Feinberg, *Harm to Self. The Moral Limits of the Criminal Law* (Vol. 3), (Oxford: Oxford University Press,1986); ——, 'Autonomy', in: J P Christman, *The inner citadel: essays on individual autonomy*, (New York: Oxford University press, 2nd ed, 2014), 54-62.]

[292] C Foster, *Choosing life Choosing death: the tyranny of autonomy in medical ethics and law,* (London: Hart, 2009) 7.

[293] Kantian autonomy is a form of substantive autonomy in so far as it accounts for acting in line with a moral rule (i.e. universal law). See: I Kant, *Groundwork of the metaphysics of morals*, H J Paton (trans) (New York: Harper, 1964), -- *Critique of Practical Reason*, L W Beck (trans) (New York: Garland, 1976).

attributing less-worth to all those who are not able to exercise this role (e.g., patients lacking capacity).

The second sense is a 'psychological ideal'.[294] Foster includes in this second category the perspective purported by Dworkin.[295]Autonomy becomes here the characteristic of someone who is self-directed and is master of his/her own life plans. An autonomous person is able to critically reflect and act upon his/her own preferences, desires, and wishes. In this sense, exercising autonomy means moving from mere instincts that, Dworkin calls first order desires, to a critical reflection on personal values and desires, which he calls second order desires. Foster, however, points out that this approach might promise more than it is actually able to achieve. In daily life, very few choices will allow for this ideal degree of critical thinking. Foster's concerns make a crucial 'reality check' point, which is worth taking into account to avoid any 'idealisation' of autonomy. For the purpose of our analysis, however, Dworkin's perspective is still relatively appealing. Dworkin's understanding of autonomy positively includes a reflective exercise within what it means to be an autonomous person, and can, despite its practical limitations, speak to some extent to the IC and abortion context, as it will be discussed below. For now, what is worth deriving from Dworkin's reflection is that autonomy is more than exercising a decision-making role: it involves also a focus on the decision-making process.

The third sense is autonomy as a reason to place some constraint on action.[296] Foster describes this as the reason why in the law certain actions cannot be performed. Take, for example, the law of consent in England and Wales. Here, doctor Y should not perform an abortion to patient X when she legally refuses it. In law, when the patient is an adult with legal capacity she can consent or refuse any medical treatment.[297] This is clearly predicted upon a protection of patients' autonomy and a constraint on clinical actions.

The fourth sense is an evaluative understanding of autonomy.[298] Understood in this way, autonomy is a quality worthy of respect *per se*. There is in this sense no need to scrutinize the grounds upon which a decision is made: whether, for instance, it is fully informed or not, or whether it will lead to a result that is beneficial for the patient or not, is irrelevant. What is relevant is the choice itself, since 'choice matters per se'. Foster believes that this understanding portrays autonomy as the supreme principle, where

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[294]C Foster, *Choosing life Choosing death: the tyranny of autonomy in medical ethics and law,* (London: Hart, 2009) 8.

[295] G Dworkin, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988) 3-20, 21-33.

[296] C Foster, *Choosing life Choosing death: the tyranny of autonomy in medical ethics and law,* (London: Hart, 2009) 8.

[297] See on this point: *Re B (Consent to treatment: capacity*) [2002] 1 FLR 1090

[298] C Foster, *Choosing life Choosing death: the tyranny of autonomy in medical ethics and law,* (London: Hart, 2009) 9.

there is no room for any concurrent evaluation concerning, for instance, patients' beneficence or harm avoidance. This recalls also what in Chapter 2 has been claimed to be the 'who-question' focus: what matters is the pregnant woman's choice. Crucially here, there will be limited space for a partnership approach between women and clinicians and hence for availability of any additional support (e.g., counselling services).

These four senses of autonomy portray a broad picture of how autonomy has been spelled out in doctrine, albeit necessarily non-exhaustive. From the Kantian perspective, to Dworkin, to autonomy as a reason to place constraints on others, to an evaluative perspective, autonomy has been given strong emphasis in the ethical and legal debates in healthcare law. The next section will bring this reflection further into the context of abortion in England and Wales, analysing the relationship between women's autonomy and abortion.

2.2 Women, as decision-makers? A holistic account of women and reproductive choice.

Before moving to an analysis of the principle of autonomy and its relevance within the IC context, it is useful to recall the role that this thesis is attributing to women's autonomy in the reproductive arena. This will help form a premise upon which a reinterpretation of autonomy can be proposed. The legal landscape in England and Wales to date does not consider women as the sole decision-maker in the abortion context,[299] given that, at least formally, RMPs can refuse to grant access to an abortion. This thesis is not proposing a shift in the *status quo* that would remove the gatekeeping role of RMPs, but rather it is proposing that the question of access is bound to the related matters of support and information provision. Previous Chapters have argued that the role of women and RMPs need to be more clearly framed as a partnership that values women's needs and circumstances, understood in a wide sense, coupled with RMPs' advice and support.

The AA has been considered by some to be unsuccessful in its attempt to safeguard women's autonomy as self-determination. I will aim to refute such views and propose a different theorization of autonomy in the abortion context. According to Jackson[300], in an approach that equates autonomy and self-determination, the current stance of the AA is not justifiable. Abortion is, in her perspective, a routine operation that should be subjected to the same regulatory system as all medical procedures. The failure to

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[299] s. 1(1)(a) AA and the requirement of the involvement of two RMPs.

[300] E Jackson, *Regulating reproduction*, (Oxford and Portland: Hart Publishing, 2001) 71-110.

'normalize' abortion hence reflects a stigmatisation of this medical intervention and a desire to exercise a medical control over it.[301] Sheldon and Boyle[302], too, consider the AA unsatisfactory, because it fails to grant women's right, based on their self-determined agency. Abortion, from their perspective, can be framed not merely as a positive liberty[303], namely a right to demand access to abortion, but as a negative liberty, namely a women's right to exercise control over their reproductive sphere free from any external interferences (e.g., medical control). Lee[304] highlights that there is a gap between the 'law on paper' (i.e., the AA) and the 'law in practice', whereby the former appears to be more restrictive than the latter, particularly with regard to the 'social ground' to abortion under s.1(1)(a). From this perspective, the law should be aligned to what already happens in practice and should therefore better protect women's autonomy as self-determination, by allowing them unfettered choice.[305]

All of these reflections on the alleged failure of the AA to promote and protect women's autonomy, however end up missing broader considerations that might arise during the decision-making process, starting at the first medical encounter. The unsatisfactory nature of an approach that equates autonomy with self-determination can be broadly appreciated, I would suggest, through a consideration of the variety of experiences associated with an abortion. Some women may perceive abortion as a 'choice' to be exercised[306], but it is contended that not all women necessarily perceive an abortion in these terms.[307] Some women may not perceive themselves as decision-

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301 See on this point: E Jackson, 'Abortion Autonomy and prenatal diagnosis' (2000), *Social & Legal Studies*, vol. 9(4), 467.

302 See on this point: S Sheldon, *Beyond control: Medical Power, Women and Abortion Law* (London: Pluto Press, 1997) 35-48; M Boyle, *Re-thinking abortion: psychology, gender, power and the law* (London: Routledge, 1997) 12-25; E Jackson, *Regulating reproduction*, (Oxford and Portland: Hart Publishing, 2001) 71-110; E Lee, S Sheldon, J Macvarish, 'The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revised' (2018), *Social Science and Medicine*, vol. 212, 26-32.

303 See on this point: I Berlin, 'Two Concepts of Liberty', in: I Berlin, *Liberty*: *incorporating Four Essays on Liberty*, (London: Oxford University Press, ed. by Hardy H, 2002) 167-217.

304 E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol 18, 283, 287. See also: E Lee, 'Tensions in the regulation of Abortion in Britain' (2003), *Journal of Law and Society*, vol.30(4), 532; K Greasley, *Arguments about Abortion: Personhood, Morality, and Law* (Oxford: Oxford University Press 2017) 203-222; E Jackson, 'Abortion Autonomy and prenatal diagnosis' (2000), *Social & Legal Studies*, vol. 9(4), 467.

305 E Lee, 'Young Women, pregnancy and abortion in Britain: a discussion of law in practice' (2004), *International Journal of Law Policy and the Family*, vol. 18, 283-304; J Keown, *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982* (Cambridge Studies in the History of Medicine), (Cambridge: Cambridge University Press, 1988) 137.

306 N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007)141-160. This thesis is using Priaulx argument in so far as it challenges the ethics of 'choice' and the abortion debate. In a 2008-piece she also reinstated that to confine the question of abortion to a woman's right to choose is to bring forward a narrow view of the problem and silencing those who do not experience this matter as a 'choice'. N Priaulx, 'Rethinking progenitive conflict: why reproductive autonomy matters' (2008) *Medical Law Review*, vol. 16, 169, 193-197.

307 A Furedi, *The moral case for abortion*, (London: Palgrave MacMillan, 2016) 161-184.

makers, but may consider that they are left 'with no choice but to choose' abortion.[308] The latter experience is summed up in Priaulx's concept of the 'harm paradox'.[309] When women deciding whether to have an abortion feel that there is no alternative but to choose abortion, every outcome is only formally an expression of a decision-making role. It would be more realistic to consider the outcome as the product of broader circumstances to which women, using Priaulx's terms, are 'conforming'.[310] Such circumstances are listed in a variety of stigma that might influence women's decisions.[311] These stigmas include, for instance, motherhood as a burden on women,[312] motherhood as a natural call[313], family-related expectations (e.g., to finish university before having a child), peer pressure (e.g., pressure from a partner or parent). The pressure to decide one way or another, is, according to Priaulx, an expression of a conformation process towards a series of external and internal circumstances, rather than one of self-determination. [314] Such pressures do not necessarily amount to a form of undue influence, namely an influence from third parties, but they nevertheless show the limitation of a 'thin' conception of autonomy. Ultimately, in her analysis, Priaulx opines that often women experience a lack of sense of control over this decision to the point of not perceiving it as a choice at all.

Drawing upon Priaulx's perspective, while also going beyond it, this Chapter will contend that the harm paradox can also flow from the lack of a due weight given to the

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[308]N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007)141-160; M Fox, 'A woman's right to choose? A feminist critique', in: J Harris, S Holm, *The future of reproduction* (Oxford: Clarendon Press, 1998)82; E Fegan, 'Recovering women: intimate images and legal strategy' (2002), *Social and legal studies*, vol.11(2),155.

[309] N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007) 161-184.

[310]N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007)113-160; L Hoggart, V L Newton, L Bury, 'How could this happen to me? Young women experiences of unintended pregnancy and abortion: key findings' (2015), The Open University, Milton Keynes, UK, online available at: http://oro.open.ac.uk/45139/1/MSI_quali-report_10-15_final_email.pdf (accessed 21st October 2020)

[311] N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007)113-140. See also: M Boyle*, Re-thinking abortion*, (London: Routledge, 1997), 102-127; M Lattimer, 'Dominant ideas versus women's reality: hegemonic discourse in British Abortion Law', in: E Lee, *Abortion law and politics today* (London: MacMillan Press LTD,1998) 59-75.

[312] See also on this point the recent NHS campaign on emergency contraception indirectly portraying a negative perception of pregnancy, news coverage available at: Evening Standard, 'Backlash over 'out of touch' and 'sexist' contraception posters asking women to choose between high heels and lipstick or dummies',(16th September 2018), online available at: https://www.standard.co.uk/news/uk/backlash-over-out-of-touch-contraception-posters-asking-women-to-choose-between-high-heels-and-a3937101.html (accessed 21st October 2020). Further negative perception of pregnancy from the news, see for instance negative experience associated with birth: BBC NEWS, 'Birth trauma mother 'wanted to die'', (4th April 2018), online available at: https://www.bbc.co.uk/news/health-43628935 (accessed: 2 October 2018) ; BBC NEWS, 'I was in a really negative terrible place', (3rd January 2018), online available at: https://www.bbc.co.uk/news/health-42557712 (accessed 21st October 2020)

[313] S Sheldon, 'Unwilling father and abortion: terminating men's child support obligations?' (2003), T*he Modern Law Review*, vol. 66, 175.

[314] An account of autonomy as self-determination, can be also unrealistic, and purport an idea of a self-sufficient and atomistic individual, a paradigm that overlooks the realty also of social forces to the production of selfhood. See on this point: A Baier, *Postures of the mind: Essays on mind and morals* (Minneapolis, MN: University of Minnesota Press, 1985)89-90.

decision-making process.[315] Ultimately, in order to take autonomy and partnership more seriously in the abortion context, proper value must be given to the path towards a choice, which starts from the first medical encounter. Autonomy, as it will be further explained below, should not be understood as a 'status' where individual agency is valued per se, but, in a thick sense, as 'capacity' or effective deliberation[316] that takes into account its actual exercise and hence the decision-making process. [317] In a dynamic sense, this understanding focuses not merely on the existence of a decision-making role alone, or on the content of the choice itself, but values the path leading towards the decision about abortion.

The proposed reframed understanding of autonomy does not deny that the practical reality might be more complex than its theoretical dimension. A relevant research study[318] has shown, for instance, that women who are uncertain about 'what to do' with an unplanned pregnancy often experience a mixture of opposing feelings, such as a desire of both independency and dependency, in wanting to be surrounded by trustworthy people. There is evidence that women do not feel that the term 'autonomy' is the one that best suits their decision, given the complexity of their decision-making and of the implications of their choice. Acknowledging that a 'gap' between theory and practice is to some extent inevitable, this thesis recognizes the value in limiting the gap, by challenging the *status quo* and (in the context of this Chapter) raising awareness as to the limitation of a thin-conception of autonomy.

2.3 The principle of autonomy in the IC literature and case law

The starting point for the proposal of a change in the conceptualisation of autonomy in the abortion context is a reflection on the common law approach to IC in England and Wales. This section offers an overview of relevant IC literature and case law that shows the weight and meaning associated to this principle. It will claim that the IC

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[315] For a critical approach see Boyle emphasising that women generally decide prior to medical meetings. However, despite some caveats, she recognizes the positive impact of social support, also from professionals, during the decision-making process to avoid post-abortion negative aftermaths: M Boyle, *Re-thinking abortion: psychology, gender, power and the law* (London: Routledge, 1997) 111-114, 120.

[316] See on the point of status and capacity: C Mackenzie, 'Feminist conceptions of autonomy', in: A Garry, S Khader, A Stone, *Routledge companion to feminist philosophy* (New York & London: Routledge, 2017) 517-527.

[317] For a further overview of the abortion rhetoric see: K Greasley, C Kaczor, *Abortion Rights: For and Against.* (Cambridge: Cambridge University Press, 2017) 1-164; S Callahan & D Callahan, 'Abortion: Understanding Differences' (1984), *Family Planning Perspectives,* vol. 16(5), 219-221.

[318] M Kjelsvik, R J Tveit Sekse, A Litleré Moi, E M. Aasen, C A Chesla & E Gjengedal, 'Women's experiences when unsure about whether or not to have an abortion in the first trimester' (2018), *Health Care for Women international*, vol.39 (7), 784, 797-798, 801.

approach, in *Montgomery* in particular, is but a starting point in the context of abortion, since it supports only a thin conception of autonomy. This analysis will ultimately form the basis for a later reconsideration of the principle of autonomy which can better suit the context of abortion and the first medical encounter.

Autonomy, understood as patients' right to be decision-makers, has been framed to be the key ethical justification for clinicians' engagement in the information disclosure processes.[319] Beauchamp and Childress[320] and also Faden[321], for example, have given crucial weight to the principle of autonomy as underlying an IC discourse. In this respect, Beauchamp and Childress emphasize that 'the primary justification advanced for requirements of informed consent has been to protect patients' autonomous choice[..]'.[322] A process of disclosure of information is framed in this sense to emphasize the importance of equipping patients during the decision-making process and to safeguard their autonomous medical decision.[323] Information serves patients' self-mastery in the medical arena. Autonomy hence becomes 'the' perspective for analysing a process of disclosure of risks, benefits, and alternatives to a medical intervention. This perspective values the contribution of patients not merely as passive recipient of a service, but as those who should be offered the opportunity to be involved in a decision-making-process that has the potential to affect their personal values, ideas, bodily integrity,[324] and responsibility in a strong sense.

However, O' Neill[325] has criticized the IC approach claiming that this is no more than an illusion. IC in her perspective is a mere formality that does not adequately safeguard

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319 On a critical point, Walker highlighted that respect for autonomy should require consent alone, not informed consent. He claims that: 'The idea that informed consent is needed in medicine and research, however, has most commonly been based on the idea that it is needed in order to respect the patient's or research participant's autonomy. This standard reason for thinking that informed consent is needed is therefore mistaken. It does not follow from this that there is no need to obtain informed consent. But if there is such a requirement, the reasons for it must lie elsewhere than a concern to respect autonomy'. T Walker, 'Respecting autonomy without disclosing information' (2013), *Bioethics*, vol 27 (7), 388, 394.

320 T L Beauchamp, J L Childress, *Principles of Biomedical Ethics*, (Oxford, Oxford University Press, 2019) 99-111.

321 R R Faden, T L Beauchamp, *A history and theory of informed consent*, (New York: Oxford University Press, 1986) 235-267.

322T L Beauchamp, J F Childress, *Principles of Biomedical ethics* (Oxford: Oxford University Press, 2019)118. A further account of autonomy in this context can come also from D Beyleveld and R Brownsword. In their book on consent they provide a Gewirthian approach of the consent process. The foundation of this process is the principle of generic consistency which requires all agents to act according to their rights and in line with the generic conditions of agency. See: D Beyleveld and R Brownsword, *Consent in the Law*, (Portland: Hart Publishing,2007) 39-55.

323 See on the connection between information and maximisation of autonomy: J Harris, *The value of life*, (London: Routledge, 2006) 198-202

324 See on this point: A M Superson, 'The Right to Bodily Autonomy and the Abortion Controversy', in: A Veltman, M Piper, *Autonomy Oppression and Gender*, (Oxford: Oxford University Press, 2014) 301-324.

325 O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), 37-39. Another relevant critical perspective on IC and autonomy is expressed by Kirchoffer, where it is argued that alternative routes which look altogether beyond IC and autonomy should be proposed. See on this: D G Kirchhoffer, B J Richards, *Beyond autonomy*, (Cambridge: Cambridge University Press, 2019) 1-14.

patients' autonomy right. The law of IC in her view protects 'sheer choice' that amounts to little more than a right to refuse treatment.[326] She refers to a 'liberty' to choose, which some patients might utilise having reflected on the matter (and thereby with autonomy), while recognising that others will not.[327] Building upon O'Neill's criticisms, it will be argued in this Chapter that a move from 'sheer choices' towards more meaningful and autonomous choice requires the adoption of a thick concept of autonomy that embraces a relational component. In doing so, the proposed conception will not only support but will also be a consequence of the principle of partnership.

Ultimately, in doctrine, a process of information disclosure can be claimed to find its justification upon the desire to equip patients in their decision-making role. This understanding, however, does not necessarily safeguard the existence of the path towards meaningful choices, and should therefore be reconsidered. This is because a pure autonomy as self-determination risks undermining patients' needs and vulnerabilities and the relevance of support during the decision-making process.

2.4 The progressive relevance of the principle of autonomy in the IC domestic case law

Domestic negligence case law, as the ambit where the law of IC has evolved, has progressively attributed stronger relevance to the principle of autonomy. Previous chapters have analysed the law of negligence. Chapter 2 provided an overview of the development of IC, and Chapter 3 has reflected on the evolution from a doctor-centred approach to a partnership-oriented approach. To these reflections, it will be added here that the law of negligence has gradually attributed stronger relevance to patients' autonomy. Whilst this is shown to be a positive development, it is argued that there are weaknesses in the concept advanced, which could be countered by a new focus on a thicker and more meaningful concept of autonomy.

The relevance attributed to patients' voices and their autonomy was emphasized firstly by Lord Scarman's dissenting opinion in *Sidaway v Bethlehem Royal Hospital*.[328] He criticized the deferential approach towards the medical professional as endorsed by the

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[326] O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), 37.

[327] 'Those who insist on the importance of informed consent in medical practice typically say nothing about individuality or character, about self-mastery, or reflective endorsement, or self-control, or rational reflection, or second-order desires, or about any of the other specific ways in which autonomous choices supposedly are to be distinguished from other, mere choices.' O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), 37.

[328] [1985] AC 871 at [877].

Bolam standard of care and proposed to give more weight in the disclosure process to patients' perspectives and their right to self-determination. Subsequently, Lord Bingham[329] in *Chester*[330] clarified that the rationale behind IC, and hence a RMP's duty to disclose, was to safeguard patients' autonomy rights. Information provision on significant risks related to the intervention was perceived to be crucial for an autonomous decision to be reached. In this perspective, autonomy was understood by Lord Bingham and Lord Steyn[331] to be a fundamental human right of every patient. This right was also tied to an enhancement of patient's human dignity,[332] broadly understood as a protection of one's own personhood (e.g. values, convictions).

This endorsement of patients' autonomy in the IC context was embraced and amplified[333] in *Montgomery*. Every adult of sound mind is considered a person holding rights of self-determination.[334] In this context Lady Hale,[335] who agreed with Lords Kerr and Reed but added her own judgment, gave relevance to a gender-based perspective focusing on the need to safeguard women's reproductive autonomy. She emphasised the importance of an information-sharing process with clinicians as a tool to give voice to women's values and unique circumstances.

On the facts of the case, notwithstanding Mrs. Montgomery's intelligence as also expressed by her educational background,[336]she was entitled to dialogue and partnership-oriented approach with clinicians in coming to a decision. Jonathan Montgomery[337] takes issue with this point. He considers Mrs. Montgomery in a position to understand by herself the risks involved and/or to ask questions. She was, from his perspective, a well-equipped 'citizen' capable of exercising her autonomy rights, without the need for the help and support from the medical sector that the judgment required. With respect, I

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329 *Chester* at [1-10]

330*Chester* at [41]

331*Chester* at [11-27].

332*Chester* at [18] and [24].

333 More crucially such understanding echoes also some international legal instruments. Amongst these it should be remembered the European convention on Human Rights, where, at article 8, key relevance is given to the right to respect for private life as the basis on which the safeguarding of patients' autonomy rights is built. The value of patient's autonomy was also supported by the relevant jurisprudence of the European Court of Human Rights, as in the case of *Pretty v UK* (2346/02). The relevance of autonomy is also echoed in another relevant international instrument, namely the Oviedo Convention 1997, which attributes, at art 5, key relevance to the autonomy principle, since it requires that medical interventions are only carried once a free and informed consent has been given. It should be specified that the UK, however, has never signed or ratified the Oviedo Convention.

334 *Montgomery* at [108]

335 *Montgomery* at [109].

336 Nadine Montgomery is a graduate in molecular biology and hospital specialist in the pharmaceutical industry, with a mother and a sister both general practitioners.

337 J Montgomery, 'Patient No Longer? What Next in Healthcare Law?' (2017), *Current Legal Problems*, vol.70 (1), 73,97-98.

would suggest that this perspective fails to fully appreciate that autonomy and partnership should be understood to be as two-sides of the same coin. In this sense, Mrs. Montgomery's medical decision should be contextualized and her vulnerabilities acknowledged, since these are aspects that inevitably affected her decision-making. In a podcast-interview with Nigel Poole, Nadine Montgomery[338] herself clarified that she did not know that natural delivery could have put her son at risk of shoulder dystocia and felt in a situation of emotional vulnerability. It was only at a later stage, after the risk materialized, through personal research together with her sister, that she found out about the term and the meaning of this medical risk. Her referral point in a medical context was with a doctor, namely someone who should have, in a relational dimension, guided and advised Mrs. Montgomery during her decision-making process. In this sense, her educational background, although relevant, was not a conclusive factor since her understanding was inevitably influenced by her emotional vulnerability. Ultimately, Mrs. Montgomery was a patient who should have been supported in her decision-making process. For instance, the doctor should have not assumed that some risks were already known, but should have engaged in a dialogue concerning risks related to both natural birth delivery and caesarean-section. The judgment hence goes someway in recognising the relevance of both partnership and patients' vulnerabilities in serving Mrs. Montgomery's autonomy in a thick sense, though this is subjected to limitations as will be later highlighted.

The court also emphasized that the RMP's duty to disclose material risks cannot be determined on the basis of whether or not a patient asks certain kinds of question.[339] In line with Lord Scarman's approach in *Sidaway,*[340] as well as Lord Woolf's in *Pearce v United Bristol NHS Trust*[341], it was held that a medical duty to warn should not be something concerning only those more *pro-active patients*, namely those who promptly ask questions. Rather, a medical duty to warn should also include those quiet patients who do not directly ask questions. This is important because a non-expert patient will not always know to ask a question that becomes relevant only with hindsight.[342]

The endorsement of the principle of autonomy in *Montgomery* also led to an assessment of risks in line with the patient's particular characteristics (e.g., the facts that Mrs. Montgomery was a diabetic patient). Thus, the mere fact that the magnitude of the

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338 Kings Chambers Podcast, 'Debrief Episode 10- Montgomery v Lanarkshire Health Board (Part I)', online available at: https://www.buzzsprout.com/179951/2077788 (accessed 21st October 2020).

339 *Montgomery* at [58,73].

340 *Sidaway* at [877].

341 [1999] ECC 167 at [172].

342 This also implies that in the abortion field, RMPs have the duty to start a conversation with women concerning risks, benefits and alternatives, even when she doesn't expressly ask for it.

risks (shoulder dystocia in this case) is relatively small cannot lead to an exclusion of this factor from the information sharing process.[343]

Although there are positive factors in the *Montgomery* case, as it is shown, for instance, by the relevance attributed to dialogue and partnership between doctors and patients, that can also point toward a thicker concept of autonomy, this potential should not be overstated. As it has been noted in Chapter 3, a key challenge of the IC literature and of the *Montgomery* case might be seen in the risk of endorsing a consumeristic approach, which also undermines the relevance to be attributed to the principle of autonomy. Medical professionals' contributions can end up being framed as a mere 'formality' to equip patients, which ultimately lacks meaningful relevance. This libertarian approach recognises the relevance of patient choice,[344] but focuses predominantly on agency, or what Foster[345] has called a 'purely evaluative-account of autonomy'. However, this approach does so potentially without any further considerations concerning an understanding of the choice(s) at stake and its potential impact. Coggon and Miola, commenting on the pre-*Montgomery* case law, argued that 'as it stands, the law appears to have shifted from allowing excessive paternalism, past liberalism and into libertarianism, with its attendant notions of self-reliance.'[346] And this could lead, I would add, to the abandonment of patients by the law. Coggon and Miola were referring to the judgment in *Al Hamwi v Johnston and another,*[347] where a lack of focus on patients' understanding and communication crucially meant that autonomy was never indeed realised, but only liberty. The current approach of the case law does not seem to differ from this description, whereby the weight given to more partnership within the autonomy context is often undermined by a consumeristic approach.[348]

As discussed in Chapter 3, the desire to provide a doctor-patient partnership is undermined by a thin conception of autonomy as pure self-determination. In such case, it is hard, if not impossible, to reconcile the two principles. Autonomy can easily become a vice for a negative form of patients' involvement in a consumeristic sense. Consumerism values patients' self-determination, but it places little value on the doctor-patient relationship. Autonomy and partnership can therefore risk pulling in two different and possibly irreconcilable directions. This is because if information serves unilaterally only patients' self-mastery, a partnership approach risks being progressively

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[343] *Montgomery* at [89]

[344] For an overview of a libertarian account of autonomy see: J Harris, *The value of life*, (London, Routledge, 2006) 157-173.

[345] See above section 2.1.

[346] J Coggon, J Miola, 'Autonomy, Liberty and Medical Decision-making' (2011), *Cambridge L J,* 523, 539.

[347] [2005] EWCH 206.

[348] See Chapter 3, section 2.1.4.

reduced and/or undermined. Clinicians' contribution and patients' autonomy can and should go together, through what will be later shown to be a revised understanding of autonomy and medical involvement.

Montgomery should be understood to be a starting point but not the end of the conversation when it comes to the formulation of the principle of autonomy: a point that was similarly made with respect to the principle of partnership in the previous Chapter. The principle of autonomy should be more clearly defined. Later sections will endorse a thick understanding of autonomy called 'authentic autonomy' that attempts to reconcile partnership and patients' autonomy in the context of abortion and the first medical encounter.

3. Re-writing the principle of autonomy for the abortion context

This Chapter has seen thus far an analysis of the relevance attributed to autonomy within the current abortion context and the IC literature. This section will propose a model of authentic autonomy as a tool that can help form a new 'how-approach' to abortion. This model will address the issue of patients' potential abandonment and the variety of interests at stake in the first medical encounter in the abortion context. It will emphasize that the safeguarding of authentic autonomy lies in the creation of a space where women can both listen and be listened to by RMPs and, on the basis of this dialogue, reach an authentic decision.

Earlier, this Chapter argued that an autonomy as self- determination approach can risk giving voice only to those women who already have a strong sense of 'ownership' of their choice. It can risk at the same time silencing those women who experience a feeling of having 'no choice but to choose' abortion.[349] Autonomy as self-determination is for them only an illusion. At least a portion of women,[350] whether or not a small minority of them, might experience a sense of abandonment to their own vulnerabilities. This understanding of autonomy can end-up presupposing an 'ideal' and unrealistic account

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[349]N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish, 2007)141-160; See also: M Fox, 'A woman's right to choose? A feminist critique', in: J Harris, S Holm, *The future of reproduction* (Oxford: Clarendon Press, 1998)82; E Fegan, 'Recovering women: intimate images and legal strategy' (2002), *Social and legal studies*, vol. 11(2), 155.

[350] S Halliday in her article on pre-abortion counselling [see S. Halliday, 'Protecting Human dignity: the dignity of choice and life' (2016), *Contemporary issues in Law,* vol 13 (4), 287, 316] points out that women often have already reached a decision before a counselling session happens. It is possible that the same line of reasoning might apply for the context of the first medical encounter whereby many women would not experience need or desire to engage with clinicians. However, data are still scarce on this point. What this thesis is claiming is that whether or not the issue of abandonment and lack of support engages a recognized majority or minority, this remains an aspect worth analysing if an understanding of the breath of experiences associated with the abortion decision-making process want to be considered.

of women in general as self-sufficient and independent beings, with little, if any, need to be supported in their decision-making process. Whilst this might be appropriate for some, it is not appropriate for all.

The first justification upon which a re-framed concept of autonomy is to be built can be encapsulated, in Maclean's terms, in the concept of women's abandonment.[351] A thin-conception of autonomy can abandon some women, for whom additional support would be helpful, to their own fate. Abandonment is the outcome of a conception of autonomy that ignores the importance of clinical partnership and patient support during the decision-making process in the abortion context.

The perils of adopting a thin conception of autonomy and the related concept of abandonment are closely tied with the arguments set out in Chapters 2 and 3 that de-medicalisation of abortion should be resisted. A pure-self-determination approach is often grounded on the idea that abortion involves non-medical issues and hence that clinical involvement should be progressively reduced or all together abandoned.

So too, the critique of a thin conception of autonomy accords with the criticism of a consumer-based approach to IC, where information is a mere formality,[352] and where clinicians are often perceived as mere service providers as opposed to partners. In the abortion context, empirical evidence has been set out to suggest that the first medical encounter is often perceived as no more than a formality, or worse, an obstacle to service access, and which should be completed as rapidly as possible. [353] Dialogue, information, and support, however, lead in a different direction than the one offered by a thin notion of autonomy: it leads to partnership and authentic autonomy.

