

THE RIGHT TO LIFE AND ABORTION LEGISLATION IN ENGLAND AND WALES: A PROPOSAL FOR CHANGE

- Jan Deckers -

1. Introduction

As in many other countries, there is significant debate in England and Wales on the law related to abortion. The views of ethicists vary between those who think that the legal grounds for abortion should be changed to allow women more freedom regarding whether or not to have an abortion and the views of those who think that abortion should be restricted further. A lot of discussion has focused on the question if unborn human beings should be granted (full) moral status or the *prima facie* right to life. In recent years, however, a fair amount of discussion has taken place on the health professional's right to conscientious objection in relation to the question if they should be allowed to refuse to provide abortion services. With regard to the right to conscientious objection, the views of ethicists range between those who hold the position that, in many situations, personal opinions should be set aside, and those who think that professional obligations should hardly ever be allowed to override one's personal conscience.¹ Discussion on the right to conscientious objection in relation to the provision of abortion featured in a public consultation launched by the General Medical Council and in its subsequent report on 'Personal Beliefs and Medical Practice', as well as in a House of Commons Science and Technology Committee report reviewing abortion legislation.² The issue is by no means absent from legal discussions that are taking place elsewhere. A 2007 issue of the *American Journal of Bioethics*, for example, was dedicated largely to the right to conscientious objection in relation to the prescribing and providing of "emergency contraception".³

This paper is written from the perspective of a scholar who adopts what might be called a pro-life position, as I hold the beliefs that human embryos are

¹ An example of the former position is Savulescu [2006]. An example of the latter is Pellegrino [2002].

² General Medical Council [2008] para. 26; House of Commons' Science and Technology Committee [2007] Vol I: para. 101.

³ Several commentaries were published in response to Card [2007].

persons from conception and that they should be granted the same *prima facie* right to life as all other human beings. While many have defended such a position in the literature, no systematic proposal to modify legislation on abortion in England and Wales appears to have been developed from such a perspective. This paper aims to fill this gap by developing a unique proposal to modify abortion legislation in England and Wales. In addition, I hope that my proposal will also inspire legal debate and reform elsewhere. Following the introduction (part 1), this paper will engage first (in part 2) with the issue that has been the subject of intense debate in recent times: the legal interpretation of the right to conscientious objection in relation to the provision of abortion services. Many health professionals appeal to this right to give recognition to their belief that unborn human beings should be granted the *prima facie* right to life. Having explained that health professionals in England and Wales are bound by a duty of care towards their patients and that they also have a limited right to conscientious objection, I discuss the scope of this right in relation to the provision of abortion services. I conclude that more clarity is needed in relation to which services health professionals can and cannot refuse, and that a smaller proportion of health professionals may object to participating in the provision of abortion if the law is changed. In part 3, I make a moral case for a substantial change in abortion legislation, based on the belief that unborn human beings should be granted the *prima facie* right to life. Contrary to a widely held view, I argue that, if such a position were to underpin the law, not all abortions would be immoral. Rather, I argue that some would be justifiable, and that health professionals should not be allowed to object to providing some abortion services.

2. Duty of care and conscientious objection in relation to abortion

Under the English and Welsh law of tort, people must exercise reasonable care whenever they perform activities that might foreseeably harm others. Such a duty of care does not extend to anybody and everybody, yet only to those who are in a relationship of "neighbourhood".⁴ While health professionals must reach a certain standard of care, they can only be found liable in negligence if the existence of a duty of care towards a particular patient has been established, and if there has been a breach of that duty. The General Medical Council, the body regulating the medical profession in the United Kingdom of England, Wales, and Northern Ireland (under the Medical Act 1858 and the Medical Act 1983) is unequivocal about the doctor's duty: "Your first duty as a doctor is to make the care

⁴ Donoghue [1932].

of your patient your first concern."⁵ When a health professional is charged with a breach of duty, two different defences could be mounted. He could concede that he had such a duty, but that he never breached it. Alternatively, he could argue either that there was no such duty, or that the *prima facie* duty which he had was overridden by another duty with greater moral weight. The latter defence is based on a conscientious objection. I define a conscientious objection broadly as an objection whereby a person refuses to perform a particular action (needed or desired by another party) because she is, after some reflection, not convinced that it would be good to perform that action.