Further justification for a proposed change in approach is founded in the variety of interests involved in the abortion context. The issue of abortion encompasses broader

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[351] A Maclean, 'Autonomy, Consent and Persuasion' (2006), *European Journal of Health Law*, vol. 13, 321-338.

[352] This perspective has also been supported by Arvind and McMahon arguing that in a consumeristic model 'The choice is the consumer's alone, and the service provider's role is simply to provide any information the consumer might require in order to make a choice. The consumer is assumed to have the ability to process and evaluate this information autonomously, and come to a satisfactory conclusion based on their preferences.' They also claim that this consumeristic approach lacks an empirical foundation, studies show that patients desire a stronger degree of involvement in the medical encounter and not simply to receive information. T T Arvind, A M McMahon, 'Responsiveness and the role of rights in medical law: lessons from Montgomery' (2020), *Medical Law Review*, vol. 28(3),445, 451-452

[353] An example of this was the push towards the use of telemedicine and the reduction of medical involvement, especially during the coronavirus outbreak. See on this point Chapter 2, section 3.4.

interests which concern other key stakeholders,[354] such as the fetus[355] and prospective father.[356] As far as the fetus is concerned, the AA does not grant a full-legal status to it.[357] Conversely, the AA adopts a gradualist approach, meaning, as Scott has described, 'the greater the development of the fetus, the more serious the reasons need to be to justify a termination'.[358] Also, the father does not have a legal right to prevent an abortion or even to be informed of the pregnancy.[359] Although both of these parties do not have any claim-right to interfere with the mothers' decision of whether or not to have an abortion, a reframed understanding of autonomy can give some protection to their interests,[360] whilst upholding the right of the woman as decision maker. This does not reduce her space of autonomy, but places it into context: a focus on the decision-making process will be also an ethical responsibility, in a relational sense, towards others with interests in the decision. This is because every choice in life is attached to a

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354 In his article, Foster (2016) also includes reference to the interests of grandparents and society at large, arguing that they should find a room within the current legal scenario. Here we are focusing on two 'key' ones (fetus, and father), of the many possible, to highlight that a redefinition of autonomy should make a room for their interests. Foster is also framing the relevance of these interests to propose a different conceptualisation, one that accounts for the concept of human dignity. See: C Foster, 'Does the English Law on Abortion affront Human dignity' (2016), *The New Bioethics* vol. 22(3), 162. The role of existing children is already in the balancing exercise of s.1(1)(a) AA, although arguably in a limited sense. For a critical view on the inclusion of the interests of fetus/fathers and the challenge purported to women's right to choose see: J Harris, *The value of life*, (London, Routledge, 2006), 159-161.

355 This thesis rejects so called 'single entity approach' where a woman is considered to be the one and only point of reference because this would mean denying a key dimension to the existence of a growing and distinct human being (i.e. fetus). See on this point in favour of the single entity approach: B K Rothman, *Recreating Motherhood: Ideology and technology in a Patriarchal society* (New York: Pantheon Books,1989) 161; see also against this approach: J Seymour, *Childbirth and the Law* (Oxford: Oxford University Press, 2000) 189]. This thesis also rejects separate entities approach whereby women and fetus are two separate individuals with separable and conflictual needs because it denies the relational dimension existent between the two. See for a critic of this: J Seymour, *Childbirth and the Law* (Oxford, Oxford University Press, 2000) 190,194]. It partially agrees with the so called 'not-one-not two approach', see in support of the 'not-one-not-two' approach: J Seymour, *Childbirth and the Law* (Oxford, Oxford University Press, 2000) 190-202, J Karpin, 'Legislating the female body: reproductive technology and the reconstructed woman' (1992), *Columbia Journal of Gender and Law* , vol.1(3),325,329; C Pickles, 'Approaches to pregnancy under the law: a relational response to the current South African position and recent academic trends' (2014), *De Jure,* vol.47(1), 20. This thesis welcomes the recognition attributed by the 'not-one-not-two' approach of both woman and fetus in a relational dimension, where the value of both is mutually recognised, even though the value attributed to a woman's right is stronger than that of the fetus. The interests of both, women and fetus cannot thus be viewed in isolation but are inter-dependent. This thesis differs from the 'not-one-not-two' approach in as much as it considers women and fetus amounting to 'two' different yet inter-related entities.

356 Mason and Laurie have argued that the father should be entitled also, at least in some circumstances, to hearing before an abortion takes place. G T Laurie, S H E Harmon & G Porter, *Mason & McCall Smith's Law & Medical Ethics* (Oxford: Oxford University Press, 11th ed, 2019) 9.1114.

357 For a further analysis of the legal status of the fetus in English Law see R Scott where she challenges, in a gradualist approach, the possibility of granting a full-legal status to a fetus. R Scott, 'The English fetus and the right to life' (2004), *European Journal of Health Law*, vol.111, 347.

358 R Scott, 'Risks, reasons and rights: the European Convention on human rights and English abortion law' (2015), *Medical law review*, vol.24 (1), 1, 2, footnote 7 which also refers to J Feinberg, 'Abortion' (1979), in: J Feinberg *Freedom and Fulfillment* (Princeton: Princeton University Press, 1992) 37.

359 *Paton v BPAS* [1978] QB 276; *Paton v UK* (1981) 3 EHRR

360 The relevance of the interest of the fetus has further been supported in subsequent cases, although these did not deal with abortion specifically. See on this point: *AG's Reference* (n.3 of 1994) [1998] AC 255, where the House of Lord was asked to rule on whether the requirement for manslaughter could be made out when a severely premature infant's death could be shown to have been caused by injuries inflicted in utero.

responsibility[361], and abortion is no exception to this. The role of information and dialogue in the abortion context has therefore a broader ethical relevance: information and dialogue put women's decision-making process into a broader relational context which goes beyond women themselves and by themselves.

Ultimately, autonomy as self-determination is marked by a series of fallacies. First, it risks abandoning or silencing at least some women. Secondly, it does not account for the breadth of interests involved, relationally speaking, in the abortion decision-making process. In light of this critique, it is proposed that journeying with the patient and accompanying her in the decision-making process through an exploration of the nature of the procedure and the options at stake can and should serve a thick or 'authentic' conception of autonomy.[362]

3.1 Authenticity: meaning and implications for the abortion decision-making context

Having provided possible justifications for the need to re-write the conceptualisation of autonomy in the abortion context, the meaning and significance of authenticity[363] should be now explored.

In order to provide an explanation of the suggested meaning of authenticity as endorsed in this thesis, it is relevant to clarify the difference between autonomy and freedom. According to Gerald Dworkin,[364] freedom is a mere condition, although a necessary one, in order to be autonomous. Freedom indeed answers the question of whether someone is free or not to make a specific decision (in our case a medical

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361 See: M Brazier, 'Do no harm, do patients have responsibilities too?' (2006), *The Cambridge Law Journal*, vol.65, 397.

362 This also indirectly serves what has been called as 'true beneficence', one which considers patients not as mere bodies, but hears also their interior vulnerabilities. See on this point: E D Pellegrino, D C Thomasma, 'The Conflict Between Autonomy and Beneficence in Medical Ethics' (1987), *Journal of Contemporary Health Law and Policy*, vol. 3, 23. See also later on patients' wellbeing section 3.3.

363 The theoretical approach proposed is placed in the context of what Mackenzie calls a weak-substantive autonomy, one that does not ask for an actual moral awareness of rights and wrongs, but that rests on the need to focus on the dynamics of the decision-making process, whether social or psychological. See: C Mackenzie, N Stoljar, *Relational Autonomy*, (New York-Oxford: Oxford University Press, 2000)19-21. However, contrary to this theory I do not claim that the content of the choice, in this case abortion, is morally-neutral or irrelevant. I think that the moral aspects of abortion form key part of the decision-making process, yet clinicians are not required to make sure that this moral awareness is existent and/or fully embraced for a successful IC-process. Clinicians are in the position to trigger evaluative processes on the side of women: authentic autonomy in the context of IC and abortion is achieved when women engage in self-reflective processes also in light of the information gained during the medical encounter. This can also resemble a thick procedural account of autonomy. See conversely for an account of a strong substantive understanding of autonomy, placing stronger relevance on moral agency: Benson P, 'Freedom and value' (1987), *The Journal of Philosophy*, vol. 84, 465; S Wolf, *Freedom within Reason* (New York: Oxford University Press, 1990) 67-93.

364 G Dworkin, 'The Concept of Autonomy', in: J Christman, *The inner Citadel: Essays on Individual Autonomy*, (New York: Oxford University press,2nd ed, 2014), 54-62.

decision) at a given time. I suggest here that autonomy, in its authentic dimension, refers instead to a broader concept. It involves firstly the identification of a person with her own values, goals, desires, which Dworkin calls first order desires, and also involves the identification with the motivation behind those values, which he calls second-order desires.[365] Furthermore, authentic autonomy requires a procedural component, namely the lack of an external influence on someone's final deliberation. As far as the latter is concerned, its meaning will be explored more clearly when dealing with the relational aspect of authentic autonomy. At this point it suffices to say that Dworkin does not exclude a relational dimension of an authentic autonomy, but considers the involvement of third parties like RMPs as tools to help patients reach an authentic autonomous decision.[366]

Dworkin's approach to authenticity, as related to the first and second order desires, is well-suited in the abortion context. It should be clarified that this section is not endorsing or engaging with Dworkin's overall conceptualisation of abortion as a right, but rather is building upon his general definition of autonomy to further unpack the meaning associated with authentic autonomy. This can be translated into a desire to foster not a mere decision-making role as an 'impulsive' agency, but to safeguard a path which has the potential to lead a woman to a more authentic decision.[367]

Authentic autonomy ultimately should foster a process of 'identification'[368] between the choice/s offered and the one that women decide to embrace. It means giving 'content'[369] to the decision-making process through the disclosure of information and also offering valuable support before a decision is reached. This decision will be focused on whether to pursue an abortion, any alternative to it, no treatment at all, or a delayed decision until a diagnosis (such as in the case of suspected fetal abnormality) is obtained.

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365 This understanding of autonomy also recalls a Kantian approach, calling for a focus not merely on the decision-making role, but on the essence of a decision and on the decision-making process. See on this point: J Coggon and J Miola, 'Autonomy, Liberty, and Medical Decision-Making' (2011), *Cambridge Law Journal,* vol. 70(3), 526.

366 See also on this point: N Levy, 'Forced to be free? Increasing patient autonomy by constraining it' (2014), *Journal of Medical Ethics,* vol. 40, 293–300; J Savulescu, 'Rational non-interventional paternalism: why doctors ought to make judgments of what is best for their patients' (1995), *Journal of Medical Ethics*, vol. 21(6),327.

367 This also resembles the shift from 'status' to 'capacity' as expressed by Mackenzie. See: C Mackenzie, 'Relational autonomy, normative authority and perfectionism' (2008), *Journal of Social Philosophy*, vol.39(4), 512, 527-530.

368 This concept also recalls a neo-Millian approach, as related to the concept of 'character'. Agency should indeed foster a process of making a choice 'our own' and in this sense a process of building our own character. See on this point O Neill's reflections on Mill's argument: O O'Neill, *Autonomy and trust in bioethics* (Cambridge: Cambridge University Press, 2009) 31.

369 This also echoes and expands the idea that patients, women in this case, have a right to know. I have argued elsewhere in favour of the existence of this right. See: T De Campos, C Milo, 'Mitochondrial donations and the right to know and trace one's genetic origins: an ethical and legal challenge' (2018), *International Journal of Law Policy and the Family*, vol.32(2), 170.

A process of identification, and hence an authentic autonomy discourse, implies both internal and external factors. Starting from the latter, Raz[370] claims that it is crucial to provide an individual with an adequate range of options from which to choose. Such alternatives are identified by the variety of morally permissible options available, not by the mere 'number' of them. For instance, a process of identification cannot happen when women are offered 'one choice alone'. Instead, where available, women should be provided with a series of alternatives from which to choose. This entails, as will be explained below, a duty incumbent on RMPs to engage in dialogue with women to offer them alternatives in line also with each woman's personal circumstances and beliefs. Furthermore, a process of identification also implies the possibility of 'not making a choice' at all as an alternative in itself that RMPs, as relevant soft law suggests[371], should provide.

This process of identification as triggered by authentic autonomy focuses also on internal aspects. Authenticity is also aimed at triggering a process of making the decision your own, as much as possible. In this sense, it gives voice to how women's external circumstances affect their 'internal' decision-making process. An identification process appreciates the wide meaning of that choice both in a medical and more personal sense.

It should be clarified that this section is not supporting either a form of purely objective moral agency or purely subjective agency. The former can be summed up in the 'ideal desire' approach[372], where women are asked to identify themselves only with external norms or standard of values, which are claimed to be objective. The latter can be summed up in the so called 'best desire' approach[373], focusing on a pure self-reflective account of a choice. Instead, the approach taken claims that both these understandings are unsatisfactory if considered in isolation and that the identification process in the context of abortion should be understood in a wider sense.

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370 J Raz, *The Morality of Freedom*, (Oxford: Oxford University Press, 1988) 369-429.

371 This is also emphasized by the latest GMC guidelines on consent: GMC, 'Decision Making and consent, working with doctors, working for patients', *above* (2020). See also: Chief Medical Officer's Scotland, 'Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016', (February 2017), online available at: https://www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/ (accessed 21st October 2020).

372 This approach gives key relevance not merely to what women may want, but to what women *should want* in the abortion context. Hence from this perspective, women, as 'responsible-decision maker' consider the reasons for acting in accordance with objective standards of value as determined at the State level. The AA accounts only to some extent to this categorization of autonomy, in so far as, for instance the interests of the fetus are taken into account (e.g. via the existence of a time limit). See for an account of autonomy as 'ideal desire': J Coggon, 'Varied and Principled Understandings of Autonomy in English law: Justifiable Inconsistency or Blinkered Moralism?' (2007), *Health Care Anal*, vol.15(3),235.

373 J Coggon, 'Varied and Principled Understandings of Autonomy in English law: Justifiable Inconsistency or Blinkered Moralism?' (2007) *Health Care Anal*, vol.15(3),235, 241.

This process of identification, furthermore, does not contradict the above mentioned 'harm paradox'[374] where women might find themselves with 'no choice but to choose'. Given the *status quo*, autonomy in its authentic form offers the opportunity to mitigate this problem by ensuring adequate time and a space to reflect upon a decision and to accommodate any relevant vulnerabilities.

What ultimately it has to be drawn from Raz and Dworkin is that women's authentic autonomy fosters not only individual agency or interests in isolation, but also considers that a bridge should be built between them through the relevance attributed to the decision-making process and a process of information disclosure. This also reflects what Woodcock claimed when urging for a richer understanding of autonomy in the abortion context:

> 'It is not enough for women to have an abstract legal right to choose whether or not to continue their pregnancies. A suitably rich conception of autonomy requires more. It requires a collaborative process of informed consent that is context sensitive and highly responsive to the needs of each patient. The merits of this kind of expanded conception of informed consent have begun to gain recognition in other bioethical contexts; we must not ignore their significance in the context of abortion.'[375]

Overall, an identification process acknowledges the reality of an abortion both in its subjective and objective dimensions. It considers its medical, moral, and subjective characterisation, and purports to integrate these aspects within the decision-making process. In this context a medical-objective component, a moral component, and a personal and contextual component are all relevant, although to different degrees which will inevitably depend on the circumstances. Ultimately, it is an account of holistic implications of a decision, that form part of the identification process in a 'how-approach'. These aspects are, to some extent, all going to implicitly or explicitly be involved during the first medical encounter. This does not mean ensuring that an actual knowledge of all such factors is in place, which is something that is not necessarily desirable nor even possible to practically realize. Clinicians, especially during the first medical encounter, should trigger a process whereby patients are offered a range of relevant information, tailored in light of their particular needs. There is no authentic autonomous choice when women are not supported in both the objective and subjective dimensions of decision-making during the first medical encounter.

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[374] See a*bove* N Priaulx (2007).

[375] S Woodcock, 'Abortion counselling and the informed consent dilemma' (2011), *Bioethics*, vol.25(9), 495,504.

It is undeniable that the practical reality of the decision-making process can still be marked by a degree of greater complexity and challenges. However, the position taken in this section is that an authentic autonomy can be safeguarded (i) when women are offered not only one choice, but a variety of choices amongst which to choose (including the one to pursue no medical intervention)[376] and (ii) when this process is supported with the help of RMPs, as will be unpacked below.

3.2 Relationality and authenticity

A further characteristic of this authentic autonomy model is its relational aspect. This component firstly recalls the principle of partnership as proposed in Chapter 3. Expanding on this point it is also evident that this also stems from a more general recognition of the embedded relational human nature. In this vein, Herring[377] and Johnson[378] believe it 'a great lie' to consider every person as an independent agent. Relationality in this sense is an inevitable characterisation of patients that also affects the decision to be made. Every 'choice' both influences and is influenced by those with whom we are in a relationship. It is therefore relevant to consider autonomy here in its authentic form, meaning in its relational dimension[379] and as a strictly interconnected choice within a particular RMP-woman context. This does not exclude the relevance of a broader relational account that can affect the decision-making process. This would include, for example, wider social circumstances as it is per the relationship with family and/or partner. Yet the relational dimension of autonomy seeks to focus on and value the contribution of clinicians and the positive role that they can exercise in serving women's authentic autonomy.

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376 See on the relevance of the aspect of 'no treatment': Chief Medical Officer's, 'Realising Realistic Medicine: Chief Medical Officer for Scotland annual report 2015-2016', (February 2017), *above*; GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), *above*, 7.

377 J Herring, 'Relational autonomy and family law', in: J Wallbank, S Choudry, J Herring: *Rights, Gender and Family law* (Abingdon: Routledge, 2009) 266-267. See also: J Herring, *Law and the relational self* (Oxford: Oxford University Press, 2019)99-140; J Herring 'Relational autonomy and rape', in: S D Sclater, J F Ebteha, E Jackson, M Richards, *Regulating autonomy* (Oxford: Hart, 2009) 113-160. This thesis is not endorsing the conception of abortion as a public good endorsed by J Herring, in J Herring, 'Ethics of care and the public good of abortion' (2019), *University of Oxford Human Rights Hub Journal*, vol. 1, 1.

378 A Johnson, *Gender Knot* (Philadelphia: Temple University Press, 1997) 30.

379 See on this point: C Mackenzie, N Stoljar, (eds.) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (New York: Oxford University Press,2000) 35-203.

The need for a relational[380] dimension is clearly applicable in the abortion context. Consider again Dworkin's perspective,[381] according to which for women to be able to reach an authentic autonomous decision it is not enough that they are 'free from' external influences (freedom in a negative sense). Instead, if autonomy is to be considered as the relational component of the RMP-woman relationship, it is crucial that women are 'free for' (freedom in positive terms). In other words, an authentically autonomous decision is characterized by a positive component, which goes beyond a mere freedom from coercion, to give due focus on the decision-making process as it is spelled out in their relationship with RMPs.

In this sense, it can be inferred that an authentic autonomous discourse forms the basis of a new 'how-approach', namely a woman's need to be supported in her decision-making path concerning an abortion. [382]

More fundamentally this can be spelled out as a duty on the side of RMPs not only to prevent women's denial of freedom, but also to *create* the conditions for an authentically autonomous decision. RMPs should in this sense work to promote the conditions where autonomy can be enhanced. This means primarily, as it has been claimed in Chapter 3, to disclose relevant information concerning risks/benefits/alternatives to an abortion, to promote women's understanding and to do so in a nuanced way. IC hence serves the safeguard of an authentically autonomous decision.

However, this will not mean denying the complexity of the reality of the decision-making process and the variety of emotions that women might experience during the first medical encounter. In a recent Norwich research study,[383] for instance, women who were ambivalent about their abortion choice experienced, on the one hand, a desire of being left alone and a longing for confidentiality and secrecy, and on the other, a desire for being accompanied and a longing for support in their difficult circumstances from people they could trust. In short, they experienced a tension between privacy and relationality which is often difficult to tackle.

Ultimately, what this tension between privacy and relationality can show is that being authentically autonomous is at least 'not entirely an individual affair', but involves

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[380] See on this point: J Herring J, 'Relational autonomy and family law', in: J Wallbank, S Choudry, J Herring: *Rights,Gender and Family law* (Abingdon: Routledge, 2009) 267.

[381] G Dworkin, The Concept of Autonomy, in: J Christman, *The inner Citadel: Essays on Individual Autonomy*, (New York: Oxford University press,1989), 54-62.

[382] On the relevance of a relational dimension in the abortion context see: S M Suter, 'The Politics of Information: Informed Consent in Abortion and End-of-Life Decision-making' (2013), *Am. J.L. & Med*, vol. 39 (7), 7, 17-18.

[383] M Kjelsvik, R J Tveit Sekse, A Litleré Moi, E M Aasen, C A Chesla & E Gjengedal, 'Women's experiences when unsure about whether or not to have an abortion in the first trimester' (2018), H*ealth Care for Women International*, vol.39(7), 784, 793.

almost inevitably a 'relational' component.[384]Authenticity hence cannot exclude the relevance played by the relational[385] aspect, of which the RMPs-women relationship is a crucial part. Without this relational component, the risk is to return to a mere consumeristic approach.

The first medical encounter hence becomes the place where clinicians and women can seek to work more closely together to safeguard women's authentic autonomy. More crucially, this means placing women's well-being, as it will be further shown below, at the heart of their relationship with the RMP. This model, recalling Chapter 3, suits the context of abortion well because some women may find themselves in a situation of distress and vulnerability, where they lack decision-making power, trust, and sometimes even self-worth. In an authentic autonomy context, women considering an abortion will have the opportunity to see themselves as persons deserving to be treated with dignity and respect during the medical encounter.

3.3 Well-being as a possible implication of authentic autonomy

So far it has been shown that a way forward to the current abortion doctrinal and normative approach should be found in a revised understanding of autonomy, so called authentic autonomy. This section argues that the major benefit of this model is the potential to enhance well-being. It will be shown firstly that the concept of well-being that this thesis is endorsing is a wide one and includes not only an objective perspective, but also a subjective one. Furthermore, this concept is strictly tied with a process of information disclosure and hence RMPs' duty to disclose both science-based and women-centred information. Ultimately, this concept of well-being is here attributed a key role[386] for the promotion of women's authentic autonomy: it is through an endorsement of women's right to information disclosure and support from RMPs that women's wellbeing can be enhanced.

The meaning attached to the concept of well-being is wide and comprises both a subjective and objective dimension. Women's wellbeing includes firstly a subjective

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[384]C Christman, 'Relational autonomy and the social dynamics of paternalism' (2014), *Ethic Theory Moral Prac,* vol. 17, 374.

[385] For a further analysis of the relational aspect see also: C Mackenzie, N Stoljar, *Relational Autonomy: Feminist perspectives on autonomy, agency and the social self* (New York: Oxford University Press, 2000) 259-279; S Potter, J B Mckinlay, 'From relationship to encounter: An examination of longitudinal and lateral dimension in the doctor-patient relationship' (2005), *Soc Sci Med*, vol. 61(2), 465; E J Speeding, D N Rose, 'Building an effective doctor-patient relationship: from patient satisfaction to patient participation' (1985), *Social Science and Medicine*, vol.21, 115.

[386] See on a critical point Taylor who recognizes a key role to a well-being discourse in a context of information disclosure, and suggests it should trump an autonomy-based one. J S Taylor, 'Autonomy and informed consent: a much misunderstood relationship', (2004) *The Journal of Value Inquiry*, vol. 38 (3), 383.

dimension, namely one that takes into account their specific needs, circumstances, values and wishes. The relevance of a subjective understanding of the concept of well-being is a reflection of the current legal approach of domestic healthcare law giving increasing recognition to patient's voices. It was the process of progressive move away from a doctor-centred approach, as expressed in Chapter 3,[387] which was legal evidence of a desire to value in our case a women-tailored approach. Recalling in particular women's rights to information disclosure as set out in the *Montgomery* case, a process of disclosure tailored to women's needs and circumstances was favoured, in preference to disclosure based on the doctor's unilateral perspective

However, recalling also Savulescu's[388]approach, medicine is inevitably a combination of both objective and subjective factors. Accordingly, there is a need to find the right balance between them. If the abortion context valued only a subjective assessment of women's well-being, this would have meant a progressive exclusion of RMPs' involvement, in a so-called de-medicalised scenario[389], and hence also the potential in some cases for abandonment.[390]It would have pushed towards a return to autonomy as mere self-determination, which would have excluded the inevitable medical characterisation of an abortion and hence the need to find the proper involvement of the medical sector in the decision-making process.[391]

The relevance of an objective component of the concept of well-being aims, conversely, to give due weight to the disclosure of medically-based information that women considering an abortion should be aware of. This discourse will be widened in Part 3, where an in-depth analysis of professional guidelines will be provided. At this stage, it is enough to say that the safeguarding of an objective component of well-being attributes key weight to the disclosure of scientifically-based information[392] from RMPs.

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[387] See Chapter 3 for an analysis of the evolution of case law from a doctor-centred to a patient-centred approach section 2.

[388] J Savulescu, 'Rational non interventional paternalism: why doctors ought to make judgements of what is best for their patients' (1995), *Journal of Medical Ethics*, vol. 21, 327–33. See also on this point: O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), 22; M Brazier, 'Do No Harm - Do Patients Have Responsibilities Too' (2006), *Cambridge L.J.*, vol. 65, 397-422; D Callahan, 'Can the Moral Commons Survive Autonomy?' (1996), *Hastings Centre Report*, vol. 26(2), 41.

[389] See further on this point Brazier, arguing that it is the role of clinician themselves that ends up being if not excluded, surely undermined as merely 'technicians': 'A wholly one sided approach to medical ethics which reduces the clinician to technician will ultimately undermine the integrity of the profession and render medical ethics otiose', M Brazier, ' Do No Harm - Do Patients Have Responsibilities Too' (2006), *Cambridge L.J.*, vol. 65, 420.

[390] See on this point: A Maclean, 'Autonomy, Consent and Persuasion' (2006), *European Journal of Health Law*, vol. 13, 321; M Hayry, 'Prescribing cannabis: freedom autonomy and values' (2004), *Journal of Medical Ethics,* vol. 30, 333,335; L P Ulrich, *The Patient Self-Determination Act. Meeting the Challenges in Patient Care* (Washington (DC): Georgetown University Press, 1999) 150.

[391]See Ch 3 for a theorisation of the concept of partnership, section 3.

[392] The relevance of an objective component of the concept of well-being can be appreciated also through the legal debate in another field of the reproductive arena, namely artificial reproductive techniques (ART). In this context, an amendment to the Human Fertilisation and Embryology Act 2008 was also proposed to include an explicit reference to women's welfare. The Human Fertilisation and Embryology (Welfare of Women) Bill (HC Bill 189) 2017-2019, called for an

They are called upon to raise awareness of the procedure itself, disclose the risks and benefits associated with an abortion together with the existence of possible alternatives. This approach is not a transposition of a 'doctor knows best' line of reasoning, namely one that seeks to impose RMP's perspective over women, but of a desire to build women's awareness of scientifically based circumstances that they can evaluate during the decision-making process.

A well-being approach in the context of IC and abortion should be understood in a wide sense. It seeks to strike a balance between a subjective and an objective dimension of women's health related interests. Authentic autonomy thus offers the opportunity to give 'meaning' to the decision-making process through the offer of advice and support in the form of information disclosure.

However, this also implies that not all 'choices' are necessarily authentically autonomous. In this respect, *Montgomery*[393] clearly specifies that patients can refuse to engage into an informative process. This does not necessarily entail an ignorance on the patient's side, given that she might have obtained this information through external sources, or that she has already made up her mind on the choice that she is willing to make. In this sense, a refusal of information may or may not coincide with a desire to remain ignorant. Nevertheless, deciding to refuse to receive the available support can also mean acting against one's own well-being. This is because authentic autonomy in its procedural dimension, although not imposing any specific final outcome, is inevitably strictly tied to a subsequent decisional dimension. Refusing to engage in the former (i.e. decision-making process) can affect also the latter (i.e. decisional dimension). Although not all women who refuse an IC process lack wider forms of support or are ignorant of relevant information, it is here contended that at least a portion of them can. For this reason, it is when the opportunity for further self-evaluation is taken -- one which offers a broader space for both an objective and subjective informative support -- that women can go beyond what O'Neill phrased as 'sheer choices' [394]towards authentic autonomous decision.

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information collection of scientifically evidenced risks associated to ART techniques and hence also to a process of information disclosure. It was claimed that this information wouldn't have been a tool to discourage or to limit the access to ART but to make participants aware of possible side-effects that can be prevented. Despite the inevitable differences between ART techniques, dealing with a woman who desires to become pregnant, and the context of abortion where there is a desire to terminate an existent pregnancy, still the concept of welfare or better well-being in its objective component can be a shared one. For an overview of the Bill, see: Parliament UK, Human Fertilisation and Embryology (Welfare of Women) Bill (HC Bill 189), online available at: https://publications.parliament.uk/pa/bills/cbill/2017-2019/0189/cbill_2017-20190189_en_2.htm#l1g1 (accessed 21st October 2020).

393 *Montgomery* at [85]

394 O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), 37.

Authentic autonomy hence offers the opportunity to embrace a process of self-reflection[395] before a final decision is reached. A focus on the 'how-approach' recognises the relevance of the decision-making process as the basis for safeguarding meaningful decisions. This discourse is ultimately aimed at offering women the space and the time to evaluate whether they are willing or not to take responsibilities, whether legal or moral, arising from the pursual of mostly abortion or childbirth.

3.4 Tackling possible criticism

It might be argued that a model of authentic autonomy has inherent limitations.[396] This section reflects on some of them and offers counter arguments in mitigation.

Firstly, it might be difficult to translate the proposed model into clinical practice.[397] In this sense, it might be argued that the shortage of time[398] and the lack of continuity of care might operate against this dialogical model. This *status quo* appears also to be crystallized and hence difficult to be overcome because aspects of clinical practice are determined at the managerial level.

Acknowledging the validity of these claims, it is nonetheless the case that an aspirational model has value: just because something is practically difficult does not entail that it is not ethically necessary. In many cases, there is sufficient time and recognition that the value of an approach can lead to its adoption and accommodation. Furthermore, managerial and funding restraints (which limit time to engage in dialogue) can be counteracted. The proposed model of autonomy should work as a strong exhortation to change the undesirable *status quo*. Ultimately, the delivery of health-related services should not only follow economic principles of efficiency and resource-

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[395] This approach echoes also the concept of 'freedom for excellence' which is aimed at pursuing choices that enable flourishing. This is crucially distinguished from a concept of 'freedom of indifference', whereby every choice is morally neutral as long as it is 'wanted'. See on this point: S Pinckaers, 'Freedom of indifference: the origin of obligational moral theory' in: S Pinckaers, *The sources of Christian Ethics,* (Washington: Catholic University of America Press, 3RD ed., 1995) 327-353 and S Pinckaers, 'Freedom for excellence', in: S Pinckaers, *The sources of Christian Ethics*, 354-378. It should be clarified that this thesis is focusing only on the decision-making process that follows an unplanned pregnancy. However, it also claims that to enable a space for reflection is of vital relevance also for reaching morally meaningful choice subsequently.

[396] For a further analysis see also: E D Pellegrino, 'Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship' (1994), *Journal of Contemporary Health Law and Policy*, vol. 10, 47.

[397] See on a general critical point of an informed-consent discourse in the medical context: O O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press,2009) 49-95; N C Manson, O O'Neill, *Rethinking informed consent in Bioethics* (Cambridge: Cambridge University Press, 2007) 68-96.

[398]P Image, 'After Bolam: what's the future for patient consent?' (2016), *The Lancet*, vol. 388 (5), online available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)32114-6/fulltext (accessed 21st October 2020).

allocation[399], but should also devote attention to the principle of patients' authentic autonomy, according to which patients' rights are not just claimed in words, but are actually realized in practice.[400]

Indeed, in *Montgomery* itself the same arguments were acknowledged and counteracted. The judges recognised the practical constraints, but demanded they give way to accommodate patient choice and partnership:

> 'It is nevertheless necessary to impose legal obligations, so that even those doctors who have less skill or inclination for communication, or who are more hurried, are obliged to pause and engage in the discussion which the law requires. This may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562 was no doubt received in a similar way by the manufacturers of bottled drinks.'[401]

The need to give voice to patients and to tackle endemic challenges is clear in the 2020 GMC guidelines.[402] The existence of practical hurdles in the delivery of health care services, including time constraints, is acknowledged. Nevertheless, the need to support patients' in the decision-making process is still given priority. RMPs are advised to find possible ways to foster a supported decision-making process, by looking either for staff collaboration or for other sources of information that can help the patient reach a decision. In extreme cases, when circumstances out the control of medical staff, mean that they cannot translate this model into practice, they should then report it to managers. Ultimately, the GMC approach proffers a practical way to reduce the current difficulties of daily practice. In summary, the pursual of an authentically autonomous decision faces practical barriers that will necessitate also policy and cultural change.[403] I will outline suggestions for revision in Chapter 5 and Chapter 6, aimed, amongst other at making the approach proposed 'workable'.

However, the proposed model, even if proved to be potentially workable, might still be criticized. In the abortion context, a dialogical relationship might place an obstacle to the rapidity of the procedure, which is considered a key part of women's

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[399] See on this point: DHSS, 'NHS Management Enquiry, Griffiths Report', (London HMSO, 1983) arguing that "the NHS is different from business in management terms', General Observation n 1, online available at: https://www.sochealth.co.uk/national-health-service/griffiths-report-october-1983/ (accessed 21st October 2020).

[400] See on the importance of translating patients' right into practice and on working on institutional changes: T T Arvind, A M McMahon, 'Responsiveness and the role of rights in medical law: lessons from Montgomery' (2020), *Medical Law Review*, vol. 28 (3), 445.

[401] *Montgomery* [at 93].

[402] GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), 7, 11, 28. This also reflected what proposed in the 2018 draft guideline: GMC, 'Decision-making and consent: supporting patient choices about health and care, Draft guidance for consultation', (2018), 36-38.

[403] For a further analysis of possible policy implications see Chapter 6.

autonomy rights.[404] Although the focus of this thesis is not an empirical one, it can be claimed here that even if there is truth in this criticism, it is also desirable that the rapidity of the procedure should be put into context: women should not feel pressurized to make any decision in the shortest time possible. Instead, they should have the time and space that they consider necessary to make personal decisions and hence to allow for an identification process to take place.

Another criticism that might be raised against my proposed account is that my understanding of autonomy reiterates the risk of a 'doctor-knows best' approach[405]: women's decision-making role would be restricted or even potentially excluded to give weight to RMPs' power. In this context, it should be pointed out that this model does not deny, but rather aims to enhance the empowerment of women through the process of identification. Adopting a model of authentic autonomy requires RMPs to recognize women as having normative authority (i.e., capability of self-regulation).[406] For instance, consider certain women dealing with the physical and psychological consequences of domestic abuse and who are also considering an abortion. Here, the role of RMPs may be key. RMPs should listen to women's challenges and circumstances, as far as this is practicable in the space of the appointment and in light of the extent to which women are open to dialogue. This understanding of the relational component therefore does not seek to reject women's decision-making role, but to enhance self-respect and self-trust[407] during the decision-making process.[408]

However, it could be argued that RMPs might still subjectively[409] shape the information provided according to their ideas/values, rather than to give weight also to women's perspective. As in every relationship, although the risk of subjective and manipulative dialogue might still be present, there is a space for overcoming such

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[404] See on the access to abortion, E Jackson, *Regulating Reproduction* (Oxford: Hart Publishing, 2001) 85-87.

[405] See: A Maclean , *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 72-109;T Tomlinson , 'The physician's influence on patients' choices' (1986), *Theoretical Medicine*, vol.7, 105; T E Quill, H Brody, 'Physician recommendations and patient autonomy: finding a balance between physician power and patient choice' (1996), *Annals of Internal Medicine*, vol. 125, 763; R M Veatch, 'Doctor does not know best: why in the new century physicians must stop trying to benefit patients' (2000), *Journal of Medicine and Philosophy*, vol.25, 701.

[406] See on this point: C Mackenzie, 'Relational autonomy, normative authority and perfectionism' (2008), *J Soc Philos* vol. 39(4),512; Benson P, 'Autonomy and self-worth '(1994) *J Philos,* vol. 91(12), 650; T Grovier, 'Self-trust, autonomy and self-esteem' (1993), *Hypatia*, vol. 8(1),99; A Westlund, 'Rethinking relational autonomy' (2009), *Hypatia,* vol. 24(4) 26.

[407] See on this point: C Blease, H Carel, K Geraghty, 'Epistemic injustice in healthcare encounters: evidence from chronic fatigue syndrome' (2017), *Journal of Medical Ethics*, vol. (43), 549; O O'Neill , *Autonomy and trust in bioethics* (Cambridge: Cambridge University Press, 2009) 28-44,73-95.

[408] A Maclean, *Autonomy, Informed Consent and Medical Law*, (Cambridge: Cambridge University Press, 2009) 231-232, 250-253.

[409] J F Smith challenges the informative role of doctors and the exchange of information with patients. She claims that the disclosure process is also affected by the authority that doctors exercise in the medical arena. Patients may hence perceive what is an opinion as an imperative or vice versa, and this might also affect the final decision patients make. J F Smith, 'Communicative ethics in medicine: The physician-patient relationship', in: S M W olf (Ed.), *Feminism & bioethics: Beyond reproduction* (New York: Oxford University Press, 1996) 184-215.

criticism. RMPs are called to strive for a dialogue, which is based on scientifically sound information,[410] not on mere personal perspectives. I am not in this sense suggesting that RMPs should be mere 'fact-provider'. I am also not denying that RMPs might well have their personal views on the issue. I am conversely suggesting that they should engage in a respectful dialogue with their patients, bringing in their expertise and advice, while also giving voice to the woman's needs and values. When the medical encounter is oriented towards dialogue and support it can trigger a positive evaluative process on the women's side, without imposing nor substituting any personal evaluation on them.

In short, a model of authentic autonomy aims to overcome an atomistic and thin understanding of autonomy, which views women as isolated decision makers. My proposed model embraces instead a holistic approach,[411] which views women within the context of their circumstances and relationships,[412] with the purpose of supporting them in their decision-making. The relevance of the first medical encounter is hence understood as serving the aim of providing support during the decision-making process through disclosure of relevant information. It should also be clarified that this will not exclude the relevance of further additional forms of support, such as referral to specialist counselling services. These have, however, been considered to be ancillary to the existence of a fruitful first medical encounter.

4. Conclusion

This Chapter proposed the principle of authentic autonomy as a basis upon which a change in approach can be fostered. It builds upon the findings of Chapter 2, which identified a lack of focus on the how-question in the ethical and legal abortion context of England and Wales.

This Chapter has firstly provided an overview of the connections between the principle of autonomy, abortion, and IC literature. It has highlighted the limits of an

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[410] For a broader account of challenges connected to medical knowledge and disclosure of risks, see: O Wegwarth, G Gigerenzer, 'Statistical illiteracy in doctors', in: G Gigerenzer, J M Gray, W Gaissmaier, *Better Doctors, Better Patients, Better Decisions: Volume 6: Envisioning Health Care 2020* (Strungmann Forum Reports, 2011) 137-152. They highlight that patients' misinformation is also related to the health illiteracy of medical professional, and in particular statistical illiteracy. The importance of the quality of information and of connected trainings and forms of support is vital in the mainstream medicine context and, I argue, more so in the context of abortion where a variety of interests is at stake.

[411] See on this point: S Suter, 'The politics of information Informed Consent in Abortion and End-of-Life Decision-making' (2013), *Am. J.L. & Med.*, vol. 39 (7), 18; S M Suter, 'The "Repugnance" Lens of Gonzalez v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies' (2008), *GEO. WASH. L. REV.*, vol. 76, 1514,1592-93; P Laufer-Ukeles, 'Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy' (2011), *AM. J.L. & MED.*, vol. 37, 567, 604.

[412] See on the relevance of the context for a true a woman-centred approach: J Bridgeman, 'A woman's right to choose?', in: E Lee, *Abortion Law and politics today*, (London: Macmillan press, 1998) 89.

account of autonomy as self-determination, which values the decision-making role per se, without any broader weight given to the decision-making process. This approach risks abandoning some women and hence silencing some of the wider interests that are involved in the decision-making process.

It has clarified the need to embrace an additional doctrinal and normative perspective in the formation of a theory of authentic autonomy. This model frames the first medical encounter between women and RMPs as one that offers the opportunity of dialogue, communication, and support.

This model fosters firstly authenticity, since it aims at triggering a process of critical reflection and hence of identification between the choices offered and the one embraced. It also fosters relationality, since it values the relational dimension between women and RMPs as crucial for the safeguarding of a thick conception of autonomy.

Chapter 4 has argued that this model of autonomy implements the 'how-approach', by valuing women's decision-making process and also by supporting the principle of partnership evidenced in Chapter 3. This model also safeguards a wide concept of well-being, understood in both an objective and subjective dimension. It further fits the context of abortion, by promoting the creation of an environment where women's vulnerability and lack of ultimate sense of control over a decision can be tackled.

Part 2 has hence provided the theoretical framework of this thesis, proposing a nuanced account of the principles of partnership and autonomy (i.e., 'how-approach'). Building upon this, the current scenario concerning the neglect of the decision-making process appears clearly problematic and in need of a change. Part 3 will now explore possible considerations for revision in the England and Wales abortion context.

Part 3

This thesis has so far highlighted that the decision-making process is often a neglected aspect in abortion legal and ethical discourses in England and Wales (Part 1). This phenomenon has been classified as problematic, in light of the principles of partnership and authentic autonomy (Part 2). Part 3 is now exploring possible alternatives. It addresses the question: *what are the possible implications of the proposed theory regarding the ethical and legal framework of abortion in England and Wales?*

Part 3 is comprised of two Chapters 5 and 6. Chapter 5 explores the potential legal consequences on the AA and the law of negligence. Chapter 6 explores the possible policy implications. In particular, Part 3 reflects on the impact on relevant professional guidelines and the need for clarity in this context.

Part 3 shows that there is a symbiotic relationship (to paraphrase Miola[413]) between legal and ethical considerations. Partnership and authentic autonomy, as the two key guiding principles adopted in this context, lead to a reflection on both legal and ethical implications in the context of abortion. The thesis calls for an enhanced abortion decision-making process and greater emphasis on the supportive role of medical professional so as to give justice to women's authentic autonomy.

[413] J Miola, *Medical Ethics and Medical Law A Symbiotic Relationship* (London: Hart Publishing, 2007)79, 209-210.

Chapter 5

Legal implications

To what extent do the AA and the law on negligent non-disclosure of information embrace a model of partnership and authentic autonomy? How far they should be amended to better safeguard the suggested framework?

1. Introduction

Chapter 5 tackles the legal implications of the proposed theoretical framework of abortion in England and Wales, as set out in Part 2. In particular, when it comes to the first medical encounter, the Chapter asks what are the legal implications of the principles of partnership and authentic autonomy. This Chapter explores possible revisions of the AA and the law on negligent non-disclosure of information as it applies to the first medical encounter with a RMP. These are the most relevant laws pertaining to the decision-making process in this field. In the criminal law realm, the AA is to date 'the' legal basis for an assessment not only of the 'legality' of abortion, but also of the relationship between medical professionals, patients, and IC-processes. In the civil law realm, the law of negligence is the legal basis on which considerations surrounding the quality of this medical encounter can be evaluated.

Chapter 5 proposes the inclusion of a consent clause in the AA to enhance a process of revised medicalisation. The Chapter argues that this is the optimal way to tackle harmful de-medicalisation practices which, as argued in Chapter 2, jeopardise the decision-making process by limiting the contribution of medical professionals. The proposed inclusion of a consent clause in the AA will be tied with the proposal of a revised approach at both common law and relevant professional guidelines. This Chapter will analyse common law, leaving professional guidelines to Chapter 6.

Common law changes in relation to non-disclosure of material information are necessary, this Chapter suggests, in promoting the principles set out in Part 2 of this thesis. This Chapter highlights ways to better interpret the materiality test in the abortion context. The law of negligence currently suffers limitations in this regard. Difficulties in identifying both actionable damages and a causal link limit the likelihood of a successful claim.[414] Also, as medical paternalism has waned and patient autonomy ascended, the IC-discourse has been given increased attention. However, as Halliday[415] has pointed out,

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[414] See on the general challenges related to the law of negligence Chapter 2 section 4.

[415] S Halliday, 'Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life' (2016), *Contemporary issues in Law*, vol. 13 (4), 287, 311.

the content of this discourse is often contested. The proposed 'how-approach', based on the principles of partnership and authentic autonomy is a tool that fosters the evolution of the law of negligence and clarifies the meaning of a process of disclosure. In this sense, the proposed model is not a mere repetition of the judgment in *Montgomery*, but uses it as a starting point to discuss an enhanced protection of the decision-making process in the context of abortion.

The overarching aim of Chapter 5 is to demonstrate how a revised medicalisation can be achieved. The proposed legal reforms, both within the AA and the law of negligence, would enhance the safeguarding of the decision-making process in line with the 'how-approach'. Building upon these reflections, Chapter 6 will then integrate the proposed legal reforms with an analysis of possible policy implications.

It should be clarified that the considerations for revision that will be portrayed will offer an optimal or 'ought to be' scenario which aims to emphasise the importance of the principles proposed in previous chapters. Whether any of these considerations will be implemented will much depend on political appeal and would potentially also call for further empirical studies on medical practice and patients' needs in this context.

2. Proposed Abortion Act 1967 reform to enhance commitment to authentic autonomy and partnership

The AA, as described and analysed in previous Chapters,[416] sets out the legal defences of what would otherwise be a criminal abortion. One of the aims of Chapter 2 was to establish that the AA, as an example of a medicalised model, leaves the door open for a process of information disclosure and support in partnership with medical professionals. However, its broad formulation does not provide sufficient protection for this approach and can result in the decision-making process being neglected. Additionally, the present move towards de-medicalisation, as expressed by the current push towards self-administration of early term medical abortion, together with what the Department of Health and Social care (DHSC) labelled the 'unacceptable' practice[417] of pre-signed notification forms, have exacerbated this phenomenon. This section looks at a reformulation of medical involvement, here phrased as 'revised medicalisation', as the optimal way forward to safeguard the two proposed principles.

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[416] See particularly Chapter 1-2.

[417] DHSC, 'Procedures for the approval of independent sector places for termination of pregnancy (abortion)', (2013), online available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/313443/final_updated_RSOPs_21_May_2014.pdf (accessed 21st October 2020), 10.

2.1 Protecting the 'how-approach' in a reformed Act: the challenges related to an IC clause

In 2008, Charles Foster recommended the incorporation of an IC clause within the AA. In a pre-*Montgomery* article, he argued that 'abortion sometimes seems to sit on a tiny island, terribly isolated from the rest of the law on consent'.[418] His persuasive view is that abortion does not and should not provide an exception to the requirements of IC that apply in other areas of healthcare law. This section concurs that it would be advantageous to strengthen the IC approach in the context of abortion, while engaging in a wider reflection on how this can be achieved within the AA. To understand both the meaning and the implications of the inclusion of an IC clause, it will consider first some legislative examples through a comparative exercise with the US, where an IC clause was included. The potentials and challenges related with the formulation of an IC clause within the Act will then be exposed. This will lead to the proposal of an alternative, which will retain the development of IC within a common law context, while also proposing the inclusion of a consent clause within the Act.

In the US legislative context of abortion,[419] the protection of IC has been included in specific clauses. These IC clauses have generally followed two broad models: substantive or procedural.[420]

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[418] C Foster, 'A lost opportunity' (2008), *The New Law Journal*, vol. 158 (7326), 889. In this piece, Foster gives an overview of possible merits and reasons for the inclusion of an IC clause in the abortion context, which this thesis supports and builds upon by providing a more detailed proposal for potential reform.

[419] For an overview of the USA regulations on this topic see: Guttmacher Institute, 'Counselling and waiting periods for abortion', online available at: https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion , 1st July 2020, (accessed 21st October 2020), this report highlights that 29 USA legislation provide a list of information a woman must be given by clinicians; National Right to life committee, 'A woman's right to know: Casey-style informed consent laws', (June 2018), online available at: https://www.nrlc.org/uploads/stateleg/WRTKFactSheet.pdf (accessed 21st October 2020), in this report it is highlighted that, as per June 2018, 28 USA stated enacted forms of IC legislations; R Benson Gold, E Nash, 'State Abortion Counselling Policies and the Fundamental Principles of Informed Consent' (2007), *Guttmacher Policy review*, vol.10 (4), online available at: https://www.guttmacher.org/gpr/2007/11/state-abortion-counseling-policies-and-fundamental-principles-informed-consent (accessed 21st October 2020); The proposal of a state-mandated regulation was also recommended in 2007 by the House of Commons Science and Technology Committee, but never implemented. See: House of Commons Science and Technology Committee, 'Scientific Developments relating to the Abortion Act 1967, twelfth report of session 2006-2007', online available at: https://publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf (accessed 21st October 2020)

[420] See for a theoretical distinction of the IC legislations: K Moredock, 'Ensuring so grave a choice is well informed: the use of abortion informed consent laws to promote state interests in unborn life' (2010), *Notre Dame Law Review*, vol. 85(5), 1973.

Substantive Model

Under the substantive model, a list of information is identified at the state level and medical professionals are required to disclose it. More specifically, the substantive model sets out state-mandated information disclosure within the abortion context in the US. The mandated information varies from state to state, but generally includes biological statements concerning fetal development, clinical statements about the abortion procedure and connected risks, and other information about the availability of external support. In *Planned Parenthood v Casey*[421] the US Supreme Court held that IC regulations, such as these drafted for the abortion context, should be subject to judicial scrutiny aimed at (i) safeguarding the truthfulness and non-misleading nature of the information disclosed and (ii) avoiding any undue burden on a woman's access to abortion. However, as will be seen below, *Casey* by no means eradicated problems associated with a substantive approach in the US. On the contrary, *Casey* perpetuated problems.

A potential advantage of substantive IC regulations is that they provide RMPs with clarity as to their legal duty. However, there are also significant disadvantages. Substantive regulations have attracted criticism on the grounds that they stigmatise and infantilise women.[422] Halliday[423], for example, has argued that such regulations can treat women as less capable than a medical professional to make decisions. Also, a mandatory list of prefixed information, irrespective of the woman's desire to receive it, can run counter to the partnership model proposed in this thesis and can potentially distort the IC process. In some cases in the US, and notwithstanding the *Casey* ruling, the required information has also been criticized as scientifically inaccurate.[424] Women are not helped

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421 505 US 833 (1992)

422 See on this point: A E Doan, C Shwarz, 'Father knows best: 'protecting women through state surveillance and social control in anti-abortion policy' (2020), *Politics and Policy*, vol.48 (1), 6; E Atkinson, 'Abnormal Persons or embedded individuals: tracing the development of informed consent regulations for abortion' (2011), *Harv JL & Gender*, vol.34, 617; M Manian, 'The irrational woman: informed consent and the abortion decision-making' (2009), *Duke J Gender L. & Pol'y*, vol. 16,223; ; C Sanger, 'Seeing and believing: mandatory ultrasound and the path to a protected choice' (2008), *UCLA L. Rev.*, vol. 56, 351; K Greasley *Arguments about abortion: personhood, morality and the law* (Oxford: Oxford University Press, 2017)207-208.

423 S Halliday, 'Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life' (2016), *Contemporary issues in Law*, vol. 13 (4), 287, 301-306.

424 See on this point: N F Berglas, H Gould, D K Turok DK, et al., 'State-Mandated (Mis)Information and women's endorsement of common abortion myths' (2017), *Women's health issues*, vol. 27(2), 129; C R Daniels, J Ferguson, G Howard, A Roberti, 'Informed or Misinformed consent? Abortion policy in the United States' (2016), *Journal of Health Politics, Policy and Law*, vol 14(2), 181; J A Robertson, 'Science disputes in Abortion Law' (2015), *Tex. L. Rev.,* vol 93, 1849; E Bernstein, 'The upside of abortion disclosure laws' (2013), *Stan. L. & Pol'y Rev.*, vol, 24, 171; I Vandewalker, 'Abortion and informed consent: how biased counselling laws mandate violations of medical ethics' (2012), *Michigan Journal of Gender and Law*, vol.19(1), 2; Y J Seo, 'Raising the standard of abortion informed consent: lessons to be learned from the ethical and legal requirements for consent to medical experimentation' (2011), *Colum. J. Gender & L.*, vol. 21, 357; A Mcmurray Roe, 'Not so informed: using the doctor-patient relationship to promote state-supported outcomes' (2009), *Case W. Res. L. Rev*, vol. 60,

in their decision-making process without truthful and accurate information reflecting both scientific evidence and subjective needs. Also, the imposition of specific information-sharing requirements can also violate medical professionals' freedom of speech and professional integrity.[425]

Procedural Model

As opposed to the substantive model, the procedural model only indicates that an informative process is legally required. This process could include a clause which considers the involvement of further medical professionals and/or counsellors, but does not stipulate the precise information to be disclosed. A procedural model has distinct advantages over the substantive model. There is no prescribed list of information, but rather a requirement on the RMP to enter a process of dialogue and disclosure. Incorporation of such a clause in the AA would, I suggest, have at least two implications, one positive and one negative.

A positive implication is the clarification of the duty incumbent on RMPs to embark on an informative process from the very first encounter. This would require RMPs to look beyond considerations relating to the legal defences listed in s.1(1) AA, to encompass a process concerning analysis of risks/benefits/alternatives through dialogue with the patient. This encourages RMPs to uphold principles of both partnership and authentic autonomy, fostering a process of revised medicalisation. This is because it can: a) minimise the progressive push towards the reduction of medical involvement (i.e., de-medicalisation), which has been argued against in Chapter 2; b) help move away from the connected trivialisation of the IC process as a tick box exercise, and towards a process that safeguards the proposed 'how-approach'.

A negative implication, however, flows from the criminal law context of the AA in which the proposed IC clause would be situated. Abortion is, in the England and Wales domestic context, a crime[426] to which the AA provides a series of legal defences. An IC clause, therefore, would be no exception to this scenario. This is important and marks a key difference between the US and England and Wales. In the US, abortion is a

205; S E Weber, 'An attempt to legislate morality: forced ultrasounds as the newest tactic in anti-abortion legislation' (2009), *Tulsa L. Rev.,* vol. 45, 359.

[425] See on this point: N N Sawick, 'Informed consent as compelled professional speech: fictions, facts and open questions', (2016), *Wash. U. J. L. & Pol'y*, vol.50, 11; D Orentlicher, 'Abortion and compelled physician speech' (2015), *Journal of Law, Medicine & Ethics*, vol. 43(1), 1,9.

[426] See on this point Chapter 1 section 5.

constitutional right[427] and it is not part of any broader criminal law framework. In the US, a violation of IC does not constitute a crime *per se*, unless States specify otherwise.[428] Rather, it constitutes a violation of a common law duty. Conversely, in England and Wales, the inclusion of an IC clause within the AA would lead to the criminalisation of a failure to obtain IC. I would argue that this would be excessive and out of line with the common law.

The penalty connected to a breach of s. 58 of the Offence Against the Person Act (OAPA) is 'penal servitude for life'. It would be indeed excessive and contrary to the developed common law for non-disclosure of material information to attract such a penalty. A more reasonable alternative would be to incorporate an IC clause, yet with a separate, lesser penalty. Our opponents would claim that a more moderate penalty, however, would only partially mitigate the problem. This is because it is the inclusion of IC *per se* within the criminal law realm that runs counter the vision of IC, based on partnership and patients' autonomy. The 'how-approach' sees as key a relationship of trust between the parties where dialogue and communication with the patient work to foster woman's autonomy -- something that does not fit a criminal law scenario.

It should also be clarified here that the difficulty in finding a balance between the existent criminal law framework and IC does not have to lead, in this thesis' perspective, to the suggestion of de-criminalisation of abortion[429] legislation altogether. De-criminalisation of abortion[430], as a process aimed at repealing the OAPA and/or the

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[427] In light of *Roe v. Wade*, 410 U.S. 113 (1973), abortion is a constitutional right based on the right to privacy of the pregnant woman. In particular, the opinion penned by Justice Blackmun established that a pregnant woman has a constitutional right to access abortion, which is absolute during the first trimester but exists throughout pregnancy. Such a right stemmed from her fundamental *right to 'privacy,'* and/or constituted an aspect of that individual '*liberty*' constitutionally protected by the 'Due Process Clause' of the Fourteenth Amendment. See on this point: *Roe v. Wade*, at [155].

[428] Some states have associated both civil and criminal law penalties with a violation of abortion laws. These regulations are subject to the scrutiny of the Constitutional court, under the 'undue-burden' requirement as outlined in *Casey*. In Utah, for instance, the violation of IC requirements is associated with: the crime of felony, administrative penalties, suspension or revocation of license. This legislation has to date not been challenged under the *Casey* approach. See: State of Utaha, Abortion Law, as amended in 2018, at 76, online available at: https://le.utah.gov/xcode/Title76/Chapter7/76-7-P3.html (accessed 21st October 2020)

[429] The process of de-criminalisation of abortion can take a variety of forms as the British Medical Association (BMA) pointed out in its 2017 discussion paper: 1) complete de-criminalisation, under which abortion is removed in full from the criminal law; 2) de-criminalisation and selective re-criminalisation, under which both the relevant sections of the OAPA and ILPA are repealed, while new specific crimes are created, as it might be in the case of abortion carried out by an unqualified individual; 3) selective de-criminalisation, under which the OAPA is repealed or amended and the ILPA is preserved, whereby abortion would be decriminalized up to 28 weeks, and the existing criminal provision would cover a lawful abortion beyond this time limit. See on this point: British Medical Association, 'De-criminalisation of abortion: a discussion paper from the BMA' (2017), online available at: https://www.bma.org.uk/media/1142/bma-paper-on-the-decriminalisation-of-abortion-february-2017.pdf (accessed 21st October 2020) 23-24.

[430] The de-criminalisation of abortion law is currently supported by the British Medical association, Royal college of midwives, Royal college of obstetricians and gynaecologists, Royal college of General Practitioners, Royal college of nursing, the Faculty of Sexual Health and reproductive Healthcare, see on this point: BMA, 'The removal of criminal sanctions for abortion: BMA position paper' (2019), online available at: https://www.bma.org.uk/media/1963/bma-removal-of-criminal-sanctions-for-abortion-position-paper-july-2019.pdf (accessed 21st October 2020)1, 3. See also: D Campbell, 'Abortion should not be a crime, say Britain's childbirth doctors' *The Guardian,* (22 September 2017), online available at:

ILPA, does not accord with the position taken in this thesis. Based on a relational perspective, this thesis has argued that the law on abortion should strive to balance women's autonomy with other interests, including the society's interest in protecting the interest of the fetus. Accordingly, the current criminal law[431] framework does and should continue to retain a balance between the interests of women, the fetus, and others (e.g. prospective fathers) that are at stake. The focus of this thesis is a narrower one and concerns specifically the relevance of IC in abortion procedures. Yet wider considerations concerning the importance of criminal law do apply. They cannot, however, be safeguarded by a process of de-criminalisation.

The current criminal scenario should stand, and IC should be still the territory of common law, particularly of the law of negligence and professional guidelines. This is because the common law framework is the most suitable to safeguard the flexibility of the decision-making process and hence of the disclosure process. And as it will be further clarified later, the law of negligence grants patients a 'right not to know'[432], namely to refuse, at their own responsibility, to engage in an IC process. The law of negligence together with professional guidelines make it possible to further develop the basis for a fruitful partnership between the parties, without the threat of committing a crime.

In sum, the inclusion of an IC clause, especially in its procedural format, within the Act brings with it positive and negative aspects. The positive aspect deals with the opportunity to safeguard IC in the abortion context and to create the basis for the safeguarding of the 'how-approach'. However, this positive aspect needs to be counter-balanced with the negative aspect, namely the consideration of IC within a criminal law framework. To be sure, to elevate IC from a common law duty to a crime would be excessive and would run counter the positive aspect brought by the principles of partnership and authentic autonomy discussed in Part 2.

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https://www.theguardian.com/world/2017/sep/22/abortion-decriminalise-crime-britain-childbirth-doctors (accessed 21st October 2020); S Sheldon, 'British abortion law: speaking from the past to govern the future' (2016), *The Modern Law Review*, vol. 79(2) 283; S Sheldon, 'The De-criminalisation of Abortion: An Argument for Modernisation' (2016), *Oxford Journal of Legal Studies,* vol. 36, 334; E Lee, 'Tensions in the regulation of Abortion in Britain' (2003), *Journal of Law and Society*, vol.30(4), 532; K Greasley, *Arguments about abortion: personhood, morality and the law* (Oxford: Oxford University Press,2017), 203-221; S Sheldon, K Wellings, *Decriminalising Abortion in UK* (Bristol: Policy press, 2020) 1-16; F Amery, *Beyond pro-life and pro-choice*, (Bristol: The Policy press, 2020)145.

[431] See in support of a criminal law framework for abortion legislation, though specifically in the USA context: M A Glendon, *Abortion and Divorce in Western Law* (Cambridge*:* Harvard University Press*,* 1987) 10-20.

[432] *Montgomery* at [85].

2.2 What would a consent clause within the AA look like?

In law, a failure to secure IC can lead to a claim in negligence, whereas a failure to secure a valid consent (based on basic information, voluntariness, and requisite mental capacity) can constitute both a battery (which is actionable per se) and potentially the crime of assault. Having dismissed the possibility to include an *informed* consent clause within the Act, given the wider criminal law challenges involved, a possible alternative route would be to strengthen the consent process within the AA through the provision of a valid consent clause.[433] This clause would then pave the way for an evolution of both the law on negligent non-disclosure of information and professional guidelines, where IC can be best developed.

Though it is the aim of this thesis to focus on principles rather than to make specific proposals for revision (which would require political debate and empirical research), it is relevant to consider how a consent clause might be inserted into the AA.

A first useful aid for the proposal of a valid consent clause is the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11. This regulation sets out the need for consent and its breach could lead to prosecution and regulatory action by the Care Quality Commission. It states:

11.—Need for consent

Care and treatment of service users must only be provided with the consent of the relevant person.

Paragraph (1) is subject to paragraphs (3) and (4).

If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.

But if Part 4 or 4A of the 1983 Act** applies to a service user, the registered person must act in accordance with the provisions of that Act.

Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment).