The right to conscientious objection appears to be protected by various legal declarations, including the United Nations' Universal Declaration of Human Rights and the European Convention on Human Rights. The latter formed the basis of the Human Rights Act 1998, which includes the following article: "Everyone has the right to freedom of thought, conscience, and religion; this right includes freedom ... to manifest his religion or belief, in ... practice and observance."⁶ However, the right to "manifest" one's belief is limited "for the protection of ... health or morals".⁷ If we apply this to the professional context in which health care professionals are situated, it can be said that a health care professional's duty of care must not be compromised unjustifiably by her right to conscientious objection. More specifically, it has been argued that for a health carer's conscientious objection to have any moral and legal weight, the objection must be based on "core values in medicine", and that the objection must be raised "in relation to controversial and contentious issues".⁸ Health carers must meet a certain standard of care regarded as appropriate by the law and the body or bodies that regulate them, which may override their right to conscientious objection.⁹

The General Medical Council recognises the doctor's right to conscientious objection. However, it also stipulates that doctors "have an overriding duty to provide care for patients who are in need of medical treatment".¹⁰ While the nature of such care has not been specified, the question must be asked if it might include

⁵ General Medical Council [2008] para. 17; Medical Act 1858; Medical Act 1983.

⁶ Human Rights Act 1998, art. 9 para. 1.

⁷ *Ibidem*, art. 9 para. 2.

⁸ Wicclair [2000] p. 205.

⁹ Whether or not the doctor was negligent would depend – by and large – on conformity with the principle set in *Bolam* [1957].

¹⁰ General Medical Council [2008] para. 25. In para. 21 it is stipulated that this includes that doctors must "ensure" that patients have "sufficient information to exercise" their "right to see another doctor", and in a footnote the provision of "contact details of an alternative doctor who is known not to hold the same conscientious objection" is mentioned as an example.

the provision of abortion services, since England and Wales have already developed legal guidance stipulating the circumstances under which appropriately qualified health professionals can be called upon to provide such services. The Human Fertilisation and Embryology Act 1990 section 37, which amends the Abortion Act 1967, lists the grounds on which a pregnancy can be legally terminated.¹¹ If the law could be interpreted as giving women the right to have an abortion provided they meet any of the legally recognised grounds, doctors would seem to have a difficult job at justifying decisions to opt out of providing services which women are entitled to. Or would they? The answer to this question would depend, at least in part, on the question if this putative right would be a negative or a positive right. If it is a negative right, health professionals would only need to make sure that they do not stand in the way of women who possess such a right. They would merely have a duty to make sure that they do not try to prevent any women who possess such a right from having an abortion. In other words, no conflict between the existence of such a right and the health professional's right to conscientious objection to providing an abortion would exist, unless the objection was to the abortion being carried out by anyone. In order for there to be a conflict between the existence of such a right and a health professional's objection to participating in the provision of abortion services, a necessary condition would be for such a right to be a positive right. Those who appeal to a right to abortion may assume that such a right should be understood in terms of a positive right, perhaps on the basis of the view that many abortions require help from appropriately skilled health professionals to carry out the necessary procedures in order for these to be carried out safely. If the inspiration for this comes from an interest-theory of rights, such as the one proposed by Joseph Raz, it could be argued that one's interest in receiving professional help with abortion can be sufficiently great to ground a legal right to receive such help in particular circumstances.¹² On this basis, it might be concluded that, if some women have a right to abortion in some situations, at least some appropriately qualified health professionals must have a corresponding duty to provide those services, at least in situations where it would not be acceptable for the woman to carry out the abortion herself.

In a thought-provoking article, Julian Savulescu has suggested (albeit not consistently) that it would be correct to assume that some women in England and Wales possess such a right.¹³ Savulescu takes issue with the existence of a right to

¹¹ Human Fertilisation and Embryology Act 1990, s. 37.

¹² Raz [1986] p. 166.

¹³ Savulescu [2006].

conscientious objection in general, as well as with the specific provision that is provided in clause four of the Abortion Act 1967, which stipulates that, subject to a particular exception, "... no person shall be under any duty ... to participate in any treatment authorised by this Act to which he has a conscientious objection".¹⁴ In Savulescu's view, health professionals should provide the abortion services which he believes women are entitled to, irrespective of their personal views. For Savulescu's legal interpretation to make sense, two conditions would need to apply. The first condition is that, if it is correct that some women possess a positive right in some situations, it would be necessary to conclude that this would imply that all health professionals have a corresponding duty, irrespective of their personal views. However, one need not necessarily imply the other. While the existence of an unconditional right implies the existence of an unconditional duty, it does not imply that everyone should be bound by such a duty. As has been remarked correctly by Daniel Hill, the state could also decide to allow health professionals the freedom to opt out, as long as it felt that this would not undermine its duty to any woman with a positive right.¹⁵ The second condition is that the law could be interpreted as providing women with a positive right, at least in some situations. The concept of a positive right is understood here to be a right to be provided with something by someone else. In this case, it would be a right to receive help to have an abortion. The problem is that such a right is not provided by the legal framework in England and Wales. Neither the Abortion Act 1967 nor the Human Fertilisation and Embryology Act 1990 give women the right to have abortions.¹⁶ Rather, the law specifies some situations where abortion is decriminalised. Therefore,