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[433] An alternative approach would have been to reframe the existent good faith requirement (s.1(1) AA) and to clarify the consent requirement in that context. This alternative however can create more problem than it solves. It is the case that the good faith clause faces already interpretative challenges: firstly, it gives a wide discretion to RMPs and it is an often easy-to-be met threshold [see in support of this point S Pattinson, *Medical Law and Ethics*, (London: Sweet and Maxwell, 6th ed, 2020) 244.], secondly in *R v Smith* [1959] 2 QB 35 at 381 was also clarified that this requirement has to be determined by the jury discretion. This double indeterminacy would not necessarily be tackled, but possibly exacerbated, by the inclusion within the Act of a more stringent tie between good faith and a clear consent requirement. For these reasons a better alternative has seemed to be the one of creating a separate valid consent clause. See further on the challenges related to good faith: Chapter 2 at 3.3.

* Mental Capacity Act 2005

** Mental Health Act 1983

A further useful aid, particularly with regard to penalties to be attached to the proposed valid consent clause, is the Human Tissue Act 2004 (HTA). Reference to the HTA will provide a more moderate penalty than that contained in section 58 of the OAPA (i.e., 'penal servitude for life'). The HTA also requires 'appropriate consent' for certain purposes. Appropriate consent is not defined in the statute save to refer to the common law. This term therefore allows the requirements of consent to adapt as the common law develops. The HTA makes it a criminal offence to remove, store, or use human tissue for certain purposes without appropriate consent. S. 5(7) HTA states:

A person guilty of an offence under this section shall be liable—

(a) on summary conviction to a fine not exceeding the statutory maximum;

(b) on conviction on indictment—

(i) to imprisonment for a term not exceeding 3 years, or

(ii) to a fine, or

(iii) to both.

Adapting these two provisions, namely Regulation 11 and s. 5(7) HTA, and subject to empirical evidence as to the appropriate penalty, I suggest that a bill to insert new sections 6 and 7 to the AA could take the suggested form:

Prohibition of activities without valid consent[434]

[434] This might also echo the Abortion Bill [HL] proposal 2019-2021 for a de-criminalisation of the AA. At the time of writing, this proposal seeks to repeal the OAPA s. 58 and s. 59. It also proposes to introduce a new crime, namely the crime of non-consensual abortion. A clinician in this context will be liable in criminal law if using threat or force towards a woman, or if s/he believes that a woman is reckless as to whether she is pregnant or as to whether her abortion results. However, this proposal is distinguished and should be dismissed for two reasons: 1) it advocates for a process of broader de-criminalisation of abortion, something that it has been rejected by this thesis; 2) it can trigger a further process of de-medicalisation within the AA, this is because reduction of medical involvement concerning the notification requirement risks leading to the commensurate reduction in the perceived relevance of clinical advice in this context; additionally it introduces the possibility of two alternative legal justifications for a legal abortion namely the consent of the patient and the doctor acting in good faith, which has potential to further limit the involvement of clinicians. The proposed consent clause, conversely, does not erase the existent criminal law framework concerning consent, nor the involvement of clinicians, but sets a clear baseline approach upon which the safeguarding of IC can be achieved.

6.—

(1) Care and treatment of service users must only be provided with the consent of the relevant person.

(2) Section 6(1) is subject to subsections (3) and (4).

(3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the Mental Capacity Act 2005.

(4) Nothing in this section affects the operation of section 5 of the Mental Capacity Act 2005, as read with section 6 of that Act (acts in connection with care or treatment).

7.- A person guilty of an offence under section 6 shall be liable—

(a) to imprisonment for a term not exceeding 3 years, or

(b) to a fine, or

(c) to both.

This alternative would be aimed at ensuring that the lack of *valid* consent is a crime, while the lack of *informed* consent is not and is dealt, instead, under the common law and professional guidelines. The AA, and hence criminal law, would provide a clearer baseline approach for the law on consent than the approach that currently exists.[435] Currently the protection of consent within the criminal law rests on the law of battery (and assault), whose support has been criticised as limited[436] in Chapter 2. The inclusion of an express consent clause would strengthen the existing legal requirement to obtain consent, aligning it with other sectors of domestic healthcare law, such as in the case context of human tissue regulations. In this way, my proposal echoes Foster's call to better align abortion law with other laws on consent, though through a different proposal of legal reform from the one he was suggesting (i.e., he proposed the requirement of an IC clause rather than a valid consent clause). My approach would also

[435] This approach builds upon the law of battery and its basic informative requirements while also more clearly aligning the AA with wider existent regulations on consent. This will be then tied with broader informative requirements as arising from law of negligence and professional guidelines. See on a reflection on the potential and limitations of battery, Chapter 2 section 4.

[436] See on a critical view of this point, Herring, Jackson and Sheldon arguing that the existent scenario concerning the law of battery and assault is sufficient and potentially also a justification for a de-criminalisation of the abortion legal scenario. J Herring, E Jackson, S Sheldon, 'Would de-criminalisation mean deregulation?', in: S Sheldon, K Wellings, *Decriminalising Abortion in UK* (Bristol: Policy press, 2020) 62-65.

help create the basis to safeguard the specific *nature* of consent, whose content should be placed to further develop within common law and professional guidelines.

So far, I have noted that the AA, as currently interpreted, neglects a due focus on the decision-making process. Revision of the Act with the inclusion of an IC-clause has been dismissed as this would elevate IC from a common law duty to a crime. An alternative route has been suggested: the inclusion of a valid consent clause. Valid consent has a lower required informational threshold than IC. So it would serve as a reminder of the necessity of consent whilst leaving the development of the informational requirements to common law and professional guidance. In relation to the common law (discussed below), the application of *Montgomery* to the context of abortion could be developed and in relation to professional guidelines (discussed in Chapter 6), would operationalize the model at a medical practice level. This Chapter has hence proposed thus far changes in the formulation of the AA to establish a clearer focus on consent procedures, in light of the proposed 'how-approach'. Strengthening the requirement of valid consent on its own, however, is not enough. It is also important that a wider informative and supportive process is safeguarded. For this reason, the next section will consider the importance of a further development of the law of negligence for non-disclosure of material information in the abortion context.

3. The law of negligence for non-disclosure of material information: emphasising the 'quality' of the medical encounter

So far, this Chapter has proposed changes in the formulation of the AA to establish a clearer focus on consent procedures, in light of the proposed 'how-approach'. Strengthening the requirement of valid consent on its own, however, is not enough. It is also important that a wider informative and supportive process is safeguarded. For this reason, this section will consider the importance of a further development of the law of negligence for non-disclosure of material information in the abortion context. The law of negligence sets out requirements as to decision-making processes designed to promote partnership and protect patient autonomy. Ultimately, it will be argued that the materiality test set out in *Montgomery* is not straightforwardly applicable to aspects of abortion and that legal clarification is needed to ensure that the common law is applicable in an abortion context. This would lead, for instance, to a clearer distinction between variant treatments (e.g. abortion methods), and alternative options (e.g. broader pregnancy options) as two heads of information disclosure. In order to present this argument, I will first explore the issue of disclosure of risks, and then move to the disclosure of reasonable treatment options, variant treatments and alternatives in the abortion context.

3.1 The disclosure of information by RMPs and possible implications of the principles of partnership and authentic autonomy

When it comes to the quality of the medical encounter, a reflection on RMPs legal duties of information disclosure is required. *Montgomery* sets out a new test for materiality of risk. This test, formulated in the context of mainstream medicine, is structured around two limbs. The first limb requires RMPs to disclose those risks and reasonable alternatives that 'a reasonable person in the patient's position would be likely to attach significance to' and the second limb requires disclosure of information where 'the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it'.[437] Part 2 of the thesis, containing Chapter 3 and Chapter 4, has noted that this test raises interpretative challenges in mainstream medicine and in its applicative dimension in the context of abortion. This section adds to that analysis a consideration of how the materiality test could potentially be developed by adopting the 'how-approach' at common law. Later on, the broader challenges concerning reliance on negligence liability will also be discussed. This section will claim that the current *status quo* of the law of negligence is but a starting point for the protection of a fruitful first medical encounter in the context of abortion. In this sense, it will be claimed that the development of the law is needed to facilitate the application of the test of materiality in a way that will uphold the principles of partnership and authentic autonomy.

Two factors should be noted in applying these two principles. One is that in interpreting and applying this analysis of the materiality test, the courts should be careful to avoid any so called 'abortion exceptionalism'[438] whereby the standard of disclosure expected in this context is above any other medical treatment or, worse, entails forms of inaccurate and misleading disclosure. This factor will be further expanded and supported by wider policy-oriented considerations in Chapter 6. Another is that it is at least theoretically possible that during the first medical encounter RMPs determine that some women are not eligible for an abortion, because for instance the pregnancy exceeds the legal time limit set out in the AA. Where this occurs, it might be assumed that the information disclosure process does not start at all as there will be no relevant medical procedure. However, it is important to recognise that the foundation of the proposals in this thesis, reflect upon but are not limited to the legal consequences of action and inaction on the part of RMPs. The ethical duty to care for the patient does not cease in circumstances that the AA does not allow abortion. An alternative pathway of care for

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[437] *Montgmery* at [87]

[438] S Halliday, 'Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life' (2016), *Contemporary issues in Law*, vol. 13 (4), 287, 315.

and support is relevant in such cases. This aspect is here merely signposted, since it is out of the scope of the current analysis.

The overall aim is hence to unpack the IC process and examine how it might be reinterpreted to fit the proposed approach in the abortion context.

3.1.1 The first limb of the materiality test in the abortion context in light of the proposed approach

This section explores the duty of information disclosure through the first of the two limbs of the materiality test as set out in *Montgomery*.[439] The first limb requires disclosure of information where a reasonable person in the patient's position would be likely to attach significance to the risk. The test asks us to reflect on what a 'reasonable patient' would want to know. It is argued, in light of the 'how-approach', this should be translated as the 'rational' component of the disclosure process. Here the discussion focusses on the first medical encounter, but notes that these considerations can and should be more widely applied to future medical encounters, in line with a dynamic model of consent.

The materiality test requires the disclosure of information that a reasonable patient 'ought to be told[440]' in the given circumstances. This entails the disclosure of 'objective' information understood as scientifically sound, accurate and relevant information. Chapter 3 discussed the proposal of a 'supported decision-making model' which reflects and reinterprets the rational non-interventional paternalistic approach as outlined by Savulescu.[441] The focus of the first limb should therefore be translated as the need to provide 'rational' information, meaning medically accurate and truthful information, upon which to base a dialogical encounter with women.

The objective aspect, however, does not necessarily mean that this is also a 'self-evident' aspect. This objective component puts emphasis on the contribution of medical experts in this context and is also inevitably the result of a prognostic evaluation of the circumstances. Disclosure under the first limb of the materiality test during the first medical encounter will reflect the legal grounds for an abortion as encapsulated within

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[439] *Montgmery* at [87]

[440] Dunn et al. have also further attempted to unpack the meaning of the first limb and they have agreed that 'reasonable' can be understood to mean the disclosure of what is 'normatively justifiable'. See on this: M Dunn M, K W M Fulford, J Herring, A Handa, 'Between the Reasonable and the Particular: Deflating Autonomy in the Legal Regulation of Informed Consent to Medical Intervention' (2019), *Health Care Analysis*, vol. 27, 110, 119-121.

[441] J Savulescu, 'Rational non interventional paternalism: why doctors ought to make judgements of what is best for their patients', (1995) *Journal of Medical Ethics*, vol. 21, 327. See also Chapter 3 section 3.

the AA. That is to say, when abortion is pursued under the so called 'social ground'. s.1(1)(a), or for risk to health and life, s.1(1)(b)-(c), or for a substantial risk of a serious fetal abnormality, s.1(1)(1) (d). When it comes to abortion for risk to life, the materiality of risks can appear to be theoretically at the highest level of 'objectivity'[442] because the risk to the mother's life is already specified and identified by the law as 'material' and it also appears to be the strongest medical reason to grant an abortion: this ground ultimately identifies the case of a medical emergency and it can be relied upon by a RMP.[443]

The 'objectivity' requirement stands along more blurred lines when it comes to the other legal grounds. A broader scope for a balancing exercise is apparent in the case of abortion for social reasons and risk to health. Both share a balancing exercise between mental and physical risks associated with abortion as compared to continuing the pregnancy. The distinction between these two grounds stands in the fact that s.1(1)(b) requires something more stringent: a medical 'necessity' and the risk of a 'grave and permanent injury' on the side of the pregnant woman. The social ground,[444] conversely, opens the gates for a balancing exercise with wider evaluation. This goes beyond a pure diagnostic analysis, which is also difficult to pre-determine. The majority of abortions in England and Wales are carried out under the social ground.[445] This fact has been also often criticised for allowing abortion on demand: as Jonathan Montgomery[446] argued, this assertion is based on the assumption that in the first 12-weeks of pregnancy carrying a fetus to term is more dangerous than an abortion. However, the risk is that there is no actual balancing exercise in practice and that 'pregnancy' can become the sole reason for believing that abortion is a less risky option. Additionally, the identification of potential mental health sequelae is still a highly disputed territory and while risk-factors have been

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[442] This statement can be partially counterbalanced by the still unknown tie between COVID-19 and pregnancy. Whether and what kind of risk this might pose to pregnant women's health is to date mostly unknown. See on this point: RCOG, Coronavirus (COVID-19) infection and abortion care, 31st July 2020, online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-COVID-19-infection-and-abortion-care.pdf (accessed 21st October 2020),21.

[443] AA s.1(1)(4)

[444] Further challenges are connected to the existence of a time limit on this ground and the difficulty in clearly identifying how to calculate it. See on this point: A Grubb, 'The new law of abortion: clarification or ambiguity' (1991), *Crim LR*, 659.

[445] 'In 2019, 98% of abortions (202,975) were performed under ground C' corresponding to s. 1(1)(a) AA. See: DHSC, 'Abortion statistics, England and Wales: 2019', (June 2020), online available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/891405/abortion-statistics-commentary-2019.pdf , (accessed 21st October 2020) 10.

[446] J Montgomery, *Health Care Law*, (Oxford: Oxford University Press, 2nd edition 2002)379. See also: S Sheldon, *Beyond Control*: *Medical Power, Women and Abortion Law* (London: Pluto Press) 86, also claiming that a further consequence is that criminal prosecution under s.1 is highly unlikely. She claims that it is impossible to challenge the 'statistical argument' whereby an abortion poses less risks than carrying a pregnancy to term and hence prosecuting a clinician on this ground. See more generally on the issue of safety of abortion compared to childbirth for instance: E G Raymond, D A Grimes, 'The Comparative safety of legal induced abortion and childbirth in the United States' (2012), *American College of Obstetricians and Gynaecologists,* vol. 119 (2) part 1, 215.

identified, engaging in an information disclosure surrounding this topic has been perceived to be a form of stigmatisation of abortion.[447] It is hence the case that the 'objective' component, especially in the case of an abortion under the social ground, risk being neglected. The 'how-approach' would conversely restate its relevance during the decision-making process.

When it comes to abortion for serious fetal abnormality, the objectivity is strongly dependent on medical expertise, and also on the effectiveness of a diagnostic test on which an abortion can be based. When an abortion is carried out under s.1(1)(d), the objective component is the result of a prognostic evaluation. In light of screening and/or diagnostic results, the prognostic evaluation have, however, an inherent degree of uncertainty. This questions the objectivity of the disclosure process under the first limb.

The issue of disclosure of risks that a reasonable patient ought to be told in the given circumstances can require RMPs to work on prognostic aspects which are in themselves marked by a lack of objectivity. The challenges inherent in a disclosure process are also apparent with the often-disputed nature of the risks connected to an abortion. Practically speaking, this means, as it will be explained in Chapter 6, that awareness of relevant professional guidelines which spell out what should generally be disclosed, should be required. It also calls for an analysis of possible risk-factors arising in the circumstances of the case and basing them on the most recent and up-to-date evidence.

The challenges related to the disclosure of objective information should be minimized through both patients' and medical professional awareness. Patients should know that they have the right to be made aware of risks. RMPs should engage in ongoing training to enhance knowledge of guidelines and up-to-date scientific evidence, and minimize the risk of non-disclosure of risks, as will be further discussed below.

In sum, the first limb can be understood as the 'rational' component of the partnership approach proposed. It can accordingly incarnate the aim for a disclosure process, based on accurate and truthful information. It can therefore avoid the spread of misinformation particularly in the first medical encounter. An in-depth analysis of its content will be provided in Chapter 6, where an exploration of relevant professional guidelines will be offered.

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[447] See on this point Lee who believed that the stigmatisation in this context arises because abortion is construed as a 'social-problem'. The disclosure of risks connected to abortion were mostly not based upon scientific evidence and upon the need to support a woman, but were a form of social control over her decision. See: E Lee, 'Reinventing abortion as a social problem: post-abortion syndrome in the United States and Britain', in: J Best, *How Claims Spread: Cross-National Diffusion of Social Problems*, (New York: Walter de Gruyter, 2001)39-68.

3.1.2 The second limb of the materiality test in the abortion context in light of the theory proposed[448]

The second limb requires RMPs to focus on the 'particular patient' whenever reasonable in the given circumstances. The test is satisfied if 'the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to [the risk, reasonable alternative or variant treatment].'[449] This second limb aims at balancing the 'objective' component of the materiality test with a weight given to a patient- and fact-sensitive considerations. Understood in light of the 'how-approach', the second limb calls for a balance to be struck between the objective and subjective components of the materiality test which minimizes the risk of a return to a consumeristic approach.[450] This section will suggest ways in which the current interpretation of the materiality test should change. In particular, this section seeks to provide a clearer formulation of duties for RMPs to tailor the objective information according to patients' circumstances during the first encounter, with no *a priori* assumption made on the patients' behalf.

It is worth noting that the existence of a 'second limb' focusing on the relevance of a subjective component of the informative process clearly differentiates this model from a model of mandatory information disclosure.[451] *Montgomery* does not mandate a set kind of information to be compulsory disclosed, but requires medically-oriented information to be balanced with patient-oriented information.

During the first medical encounter, the reflection upon the subjective component of the materiality test requires the circumstances under which an abortion is sought to be taken into consideration. In this sense, an understanding of the legal ground that is deemed to be the legal justification for an abortion procedure is a starting point for dialogue between the parties. For example, under s.1(1)(a), the elective component appears to be stronger than the existence of a medical diagnosis (if any), when contrasted with the other sub-sections where abortion is sought in cases of serious fetal abnormality or risk to life and health. In the scenario portrayed by s. 1(1)(a), a reflection on the actual circumstances faced by the patient is a relevant tool to offer support during the decision-making process and hence safeguard authentic autonomy. In this sense, the

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[448] *Montgomery* at [87].

[449] *Montgomery* at [87].

[450] See Chapter 4.

[451] This recalls the above differentiation between IC substantive and procedural models. A mandatory information model is a substantive model, whereas *Montgomery* is more lenient towards a procedural model.

RMP needs to balance both objective and subjective elements before signing the notification forms and granting legal access to an abortion.

It should be clarified that, according to Pattinson[452], this second limb has generally been given little weight by the courts. The 'how-approach' in this sense challenges the *status quo* and pushes towards a change of approach. This is because it has potential to underscore the relevance of a positive balance to be sought so as to safeguard a fruitful medical encounter and a move towards the protection and promotion of authentic autonomy.

It is also true that the balance between the two limbs is not easy to achieve and *Montgomery* itself is not clear on this point. Previous chapters[453] have highlighted the existence of a tension between the drive towards partnership, authentic autonomy, and a consumeristic approach. In the context of abortion, adherence to the second limb risks being translated as a requirement for RMPs to prioritise access to medical services over dialogue and informative processes. Conversely, the second limb of the materiality test, in light of the model proposed should lead instead towards a revised medicalisation, where dialogue, communication, and a balancing exercise between medical needs and subjective circumstances is sought and given more weight. This is also the reflection of the proposed model of supported decision-making[454], whereby RMPs are seen not as intruders or as 'antagonist', but as advisors and partners in the process of information disclosure which precedes a final decision.

The subjective component analysis can also lead women to openly refuse an IC discourse and pursue an abortion without engaging with the IC process.[455] This aspect will be further explored below. It is enough for now to say that attention to the patient calls for respecting the lack of desire to engage in an informative approach. However, this should be the result of a listening exercise on the side of RMPs and not of any assumption on their behalf.

The second limb can therefore be understood as to exemplify the need not to focus on the subjective aspect in lieu of the objective one, but instead to strive for a better balance between the two. Expectations of rapidity of the procedure can lead towards an increase in a consumeristic approach, which this thesis criticizes. Rather, the emphasis should be on a decision-making process oriented towards partnership and authentic autonomy. RMPs' duty to disclose material risks in the abortion context,

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[452] S Pattinson, *Medical Law and Ethics*, (London: Sweet & Maxwell, 6th ed., 2020) 117.

[453] See particularly Chapter 3-4.

[454] See also on this point Chapter 3 section 3.

[455] This is also clearly supported in *Montgomery* at [85].

should therefore aim to bring forward a revised medicalisation that strives for a communicative exercise between the parties.

3.2 Disclosure of reasonable treatment options, variant treatments and alternatives

The process of information disclosure, as required by the test of materiality, also encompasses the disclosure of treatments options, variant treatments, and alternatives. Previous chapters have highlighted that this aspect of *Montgomery* raises issues concerning the possible overlap with the *Bolam* standard of liability. This challenge can also be reported in the abortion context, especially when the diagnostic component is strongly evident. The 'how-approach' will seek to highlight possible challenges, while offering ways to ameliorate them. It will be claimed that when it comes to the disclosure of variant treatments and alternatives, a different emphasis between the first encounter and subsequent encounters can be identified. It can be the case that during subsequent encounters, namely those that happen after the 'approval' of a legal abortion, more weight is devoted to the variant treatments rather than the alternatives at stake. The issue of subsequent encounters will be offered only as a point for consideration. In recognizing that further empirical research is required to develop the matter, it recognizes that it is beyond the scope of this thesis. However, what needs to be stressed at the theoretical level is that, although a difference in emphasis can happen in the medical practice, none of the components of the disclosure process should be deemed to be *a priori* excluded by medical staff.

The disclosure of treatment options is built upon the selection of treatment options by RMPs. The issue can arise also in the abortion context, especially when abortion is carried out under s. 1(1) (b) and (d) that is to say when a stronger diagnostic component is evident, rather than s. 1(1) (a) and (c). In this context, recalling what said in previous Chapters, an overlap between the standard of disclosure laid down in *Bolam* and *Montgomery* arises. Abortion on ground (b) is carried out for 'risk to health' to the pregnant woman. During the first encounter, RMPs are in these circumstances called upon to identify a medical necessity to prevent a grave and permanent injury to the physical and mental health of the mother. They need to find a medical reason that renders abortion necessary to prevent an injury, which is framed to be grave and permanent. There are no social considerations that need to be taken into account under this ground, but it becomes more strongly an issue of framing and disclosing medical treatment options. A further possibility of overlap arises on ground (d), that is to say, abortion for substantial risk of serious fetal abnormality, whereby the RMPs diagnostic/prognostic evaluation appears to be more strongly evident. This is because in

this context the existence of a risk of a serious fetal abnormality is the ground upon which both the selection of treatment and the disclosure of possible variants is sought. This shows that when a more stringent diagnostic/prognostic aspect is in place, the overlap between *Bolam* and *Montgomery* standards becomes more clearly evident.

Conversely, the possibility of an overlap between *Bolam* and *Montgomery* is harder to see for an abortion under s.1(1)(c). When abortion is carried out to save the life of the mother it is framed purely as a medical intervention which leaves little or no space for treatment options. In this context, it seems that there are no treatment options, at least in principle, that need to be disclosed and hence less issues of overlap between the two tests.

The issue of a possible overlap is also less theoretically evident in the context of abortion for social reasons under s.1(1)(a). Previous chapters have highlighted that the issue of abortion poses both medical and broader social considerations. These aspects also affect the disclosure of treatment options. Abortion under s.1(1)(a) can be framed as being more elective in nature. The relevance of the medical diagnostic component may be present, but is less relevant, hence the aspect of treatment selections and disclosure does not strongly arise. In other words, there are not, generally speaking, pure diagnostic reasons that drive towards the disclosure of a different treatment in a first place.[456] In this sense *Bolam* has a narrower relevance in this context.

Ultimately the issue of a possible overlap between treatment options and disclosure of options raises the problematic overlap between *Bolam* and *Montgomery*. This is because different standard of information disclosure apply: *Bolam* is strongly doctor-centred, and *Montgomery* is more patient-centred. The *Bolam* legacy hence carries with it the risk of a return to a more paternalistic approach instead of a partnership approach. This can be reflected also in the abortion context where there is a stronger diagnostic/prognostic reason behind this medical intervention. When abortion is carried out on stronger elective rather than medical considerations this overlap becomes less evident, because purely medical aspects have to be balanced with concurrent 'social considerations'.

The suggestion does not lay here in a return to a *Bolam* approach altogether, but to a recalibration between *Bolam* and *Montgomery*. The proposal of a revised medicalisation emphasizes the relevance of dialogue over a unilateral approach that seeks to emphasise the relevance of medical professional advice in opposition to patients or vice-versa. In particular, *Bolam* would still be framed as the right test in relation to

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[456] It should be acknowledged that the broadness of s.1(1)(a) does not exclude the potential for a legal abortion due, for instance, to the likelihood of an abnormality to arise, as resulting from a preliminary screening test (e.g. first scan or blood test) rather than a subsequent diagnostic test.

matters of clinical expertise, as it is for instance in the case of formulation of treatment options (e.g., in the case of a diagnosis of a substantial fetal abnormality). Yet, given the interconnection between clinical and elective aspects, which is particularly evident in the abortion context, a commitment to partnership requires more.[457] Beyond the tort law spectrum, partnership should be enhanced through professional guidelines, to calibrate the disclosure process with patients' values and circumstances.

The process of disclosure of treatment options, looked at more closely, also encompasses a reflection on variant treatments and disclosure of alternatives. What will be shown in the following paragraphs is that these constitute two separate, yet interconnected, heads of disclosure that risk being neglected or amalgamated. The argument will be developed in Chapter 6[458] to show that professional guidelines on consent and abortion extensively explore variant treatment, whilst neglecting and/or amalgamating the disclosure of alternatives.

Starting with the disclosure of variant treatments, this implies the disclosure of the different abortion methods and connected potential risks. This is consistent with the approach supported by current professional guidelines, as will be further explored in the next Chapter.[459] The baseline of disclosure of variant treatment is therefore a reflection on the different relevant abortion methods. Depending on the gestation at which abortion is contemplated, these methods include: medical abortion, surgical abortion, and home abortions (where there is the possibility to carry out part or the whole of the abortion procedure at home when a pregnancy does not exceed 9 weeks and 6 days).[460] The choice of method is generally influenced by the stage of pregnancy, although some weight is also given to the preference of the patient. In this context, the 'how-approach' would help clarifying that RMPs should engage in a dialogue around risks connected to different methods in light of, for instance, stages of pregnancy and wider medical circumstances. A failure to do so would potentially amount to a breach of the materiality test.

A further separate aspect deals with the disclosure of reasonable alternatives, that is to say wider pregnancy options**.** The issue of alternative disclosure clearly arises both for abortion on social grounds, risk to health, and serious fetal abnormality. A possible exception can be found when abortion is carried out for risk to life, given that there are

[457] See for a wider analysis of the implications Chapter 5-6

[458] Chapter 6 section 2.6.

[459] See Chapter 6.

[460] See on this point Chapter 2 and 6.

no alternatives that can be disclosed as a matter of reason.[461] In the recent post-*Montgomery* case of *Thefaut v Johnston*[462] it appears that, when it comes to elective procedures, the issue of dialogue around 'traditional alternatives' is perceived to be of key relevance. It is arguable that RMPs should engage in an exploration of the broader pregnancy options together with connected risks and benefits. This can include[463] childbirth or in utero surgery when applicable. Currently professional guidelines, as will be further explored in Chapter 6[464], encourage a dialogue around variant treatments and connected risks. However, at the same time, they are not equally supportive of a dialogue around reasonable alternatives. A dialogue which rests only on disclosure of variant treatments (i.e., abortion methods) and fails to engage in a respectful and open conversation around reasonable alternatives (i.e., pregnancy options) could potentially amount, in the proposed approach, to a violation of the materiality test. Something which is not clear at present is where the materiality test risks being neglected. The 'how-approach' could suggest that an RMP should not make any *a priori* assumption on behalf of the patient, but in light of a dialogue with her, should tailor the disclosure process to both medical aspects and the 'subjective' circumstances of the patient.

Disclosure of alternatives also encompasses pursuing 'no treatment'.[465] This aspect encourages RMPs to clarify to patients that they have the possibility to delay the appointment (for example, pending further diagnostic tests or to allow more time to decide) and even not to move forward with an abortion if they so wish. In a post-*Montgomery* Scottish case, *Johnstone v NHS Grampian*,[466] the point of disclosure of alternatives was further specified. The court in this case concerning the disclosure of risks and alternatives connected to a transsphenoidal surgery claimed that the disclosure of no treatment amounted to a reasonable option to be disclosed only when clinically indicated. Although the context of that case is different, it could be used as a reminder that the disclosure of alternatives is not a 'tick-box' exercise, but should be based instead upon a clinical judgement of the circumstances, tailored in light of the given scenario. It is therefore suggested that the second limb of the materiality test in the abortion context should also include reference to the option of pursuing 'no treatment', when clinically

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461 This does not exclude the legal possibility that women can refuse a medical treatment even when this will put their life at risk. See on this point: *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649.

462 [2017] EWHC 497 (QB).

463 Further options are explored in Chapter 6 (section 2.6) and include reference also to the possible future application of artificial wombs.

464 Chapter 6, see particularly section 2-3.

465 This recalls the latest guidelines on consent by the GMC, where a discussion around the possibility of 'taking no action' is suggested. See: GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), 7.

466 [2019] ScotCS CSOH 90 at [150].

indicated. For instance, no treatment might be clinically indicated in case of surgical abortion involving a COVID-19 positive woman when there is no possibility to further delay the intervention (e.g., because this will exceed the time limit set by the Act). This would be particularly relevant for those legal defences where, as stated above, a stronger diagnostic/prognostic component is evident, s.1(1) (b) and (d). Raising awareness of this alternative[467] becomes especially relevant where a diagnostic/prognostic component is more clearly present and also forms of de-medicalisation are in place.

During the first medical encounter, considerations of what amounts to variant treatments and reasonable alternative have crucial relevance for the disclosure process. If the proposed approach was adopted this could mean clearer enunciations that encompass:

1) variant treatments would include dialogue around risks connected to relevant abortion method(s);

2) reasonable alternative options would include:

- disclosure of broader pregnancy options and connected risks;

-disclosure of the option of 'no treatment', when clinically advisable.

The proposed approach would hence clarify, that a breach of the materiality test would more clearly arise when RMPs fail to disclose both 1) and 2), when the circumstances of the case, and hence a balancing exercise between the two limbs, would suggest that disclosure is required. It should be acknowledged that this will still leave the tricky issue of proving the causal link with the patient, for a successful claim in negligence to arise.

Authentic autonomy through partnership implies that there is a dialogue that encompasses disclosure of risks, treatment options, variant treatments, and alternatives and that no assumptions on behalf of the other party are made, while refraining from imposing a specific view-point on them. A failure to do so would amount to a breach of the materiality test. Clearer interpretative ways than the present ones have been suggested for the abortion context. It should be added here that, notwithstanding the emphasis in this Chapter on the first medical encounter, the consideration of reasonable alternatives is also relevant to subsequent medical encounters, once a RMP has considered whether a legal defence to the OAPA exists.

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[467] Recent case law has also clarified that the disclosure of 'no treatment' as an alternative is subject to further restrictions. This option should be disclosed only when the clinician deems it to be reasonable. See on this point: *Brady v Southend University Hospital NHS Foundation Trust* [2020] EWHC 158 (QB); *McCulloch v Forth Valley Health Board* [2020] CSOH 40.

3.3 Possible wider challenges concerning the law of negligence

In light of the suggested developments for the law of negligence and in order to enhance the civil law's adherence to the implications of the 'how-approach' proposed thus far, the following subsection draws conclusions and outlines possible challenges in the law of negligence. The materiality test, interpreted in line with the proposed principles of the 'how-approach', requires RMPs to engage into a dialogical approach concerning risks, benefits, variant treatments, and alternatives. However, the law of negligence, as a possible vehicle of a revised medicalisation, is subject to certain limitations. The following section will reflect on some of these, to claim that the law of negligence should be but a starting point for a revised medicalisation to be safeguarded. The subsequent Chapter will address soft-law mechanisms for furthering the development of the proffered principles.

3.3.1 Is there a right to refuse IC?

A first preliminary question concerns the proposed approach and patient's right to refuse IC.[468] The 'how-approach' would not deny, as clarified in Chapter 4[469], the existence of this right, but would place it in context. The premise for lawfully[470] treating a patient is the provision of, at least, basic information from RMPs as part of the requirement for valid consent. In the context of the law of negligence, a broader disclosure of the nature and purpose of an abortion is required so as to avoid liability on the part of medical professionals. However, as Pattinson highlights[471], it is hard to imagine that there would be legal repercussion when a RMP does not disclose information to a patient who has voluntarily refused to receive it. *Montgomery* also clearly specifies that patients can refuse to engage in an informative process:

> 'A person can of course decide that she does not wish to be informed of risks of injury (just as a person may choose to ignore the information leaflet enclosed with her medicine); and a doctor is not obliged to discuss the risks inherent in treatment with a person who makes it clear that she would prefer not to discuss the matter.'[472]

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[468] Also referred to as 'right not to know'. See on this point E Cave, 'Valid Consent' (2020), *Journal of Medical Ethics*, 0, 1, 3.

[469] Chapter 4 section 3.

[470] Avoidance of liability in tort law of battery and crime of assault.

[471] S Pattinson, *Medical Law and Ethics*, (Sweet & Maxwell, 6th ed, 2020) 124.

[472] *Montgomery* at [85].

The relevance of dialogue around material information therefore can be dismissed altogether if the patient decides that she wishes it. This does not necessarily entail an ignorance on the patient's side, given that she might have sort information through external sources, or that she has already made up her mind. In this sense, a refusal of information might or might not coincide with a desire to remain uninformed of material information.

This is also tied with the claim made in Chapter 4 around authentic autonomy. In that context, it was highlighted that refusal of information comes with ethical responsibilities. The model of authentic autonomy proposed is based on the assumption that dialogue and communication form relevant premises of the final decision to be taken. This is firstly because one cannot be authentically autonomous without knowing what one is choosing and hence what the risks/benefits and alternatives connected to a choice are. Secondly, in the abortion context, Part 2 (containing Chapters 3 and 4) has additionally claimed that women carry an ethical responsibility to be informed towards a) themselves and those who will be further affected by their choice which are to state some; b) the fetus; c) potential father. Although no legal right is owed towards b) and c) it is still the case, as has been argued above, that ethical duties arise.[473]

3.3.2 Is there a potential claim in negligence for non-disclosure of information in the abortion context?

A further question that should be asked is whether there is a potential for a future claim in negligence towards RMPs for non-disclosure of information in the abortion context. It has been claimed in previous chapters, Chapter 2 in particular, that there are both general and particular challenges that might arise in the context of the law of negligence. As far as the former general challenges are concerned, they were identified in the still pervasive influence of the *Bolam* in the mainstream medicine context. In this vein, the recent case in *Mordel v Royal Berkshire NHS Foundation Trust*[474] clarifies the relevance of the law of *Montgomery* and of an IC process, while also reiterating this challenge.[475] This is because it still seems that courts are influenced by an application of *Bolam*[476], whose test has left a strong legacy.[477] Some of these challenges, as suggested in

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[473] See on this point: M Brazier, 'Do no harm- do patients have responsibilities too?' (2006), *The Cambridge Law Journal*, vol. 65(2), 397.

[474] [2019] EWHC 2591 (QB) at [87].

[475] See also on this point Ch 3 section 2.1.4.

[476] [1996] 4 All ER 771

[477] E Cave, C Milo, 'Informing patients: the Bolam legacy' (2020), *Medical Law International*, 0, 1.

Part 2, can be ameliorated through a revised medicalisation, which accounts for dialogue and support, while engendering an authentic autonomy. In other words, this model can lead towards a recalibration of both medical and patient's involvements, which can also limit the impact of *Bolam's* legacy.

This, however, does not exclude the existence of particular challenges. A key challenge is the lack of successful claims in negligence in the abortion context, though there have been successful claims related to wrongful birth.[478] Take, as an example, the wrongful birth case of *Mordel,*[479] where the failure to comply with an IC process led the court to award damages to the claimant. [480] The lack of a successful claim beyond the wrongful birth remit might be associated to the general reluctance of courts to award damages for failures within the IC process itself, [481]where this does not result in harm beyond the informative violation per se. This can also be explained because, as it has been noted in Chapter 2, it is hard to see women starting a successful negligence claim for a failure to be provided material information before an abortion when this does not result in financial implications posed by the birth of a child. A particularly tricky point here is the issue of causation as a key aspect that might also be difficult to satisfy.[482] In a nutshell this *status quo* might be due a) to the general reluctance of courts to grant damages for a violation of IC processes itself;[483] and also b) to the potentially difficulty in proving that the harm arising is causally related to the RMPs' lack of disclosure. These challenges often lead to the lack of an actual claim in this context.

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[478] With this term it is intended the prenatal negligence leading to the birth of a disabled child. Key precedents in the context of actions that parents can bring are: *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] EWCA Civ 530 and *Groom v Selby* [2001] EWCA Civ 1522 where the Court of Appeal held that the extra expenses associated with the raising of a child with a significant disability may be claimed. For an overview of this topic, concerning the actions that the child can bring and ethical issues arising see: S Pattinson, *Medical Law and Ethics* (Sweet & Maxwell, 6th ed, 2020) 329-345. For a critical analysis of the tie between abortion and wrongful birth see Glesson [K Glesson, 'The strange case of the invisible woman in abortion-law reform', in: J Jones, A Grear, K Stevenson, R A Fenton, *Gender, sexualities and law* (Abingdon: Routledge, 2011) 215-226], arguing that beyond the AA stands a formulation of the contribution of medical professional that is problematic. They are framed as intruders rather than partners. This formulation ultimately can adversely impact medical professionals themselves: the desire to protect them from criminal liability has the potential to shift towards the high risk to be sued for wrongful birth claims. The voice of women and their information-oriented interests can also be neglected within the Act and only find a claim when liability for wrongful birth arises. However, a pure IC discourse can still be neglected when this is not reflected in an actual harm.

[479] See also Chapter 3 section 4.2.

[480] I have also personally investigated via two freedom of information requests to NHS Resolution. They have not been able to provide data on this issue, this seems to be due also to problems with their search engine system.

[481] *Shaw v Kovac* [2017] EWCA Civ 1028. See also: *Diamond v Royal Devon and Exeter NHS Foundation Trust* [2017] EWHC 1495 (QB); T Keren-Paz, 'Compensating Injury to Autonomy in English Negligence Law: Inconsistent Recognition' (2018), *Medical Law Review*, vol. 26 (4), 585.

[482] See on this point: G Turton, 'Informed consent to medical treatment post-Montgomery: causation and coincidence' (2018), *The Modern Law Review*, vol.27(1), 108, 115-134.

[483] See relevant case law on this point, Chapter 2 section 4.2.

It is hence the case that the potential for a negligence claim arising in the context of abortion is an open question. However, whether or not in the future the possibility of an effective and successful claim will arise, this thesis wants to set out the advantages of making clearer to RMPs, patients, and the courts the potential to develop the materiality test leading to a better specification and recalibration of the two limbs. RMPs should be aware of the importance of a partnership-oriented approach which encourages them to engage in a dialogical encounter that suits the principles of partnership and authentic autonomy before any decision is sought. Patients should be made aware that they have a right to be supported and to be informed. For example, if after an abortion, in a future pregnancy the risk of pre-term birth[484] is materialised and this is something that they have not been warned about, they should be advised to consider it a negligence claim. Admittedly, the issue of proving the existence of a causal link will not be an easy hurdle to satisfy, and the success of the claim will strongly depend on this. However, the law of negligence ultimately is but a starting point, that is, one of a number of components of the proposed development of a revised medicalisation in the abortion context.

4. Conclusion

Chapter 5 has analysed the possible considerations for legal reform of the first encounter between a woman and a RMP in light of the proposed 'how-approach'.

Chapter 5 started with a proposal to reform the AA in order to better implement the principles of partnership and authentic autonomy. A new consent clause has been proposed, which attracts criminal law penalties for abortion without valid consent. It emphasises the positive contribution of medical professionals, while also criticising those attempts to significantly reduce their involvement by framing them as intruders. The proposed amendment of the Act is here suggested as the optimal tool to safeguard the 'how-approach' developed in Part 2.

This Chapter then moved to an analysis of the importance of wider changes within the law of negligence for non-disclosure of material information. It argued that the law of negligence should adapt to ensure that women who are not properly informed in the abortion context have equality of access to justice with patients in other health contexts. It analysed the two limbs of the materiality test, claiming that the first limb should resemble the 'rational' aspect of the model of rational non-interventional paternalism proposed in Chapter 3. It then clarified that the second limb, namely the

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[484] See on this point: RCOG, 'The care of a woman requesting induced abortion', (2011) online, available at: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/ (accessed 21st October 2020) 9. Further analysis is provided in Ch 6.

particular-patient limb, would optimally balance with the first limb, rather than be considered an alternative to it. This balance between objective and subjective information is often not easy to achieve, but the proposed model of revised medicalisation, with its focus on dialogue and partnership, would strive towards achieving improvements in this regard.

It then analysed the aspect of treatment options, variant treatment, and alternatives. The proposed 'how-approach' has clarified that: 1) disclosure of treatment options raises the issue of the overlap between *Bolam* and *Montgomery* and thus invokes different standard of disclosure which can be better recalibrated; 2) disclosure of variant treatment and alternative are two separate yet interconnected heads of disclosure which should not be neglected or amalgamated.

A reflection on the law of negligence inevitably faces crucial challenges concerning the difficulties in bringing a successful claim in this context (as related to the issues of causation and actionable damages). These limitations have been acknowledged and it has been stressed that the principles of partnership and authentic autonomy work to minimise these challenges in at least two ways by: 1) fostering both RMPs and patients' awareness of their duties and rights, and 2) pushing towards a gradual evolution of approach in relation to the materiality test. The law of negligence is ultimately but a starting point and one of a number of components of the proposed development of a revised medicalisation in the abortion context.

Chapter 6 will now explore the content of the disclosure process in light of professional guidelines, with the goal of fostering an environment where no assumptions on behalf of women are made and where a broader space for discussion is sought.

Chapter 6

Policy-implications

To what extent do PG concerning abortion and IC embrace a model of partnership and authentic autonomy? How far should they be amended to better safeguard the suggested framework?

1. Introduction

Having explored the legal implications of the principles of partnership and authentic autonomy in Chapter 5, Chapter 6 considers (i) how far professional guidance (PG) upholds the principles of partnership and authentic autonomy set in Part 2 of the thesis, (ii) and what might be done to improve PG, supporting also the proposed legal changes set out in Chapter 5.

PG provide clinical standards for RMPs. They sit, using an expression of Miola[485], in a symbiotic relationship with the law. In this sense, they both translate the implications of the law for RMPs and set out ethical standards that might go beyond the letter of the law. As we have seen, PG on consent from the General Medical Council (GMC) was influential in *Montgomery*, and since that time the GMC has been working on a new guidance to flesh out and operationalise the *Montgomery* judgment.

This Chapter will firstly analyse how PG applies to information disclosure in the abortion context. It focuses briefly on how PG deals with IC requirements from the GMC perspective, and then turns to specialist abortion guidelines, particularly from the Royal College of Obstetricians and Gynaecologists (RCOG), National Institute for Health and Care Excellence (NICE) and the Department of Health and Social Care (DHSC). It will suggest that PG should minimize the risk of unjustified non-disclosure of relevant information[486] by RMPs, adopting a clearer and more consistent approach. It will then analyse how PG provide opportunities of actual support for women. It will suggest that PG should enhance the opportunity of practical and emotional support offered by RMPs both within the disclosure process and also beyond it (e.g. by signposting counselling services). By adapting both law and PG, there is potential to implement a clearer and more consistent overall approach to enhancing partnership and authentic autonomy.

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[485] J Miola, *Medical ethics and medical law: a symbiotic relationship* (Oxford: Hart Publishing, 2007) 79.

[486] This sets a higher standard compared to the one suggested for the law of negligent non-disclosure of material information.

2. PG and information disclosure

2.1 *Montgomery* and PG: an enunciation of principle?

After the judgment in *Montgomery* in 2015, the relevance of IC has been gradually recognised in the mainstream medicine context and also in the abortion context. Lords Kerr and Reed in *Montgomery* relied on and endorsed the General Medical Council's (GMC) guidance on consent 2008[487], but also went beyond this guidance, prompting a revised and new set of draft guidelines in 2018, which were then published in 2020.[488] The GMC generalized guidelines on consent have hence offered both the background before *Montgomery* came to being and the future orientation of it. Particularly relevant is the proposal by the GMC of supported decision-making.[489]

Specialist guidelines, namely those PG that deal with specific branches of healthcare, have also incorporated the *Montgomery* judgment. Whilst it was not clear that *Montgomery* would apply in all healthcare contexts[490], in September 2019, the NICE, in its revised guidelines on 'Abortion Care', openly recognized the relevance of an IC-process in the specific context of abortion.

A similar process is true in relation to RCOG[491] which, in its 2019 report titled 'Better for women', has highlighted that women when faced with reproductive choices need accurate information and support in navigating them. This is particularly important because:

> 'many girls and women seeking information about their health discover an overwhelming amount of information available to them. This information comes from a multitude of different sources and is of variable quality'.[492]

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[487] GMC, 'Consent: patients and doctors making decisions together', (2008), online available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent (accessed 21st October 2020).

[488] GMC, 'Decision-making and consent: supporting patient choices about health and care, Draft guidance for consultation', (2018), online available at: https://www.gmc-uk.org/-/media/ethical-guidance/related-pdf-items/consent-draft-guidance/consent-draft-guidance.pdf (accessed 21st October 2020); GMC, 'Decision Making and consent, working with doctors, working for patients', (2020).

[489] GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), 17.

[490] E Cave, C Milo, 'Informing patients: the Bolam legacy' (2020), *Medical Law International*, 0, 1.

[491] Additionally, in 2017, the Royal College of Nursing has also highlighted that: 'A primary principle in termination of pregnancy care is to ensure that a woman should always be given as much information as possible about available options, and the opportunity to discuss the risks and benefits as well as the emotional, psychological and social issues of continuing or not continuing her pregnancy'. Royal College of Nursing, 'Termination of Pregnancy', (2017) online available at: https://www.rcn.org.uk/professional-development/publications/pub-005957 (accessed 21st October 2020) 4.

[492] RCOG , 'Better for women', (2019) online available at: https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf (accessed 21st October 2020) 56. This approach also echoes a previous RCOG guideline, where the

The recognition of the relevance of an IC-oriented discourse, both within GMC and within specialist guidelines, however, does not necessarily mean that current PG endorses and embraces the model framework of authentic autonomy and partnership as proposed in Part 2 of this thesis. As we saw there, *Montgomery* makes an important contribution to the establishment of these principles, but Part 2 has set out ways in which they might be further developed. An interpretative exercise through the lens of the proposed framework (i.e., 'how-approach') is therefore required to assess how far PG support the proposed model. Thus, whilst the acknowledgement of the relevance of *Montgomery* in the abortion context is a welcome development, it is not sufficient to ensure the protection of the proposed principles (i.e., 'how-approach'). The Chapter begins by looking at information disclosure and then turns to enhancement of support.

2.2 Disclosure of risks and PG: current approaches and considerations for revision

Chapter 5 has explored the legal relevance of an IC-process within the AA and tort law and the positive contribution of RMPs in this context. This section unpacks how specialist PG[493] deal with the issue of information disclosure, as the starting point of an IC-process. The content of the disclosure process in the abortion context is discussed in a variety of relevant specialist PG. However, PG do not necessarily give sufficiently detailed operational guidance as to what should be discussed. Crucially, this can mean that the requirements of an IC-approach are opaque and uncertain. This raises the risk of unjustified non-disclosure of relevant information, beyond the remit of the materiality test, which has potential to impact on authentic autonomous decision-making.

Before exploring relevant PG, there is a preliminary challenge that should be explored. This relates to the level of disclosure. Woodcock[494], in a pre-*Montgomery* paper, called this a 'dilemma' faced by RMPs in the abortion context because the content of the disclosure process is often not clear-cut. Full-disclosure[495], meaning complete disclosure, of information can be positive for some patients, yet trigger negative reactions for

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importance of consent as a process was reinstated. See on this point: RCOG, 'Obtaining Valid Consent Clinical Governance Advice No. 6.', (2015) online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6. (accessed 21st October 2020).

493 This reflection also implements the one provided in Ch 2.

494 S Woodcock, 'Abortion counselling and the informed consent dilemma' (2011), *Bioethics*, vol.25 (9), 495.

495 For a position in support of full-information disclosure see: H Spear, 'Regarding Abortion: informed consent or selective disclosure?' (2004), *Nurs Forum*, vol. 39 (2), 31.

others. An example in the abortion context provided by Woodcock, is the disclosure of information concerning fetal development. Routine discussion of fetal development may be time consuming and could potentially bombard women with information they do not need. Instead, a better use of time would presumably consist of listening and responding to women's informative needs. Equally critical appears to be, according to Woodcock, a process of selective disclosure, understood as the withholding of some information *a priori* deemed to be harmful by RMPs. The risk of selective disclosure is that of an informative process that returns to a doctor-centred approach. In this thesis' perspective, it also risks neglecting partnership and authentic autonomy. In light of the risk connected with selective disclosure, Woodcock suggests working on a fully patient-specific approach, namely a process of disclosure that is framed in line with the circumstances of the case.

Chapter 5 has partially disagreed with Woodcock. When interpreting the materiality test of disclosure, Chapter 5 broadly sought to clarify that there is a need to balance both medical expertise and patients' desires. Chapter 5 then clarified that it is both impossible and not necessarily desirable for the abortion legislation to list all the information that patients need to be provided with. Instead, a valid consent requirement should be adopted, Chapter 5 concluded, as a reminder of the need to embark on a consent process. In light of the suggested reform, it is of key relevance that specialist PG are able to offer relevant information to RMPs engaging in disclosure processes and IC. In this vein, a process of disclosure of information, as fostered through specialist PG, has as its starting point to strive towards awareness on the side of RMP of the information that patients ought to know in the given circumstances. This information will then be necessarily recalibrated and disclosed in light of the needs of patients, as arising also from a conversation with them. This does not mean bombarding the patient with information or leaving it completely to the subjectivity of the patient, but entering the medical encounter with both due medical knowledge and no assumption on behalf of the patient. The information should therefore be selected in and responsive to the encounter itself, and not outside of it.

Conversely, an *a priori* exclusion of information from the medical encounter without an actual conversation with the patient is an unjustified phenomenon that can happen in two broad ways. Firstly, at the organisational level, with the lack of clarity within PG and also the lack of necessary trainings that promote RMPs' awareness of what should be disclosed. Secondly, this is reflected in the encounter itself whereby, either because of unknown information, or because of subjective assumptions, RMPs might not disclose certain information. Working at the PG-level, hence, aims to minimize the challenge of unknown risks. Imagine this like a waterfall where information flows from the doctor to the patient. This does not mean that RMPs are the

sole source of information, but recognizes that, especially during the first medical encounter, they are a key link in the informative chain.

Following from this consideration, it becomes crucial to highlight what should be disclosed according to the current formulation of PG. The focus will be on the approach purported by specialist PG,[496] differentiating between situations not involving fetal abnormality, which have a strong elective element (discussed in NICE 2019[497] and RCOG 2011[498], 2015[499], 2020[500]), and those involving serious fetal abnormality, which have strong prognostic/diagnostic component (discussed in RCOG 2010[501]which is the only specialist PG focusing on this topic exclusively). The focus is not exhaustive, but these guidelines have been selected for their relevance for the discourse at stake and as examples of the challenges inherent in the disclosure process. It will be shown that the aim of PG is to provide clinicians with a coherent, though indicative, list of information for the doctor. This will form a relevant 'knowledge-package' for RMPs engaging in subsequent disclosure processes to patients.

2.3 Disclosure of risks in elective abortion for non-diagnostic reasons and the need for clarity

The first ambit of analysis is the disclosure of risks when abortion does not follow a prognosis/diagnosis of serious fetal abnormality. Reference to this is included in RCOG 2011, 2015, 2020, and NICE 2019. It will be shown that relevant specialist PG embrace to an extent the framework proposed in Part 2, in its broad recognition of the relevance of the disclosure of risk process. However, issues of lack of clarity still emerge, which carry with them the challenge of unjustified non-disclosure on the side of RMPs. This has the potential to jeopardise the 'how-approach' because of two reasons: 1) the

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496 The PG included in this Chapter are live PG which are to date a key referral point for RMPs. These are adjourned at 21ST October 2020.

497 NICE, 'Abortion care', (2019), online available at: https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693 (accessed 21st October 2020).

498 RCOG, 'The Care of Women requesting induced abortion', (2011), available at: https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf (accessed 21st October 2020)

499 RCOG, 'Best practice in comprehensive abortion care', (2015) https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf (accessed 21st October 2020).

500 RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31ST July 2020), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-COVID-19-infection-and-abortion-care.pdf (accessed 21st October 2020).

501 RCOG, 'Termination of pregnancy for fetal abnormality', (2010), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/terminationpregnancyreport18may2010.pdf (accessed21st October 2020)

lack of a consistent approach concerning risk disclosure throughout PG; 2) the prioritisation of access-related concerns over a focus on the decision-making process.

The first challenge relates to a lack of a consistent approach through PG concerning disclosure of both physical and psychological risks. This has the potential to lead to non-disclosure by RMPs contrary to the proposed 'how-approach'. This claim is based upon the premise that PG clearly serve the aim of professional formation for RMPs, detailing relevant information to disclose in light of patient needs and values.

When it comes to the disclosure of physical risks in the context of an elective abortion for non-diagnostic reasons, NICE 2019[502] follows in the footstep of RCOG 2011 and 2015 and unpacks the risks connected to abortion, whether this is through a surgical or a medical abortion. It adds to previous PG, in light of the legalisation of the home use of the second abortifacient pill, misoprostol, for early term medical abortion[503], the need to make clearer the opportunity of post-abortion support, especially because part of the treatment is administered in an unsupervised setting.[504] Both RCOG 2011 and NICE 2019 refer to the possible complications that can arise following an abortion. RCOG 2011,[505] in particular, highlights that women should be informed of a rare but serious complications of uterine rupture. Also, information concerning uncommon complications should be provided. These include: severe bleeding requiring transfusion, uterine perforation and cervical trauma. It also specifies that women should be informed of a failed abortion and the small risk of further surgical intervention following it, as well as the risk of post-abortion infection. However, while RCOG 2011 specifies risks of long-term physical complications, this risk is something that is not included in NICE 2019. RCOG 2011 highlights that women should be made aware of 'a small increase in the risk of subsequent preterm birth, which increases with the number of abortions.'[506] All of these possible complications or unwanted side-effects justify the importance of reading these PG together so as to minimize the risk of unjustified non-disclosure on the side of RMPs.

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[502] NICE, 'Abortion care', (2019), 10-15.

[503] DHSC, 'Approval of home use for the second stage of early medical abortion' , (14 January 2019), online 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 21st October 2020). See also Chapter 2, section 3.

[504] This need for further support can be considered to be exacerbated in the context of a fully unsupervised procedure, as it is in light of the home use of both abortifacients during the coronavirus (COVID-19) pandemic. However, the issue is left not sufficiently specified by RCOG 2020 on abortion and COVID-19. See: RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31ST July 2020), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/2020-07-31-coronavirus-COVID-19-infection-and-abortion-care.pdf (accessed 21st October 2020).

[505] RCOG, 'The Care of Women requesting induced abortion', (2011), 5.5, 5.6.

[506] RCOG, 'The Care of Women requesting induced abortion', (2011), 5.12. It should be specified that according to RCOG there is still insufficient evidence to imply causality.

The same lack of a consistent approach is evident in the context of disclosure of psychological risks. When it comes to the risks of psychological sequelae, the approach of relevant PG appears not to be necessarily uniform. NICE 2019, for instance, only specifies that there is no increase in risks of mental health issues for those women who opt for an abortion.[507] However, this statement needs to be read in combination with previous PG. Going back to RCOG 2011[508] the existence of risk factors connected to psychological sequelae were enunciated. In particular, RCOG 2011 highlights that an unintended pregnancy experienced by a woman with a past-history of mental health can trigger further negative psychological aftermath. The issue of psychological sequelae was also analysed by the Academy of Medical Royal Colleges which, in 2011,[509] undertook a systematic review of mental health outcomes of induced abortion. This report concluded that it is the unwanted nature of the pregnancy that leads to an increased risk of mental health problems, whether or not this ends up in an abortion. Although the report seemed to suggest that the outcome is somehow neutral in this respect, crucially, it also identified the past history of mental health problems as a risk factor.[510] This ultimately suggests that it is not only the unintended/unwanted nature of pregnancy that can trigger negative aftermath, but that wider medical and non-medical factors may also be relevant. Subsequent RCOG guidelines[511] do not refute this point, but simply leave it undiscussed. This raises once again the challenge of lack of consistency across PG.

Overall, although the above-mentioned PG have as a starting point the 'safety'[512] of the procedure, they approach the disclosure of risk with slightly different perspectives. RCOG 2011 provides also a broader look at the long-term both physical and psychological aftermath. NICE 2019 instead devotes more attention to short-term access-oriented approaches. It delves more into an enunciation of suggested medical prophylaxis connected to specific abortion methods and ensuring that the service is provided timely, without delays and stigmas.[513] In the same vein, RCOG 2020[514], is

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[507] NICE, 'Abortion care', (2019), 30.

[508] RCOG, 'The Care of Women requesting induced abortion', (2011), 5.14

[509] Academy of Medical Royal Colleges, 'Induced abortion and mental health', (2011), online available at: https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf (accessed 21st October 2020).

[510] See *above* Academy of Medical Royal College, (2011), 125-126.

[511] It should be clarified that both RCOG 2010 and 2011 are still live guidelines.

[512] See NICE, 'Abortion care', (2019) at 1.2.1; RCOG, 'The Care of Women requesting induced abortion', (2011), at 5.1; RCOG, 'The Care of Women requesting induced abortion', (2011), 5.14; RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 9.

[513] NICE, 'Abortion care', (2019), on waiting times at 1.1.5-1.1.8, avoiding stigma at 1.1.17-1.1.18; on medical prophylaxis at 1.3-1.5, 1.7-1.13.

[514] RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 8.

crucially concerned with access in a public health crisis. The related challenge faced by PG is that of placing a considerable weight on access-concerns which has potential to minimize other considerations around autonomous decision-making.

Beyond the lack of a consistent approach through different PG, it is hence the case that a further interconnected challenge can be found in the relationship between access to abortion and IC process. Access to abortion is a key corollary of legalising abortion, yet it is not the sole aspect. A major focus on access to abortion *per se* risks jeopardising the protection of the decision-making process[515] reiterating the consumeristic approach that was criticised in Chapter 3 and 4.[516] An access-oriented approach can view the time spent in an informative process as an obstacle to the rapidity of the procedure, rather than a potential to safeguard authentic autonomy. This access-oriented approach was expressed clearly by NICE 2019[517], RCOG 2019[518] and 2020. In all of them, access is framed as a key priority. The latter RCOG 2020[519] can be partially justified by the exceptional circumstances of the COVID-19 pandemic, whereby issues of containing the spreading of the virus could affect access to abortion clinics, however, this approach is not just an 'exceptional pattern for exceptional circumstances', since an access-oriented approach has been given key weight already before the pandemic.

The access-oriented approach endorsed by NICE 2019, but also RCOG 2019 and 2020, can hence overlook the existence of risk factors in the given circumstances and subsequent risk disclosure. This is also because, as said above, the disclosure of risks is often left under blurred lines. Take, as an example. NICE 2019. On one side, it states that abortion is not associated with increased risks of infertility, breast cancer, and mental health.[520] On the other hand, the same guideline specifies that: 'while abortion is very safe overall, there was evidence that morbidity and mortality increases for every additional week of gestation, so earlier abortions are safer'.[521] The statement that 'earlier abortions are safer' should not lead to the assumption of the irrelevance of the consent-process in the name of rapidity. A possible consideration of revision of PG, conversely, can be to better translate that access-oriented approaches should never lead to the result of unjustified non-disclosure. RMPs should be made aware of all risks and should be

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[515] With this is not meant that a focus on access means lack of focus on IC per se, but only that it can trigger an approach that can undermine its relevance.

[516] Chapter 3 section 2.1.4 and Chapter 4 section 2.4.

[517] NICE, 'Abortion Care', (2019), 5,8.

[518] RCOG, 'Better for women', (2019) available at: https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf (accessed 21st October 2020) 144-148.

[519] See: RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020).

[520] NICE, 'Abortion Care', (2019), at 1.2.1

[521] NICE, 'Abortion Care', (2019), 26.

trained in how to communicate these without fearing that a disclosure process is only an obstacle in accessing abortion.

It is hence important that a focus on the rapidity in accessing the service, does not lead to the assumption of the futility of the disclosure process in itself, or to some of its parts. In other words, the risk that should be minimized is that the IC-approach becomes only a formality that needs to be quickly fulfilled in order to avoid delays and/or the (rare) possibility of liability on the side of RMPs.[522] Crucially, IC is much more than a legal requirement: it is the gateway for the safeguarding of partnership and authentic autonomy.

In this vein, a model of revised medicalisation aims not to overlook risk disclosure in the name of rapidity of the process and access-oriented concerns. It is correct that there should not be 'unnecessary' delays. But this requirement is not in opposition with the other requirements of awareness of risks and space for its disclosure. Additionally, the challenge of unjustified non-disclosure of relevant information can arise also when there is a lack of sufficient trainings on the side of RMPs and, hence, poor awareness of the risks to be disclosed. This should also be further addressed.

Drawing upon the interpretation given to the materiality test in *Montgomery* and expanding beyond the tort law spectrum, RMPs are called to take into account all of these risks and disclose them. They should also balance this 'objective', scientifically accurate, component with the 'subjective' relevance of the specific circumstances of each woman. This deny neither the existence of a strong debate concerning the issues at stake, nor the often contested nature of a risk-analysis itself as a tool to stigmatize women.[523] The term 'objective' is here intended to express the relevance of a disclosure process which is based on scientifically accurate information. Disclosure of these risks can hence imply that a balance between 'objective' aspects and 'subjective' risks, that is to say patients' needs and vulnerabilities, should be assessed and acted upon by RMPs.

RMPs should also not make assumptions on behalf of women, but should give due space for an actual dialogue with them. For instance, the unintended nature of the pregnancy should not be considered *a priori* a determinative factor which exclude any dialogue between the parties. Objectivity and subjectivity 'meet' when communication between the parties starts. This is admittedly not a straightforward process, but is required if both partnership and authentic autonomy want to be safeguarded.

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[522] For an analysis of the legal context concerning criminal law see Chapter 1 section 5, and tort see Chapter 2 section 4.

[523] On this point see E Lee arguing that a risk-based analysis, in particular a reflection on the psychological aftermath of abortion, aims ultimately to construe abortion as a social problem. See: E Lee 'Post-abortion syndrome: reinventing abortion as a social problem', in: J Best, ed. *How Claims Spread: Cross-National Diffusion of Social Problems* (New York: Aldine de Gruyter, 2001) 39-68.

In sum, this section has highlighted that specialist PG on disclosure of risk for elective abortion shows 1) a lack of consistency; and 2) a predominant focus on access to abortion services. These two aspects have the potential to jeopardise the disclosure-process and lead to unjustified non-disclosure of information. To minimise this risk: a) PG should be revised, and/or translational guidelines be proposed, so as to provide RMPs with an up-to-date indicative list, of coherent information to pass on to the patient; b) PG should more clearly recalibrate the relevance of access to abortion services with the importance of the disclosure process; c) pending reform of RMPs' trainings should be adapted to minimise the risk of unjustified non-disclosure, in light of the discrepancies across PG.[524]

2.4 Disclosure of risks in case of a serious fetal abnormality and the need of clarity

This section turns to the context of serious fetal abnormality. Current specialist PG provide a system that emphasizes the relevance of risks disclosure as a form of support that should be provided to women and/or couples who are considering abortion in these circumstances. However, the lack of a clear definition of serious abnormality constitutes a key informative challenge that impacts also the disclosure process. This is further exacerbated by the advent of non-invasive-prenatal-testing (NIPT), a screening test which will provide the patient with a potentially wide amount of information. It will be suggested that the challenge of unjustified non-disclosure should be minimized by future PG[525] through a clearer definition of serious abnormality.

2.4.1 The lack of a clear definition of 'serious fetal abnormality' and the need for one

It is the fact that a diagnosis of a serious fetal abnormality has arisen, or is likely to arise given a degree of diagnostic uncertainty, that leads women (with or without their partners) to consider an abortion. A further peculiarity of this situation is that the first

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[524] This will surely also transversally help the field of the law of negligence, to further clarify the content of the materiality test of information disclosure. However, it should be clarified that the issue of risk disclosure and the possibility of improvements in this field is also connected with broader educational changes in approach. One of the key challenges here is the limited statistical literacy skills offered during medical schools which impacts on how clinicians approach and read risk analysis and hence also disclose information. A wider change in educational practices should be also explored. For an analysis in support of this latter point see: G Gigerenzer, J M Gray, W Gaissmaier, *Better Doctors, Better Patients, Better Decisions: Volume 6: Envisioning Health Care 2020* (Strungmann Forum Reports, 2011) 138-152.

[525] The question of abortion for serious fetal abnormality is also placed in the broader framework of: 1) the ethical and legal challenges concerning screening; 2) the debate surrounding the issue of a discrimination towards people with disabilities for the fact that no time limit is considered by the AA. This section is acknowledging this broader framework, but it is focusing on a specific question: 'what should RMPs disclose in these circumstances?'.

medical encounter with an RMP and a woman seeking an abortion related to fetal abnormality is likely to happen after medical consultations concerning the abnormality itself. What previously was, in lay terms, a 'wanted' and/or 'planned' pregnancy, can become, due to this change in circumstances, potentially 'unwanted'. The information disclosure process for serious fetal abnormality and connected informative duties has been unpacked in relevant PG. RCOG 2010 is the only specialist PG focusing on this topic exclusively. It clearly specifies that this pathway of care and information disclosure is a potentially more distressing[526] procedure, because it impacts on a previously 'desired' pregnancy. A key challenge for the risk disclosure process in this context is the lack of a clear definition of what constitutes a serious fetal abnormality. It will be shown that this lack has the potential to negatively affect the disclosure process. Therefore, there is a need for more clarity on the terminology if patients' authentic autonomy is to be adequately safeguarded.

The difficulty in determining serious fetal abnormality has the potential to impact upon the disclosure process. It makes it difficult to provide RMPs with an indicative list of information to be disclosed within PG. Uncertainty can surround the identification of an abnormality as 'serious', the likelihood of the fetus carrying the abnormality, any remedial potential (such as medication or fetal surgery), as well as any connected long-term risks that the born-alive child might or might not face. Yet these are relevant factors that might well contribute to an authentically autonomous decision.

RCOG 2010 does not provide a definition of 'serious fetal abnormality'. Although it specifies possible categories of serious abnormalities, it does not delve into their identification or connected risks. It states that the risk of a serious abnormality 'depends upon a series of factors, such as the nature and severity of the condition, and the timing of the diagnosis, as well as the likelihood of the event occurring'.[527] However, its interpretation has been left 'on a largely subjective basis',[528] this leading to a broad margin of appreciation for RMPs.

The issue of a definition of a serious fetal abnormality has been analysed in only one case: that of *Jepson v The Chief Constable of West Mercia Police Constabulary.* [529] In this case, the Church of England vicar sought judicial review for the lack of criminal prosecution of a RMP who performed an abortion on a fetus with a cleft palate. The issue at stake was whether cleft palate was a sufficiently 'serious abnormality'. Whilst permission was granted to proceed with judicial review, the Crown Prosecution Service

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[526]RCOG, 'Termination of pregnancy for fetal abnormality', (2010), 20-22.

[527]RCOG, 'Termination of pregnancy for fetal abnormality', (2010), 8.

[528]RCOG, 'Termination of pregnancy for fetal abnormality', (2010), 8

[529] [2003] EWHC 3318 (Admin).

did not pursue the case because the doctor had acted in good faith that there was a substantial risk of serious abnormality.

Following this judgment, RCOG 2010 highlighted that a precise definition would be impractical for two reasons:

> 'Firstly, sufficiently diagnostic techniques capable of accurately defining abnormalities or of predicting the seriousness of outcomes are not currently available. Secondly, the consequences of an abnormality are difficult to predict, not only for the fetus in terms of viability or residual disability, but also in relation to the impact in childhood as well as on the family into which the child would be born'.[530]

The DHSC in 2013 concurred with RCOG 2010 that a clear definition is not required when it was concluded that:

> 'it is unrealistic to produce a definitive list of conditions that constitute serious handicap since accurate diagnostic techniques are yet unavailable. Likewise the consequence of abnormality are difficult to predict.' [531]

Setting aside the potential issues with a low threshold for serious abnormality from the perspectives of disability rights and fetal protection, the lack of a definition is nevertheless problematic, because it can impact upon the disclosure process. This is because it can jeopardise what information should be disclosed by RMPs in these circumstances. This approach should be hence reconsidered. Particularly, two claims made by RCOG 2010, whereby a definition would be impractical, should be revisited. The first reason proposed by RCOG 2010 concerned 'the lack of diagnostic techniques'. But, as science, diagnostics, and screening techniques improve, this claim becomes increasingly dubious. Take, as an example, the case of non-invasive-prenatal testing (NIPT).[532] NIPT is a screening test which allows the possibility of finding out genetic

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[530] RCOG, 'Termination of pregnancy for fetal abnormality', (2010), 9-10.

[531] DHSC, 'Procedures for the approval of independent sector places for the termination of pregnancy (abortion)', (2013), online, available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/260470/RSOPs.pdf (accessed 21st October 2020) 28

[532] The 2017 Nuffield guidance on NIPT define it as:
'Small amounts of DNA, often referred to as 'cell free DNA' (cfDNA), circulate in everybody's blood. In the late 1990s, it was discovered that cfDNA from the placenta can be detected in the blood of pregnant women. The placenta develops from cells formed during the first stage of pregnancy from the fertilised egg; hence, its genetic makeup is very similar, though not always identical, to that of the developing fetus. The amount of placental cfDNA in the woman's blood increases as the pregnancy progresses, and is cleared from the woman's circulation within hours of birth, so it is specific to the woman's current pregnancy. This discovery opened up the possibility of finding out genetic information about the fetus by means of a maternal blood test. Techniques have been developed that reliably test placental cfDNA from around nine weeks of pregnancy, which is when there is usually enough cfDNA in the woman's blood to get an accurate result. This is called non-invasive prenatal testing (NIPT). 'Non-invasive' refers to the fact that the test can be carried out without inserting a needle into the abdomen or cervix of the pregnant women to collect cells from the amniotic sac or placenta. 'Prenatal' means before birth or during pregnancy'. Nuffield Council on Bioethics, 'Non invasive prenatal testing: ethical

information concerning the fetus through non-invasive means, that is to say through maternal blood test. NIPT brings advances in accuracy (e.g., combined screening test) for the diagnosis of Down's, Edward's and Patau's syndromes. In some circumstances[533] it can provide more accurate[534] and timely test results as compared to other prenatal screening.[535] As accuracy improves, scientific advancements challenge the idea that a definition of serious abnormality is necessarily impractical.

The second reason offered by RCOG 2010 concerned the long-term impact on the future child. It is true that this is often very difficult to predict. Yet, this is often an intrinsic aspect of prognostic, and hence future-related clinical evaluations. The unpredictability of long-term factors should therefore not be used as a justification to set aside the need for a clear definition of serious fetal abnormality in the first place and to dismiss RMPs informative role. PG should, in this respect, strive towards a definition of a serious abnormality, as a tool to support the decision-making process.

In conclusion, from a process-based (i.e., 'how-approach') perspective there are arguments that support the need to address the lack of definition of serious fetal abnormality – a gap that is not filled by the AA, case law, or PG. It is argued that PG, rather than the law, is the appropriate place to provide guidance, given the need for a nuanced and flexible approach that can be adapted in line with scientific developments. It is therefore advisable, in light of the framework proposed in Part 2, that PG, in particular RCOG 2010, is amended so as to introduce a clearer definition of serious fetal abnormality.

Two possible ways of achieving this are suggested here: a positive and/or a negative definition of serious fetal abnormality. The first consideration for revision, might hence include a wider indicative list of possible serious fetal abnormalities (both genetic and general conditions).[536] Possible ways to achieve this could be through a reliance on a deductive approach. For instance, in light of NIPT and connected post-NIPT diagnostic tests, those serious (genetic) fetal abnormalities that can now be screened and then diagnosed with sufficient accuracy, could be included within PG together with related risks. An additional justification for the inclusion of a wider list of serious fetal abnormalities within PG can be also found looking at the approach adopted

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issues', (2017), online available at: https://nuffieldbioethics.org/assets/pdfs/NIPT-ethical-issues-full-report.pdf, (accessed 21st October 2020) 2.

[533] Only for genetically transmitted conditions.

[534] See on this point: Nuffield Council on Bioethics, 'Non-invasive prenatal testing: ethical issues', (2017), 2.

[535] For an account of the advantages of NIPTs see: Nuffield Council on Bioethics, 'Non-invasive prenatal testing: ethical issues', (2017), 4.

[536] Particularly risks connected to the abnormality itself –as likely or not to arise-and its implications in the case in which the abnormality will arise.

by the Human Fertilisation and Embryology Authority (HFEA). The HFEA in the different, yet interrelated context of pre-implantation genetic diagnosis, expressly lists all the conditions for which a screening by a registered clinic is licensed. The HFEA licenses certain serious and significant genetic conditions for pre-implantation genetic diagnosis so that healthy embryos can be selected.[537] Application of a similar approach, though with a provision of an indicative and not closed list of conditions, might help to enhance certainty and clarity and thus enhance the process of information disclosure.

However, this 'positive' approach is potentially problematic insofar as it sends further implicit discriminatory messages. For instance, it can lead towards a false assumption that every time those serious abnormalities are detected, the inevitable outcome should be that of an abortion. Furthermore, on a broader scale this might mean sending the message that all those carrying these abnormalities are to be somehow stigmatized. The benefit of a clearer identification of a serious fetal abnormality can hence be positive as far as clinical knowledge is concerned, but could also have negative impacts that should be stated and mitigated. If PG are meant, primarily, to work on clinical formation, it is important to clearly state that these should lead neither to clinical assumptions on behalf of patients, nor to broader forms of stigmatisation. For these reasons a positive approach is rejected.

An alternative is to formulate a negative definition of what is *not* [538]a serious fetal abnormality. For instance, clarifying that those medical conditions, where remedial treatments are available, will not normally amount to a serious fetal abnormality (e.g., cleft lip without association with cleft palate, where remedial surgery can be offered as remedial treatment). This minimal approach can be a way to both offer guidance to clinicians and help patients navigate the vast amount of information available. This would also minimize the risk of stigmatisation. Training in support of new guidance would also be essential.[539]

When it comes to disclosure of risks connected to a serious fetal abnormality, especially those abnormalities that NIPT will be able to screen with more accuracy, it is crucial that PG on abortion gives relevance to provision of accurate information, and limits assumptions made on behalf of women or the couple who is facing these circumstances. NIPT will make a wide amount of information available to patients and guidance on their accuracy and also on their relevance as to whether or not a fetal

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[537]HFEA, 'PGD conditions', online available at: https://www.hfea.gov.uk/pgd-conditions/ (accessed 21st October 2020)

[538] This approach has been also proposed in a recent bill proposal: Abortion (Cleft Lip, Cleft Palate and Clubfoot) Bill 2019-21. This is aimed at identifying Cleft Lip, Cleft Palate and Clubfoot as not amounting to serious fetal abnormality.

[539] This will help also identifying the eligibility to an abortion under s.1(1) (d) AA. However, a more restricted interpretation of this section will not exclude the possibility to still rely on the broad formulation of s.1(1)(a) AA.

abnormality is serious should be provided. This also reinforces the point made above concerning the need to provide a clearer definition of 'what isn't a serious abnormality'. This should be also tied with a further clarification that the 'easiness' of the test and the greater accuracy does not mean diagnostic 'certainty' of the result, given that false positives are still a possibility.[540] More research and clearer guidance on the risk disclosure path is needed,[541] especially in light of NIPT, so as to enable patients to be supported during their decision-making process and to safeguard their authentic autonomy. In particular, provision of scientifically accurate information and mitigation of non-disclosure should be seen as a key direction for future guidelines. Existing PG on disclosure of risks in the context of serious fetal abnormality endorse, to a certain extent, the proposed framework proposed in that they recognise the relevance of an IC-process. However, the lack of a clear definition of what a substantive abnormality is/is not can negatively affect the disclosure process and lead to non-disclosure. It is hence advisable that future iterations of guidance strive for greater clarity of definitions so as to better guide RMPs.

2.5 Conclusion

The question of disclosure of risks in the abortion context has been unpacked across a variety of specialist PG. To date they recognize the relevance of an IC-approach. However, they are marked by a lack of clear and consistent approach. In the case of an elective abortion for non-diagnostic reasons, the discrepancies amongst specialist PG may lead to unknown risks on the side of RMPs and, therefore, unjustified non-disclosure. In the case of serious fetal abnormality, the lack of a clear definition of what a serious fetal abnormality is/is not coupled with the lack of a clear analysis of the challenges that follow the wider availability of NIPT can also affect the disclosure process. Specialist PG embrace the framework proposed in Part 2 to an extent, but they need to more clearly translate the issue of disclosure of risks so as to minimize the possibility of unjustified non-disclosure, which can affect the safeguarding of patients' authentic autonomy.

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[540] Nuffield Council on Bioethics, 'Non invasive prenatal testing: ethical issues', (2017), 12, para 1.18.

[541] A further and more recent example can be the still unknown connection between COVID-19 and vertical transmission (i.e. mother-baby) before/or after birth. RCOG 2020 mentioned this aspect in its 2nd version, yet this matter is not specified in later versions. 'Current evidence, based on a small number of cases, suggests that COVID-19 is not present in genital fluid, although it is too early to know whether vertical transmission is a significant risk', RCOG, 'Coronavirus (COVID-19) infection and abortion care', 2ND version, (3rd June 2020), 17. No mention in RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020).

2.6 Disclosure of variant treatments and alternatives in the context of PG

The process of information disclosure encompasses not just risk disclosure, but also disclosure of variant treatments and broader alternatives. Chapter 5 has explored the legal dimension of this issue offering an interpretation of the law of negligence in light of the proposed principles. This section analyses it within the context of PG and unpacks possible challenges and ways forward. The aim here is to further highlight that the disclosure of abortion methods (i.e., variant treatments) within PG should be tied with the disclosure of broader pregnancy options and the possibility of pursuing no treatment (i.e., alternatives). It will argue that current PG are clear on the former, but risk jeopardising the latter. These are, however, two interconnected heads of disclosure, which should be given wider relevance within PG so as to minimise the risk of them being neglected or amalgamated during the disclosure process.

2.6.1 Disclosure of variant treatment and alternative options

The disclosure of variant treatments implies, as stated in Chapter 5, a process that fosters the disclosure of different abortion methods: medical and surgical. PG are clear on the point of disclosure of variant treatments -- that is to say, the disclosure of abortion methods in light of timing of pregnancy and patients' preferences. This is clarified in RCOG 2011,[542] RCOG 2020,[543] and NICE 2019.[544] The issue of disclosure of variant treatments is also tied with the disclosure of alternatives. However, when it comes to disclosure of alternatives, there are inconsistencies in current PG. It is argued that the disclosure of alternatives in light of the framework proposed in Part 2 does not simply require the disclosure of abortion methods depending on the pregnancy stage, as noted in Chapter 5, but also require a consideration of broader pregnancy options (such

[542] RCOG, 'The Care of Women requesting induced abortion', (2011), 2.4.

[543] RCOG 2020 on abortion and COVID-19 adopts a slightly different focus. It is mainly concerned with facilitating home use of early medical abortion. However, the possibility to suggest a different method is still recognized, and this is claimed to be influenced by women's clinical conditionS (whether it is suspected or a confirmed case of COVID-19). The impact of COVID-19 and the decision to opt for medical/surgical, is however left not fully clarified.

[544] NICE, 'Abortion Care', (2019), 1.6.

as childbirth, adoption, prenatal/fetal surgery[545], after birth surgery[546], and -- in the future -- also artificial wombs[547]). When setting out the test of materiality in Chapter 5, it was argued that it is important to separate the discussion on abortion methods and variant treatments from disclosure of alternatives. This point is also relevant in the context of PG. So this section highlights the need for a clearer approach. In particular, it argues that positive lessons can be derived from PG concerning abortion for serious fetal abnormality and that there is potential to expand this approach to the context of elective abortion for non-diagnostic reasons.

The disclosure of alternatives to abortion is not consistently advised as part of the disclosure process in relevant PG. Starting from the most recent, RCOG 2020[548] and NICE 2019 [549] do not expressly refer to this point. This approach might be due to the fact that the key focus of these PG seems to be access to abortion services. However, as also pointed out in Chapter 5, an IC-approach cannot entail a focus only on variant treatments. It should also embrace reference to broader pregnancy options. The key reason for this is the risk of leading towards unjustified non-disclosure of information.

Conversely, evidence of some consideration on disclosure of broader pregnancy options is evident in RCOG 2011[550] and the DHSC 2013.[551] RCOG 2011 suggests that RMPs should engage in dialogue concerning pregnancy options.[552] The DHSC 2013 specifies that 'women must be given impartial evidence based information covering the

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[545] The Royal college of Midwives in its 2018 'Evidence-based midwifery' publication has included an article on intrauterine prenatal surgery as a possible alternative to abortion. According to Sinclair, 'intrauterine fetal surgery is used to treat a wide range of birth defects, such as gastrochisis, diaphragmatic hernia, heart defects, obstructive uropathy, spina bifida and teratoma' M Sinclair, Intrauterine prenatal surgery: an alternative to abortion', in: RCM (2018), *Evidence based midwifery*, vol. 16 (2), 1, 39. This has the potential to be an alternative course of action to abortion, one that should be signposted to patients as a tool to facilitate informed decisions.

[546] Take the case of cleft palate and the possibility of having a post-birth surgery.

[547] With the term Artificial womb, 'ectogenesis', is meant the possibility that the gestation of fetuses is conducted outside the maternal womb. Ectogenesis is currently not technically possible. Yet this technology, already used in animals, carries with it the potential in the future to be a good alternative to abortion. When and if the possibility of using ectogenesis becomes a more feasible reality it is advisable that also this opportunity would be disclosed by clinicians. See in favour of this: T Takala, 'Human before sex? Ectogenesis as a way to equality', in: F Simonstein , *Reprogenethics and the future of gender* (Dordrecht, NL: Springer, 2009) 187–95.

[548] RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 17, narrowly refers only to abortion methods (medical and surgical) and to discussion on 'contraceptive options' which crucially do not amount to alternatives. This is because when a woman faces an unplanned pregnancy the use of a contraceptive option is not an alternative to her current circumstances. Reference to alternatives, although indirect, could be noted in its suggestion to delay an abortion in light of the clinical circumstances.

[549] NICE, 'Abortion Care',(2019), 5.

[550] No discussion on this point in in RCOG, 'Best practice in comprehensive abortion care', (2015).

[551] DHSC, (2013), *above*.

[552] RCOG, 'The Care of Women requesting induced abortion', (2011), 4.14.

following: alternatives to abortion (for instance adoption and motherhood)'.[553] However, this is a weak provision: it is a suggested practice that can be utilised 'if required', and not as a necessary part of the information disclosure process.

A specific example of disclosure of alternatives and of a lack of a clear approach within PG is the opportunity for a woman of pursuing 'no treatment' and hence to cancel or delay the appointment for an abortion. The 'no treatment' or delayed option constitutes an integral part of the most recent GMC 2020 guidelines on consent,[554] and so it is a recognised requirement in mainstream medicine. However, it does not appear to be sufficiently and consistently made clear in different specialist PG in the context of abortion. A possible reason of this discrepancy can be found in the elective nature of abortion. In this sense, unlike the RCOG 2011[555], NICE 2019 does not refer to the possibility to cancel the abortion appointment or to delay it. The 'no treatment' or delayed option has also been specified, although somehow indirectly, by the 2019 joint clinical guidelines concerning early term medical abortion at home, issued by RCOG together with the Faculty of Sexual and Reproductive Healthcare and the British Society for Abortion Care Providers. In this specific context, it has been specified that women need to know, 'who to contact in case she changes her mind and continues the pregnancy […]'.[556] This indirectly suggests that women should be made aware of the option not to take the second abortifacient pill,[557] misoprostol. In RCOG 2020[558], it was also added that the option of delaying the treatment is the best one when women have symptoms of COVID-19 or a confirmed infection. However, the option of a 'change of mind' is not clearly explored. The opportunity to pursue no treatment plays a crucial role within the safeguarding of authentic autonomy, because it is a key reminder that there is

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[553] See also: required Standards operating procedures (RSOP) 11 which also says '[…]abortion methods appropriate to gestation, the range of emotional responses that may be experienced during and following an abortion, what to expect during and after the abortion, full discussion of contraception options and the supply of chosen methods, testing for sexually transmitted infections including HIV'. DHSC, 'Procedures for the approval of independent sector places for the termination of pregnancy (abortion)', (2013), 19.

[554]This recalls the latest guidelines on consent by the GMC, where a discussion around the possibility of 'taking no action' is suggested. See: GMC, 'Decision Making and consent, working with doctors, working for patients', (2020), 7 and GMC, 'Decision-making and consent, supporting patient choices about health and care, Draft guidance', (2018), 11-12, at para.25.

[555] RCOG, 'The Care of Women requesting induced abortion', (2011), 4.25. This approach has been also reiterated in Royal College of General Practitioners, 'Position Statement on Abortion', (2012), online available at: https://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP_Position_Statement_on_Abortion.ashx (accessed 21st October 2020)recommendation 5, p. 4 . Also RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), although this is an indirect reference, see recommendation 3.2, 19-21.

[556] RCOG, FSRH, BSACP, 'Clinical guidelines for early medical at home-England', (2019), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf (accessed 21st October 2020) 6

[557] This is further relevant during the COVID-19 pandemic context whereby the home use of both abortifacients has been granted.

[558] RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 19-20.

the possibility for the patient to pursue a different path, should she wish to do so. It is hence suggested that this aspect should be further fostered through PG.

Furthermore, when it comes to disclosure of broader pregnancy options, the approach embraced by PG falls short of the framework proposed in Part 2. Adoption of this framework would require a clearer inclusion within the information process of wider pregnancy options.[559]

A positive exception, however, can be found in the context of PG concerning abortion for serious fetal abnormality. In that context, RCOG 2010[560] calls for a pathway of disclosure of broader pregnancy options and for minimising the risk that a woman might feel pressured to follow a particular course.[561] In light of the likelihood of differential diagnosis, RCOG 2010 calls for an involvement of experts who have knowledge about prognosis and available options. In my article together with Cave, we have further clarified that in the mainstream medicine 'dialogue around differential diagnosis is required when it affects the range of alternative and their relative risks and benefits'.[562] The clearer requirement of dialogue around pregnancy options is a positive aspect of PG because it can enhance patients' authentic autonomy. I therefore argue here that a dialogue around pregnancy options should be expanded across the abortion context. Signposting pregnancy options and substantiating them with the availability of after birth support are hence enunciated as examples of good practice in information disclosure. Though the RCOG focused on this approach exclusively in relation to fetal abnormality (because of the likelihood of differential diagnosis to arise), it has wider relevance because it can safeguard the disclosure process. The safeguarding of an authentically autonomous decision is built upon the awareness that there is a broader spectrum of options and that no assumptions on the preferability of those options should be made by RMPs, except on the basis of conversations with the individual. Ultimately no *a priori* exclusion of its mention should be made by RMPs.

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[559] PG also address the issue of offer of a discussion around contraception options (see for instance RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 18). However, this is not an alternative to abortion per se, but can be classified as a form of ongoing and long term support that can be signposted during the decision-making process.

[560] RCOG, 'Termination of pregnancy for fetal abnormality', (2010), 21-22.

[561] A different approach is the one adopted by RCOG 2020 where no reference is made to broad pregnancy options, its focus is access to abortion during a pandemic.

[562] E Cave, C Milo, *above* (2020), 1, 14. In Chapter 5 it has been noted that this is an issue of potential overlap between the *Bolam* test of liability and the *Montgomery* test.

2.7 Conclusion on PG and information disclosure of risks, variant treatments and alternatives

A pathway of information disclosure which safeguards both partnership and authentic autonomy clearly calls for avoidance of unjustified non-disclosure of information based on assumptions made on behalf of the patient. This risk should be firstly minimized through clearer PG which make a consistent reference to the 'what' of disclosure and are hence also able to equip RMPs in this context. This also entails the endeavour to avoid unknown risks together with ongoing training on how to communicate sensitive information in the abortion context. Partnership and authentic autonomy call for a process of information disclosure which balances both medical expertise and patients' needs. This balance, however, does not mean that RMPs should unilaterally withdraw information from patients, or impose information on them, but instead engage in an actual and respectful dialogue with them. Specialist PG should more clearly translate this approach and hence calibrate medical expertise with patients' voices, their needs, and vulnerabilities.

Particularly, it has been suggested that:

1) when it comes to disclosure of risks: in the context of elective abortion, a more coherent approach should be elucidated, recalibrating access to abortion with the relevance of the disclosure process included within PG; in the context of serious fetal abnormality, a clear definition of what an abnormality is not should be set out;
2) when it comes to disclosure of variant treatment and alternatives: PG should make a clearer enunciation of pregnancy options as a separate head of disclosure from disclosure of abortion methods.

These suggestions are offered here as possible ways to translate the 'how-approach' within PG in the context of information disclosure. Later sections will engage with the ethical duty to enhance opportunities to support women both during and beyond the first medical encounter.

3. PG and enhancement of support

The possible considerations for revisions that follow the 'how-approach' have led thus far to a reflection on the issue of information disclosure in its aspect of disclosure of risks, variant treatments, and alternatives. However, an IC-approach does not stop here. The following sections reflect on how to translate the ethical duty of RMPs to enhance support in the decision-making process concerning abortion. This is because

the principles proposed in Part 2 do not only encourage a process of information disclosure, but also strive for an enhancement of a variety of forms of patient support. The actual support of women, or, at least, an opportunity to provide it, is considered a relevant aspect within the information disclosure process itself and beyond. Dialogue should be oriented towards understanding the information provided, but also towards making available wider forms of emotional support, such as counselling services.

The law of negligence, as it has been noted in Chapter 5, is of limited help in this regard. The law of negligence requires RMPs to disclose information that is material, as arising both from medical expertise and from a patient-centred approach. However, there is only a limited legal duty to strive for a support-oriented approach. For instance, there is no legal duty to enhance patients' understanding of the information provided but only to avoid, in a minimal approach, misunderstandings.[563] There is also no legal duty to signpost forms of external support like counselling services.

This section goes beyond the law of negligence and highlights the existence of an ethical requirement to strive for a process that better safeguards authentic autonomy in the context of abortion and the first medical encounter. There are at least two ways through which support can be more concretely safeguarded: 1) the establishment of an ethical duty to attempt to enhance understanding of the information provided; 2) the need to signpost further opportunities of wider emotional support (e.g., counselling services and involvement of relevant third parties).[564] In the following sections, it will be explored how far PG have implemented this approach and how they can in the future provide an enhancement of it.

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[563] Before-*Montgomery* in *Al Hamwi v Johnston & Another* [2005] EWCH 206 at [43], Simon J. claimed 'Clinicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided; but the obligation does not extend to ensuring that the patient has understood'. The key question is: has the RMP provided a negligent advice that has led to patients' misunderstanding? Post-*Montgomer*y case law has focused on the content of medical advice and asked whether the RMP has led the patient to misunderstand the issue at stake. In *Webster v. Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62; *Lunn v Kanagaratnam* [2016] EWHC 93 (QB), *Shaw v Kovac and University Hospitals of Leicester NHS Trust* [2017] EWCA Civ 1028 it was the lack of complete disclosure the key aspects that was examined as a factor that could have led to patients' misunderstanding. The materiality test in *Montgomery* has been interpreted so as to require a disclosure of what a reasonable person in the patient's position would have needed in order to avoid misinterpreting the issue. The duty to avoid misunderstanding was also explored in *Darnley v Croydon Health Services NHS Trust* [2018] UKSC 50. In this case the issue concerned the misleading nature of the information provided by a receptionist concerning waiting times that led to patient's misunderstanding. In *Worrall v Dr Helena Antoniadou* [2016] EWCA Civ 1219 then it was the use of non-committal advice by a clinician that was claimed to have led the patient to misunderstanding, even though the claim failed on causation grounds. The materiality test in Montgomery has been hence interpreted in a way that legally requires clinicians to avoid misunderstanding through an accurate, clear and patient-tailored disclosure. Crucially no duty to ensure understanding or to only enhance its protection is hence legally required.

[564] An additional aspect is also the opportunity to discuss future contraception options, although as said above this does not amount to an alternative to abortion, but figures as a form of wider support.

3.1 Proposing different modality for enhancing support within the abortion context: enhancing understanding of the information provided

The first modality through which support can be safeguarded deals with the disclosure process itself. It will be claimed that RMPs, in light of the proposed framework, are ethically required to strive for an enhancement of understanding of the disclosed information in the abortion context. IC-processes should not be oriented to a mere listing of relevant information, but should also attempt to check or enhance understanding. The law of negligence is unsatisfactory in this sense. This approach is relevant both within the mainstream medicine context, and also, as it will be explained below, within the abortion context. This does not mean that RMPs can or should guarantee that knowledge and understanding of all relevant information is achieved by women, which is, in many ways, undesirable and impossible. More concretely, it will be suggested that guidelines should work towards enhancing the possibility of making information relevant for the patient so as to enable the possibility to act upon them. This is framed here as a tool to safeguard the protection of the proposed principles, because it can offer not only the opportunity to render the information personal but also the needed support during the disclosure process to each patient.

3.1.1.1 Duty to enhance understanding: meaning for the mainstream medicine context

Before embarking on a reflection concerning the implications of an ethical duty of RMPs to enhance patient understanding in the abortion context and its implications for PG, it is important to take a step back and clarify the meaning attached to these two concepts: 'understanding' and its 'enhancement'. Underlying this discourse, there is a general acknowledgment that 'understanding', as a term on the spectrum of the same concepts as 'knowledge', already plays an important role within the mainstream medicine context. RMPs and patients can have different professional and personal expertise and can often find themselves experiencing gaps in understanding. In the context of a decision-making process, patients can experience this gap not only due to a lack of *transfer* of understanding from the RMP, but also due to a *lack* of understanding on the part of the RMP. The role of an RMP is not fulfilled merely with the disclosure of information in a unidirectional sense where the information goes 'from the RMP, to the patient'. Instead, the role of RMPs involves a multi-directional process. It involves dialogue and partnership with the patient and acknowledgement of the broader circumstances that the patient might face and experience. It is hence not enough to disclose information, but understanding is key to safeguard authentic autonomy.

However, there is scholarly scepticism as to the discourses concerning knowledge/understanding in the health sector.[565] Some frame it as an authoritative tool to reiterate an imbalanced, doctor-centred approach. The existence of possible 'knowledge/understanding' gaps from the patients' side has been used as a mechanism to trivialize patients, and to render them passively subject to a 'doctor knows best' approach. Feminist theorists[566] have also emphasized that 'knowledge' as a source of authority can be a tool to reiterate male 'patriarchy' over the female body and hence constitute a form of male oppression and stigmatisation of women.

Also, as O'Neill[567] has persuasively argued, it is not fully within the control of doctors to ensure actual understanding of the information provided. However, though actual understanding is ethically contentious and also often times out with medical control, what is and should still be within their 'control' is starting a process that facilitates a personal account of the disclosed information. This process, started in partnership with the patient, can lead towards a re-consideration of the information and towards a more personal and self-aware decision. This is particularly relevant given that many patients experience difficulties in remembering the information received due to various factors like age, anxiety, distress, and sometimes educational background.[568] This process hence aims to facilitate a move away from information as merely 'what the RMP said and I should' towards 'what the RMP advised and I decided, based on my unique life-circumstances'.

This also implies that the level of understanding to be expected is not prefixed, but necessarily context and patient dependent. It is not possible to consider a pre-fixed threshold of understanding that the RMP should achieve. As it will be also explored in the following sections, understanding is highly influenced by a series of factors that RMPs are called to take into account, like the nature of the intervention, possible harms involved, and patients' vulnerabilities within and outside the medical context.

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[565]Relevant on this point is Freidson's reflection: when talking about knowledge in professional contexts, he considers knowledge to be not expression of power in itself, but as a source or better an instrument of power used by professionals and their institutions to influence and shape others' behavior. He echoes and goes beyond Foucault who considered knowledge to be a source of power mostly in itself. See: M Foucault, *Power/knowledge: selected interviews and other writings, 1972-1977,* (Colin Gordon, Brighton: The Harvester Press, 1980)183-192; E Freidson, *Professional Dominance* (New York: Atherton Press, 1970)123-125 ; -- *Professional Powers: A Study of the Institutionalisation of Formal Knowledg*e. (Chicago: University of Chicago Press, 1986.) 1-19; I Illich, *Medical Nemesis* (New York: Pantheon Books, 1976) 1-16.

[566] See for instance: L Code, *What can she know* (New York: Cornell University Press, 1991) 181- 220. See also on a critical approach: UN General Assembly on 'instrumentalisation of women's body' and denial of autonomy in general and especially on over-medicalising and patalogising women. United Nations, General Assembly, 'Report of the Working Group on the issue of discrimination against women in law and in practice', **(**8 April 2016), online available at: https://www.refworld.org/docid/576158e84.html (accessed 21st October 2020) 12-14.

[567] O O'Neill, 'Ethics of Communication' (2009), *European Journal of Philosophy* , vol.17(2), 167.

[568] See on this point: R P C Kessels, 'Patients' memory for medical information' (2003), *Journal of the Royal society of medicine*, vol. 96, 219.

Patients' vulnerabilities and 'knowledge gaps' are not to be framed as an excuse for RMPs to impose their point of view. Conversely, this can be considered as a starting point of a partnership approach and of a strengthening of RMPs ethical duties. RMPs are called upon to facilitate understanding of the information provided so as to enable patients to safeguard their authentic autonomy. This additional ethical duty, as a consequence of the 'how-approach', is relevant in relation to mainstream medicine but also relevant, as it will be explained below, in the abortion context. This affects the formulation of current PG.

3.1.1.2 Duty to enhance understanding in the abortion context and PG

The previous section has clarified that a duty to enhance understanding is a duty for RMPs in the context of mainstream medicine when they are disclosing information. This ethical duty has also clear implications in the abortion context. This section explores to what extent this ethical duty has been embraced within PG and how it can be better safeguarded.

To enhance understanding in the abortion context has at least two recognizable meanings: (i) the orientation of the disclosure process, and (ii) the endeavour to work on the modality of disclosure and communication skills. Firstly, it can be translated as the 'orientation', that is to say, the desire to move from mere information provision to personalized informative processes. This term here means a process where the RMP hears the voice of patients and strives to make this information meaningful, minimising the possibility of informative harms.[569] This is also, to an extent, the direction that can be found in relevant PG. RCOG 2011, for instance, recognizes that disclosure in the abortion context concerning 'complications and risks should be discussed with women in a way that they can understand and should emphasize the overall safety of the procedure'.[570] The same approach was also laid down in the DHSC 2013 report on abortion, in which understanding the relevant information is considered a key part of the consent-process.[571] PG therefore already appear to embrace this first meaning: PG already establishes a duty to enhance understanding as the orientation of the disclosure process.

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[569] For a further analysis of this point see below section 4.

[570] RCOG, 'The Care of Women requesting induced abortion', (2011),8, para 5.2.

[571] DHSC, 'Procedures for the approval of independent sector places for the termination of pregnancy (abortion)', (2013), 15.

Secondly, to enhance understanding also means to work on the modality of disclosure. There is likely to be limited enhancement of understanding if RMPs do not focus on the format of information, the mechanisms of disclosure, and the collaboration with other medical staff in this respect. The issue of format of information has been widely explored in PG. RCOG 2011 [572]and DHSC 2013[573] both consider the relevance of a variety of languages and format of information delivery. NICE 2019 has also started developing forms of decision-aids as tools[574]to help women during the decision-making process. However, this particular issue of decision-aids could be further improved: crucially, these PG have been drafted with a focus on variant treatments – that is to say, an analysis of different abortion methods. In light of the proposed framework, it can be advised that decision-aids tools are to be developed also in the context of risk disclosure and broader alternatives. The issue of understanding enhancement is thus recognised, but more can be done to advance it. An extension of the availability of decision-aids tool is a viable possible option in this respect.

Furthermore, the issue of modality of disclosure and understanding is not just related to the format of information, whether written or through online tools, but is also more crucially related with the means of disclosure and hence how information is communicated. An emphasis has to be given to the culture and attitude of RMPs. NICE 2019, in this vein, talks about 'avoidance of stigma'[575] as a key issue in this context. It is crucial that no woman is stigmatized for the circumstances she is in and for the fact of considering an abortion. Together with the need to avoid the occurrence of stigmas, the principles of partnership and authentic autonomy also call for the need to engage in a broader dialogue with the patient, where truthful yet contextualized information is shared, and where both parties can contribute with their 'expertise'. This will reflect the suggestions formulated above concerning the disclosure process.

The issue of modality of disclosure also points to the relevance of training for RMP. It is essential that RMPs themselves understand that an IC-oriented approach does not negate the provision of medical advice. The disclosure process is more than mere information provision: it serves the aim of supporting the patient in the decision-making process. In this sense, RMPS should not only strive for a patient-oriented approach, but work to build a relationship with them. They are not antagonists, but

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[572] RCOG, 'The Care of Women requesting induced abortion' (2011), 37, para 5.2.

[573]DHSC, 'Procedures for the approval of independent sector places for the termination of pregnancy (abortion)', (2013), RSOP11, 19.

[574] NICE, 'Patient decision aids and user guides', (2019), online available at: https://www.nice.org.uk/guidance/ng140/resources/patient-decision-aids-and-user-guides-6906582256 (accessed 21st October 2020)

[575] NICE, 'Abortion Care', (2019), 10, para 1.1.17-1.1.18.

partners in the decision-making process. Partnership and authentic autonomy entail a process where RMP can -- and should-- be able to advice their patients, especially when there are medical prognostic reasons used as the baseline for an abortion (e.g., in the case of a serious fetal abnormality). Communication skills entail providing a space for mutual respect, while also engaging into a dialogical approach, which finds a due space for both RMPs and patients.

Crucially, an understanding-oriented approach is also strictly interconnected with the issue of time for a fruitful medical encounter. Time is surely not a 'neutral' aspect in the context of abortion. This is, firstly, because it is tied with the advance in pregnancy stage and also with increase in risks related to abortion methods.[576] NICE 2019, for instance, clarifies that ' while abortion is safe overall, there was evidence that morbidity and mortality increases for every additional week of gestation, so earlier abortion are safer'.[577] In light of this, NICE 2019 focuses on avoidance of delays and strives for an access-oriented approach.[578] However, time is also of crucial relevance for the issue of understanding: there is no enhancement of understanding if RMPs and patients do not have sufficient time and space for a fruitful medical encounter. It is also key that RMPs signpost the opportunity of follow-up and that patients know that they can, if there is a clinical need or patients so wish, to take time to process the information provided.

NICE 2019 also says that information should be disclosed as soon as possible so as to enable patients to prepare for an abortion.[579]One advantage of timely information disclosure is that it can enhance the time that women have to consider the information provided.[580] However, the feeling of time pressure here can be an issue. This has been signposted by Nuffield Council on Bioethics in 2017[581] when reflecting on abortion for serious fetal abnormality. The line between having the time to process and feeling pressurized towards reaching a decision in the shortest time possible is thin, but crucial here. RMPs should use available tools to give women sufficient space to allow a meaningful conversation.

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[576] NICE, 'Abortion Care', (2019), 26.

[577] NICE, 'Abortion Care', (2019), 26. This was also reinstated in RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 9, para 1.4.

[578] NICE, 'Abortion Care', (2019), 9, para 1.1.5- 1.1.8.

[579] NICE, 'Abortion Care', (2019), 11, para 1.2.3.

[580] This also echoes the 2020 Paterson Inquiry chaired by Rev'd Graham James. This report made further recommendations to improve the consent process, including writing to patients to outline their condition and treatment and to make sure the patient's GP is also informed, and giving patients a short period of time to process information about diagnosis and treatment options before surgical procedures. See: DHSC, 'Paterson Inquiry Report', (February 2020), online available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf (accessed 21st October 2020), 218-219

[581] Nuffield Council on Bioethics, 'Non invasive prenatal testing: ethical issues', (2017), 53-54, para 2.52.

Another challenge to the enhancement of understanding in the first medical encounter is the push towards the use of telemedicine (e.g., phone or video call).[582] Telemedicine can be an effective tool, in so far as some patients might express a preference for it. Also, it is pertinent at times to reduce access-related concerns.[583] However, telemedicine can also undermine the safeguarding of the proposed process-driven framework. A model of revised medicalisation that strives towards enhancement of understanding should reconsider the involvement of telemedicine. It is advisable that the first encounter between a woman and RMP[584] happens face-to-face.[585] This gives the opportunity for an authentically autonomous decision to be reached in partnership. Telemedicine is more appropriate in relation to further encounters (e.g., the involvement of the second RMP and wider medical staff). In this respect, the use of telemedicine for the first and only medical encounter during the COVID-19 pandemic,[586] should be considered contingent to the circumstances and hence extremely exceptional.[587]

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[582] NICE, 'Abortion Care', (2019), 9, para 1.1.9. This also reflects more broadly the Long Term NHS plan 2024 where it is set as a goal to 'redesign services so that over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits, removing the need for up to 30 million outpatient visits a year. This will save patients time and inconvenience, will free up significant medical and nursing time, will allow current outpatient teams to work differently, and will avoid spending an extra £1.1 billion a year on additional outpatient visits were current trends simply to continue. These resources will instead be used to invest in faster, modern diagnostics and other needed capacity' see: NHS, 'The NHS Long Term Plan', (2019) available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (accessed 21st October 2020) 28.

[583] See on this point in favour of the use of telemedicine as a tool to overcome access related concerns in USA: E Raymond, E Chong, B Winikoff, et al., 'Teleabortion: evaluation of a direct to patient telemedicine abortion service in the United States' (2019), *Contraception*, vol.100(3), 173; U D Upadhyay, D Grossman, 'Telemedicine for medication abortion' (2019), *Contraception*, vol. 100(5),351; K Ehrenreich, C Marston, 'Spatial dimensions of telemedicine and abortion access: a qualitative study of women's experiences' (2019), *Reproductive Health*, vol.16(94),1. See also a 2019-literature review on the acceptability of the use of telemedicine in this context: M Endler, A Lavelanet, A Cleeve, B Ganatra et.al, 'Telemedicine for medical abortion a systematic review' (2019), *BJOG*, vol. 126(9), 1094.

[584] This also suggests that, in light of the legal duties envisaged in Chapter 5, priority should be given to the involvement of RMPs over wider medical staff (e.g. nurses). The first encounter should hence be between a pregnant woman and an RMP. This approach does not deny what stated in *Royal College of Nursing of the UK v DHSS,* which opened up the possibility to delegate the consent process to wider medical staff, yet it recognizes as optimal the involvement of RMPs. This suggestion will ask the DHSC to slightly reconsider its 2013 position (see Chapter 5) concerning the involvement of medical staff, particularly where it was encouraging forms of wider medical delegation. It is hence advisable that in light of the existence of wider legal duties on the side of RMPs their involvement should be prioritized whenever possible.

[585]See: T Greenhalgh, S Vijayaraghavan, J Wherton, S Shaw et al, 'Virtual online consultations: Advantages and limitations (VOCAL) study' (2016), *BMJ Open*, vol. 6,1. They outline the theoretical acceptability of telemedicine, while pointing out technical, logistical and regulatory challenges that can contribute to clinical risks to patients. See also on this point Chapter 5.

[586] RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 5.8.

[587] Additional challenges, which have not been explored in this Chapter are related to the use of telemedicine and patients' safety. I am here only outlining a possible challenging scenario connected to the lack of routinely ultrasound during the COVID-19 pandemic. Take as an example the incidence of further clinical complications, e.g. an ectopic pregnancy, which is often detected via ultrasound scan. This diagnosis, though statistically rare, risk being delayed and has the potential to negatively affect women's health. On this point RCOG 2020, on abortion care during COVID-19, (31ST July 2020 ed.), though showing reluctance towards the routinely use of ultrasound, outlines circumstances in which ultrasound should be undertaken. These are: 'If a woman is unable to provide either a known date of conception or LMP of reasonable certainty to be able to offer care within thresholds of eligibility or skill (e.g. 10–12 weeks for an early medical abortion under current regulations; 14 weeks for a vacuum aspiration).History or symptoms suggestive of a high risk of ectopic pregnancy; for example: Presence of unilateral abdominal pain and vaginal bleeding/spotting which could indicate an ectopic pregnancy;

Conversely, preserving the existence of the first medical encounter as a face-to-face encounter, in 'normal' circumstances (i.e., outside pandemic contingencies) will safeguard the importance of trust and partnership in the clinical setting.[588] While telemedicine can be a tool to ensure continuity of dialogue with RMPs[589], it could also risk diminishing the relevance of partnership.[590] The latter is also the basis for an understanding-oriented approach. The use of telemedicine should therefore be monitored and face-to-face encounters favoured in a post-pandemic context. This is not because RMPs are 'the' repository of knowledge, but because it is through a relationship with them that the decision-making process can be supported.

An authentic autonomy-oriented system should, therefore, strive towards safeguarding partnership and establishing a relationship of trust between patients and RMPs since the first encounter. Trust and partnerships are here the foundation upon which enhancement can be built. PG should clarify the importance of allowing space and time for a fruitful medical encounter. De-medicalisation and access-oriented approaches should not undermine the importance of working on making the information pertinent for the patient.

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an intrauterine contraceptive in situ at the time of conception; Prior ectopic pregnancy; history of tubal damage or surgical sterilisation'. RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020),14.

588 See also on the relevance of having a first face-to-face meeting before a video-consultation as a tool to build trust. This is understood to be a premise for possible subsequent video-consultation: T Greenhalgh, S Shaw, J Wherton et al, 'Real-World Implementation of Video Outpatient Consultations at Macro, Meso, and Micro Levels: Mixed-Method Study' (2018), *J Med Internet Res*, vol.20(4), e150.

589 See also an empirical study conducted in Utah, where IC is mandatory, comparing the characteristics of patients having IC before abortion in-person and telemedicine. Patients who used the latter have been a minority (9%) and were more likely to live far from state and from abortion clinics offering IC visits. 91% of IC were still in person showing that patients still prefer to engage, when no other barriers are in place, with actual meetings with RMPs. See: S Daniel, S Raifman, S Kaller, D Grossman, 'Characteristics of patients having telemedicine versus informed consent visits before abortion in Utah' (2020), *Contraception*, vol. 101 (1), 56.

590 In a 2020 consultation response, which explored the delivery of services post-COVID-19 outbreak, the Faculty of Sexual and Reproductive Healthcare (FSRH), has highlighted that the increased use of forms of telemedicine in the abortion context carries also some drawbacks. Particularly it claimed that: 'The decreased availability of face-to-face consultations is having detrimental impacts on the SRH care of vulnerable groups. Without face-to-face consultations, picking up on safeguarding issues, domestic abuse and teenage pregnancy is more difficult. The availability of different modalities of consultation – face-to-face, remote and online – is vital to provide comprehensive SRH care for all women and girls now and beyond the pandemic…. Remote and online services are a complement, not a substitute, to face-to-face consultations and, irrespective of consultation modality, best practice and guidelines must be observed to ensure safety and quality of care'. FSRH, 'FSRH consultation response: capturing clinical changes in the NHS by NHS England and improvement', (30th June 2020), online available at: https://www.fsrh.org/news/fsrh-responds-to-nhs-capturing-clinical-changes-survey/ (accessed 21st October 2020)

3.2 Fostering the opportunity of emotional support in the abortion context: the routine offer of counselling services and invitation to involve relevant third parties

Another way of improving support is through fostering the opportunities of emotional support.[591] This section will suggest that this approach can be promoted in at least, two ways: 1) the routine availability of counselling sessions; and 2) the offer to involve relevant third parties (such as fathers). Counselling is here framed as the opportunity for women considering abortion to not only receive emotional and psychological support by trained personnel during and after the decision-making process, but also have the opportunity to consider possible practical alternatives to abortion.[592] In this section it will be argued that the pursual of 'support' during the decision-making process is also tied with the opportunity for RMPs to routinely offer this service -- something that is not included within PG at present. Furthermore, the possibility to involve relevant third parties is here framed as a way to receive additional support in the decision-making process as well as to minimize any feeling of abandonment and isolation that some patients might experience. It is suggested here, that specialist PG should enhance the provision of emotional support.

A support-oriented approach, in light of the 'how-approach', would ideally strive not only for an enhancement of understanding of the information provided, but also for opportunities for emotional support to women in the context of abortion and the first medical encounter. The Royal College of General Practitioners in its position statement on abortion, for instance, when looking at the abortion decision, considered that:

> 'Unplanned pregnancy may involve complicated and ambivalent feelings. A decision to continue or not with a pregnancy is an important life event that needs careful consideration. Pregnancy brings with it physiological, emotional and psychological changes which can make decision-making increasingly difficult, particularly as the pregnancy progresses. It is important to give women the

[591] I am here focusing on this aspect since this has been often neglected and jeopardised throughout PG. I am taking aside a discussion around contraceptive options which is consistently considered as an aspect of abortion care across PG.

[592] Counselling can additionally have an important role in the aftermath of the decision itself, however this post-IC aspect will not be analysed, as it appears to be beyond the scope of this research whose focus is on the decision-making process stage.

opportunity to consider the issues in a confidential and non-judgmental environment'.[593]

Given the emotional component that can be entrenched in the context of abortion as arising from unplanned pregnancies, enhancing support requires also taking these aspects into account. In this sense, enhancing emotional support has implications not just within the disclosure process itself, but also beyond it, and encourages RMPs to signpost wider opportunities. Imagine, in this sense, a sliding-door effect, where the role of RMPs during the first encounter can be one of signposting the existence of further 'doors' that can be opened up, should the patient so wish.

3.2.1 Proposal for the routine offer of counselling services

A significant ingredient of this 'sliding-door' is the routine offer of counselling service[594]. RMPs during the first medical encounter can signpost the opportunity of receiving emotional support during and after the decision is reached, should the patient so wish.

Specialist PG have made clear that counselling should be available, but have not gone as far as requiring that it is routinely offered.[595] Counselling can be offered upon request or if the RMP envisages that the circumstances of the case suggest it would be appropriate. The suggestion that it should be extended to a routine offer flows from the potential to exclude patients who might benefit from counselling, but who do not make, for a variety of possible reasons including existing vulnerabilities, that potential clear in their consultation(s) with the RMP. NICE 2019, for example, considers that counselling will not be beneficial for all women seeking abortion, and as a result, places an obstacle

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[593] Royal College of General Practitioners, 'Position Statement on Abortion', (2012), online available at: https://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP_Position_Statement_on_Abortion.ashx (accessed 21st October 2020) 3.

[594] It should be clarified that there is a crucial complementarity between an informed-consent approach and counselling sessions. Building upon Halliday perspective, the former is focused on the issue of information disclosure by RMP, the latter in its form of 'decision counselling' engages with psychological and emotional aspects. Differing however from her point of view, where she supports the need for a reduction of medical involvement, counselling is here understood as a complementary tool to medical involvement. It is both possible and necessary to recalibrate the relevance of them both. This means that a support for the routine availability of counselling services does not entail a process of de-medicalisation, but is compatible with a revised medicalisation. There is a room for both, for the need to better translate the informed consent process during the medical encounter, but also for the importance of signposting the opportunity of wider forms of support. See on a critical point: S Halliday, 'Protecting human dignity: the dignity of choice and life' (2016), *Contemporary issues in law*, vol.13(4), 287,312.

[595]Counsellors, that is to say, trained personnel providing their service within NHS and registered charities. To date their provision is often patchier especially within NHS services. See on this point: S Halliday, 'Protecting human dignity: the dignity of choice and life' (2016), *Contemporary issues in law*, vol.13(4)287, 312.

because it delays access to the service. RCOG 2011[596] goes a step further. It sees the offer of counselling services as optional and embraces a differentiated approach. Although counselling is not considered to be compulsory in this context, medical staff is urged to identify those women in need of more support during their decision-making processes.[597] RCOG 2010[598] goes further still in relation to the specific issues of serious fetal abnormality. It recognises the key role that counselling services can play in helping patients consider the options at stake and in providing opportunities of support. RCOG 2010 represents the right approach that supports patients' authentic autonomy and should be expanded beyond the remit of fetal abnormality.

A significant advance was made in 2013 when the DHSC set as an ambition that 'all women requesting an abortion should be offered the opportunity to discuss their options with a trained counsellor'. [599] It recognized that the reality of abortion practice is not uniform when it comes to counselling provision. It stated the need for professional advice in the form of different degrees of support in line with women's circumstances.[600]

Potential risks related to counselling are: a) delay in accessing abortion; b) costs; c) a return to a doctor-focused approach. To use an expression of Lee,[601] abortion is here framed as a form of social problem, where women need to justify their choices. Counselling, in this critical perspective, would therefore reiterate the risk of reducing women's agency and strengthen a medicalised approach.

On a closer analysis, however, the proposal of a generalized rather than selective (differentiated) form of counselling offer would support a thick conception of autonomous decision making. This will be a relevant tool to complement clinical expertise. Hare and Heywood[602] claimed that it is striking that abortion, although often sought for 'social' reasons, does not legally provide for the opportunity of counselling services. Counselling presents an opportunity within the decision-making process to not only receive relevant information, but also to be heard by counsellors. Listening and dialoguing in this context are key aspects of the decision-making process, together with the opportunity to be offered valid forms of concrete support and alternatives.

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[596] RCOG, 'The Care of Women requesting induced abortion ',(2011), 4.14.

[597] RCOG, 'The Care of women requesting induced abortion', (2011), 10, 47, para 6.2.

[598] RCOG, 'Termination of pregnancy for fetal abnormality',(2010), 22-23.

[599] DHSC, 'A Framework for sexual health involvement in England', (2013) online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf , (accessed 21st October 2020) 26.

[600] DHSC, 'A Framework for sexual health involvement in England', (2013), 36.

[601] E Lee, 'Tensions in the regulation of Abortion in Britain' (2003), *Journal of Law and Society*, vol.30(4), 532.

[602] M J Hare, J Heywood, 'Counselling needs of women seeking abortions' (1981), *Journal of Biosocial Science,* vol. 13 (3), 269.

Vandamme et al. 2013-research study also support this position as tenable.[603] Their empirical work focuses on pre-abortion counselling, showing that this can be a positive experience for a woman's decision-making process, because it can increase her decisiveness and reduce distress.

> 'Results showed that although women are in a rather negative mood and feel somewhat hesitant towards the counselling session when they enter the abortion centre, they highly appreciate the standardised as well as tailored sessions, and feel better afterwards'.[604]

This 2013-study highlights that, although women were reluctant about agreeing to a counselling session, fearing a possibility of judgement, many of them changed their mind after the session and were enthusiastic about it. This shows that a support enhancement, for instance through the above mentioned generalised offer of counselling services, can have a positive instrumental value that extends beyond women's *prima facie* reluctance. However, the fact that many women feared the counsellors' involvement shows that a change in attitude is auspicial.

But this approach should be also further contextualised. Empirical research conducted by Lee et al. [605] pointed out that the challenge in this context can also be that of over-counselling women and hence forcing them to go through what is deemed to be an unnecessary exploration of pros and cons. In the same study, however, it was also pointed out that some women complained about the lack of time to talk about their decision. In this sense, given the necessary variety of experiences associated with the decision-making process, the generalised offer of counselling services, for instance, would be a tool to strike a balance amongst all of them. It would also minimize the risk of non-disclosure, while leaving open to the patient the possibility or not to embrace the opportunity that is offered. More extensive research into this field is surely needed, especially to further explore women's perceptions so as to offer useful suggestions and foster more trust and openness in the women-RMPs relationship.

Furthermore, enhanced support can also be a positive tool for those women who are at higher risk to incur mental health problems after an abortion. This is particularly

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[603] J Vandamme, E Wyverkens, A Buysse, C Vrancken, R Brondeel,' Pre-abortion counselling from women's point of view' (2013), *Eur J Contracept Reprod Health Care*, vol. 18(4), 309.

[604] J Vandamme, E Wyverkens, A Buysse, C Vrancken, R Brondeel,' Pre-abortion counselling from women's point of view' (2013), *Eur J Contracept Reprod Health Care*, vol. 18(4),309,315.

[605] E Lee, S Clements, R Ingham, *A Matter of Choice?* (York: Joseph Rowntree Trust, 2004) 27; see also S Woodcock, 'Abortion counselling and the informed consent dilemma' (2011), *Bioethics,* vol. 25(9), 495.

relevant for those experiencing ambivalence[606] about the abortion decision, pressure, [607] or lack of social support from others.[608] Given that these group of women are also at higher risk of negative long-term aftermaths, enhancing their understanding of the information provided and providing support for them can be beneficial in their decision-making process. However, this does not mean that only specific groups should be identified and supported. This is also not always possible. Support should be the rule, while open to necessary recalibration in light of the specific circumstances.

Furthermore, as also stated by the HFEA in the different context of reproductive technologies, the provision of counselling is not an assessment of a 'person's suitability to receive the treatment.' [609] It is not a tool to scrutinize the reasoning and restrict access to the service, but to safeguard the emotional, psychological, and wider personal aspects involved in the decision-making-process. The offer of counselling should be considered to be relevant across reproductive services. Reproductive technologies and abortion are surely two different contexts. In the former case women are seeking a pregnancy, and in the latter they are seeking to terminate it. However, both can be broadly included in the wider categorization of 'reproductive services' where shared women's needs can be identified, as it is per the case of counselling. A consistent offer of counselling in the abortion context would mean that women would be supported in their decision-making process, and possibly also afterwards, and safeguarded in their authentic autonomy. It can additionally be a way to better align the abortion context with other parts of the healthcare law sector, as Foster[610] has suggested in relation to reproductive technologies.[611] RMPs during the first medical encounter should hence signpost the opportunity of wider forms of emotional support, as it is in the case of counselling sessions.

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[606]See on this point: V M Rue, P K Coleman , J J Rue, D C Reardon,.'Induced abortion and traumatic stress: a preliminary comparison of American and Russian women' (2004), *Med Sci Monit,* vol.10(10) SR5–SR16; A Kero, U Hogberg, L Jacobsson, et al., 'Legal abortion: a painful necessity' (2001), *Soc Sci Med,* vol. 53(11), 1481.

[607]See for instance: S Sihvo, N Bajos, B Ducot, et al. , 'Women's life cycle and abortion decision in unintended pregnancies' (2003), *J Epidemiol Community Health,* vol. 57(8),601.

[608] See on this point B Major, J M Zubek, M L Cooper, et al. 'Mixed messages: implications of social conflict and social support within close relationships for adjustment to a stressful life event' (1997), *J Pers Soc Psychol,* vol.72(6),1349; B Major, C Cozzarelli, A M Sciacchitano, et al., 'Perceived social support, self-efficacy, and adjustment to abortion' (1990), *J Pers Soc Psychol,* vol. 59(3), 452.

[609] HFEA, 'Code of Practice', 9th Edition, (2019,) online available at: https://portal.hfea.gov.uk/media/1527/2019-12-16-code-of-practice-9th-edition-december-2019.pdf (accessed 21st October 2020) 27, para 3.7

[610] Foster C, 'Does the English Law on Abortion affront Human dignity' (2016), *The New Bioethics,* vol. 22(3), 162.

[611]See on this aspect also C Foster, believing to be a great inconsistency of the law, the lack of proper pre-procedure counselling in the abortion context. See: C Foster, 'Does the English Law on abortion affront human dignity' (2016), *The New Bioethics*, 162, 182.

The proposal of a generalized offer of counselling service would require a change in perspective across relevant PG.[612] During the first medical encounter, RMPs should offer the opportunity of emotional support through these services. This could also be seen as a way to implement those already well-recognized needs of signposting further opportunities of additional ongoing care (e.g. advice on contraception plans).[613] Ultimately, the need to frame the RMPs as advisors, coupled with the desire to support women's decision-making process and to not abandon them calls for a change in approach. It is hence not enough to protect women's agency-alone without a due weight given to the choice dynamics which should also include signposting the availability of wider forms of support.

3.2.2 The offer of involvement of relevant third parties

A further practical way to enhance emotional support in the abortion context can be the involvement of relevant third parties.[614] It will be argued in this section that PG have neglected this question and therefore a change in approach is needed. This will encourage RMPs during the first encounter to signpost this further 'sliding- door'.

The issue is considered by RCOG 2010[615] in its guidelines concerning serious fetal abnormality.[616] In that context, RCOG considers the role played by the prospective

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[612] This proposal echoes the Lane Committee Report on the Working of the AA 1974 which suggested the 'opportunity to obtain adequate counselling before an abortion decision'. (See, Report of the Committee on the Working of the Abortion Act, Cmnd 5579, 1974, vol I, 94-96, para 291.) The Committee thought that a counselling session formed part of the RMPs role and should have served various aims. Firstly, it should have offered a woman the space and the time to discuss her feelings and anxieties in an informal an unhurried context. On a more specific level, counselling should have also raised awareness concerning the nature of the procedure as well as connected risks/benefits and alternatives. The focus of the counselling session was also suggested to go beyond pure medical advice, signposting possible opportunities to receive support before and after a decision was taken, whether or not it resulted in an abortion (e.g. with the involvement of social workers, psychiatrics). The Report did not deny the daily time-constrain of medical practice, but claimed that the importance of offering support and advice to women trumped any concerns related to time and rapidity of the procedure. Nevertheless, the report was not welcomed and did not find a specific room within the law. It was heavily criticized as an instrument of medical control and of stigmatisation towards women. A woman, in this critical vein, was thought to have been wrongly perceived as lacking a decision-making power and the only way to overcome such shortcoming was re-establishing RMP's control over her choice. In this respect, Lee believed that abortion was construed as a 'social-problem' where the possible risks connected to it were not based upon scientific evidence and the need to support a woman, but were a form of social control over her decision. See: E Lee, 'Tensions in the regulation of Abortion in Britain' (2003), *Journal of Law and Society*, vol.30(4), 532.

[613] See on this point: RCOG, 'Coronavirus (COVID-19) infection and abortion care', (31st July 2020), 11; NICE, 'Abortion care', (2019), 1.15.

[614] This could additionally work as a tool to enhance understanding. When third parties are involved in the information sharing process this can help the patient remembering and going-through the information received.

[615] RCOG, 'Termination of pregnancy for fetal abnormality', (2010).

[616] This approach has been also supported by Royal College of General Practitioners,'Position Statement on Abortion' , (2012), online available at: https://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP_Position_Statement_on_Abortion.ashx (accessed 21st October 2020) 3, which, although recognises that the

father. The involvement of the partner is framed here as a potential form of support during the decision-making process.[617] A tool to make the voice of both prospective parents heard could be suggested to be extended from the serious fetal abnormality context, also to the broad context of decision-making concerning an elective abortion for non-diagnostic reasons.

Prior to the appointment, clinicians could ask women whether they have any relevant third parties, such as the prospective father, or a relative, or friend, who they wish to be with during the first encounter. This has been encouraged by the Royal College of Nursing[618] as a form of support which women contemplating abortion may find helpful. This can help making the patient feel more at ease,[619] while leaving up to them the opportunity to welcome or reject the offer of third parties' involvement. Although in law the prospective father has no legal claims to interfere with an

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decision and connected responsibilities remains on women, it may be appropriate to involve a partner or a family member within the decision-making process.

[617] RCOG, T'ermination of pregnancy for fetal abnormality', (2010), 22-23. Additionally, beyond the context of the first medical encounter, RCOG together with Faculty of Sexual and Reproductive Healthcare and the British society for abortion care provider, in their 2019 clinical guidelines for medical abortion at home in England, have also widened the role of third parties. Their role can be relevant as a form of support during the abortion process which will take place outside the clinical setting. It hence suggests RMPs to advice women who are opting for an early term medical abortion at home that: 'having a partner or trusted adult companion to give support at home is recommended, although if the woman makes an informed choice not to involve anybody else then this should be respected. It has not been standard practice in England to require an adult to be at home following administration of misoprostol, and there are rare scenarios where it may not be appropriate (e.g. where an adult partner is coercive, or where a partner is away and delay to treatment would increase distress or risk of complications).' See: RCOG, FSRH, BSACP, 'Clinical guidelines for early medical at home-England', (2019), online available at: https://www.rcog.org.uk/globalassets/documents/guidelines/early-medical-abortion-at-home-guideline-england.pdf (accessed 21st October 2020) 5.

Additionally, drawing upon the experience of reproductive technologies, wider forms support for partners can be also signposted. The HFEA, for instance, lists opportunities for men as well to find emotional support when facing fertility issues and the choice to opt for a fertility treatment See on this point: HFEA, 'Getting emotional support', online available at: https://www.hfea.gov.uk/treatments/explore-all-treatments/getting-emotional-support/ (accessed 21st October 2020). This also finds broader support in NICE, 'Abortion Care', (2019), QS15 Statement 13, according to which 'patients' preference for sharing information with their partner, family members and/or carer are established, respected and reviewed through their care'. This is also included within the CQC, 'Inspection standard: independent acute hospitals', online available at:https://www.cqc.org.uk/sites/default/files/20180706_9001228_Additional_service_Gynaecology_and_Termination_of_Pregnancy_framework_v2.pdf, 39 (accessed 21st October 2020).

[618] Royal College of Nursing, 'Termination of Pregnancy', (2017), online available at: https://www.rcn.org.uk/professional-development/publications/pub-005957 (accessed 21st October 2020) 9.

[619] A study by Kessels [R P C Kessels, 'Patients' memory for medical information' (2003), *Journal of the royal society of medicine*, vol. 96, 219] has also found that patient's memory of medical information is often poor. This affects, amongst others, the possibility for them to understand information. Factors like age, anxiety and distress, educational background, perceived importance/lack of importance, form of information can impact on patients' memory. A potential tool to minimize also this issue can be the opportunity to involve relevant third parties.

abortion,[620] his interests can be taken indirectly[621] into account. This does not deny that the involvement of third parties can also trigger forms of direct or indirect exercise of undue influence, which should be born in mind by RMPs. However, while RMPs should be mindful of this shortcoming, RMPs also should not make any *a priori* assumption leading to the exclusion of what can be a positive opportunity.

RMPs during the first encounter can trigger processes that can enhance support. Both the opportunity of signposting the availability of counselling services, together with the opportunity of involving relevant third parties are here seen as possible implications of the proposed framework. The safeguarding of patient's authentic autonomy and partnership encourages PG to make more room for emotional support during the decision-making process, but also beyond it.

3.3 PG and enhancement of support: conclusion

Is has been argued that PG should not only strive for information disclosure, but also work for an enhancement of support for women in the context of abortion and the first medical encounter. This has at least two clear implications. The first deals with the decision-making process itself and calls for an enhancement of understanding of the information provided. This approach finds a space within current PG. However, a process of de-medicalisation could potentially undermine it. Within the proposed framework, PG should translate more clearly the importance of allowing time and space for an understanding-oriented medical encounter. The second implication deals with an enhancement of emotional support, which should be implemented by signposting the availability of counselling services and offering the possibility to involve relevant third parties. PG do not fully recognize the importance of these aspects,[622] which are key for

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620 The father has no legal rights according to the Abortion Act 1967, he has also no right to be informed that an abortion has taken place or to be consulted during the decision-making process. The issue was explored in *Paton v Paton v British Pregnancy Advisory Service Trustees and another* (1979) QB 276 [at 181] where Sir George Baker held that the husband 'has no legal right enforceable in law or in equity to stop his wife having this abortion or to stop doctors from carrying out the abortion'. The issue was than explored by the ECHR in *Paton v UK* (1981) 3 EHRR where the Commission held that the rights of the mother under art 8(1) outweighed those of the father. This point has been criticized by Mason and Laurie [G T Laurie, S H E Harmon, and G Porter, *Mason and McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press, 10TH ed, 2016) 9.114] who believe that, at least in some circumstances, fathers should be involved during the decision-making process. Fox, has also argued that they should be involved during the counselling process. See: M Fox, 'Abortion decision-making—taking men's needs seriously', in: E Lee *Abortion Law and Politics* (Palgrave, 1998a), 198-215..

621 This approach does not deny, what Barton et al., pointed out, namely that poor relationship can be a risk factor for psychological distress for women in an unintended pregnancy. See: K Barton, M Redshaw, M A Quigley, C Carson, 'Unplanned pregnancy and subsequent psychological distress in partnered women: a cross-sectional study of the role of relationship quality and wider social support' (2017), *BMC Pregnancy and Childbirth*, vol. 17, 44.

622 It should be also added that, if the suggested considerations for revision are implemented, it would be also expected that the Care quality commission inspection standards would be also updated consequentially. The CQC commission is the independent regulator of health and adult social care in England. It sets standards of care expected by care provided, both

the safeguarding of the proposed principles. Reformed PG, it been suggested, should make space for them.

4. Recognising the benefits and minimising possible informative harms

The existence of a legal duty to information disclosure together with an ethical duty to enhanced support (in the form of enhanced understanding of the information provided and enhanced emotional support) are not free from challenges. This section considers possible counterarguments to the approach proposed thus far. In particular, it tackles the claim that the proposed approach is harmful and a source of unnecessary delay in accessing abortion services. Creating the conditions for a self-awareness process regarding, for instance, potential risks/benefits, alternatives to an abortion, and availability of emotional support can be perceived to be a cause in itself of distress and delays that should be avoided. This section counters this criticism and explains how the proposed framework (i.e., 'how-approach') will offer ways to minimise concerns.

An ethical obligation of RMPs, as framed by Beauchamp and Childress, is to avoid the occurrence of harm.[623] Though it has been proposed that a 'how-approach' would enhance wellbeing, critics perceive an IC-discourse in the abortion context as a potential source of harm that can restrict access to abortion and stigmatise women.[624] In order to respond to this claim, it should be firstly clarified what can amount to an informative harm in the abortion context and then show how the suggested considerations for revision will attempt to minimise that potential and maximise the

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within and outside the NHS. It works to monitor, inspect and rate the way in which such medical services are run and takes actions to foster compliance. The ultimate aim that this independent regulator serves is to 'make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve' Care quality commission, 'About u's, available at: https://www.cqc.org.uk/about-us (accessed 21 October 2020). CQC has two specific inspection frameworks, distinguishing between NHS and non-NHS service providers. See: Care quality commission, 'Inspection framework NHS acute hospitals, Additional service: Gynecology and Termination of pregnancy', (2018)-latest version-available.at:https://www.cqc.org.uk/sites/default/files/20180706_9001228_Additional_service_Gynaecology_and_Termination_of_Pregnancy_framework_v2.pdf (accessed 21st October 2020); Care quality commission, 'Inspection framework: independent acute hospitals (and single specialty), Core service (or single specialty): termination of pregnancy',(2020), online available at: https://www.cqc.org.uk/sites/default/files/20191219_IH_TOP_inspection_framework_v6.pdf (accessed 21st October 2020). To date these two distinct inspection frameworks reflect the above mentioned PG scenario in the context of abortion. As noted in Chapter 2, the CQC has also played a key role in signaling issues around consent in the abortion medical practice. It hence becomes inevitable that if the above mentioned considerations for revisions are implemented also the inspection framework will be also amended as a consequence. This will be a tool to safeguard that both NHS and non-NHS clinics practically administer abortion in light of PG. See also Chapter 1, footnote n. 19.

623 See on non-maleficence: T L Beauchamp, J F Childress, *Principles of biomedical ethics* (Oxford: Oxford University Press, 2019) 155-200.

624 See on this point: E Lee, 'Tensions in the regulation of Abortion in Britain' (2003), *Journal of Law and Society*, vol.30(4), 532.

benefit of authentically autonomous approach. Three different points are taken into account, namely: 1) the nature, 2) the quality of information, and 3) the communicative dynamics, to show how potential detriments associated with the proposed approach could potentially be minimized.

The first point that needs to be analysed here is the nature of the information provided. This point builds upon the reflection in Chapters 1 and 2 that the information concerning abortion involves both medical and non-medical aspects. The medical aspects refer to the nature of the intervention in itself -- that is to say, medical or surgical abortion depending on the time of gestation, disclosure of connected risks in line with women's medical-background and circumstances, and signposting of possible benefits and alternatives. The non-medical aspects of the information disclosure involve, amongst others, an acknowledgement of the wider personal needs and social circumstances of women. It is apparent that this information can be perceived to be of a highly sensitive nature for women because it involves medical and non-medical aspects concerning primarily women's health and its impact on fetal life,[625] while also affecting existent/absent partners and broader personal circumstances. It is thus possible that attitudes towards this information might differ. Some women might consider it harmful in itself to know, for instance, about the nature of the procedure and long-term risks, whilst some others might show openness to it and benefit from it. In some circumstances of particular distress, women might decide to approach a decision based only upon their 'current desires' and reject the opportunity to make an informed decision by refusing an authentic autonomous choice.

There are then two possible harms here: 1) short-term harm due to the perceived harmful nature of the information itself -- that is to say, a personal reluctance towards this information and its understanding; 2) long-term harm, based on the lack of an informed and hence authentic autonomous choice. It should be clarified that a support-oriented approach recognizes the possibility of the occurrence of these two related harms and aims to facilitate and encourage, rather than impose, the internalisation of the disclosed information. What is proposed is therefore a contextualised approach that minimises the occurrence of harm and tries to seek a balance between current and long-term harms, because it is the woman who has the ultimate control over the information she wishes to understand and the support she is open to receive. Ultimately, the nature of the information can lead towards possible occurrence of harm, but a support-oriented

[625] This thesis recognizes that both women and fetus play a role in the abortion discourse. It hence rejects single-entity approaches by which it is acknowledged the existence of women-alone, and supports relational accounts of autonomy, which give weight to the existence of two different yet inter-related entities. For a further explanation see Chapter 4 footnote n. 356.

discourse tries to minimise that potential and to maximise well-being through the offer of an opportunity of tailored medical support.

The second point deals with the quality of the information provided. Distress and harm are not necessarily a direct consequence of the information in itself, but often times of the quality of the information provided. Partially disagreeing with Woodcock[626], who considers the information to be disclosed often harmful in itself, this section argues that, if the information is inaccurate or misleading, this is surely harmful. Information should never be a sword thrown upon women. This warning is further supported by a research study by Littman, which focussed on women considering the possibility of an abortion, claiming that misleading information can cause distress.[627] This also recalls O'Neill[628] and her focus on an assessable informative process whereby the information provided reflects a scientifically accurate and reliable perspective upon which women can base their personal decision. This then entails that, when talking about the minimisation of harm in this context, RMPs play a vital role because they are called to work on the quality of the information provided and to disclose and facilitate understanding only of accurate, truthful, and non-misleading information.

The third point deals with the communicative dynamics. To facilitate a discourse that emphasises authentic autonomy and minimises the occurrence of harm, it is important to emphasise the significance of the communicative process. In other words, authentic autonomy does not rest purely on the disclosure of contextualised and accurate information, but also underlines that 'communicative norms matter'.[629] With this expression it is meant that RMPs are called to engage in dialogue with women in a supportive and non-judgemental way. The values that the communicative process should embrace are:[630]

1) openness and respect - the standpoint of the communicative process should be an acknowledgement, whether expressed or not, of the personal and/or moral sensitivity of the matter and the need to respect different perspectives;

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626 Woodcock, (2011) *above*.

627See on this point: LL Littman, A Jacobs, R Negron, T Schocher, M Gold, M Cremer, 'Beliefs about abortion risks in women returning to the clinic after their abortion: a pilot study' (2014), *Contraception*, vol. 90(1), 19.

628 O'Neill O, 'Ethics of Communication' (2009), *European Journal of Philosophy*, vol. 17 (2), 167, 171-178. It should be clarified that O'Neill was critical towards IC. However, this section is considering her perspective as still relevant for an account of the norms of communication.

629 This point echoes O' Neill approach as clarified in the *Ethics of Communication* (2009), *above*, 172.

630 This point echoes also Wyatt in its proposal of a model of expert-expert relationship between RMPs and women considering an abortion. See: J Wyatt, 'Medical Paternalism and the Fetus' (2001), *Journal of Medical Ethics*, vol. 27 (2), 15.

2) honesty - duty holders should embark into a communicative process, which reflects the knowledge and experience they have, acknowledges possible shortcomings, and values each woman's unique standpoints.

It is possible that the standpoints from which RMPs and women might come from can differ. This asks the parties to build a communicative bridge between them, addressing variations in both circumstance and need. Take, for instance, a difference in moral viewpoints. Medicine, as Kennedy[631]argues, involves not merely technical questions, but also inevitably moral and ethical ones.[632] This is particularly so in the case of reproductive health and abortion in particular. It is undeniable that a decision concerning an abortion involves also considering personal values. It is further plausible that RMPs and women may find themselves holding different moral standpoints with some clinicians deciding for instance to exercise their right to conscientious objection to an abortion. However, beyond the spectrum of those holding a conscientious objection, the difference in moral viewpoint should be considered to be the beginning of a dialogical encounter rather than the end of a conversation.[633] Both parties should embark in the communicative process bearing this aspect in mind and starting an open and fruitful conversation from that point, while seeking to provide neutral advice.

In summary, it has been argued that it is ethically important to strive for supported decision-making in the form of disclosure of truthful, accurate, and non-misleading information, provided in a non-judgemental way and aiming at enhancing understanding. This position recognises abortion as a personal experience and aspires to facilitate, rather than impose on women, a supportive process that fosters authentic autonomy.

4.1 Facilitating authentic autonomy or limiting women's 'space of control'?

A further challenge that can be faced by the proposed approach, deals with the enhancement of autonomy itself. There might be a general fear that the suggested approach is no more than a tool to impose a specific choice upon women and hence to deprive them of their own 'space of control'. This section expands upon considerations

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631I Kennedy, *The Unmasking of Medicine*, (London: Granada,1983) 81-130. See also: J Wyatt , 'Medical Paternalism and the Fetus' (2001),*Journal of Medical Ethics*, vol. 27(2), 15.

632 See also on this point M Brazier , 'Do no harm-do patients have responsibilities too?' (2006), *Cambridge Law Journal*, vol.65 (2), 421, arguing that physicians are not merely technicians.

633 See on the moral dimension of an abortion discourse: D Callahan, 'An ethical challenge to prochoice advocates' (1990), *Commonwealth*, vol.23, 681, 685-686.

provided in Chapter 4 and 5. It offers a further clarification of the authentic autonomy approach and of the proposed changes within PG.

The fear that the proposed considerations for revisions of PG can lead towards the reduction of women's autonomy rather than towards its safeguarding might come from a misunderstanding of the meaning of authentic autonomy. This principle, in its instrumental dimension, calls for the creation of a supportive environment where a deeper level of agency can be facilitated. It does not ask to impose any specific decision on women, nor does it ask to deprive them of their decision-making role.[634] Rather, it calls upon RMPs to work on the background conditions that can unpack this result. In other words, it is key that RMPs not only disclose accurate and truthful information, but also work on the disclosure dynamics so as to enhance the possibility that this information is made, as much as this is possible, 'ready to be used' in the given circumstances.

The expression 'ready to be used' means in the end that RMPs need to work on the accessibility[635]of the information provided, together with the opportunity of engaging in dialogue, and signposting wider opportunities of emotional support. They should, for instance, convey information in a way that women, given for instance their educational and medical background, can understand and also make them aware of wider forms of emotional support (e.g., availability of counselling services).

Ultimately, if authentic autonomy is all about creating the conditions for a move beyond what was called in Chapter 4 a feeling of 'not having a choice, but to choose'[636] (i.e., a harm paradox), it is evident why it is important not simply to provide a list of information, but to enhance support. The existence of feelings of abandonment and lack of awareness of the choices on offer, as key problems in the abortion context, can best be tackled through the proposed considerations for revision.

Particularly, an ethical duty to enhance support is hence good in its instrumental dimension, not because RMPs impose a specific decision on women, but because women are provided with the tools to be safeguarded in an authentic autonomous decision. This concept claims that it is beneficial for most women to be supported in their decision-making process and to be valued not as mere empty decision-makers, but in their understanding of the information upon which to base a final decision.

The desire to enhance support will also necessitate at the more general level that there be a common effort to provide further wider support to women and families.

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634 This is understood in the context of the role attribute within the AA.

635 O'Neill O, 'Ethics of Communication' (2009), *European Journal of Philosophy*, vol. 17 (2), 167, 171-178.

636 N Priaulx, *The harm paradox: tort law and the unwanted child in an era of choice* (London: Routledge, Cavendish,2007)141-160.

Enhancing support, as Halliday has also suggested, can well be brought into place 'for example by providing subsidized childcare, paid parental leave and more general support for families in the case of those who wish to continue the pregnancy […]'.[637] Enhancing support does not only mean making a space within PG for an enhancement of understanding and emotional support within the first medical encounter, but also encourages to work on the broader social conditions behind an unplanned pregnancy.

Ultimately the proposed approach is in line with the protection of a thick level of agency, which goes beyond the protection of self-determination alone. This is because it provides the opportunities to receive further support during the decision-making process in a medical context and minimise the risk of patients' abandonment.

5. Conclusion

This Chapter has sought to implement the considerations for revision as proposed in Chapter 5. It has focused on PG in the context of IC and abortion. It has asked two broad questions: how far PG embrace the framework proposed in Part 2, and how should they better implement this framework.

To answer these questions, Chapter 6 has firstly devoted its attention to the issue of information disclosure. It has argued that a key challenge for the protection of principles of partnership and authentic autonomy is the risk of unjustified non-disclosure of relevant information from RMPs. This has led to the consideration that PG should minimize this risk, enhancing clarity and consistency across PG as well as fostering RMPs' trainings.

The Chapter has then moved its attention to the issue of enhancement of patients' support in the abortion context. It has suggested that this should take at least two forms: enhancement of understanding of the information provided and enhancement of emotional support. Information disclosure means little if opportunities of further practical support are not enhanced.

Chapter 6 has then clarified that the potential harmful nature of the information disclosed is a key issue here. The suggested framework acknowledges this aspect and attempts to minimize it through a focus on the accuracy and truthfulness of information, and on communicative dynamics. This will help contain the risk of harming patients by sharing inaccurate information, while fostering empathy and dialogue between the parties. Furthermore, the proposed considerations for revision will not reduce women's

[637] S Halliday, 'Protecting human dignity: the dignity of choice and life' (2016), *Contemporary issues in law*, vol.13(4), 287, 322.

space of control, but will strive for a move from pure self-determination approaches to authentic autonomy.

It would also be advisable to create translation guidelines, in the form of briefings that RMPs can use to prepare for the first encounter. NICE and RCOG could hence envisage working together for the creation of unified documents which can spell out the suggestions proposed.

Ultimately, this chapter has sought to show that relevant PG have partially embraced the framework proposed in Part 2, but there is still a space for a clearer translation within future PG so as to better implement the principles of partnership and authentic autonomy.

Chapter 7

Conclusion

The journey conducted thus far, the thesis' contribution to knowledge, and the way ahead.

1. Introduction

Chapter 7 provides the concluding remarks of the reflection presented in the past Chapters, setting out the main contributions that this work has made to the fields of healthcare law and ethics. It argues that the neglected theme of decision-making process in the context of abortion in England and Wales is a problematic phenomenon that needs to be addressed. In light of the principles of authentic autonomy and partnership, as derived and adapted from the Supreme Court judgment in *Montgomery*, it claims that law and policy-makers should adopt a more process-orientated approach (i.e., 'how-approach'). This Chapter also explores possible limitations of this project and outlines future research paths that can drive implementation forward in the future.

2. The status quo

This thesis explores a phenomenon: the neglect of the decision-making process in the context of abortion in England and Wales. It has chosen the perspective of the first medical encounter as the first link in a chain of medical support that is, I suggest, often undervalued (see Part 1, Chapter 2[638]). The AA 1967 takes a medicalised approach to abortion requiring RMPs to certify in good faith that one of the legal defences listed in the Act is satisfied. However, there has been recent emphasis in England and Wales on the progressive reduction of medical involvement in abortion and a push to uphold access to abortion in a de-medicalised setting. The drawback of this approach is that it considers clinicians and patients as antagonists rather than partners and can result in undermining the positive contribution that they can make together during the decision-making process. This phenomenon of de-medicalisation can be supported recalling two examples explored through the thesis: firstly, the interpretation in common law and professional guidance of the requirement of good faith as laid down in the AA, together with the questionable practice of pre-signed notification form, can frame the consent

[638] This Chapter addressed the first research question namely, how far is the approach taken in relation to the common law in England and Wales on IC mirrored in abortion law and professional guidelines?

process as a mere formality and risk jeopardising an IC process; secondly, the progressive reduction of clinical involvement in the aftermath of the legalisation of 'home abortion' has signified that the procedure for part or all of an early term abortion happens in an unsupervised settings. True, these examples do not exclude clinical involvement. However, they risk sending the message that this involvement is of limited relevance. They also risk frame medical involvement as a conflict with patient rights. Finally, it suggests that prioritisation should be given to access-related concerns. De-medicalisation of abortion hence risks jeopardising the protection of the decision-making process and therefore of IC.

As showed in Chapter 2, the law of tort is of limited assistance in addressing the issue of the optimal decision-making process. Trespass to the person, for instance, can only guarantee that there are no abortions without consent, but not that an informed consent process is achieved. The law of negligence is also very limited in terms of potential claims. Challenges related to proving that the harm arising is causally related to the RMPs' lack of disclosure, limit the relevance of negligence generally and particularly in the context of abortion. However, the law of negligence, as it will be showed later, has and does provide a positive route for a reconsideration of relevant principles that can and should inform medical practice. This has been influential in the development of professional guidelines which increasingly recognise the importance of a positive relationship between patients and clinicians and the informative role exercised by the latter. Nevertheless, professional guidelines are often not clear both on the point of the 'what' to disclose, but more crucially, on 'how' to balance access related concerns with support and time devoted to the decision-making process.

3. How can *Montgomery* inform the context of abortion?

This *status quo* is in stark contrast with the progressive importance attributed to IC discourses in light of the judgment in *Montgomery*. As discussed in Chapters 3 and 4[639], *Montgomery* gives prominence to two principles in particular: partnership and patients' autonomy. This thesis has taken these principles and developed a theory with regard to each to enable them to be better and more consistently interpreted in law and guidance in the context of abortion. As discussed in Chapter 3, the partnership principle emphasises dialogue, support, and communication between the parties. Clinicians are to be framed as partners in the abortion context, not as antagonists. This means that,

[639] These Chapters constituted together Part 2 and addressed the second research question namely, why is a focus on the decision-making process important in the context of abortion and the first medical encounter?

starting from the first encounter, they should trigger an informative process which is both scientifically accurate and tailored in line with patients' needs, values, and vulnerabilities.

The second principle, patient autonomy, is much contested. The definition adopted in Chapter 4 requires that it does not lead to a consideration of patients as mere consumers. There is danger of such an interpretation due to reference to consumerism in *Montgomery*. In the abortion context, consumerism would risk leading to a focus on access per se, without a due weight given also to the decision-making dynamics. Authentic autonomy in this sense values not just the attribution of a decision-making role, but values also the process that brings the patient towards a more personal decision and partnership between patients and clinicians. The relevance of a focus on the decision-making process is framed as being particularly beneficial for those women who do not experience abortion as a 'choice', but feel that in light of an unplanned pregnancy, they have no choice but to accept an abortion. The proposed approach seeks to give space and time, especially, but not limited to, those patients with vulnerabilities, giving them the chance to be heard and considered not as a mere routine case, but as persons worthy of receiving informative support.

4. The contribution to knowledge

The first medical encounter is a key link in a chain of medical support to be offered in the abortion context (Chapter 2). This is because this specific encounter is vital for the pursual of partnership and authentic autonomy in the abortion context, that I have phrased as 'how-approach' in Chapters 3 and 4.

The current legal formulation of the AA in England and Wales, although formally medicalising abortion, has in recent times been subject to measures and pressures that undermine the involvement of clinicians in a partnership role with women. The first consideration for revision is an inclusion of a consent clause, which will strengthen the consent process in a criminal law context, as argued in Chapter 5[640]. RMPs, who are in charge of assessing the existence of the legal defences as set out by the AA, should be under a clear duty to also engage in a consent process. This approach will form the baseline for the safeguarding of the principles of partnership and authentic autonomy.

The law of negligence, and specifically the law related to non-disclosure of information about risks and alternatives, can be interpreted and developed in light of the

[640] Chapter 5, together with Chapter 6, formed Part 3 of this thesis and addressed the third research question namely what approach is needed to support the decision-making process in abortion in England and Wales?

proposed principles (i.e., 'how-approach') to clarify the informative role of RMPs. It is important that the first encounter between the RMP and a woman is a space where dialogue and communication should focus on disclosure of risks, benefits, and reasonable alternatives, which are to be framed considering both an objective medical evaluation and a more subjective patient-centred component.

A key role should also be played by professional guidelines on consent, as argued in Chapter 6. It is important that they:

a) better spell out the content of the disclosure process, enhancing its clarity and consistency, particularly concerning the differentiation between disclosure of variant treatments (abortion methods) and alternatives (wider pregnancy options);

b) support the existence of a face-to-face first medical encounter, but recognize that the role of telemedicine can be a helpful tool in exceptional circumstances (e.g. public health emergencies) which should not be abused. Telemedicine should be preferred for later forms of support as a tool to ensure continuity of dialogue between the parties, not as a form of trivialising medical involvement;

c) emphasize that clinicians should work on wider forms of support, communicating information in a way that patients can understand and signposting the availability of counselling services, together with the possibility to involve third parties during the medical encounter with the woman's consent. RCOG and/or NICE could issue translation guidelines, together with briefings and trainings to medical professionals to implement these revisions. These policy changes would also inevitably affect, *a cascade*, the inspection frameworks for private and public abortion providers issued by Care Quality Commission, since these are built upon relevant PG.

Considered together, these proposed considerations for revision will serve the purpose of moving from a focus on access-related concerns, to a model of revised medicalisation which addresses and promotes both partnership and the authentic autonomy of the patient.

5. Limitations

This research project is built on doctrinal and normative considerations as arising from the law of IC. The tenure of these arguments has not been tested via any empirical work. A way forward to implement and test this approach will be to embark on empirical studies that can better shed a light on the current *status quo* and test the proposed measures to ensure their efficacy in practice.

The considerations of revisions outlined for the limited context of the first medical encounter, can be then complemented by an analysis of the broader decision-making process in the abortion context. An exploration of both subsequent forms of care and the interplay between the role of RMPs and other medical staff in the decision-making process can be also further analysed in future research.

Additionally, the relevance attributed to the 'how-approach' in the context of abortion, can also be further expanded and its application proposed in wider healthcare law contexts. An interesting development for this project would also be, for instance, an exploration of the role of IC in the context of COVID-19 vaccines provision.

6. The way ahead

This project recognizes that the issue of abortion is not 'solely' medical, yet it highlights that this should not count as a justification for reduction of medical involvement, if IC wants to be safeguarded. De-medicalization, as an expression of the desire to privatize abortion, has as its starting point the safety of abortion and the willingness to increase patients' self-determination. However, clinicians' role in the IC context, goes beyond the protection of safety to also encompass an advisory role. Also, autonomy as self-determination does not encapsulate necessarily the experience of every patients and is ill-placed for those who experience vulnerabilities. This understanding of autonomy can often become a vice for a form of patient's abandonment. The way ahead, which should be embraced by both law and professional guidelines, is hence a form of revised medicalisation, which better calibrates medical advisory role and patients' needs and values.

This project hence aims to leave the reader with a simple, but clear statement: the time spent in a fruitful communication between women and RMPs in the abortion context is time of medical care. The time spent informing the patient is not to be framed as an obstacle to access related concerns, or a way to impose a decision on the latter, conversely it is an expression of medical care which values a partnership between clinicians and women and that safeguards women's authentic autonomy.

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