I take it that the correct legal interpretation is that health professionals are not "under any duty" to provide or even participate in the provision of abortion services, subject to the exception set out in section 4(2) of the Abortion Act 1967. Here, it is stipulated that the conscientious objection clause does not apply where a duty exists "to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman".¹⁷ It does not state, however, that such a duty would spring forth from the

¹⁴ Abortion Act 1967 s. 4 para. 1; I shall not deal here with the interesting question of why the legislator did not simply rely on the recognition of a general right to conscientious objection, but felt the need to articulate a specific right to conscientious objection in relation to abortion.

¹⁵ Hill [2010] p. 348.

¹⁶ Many legal scholars support the view that this is a correct interpretation of the law. See for example McLean [1992] p. 100; Brazier, Cave [2007] p. 354; Mason [2007] p. 26.

¹⁷ Abortion Act 1967 s. 4 para. 2.

recognition of a woman's positive right. A lot of debate has taken place on the question if the provision of some abortion services, for example referring a patient to an abortion clinic or to a consultant, would be included within the meaning of the words "participate in any treatment".¹⁸ In the case of *Barr v. Matthews*, Alliot J. expressed the view that "once a termination of pregnancy is recognised as an option, the doctor invoking the conscientious objection clause should refer the patient to a colleague at once".¹⁹ Also, the National Health Service (NHS) (General Medical Services Contracts) Regulations 2004 state that "a contractor whose contract includes the provision of contraceptive services shall make available to all its patients who request" a termination of pregnancy "prompt referral to another provider of primary medical services who does not have" a conscientious objection "where the contractor has a conscientious objection to the termination of pregnancy".²⁰ It would therefore seem to be illegal for any "contractor" (for example, an individual general practitioner or a general practice) who offers contraceptive services to refuse to refer a pregnant woman who seeks an abortion to another GP.

I believe that this legal situation is unsatisfactory on two counts. Firstly, as the law stands, women still depend entirely on decisions made by health professionals or the courts to determine the question of whether or not a duty to carry out an abortion exists. If women were given a positive right to an abortion in some situations, however, it would give clear backing to the view that their right should prevail in those situations. The question of which situations should qualify will be addressed in the next part. A second reason relates to the fact that, while the law recognises that it is acceptable to refuse to participate in many abortions, it also stipulates that some people have a duty to refer people on. This situation has been challenged by Daniel Hill, who has argued that, given that "any consistent person opposed to" carrying out a particular abortion "will also be opposed to being an

¹⁸ The case of *Janaway* [1988] describes a case of a secretary who sought judicial review of her dismissal by the Health Authority after her refusal to write a letter of referral for an abortion on conscientious grounds. The case illustrates that people who are not directly involved with carrying out the abortion may nevertheless perceive that they might be "participating" by carrying out certain duties, for example administrative duties, that arise by the abortion request. For a discussion, see Foster [2005]. While there are no data on the question if significant numbers of doctors in England and Wales might object to referring for an abortion or to engaging in other activities related to it, a 2007 survey reported in the *New England Journal of Medicine* sparked significant debate on this issue as it was found that many doctors in the United States of America did not consider that they had a duty to "refer patients for legal but morally controversial medical procedures" (Curlin, Lawrence, Chin et al. [2007] p. 593.). For further discussion, see Hill [2010] pp. 345-346.

¹⁹ Barr [1999] p. 227.

²⁰ The National Health Service (General Medical Services Contracts) Regulations 2004, s. 3 para. 1 and s. 4 para. 2.

accessory in any way" to that abortion, "there should be exemption from any kind of participation" in abortions other than those one is not legally allowed to object to participate in.²¹ The need to address this situation is all the more urgent in light of the fact that a 2007 report by the House of Commons' Science and Technology Committee acknowledges that a significant proportion of health professionals in England and Wales are unhappy to be involved in abortion services.²² This suggests that many have moral objections to the current law.

In the remainder of this paper, I shall propose a comprehensive review of the law on abortion in England and Wales from the perspective that unborn human beings should be granted the equal right to life that is possessed by other human beings, thereby distinguishing between situations where the right to conscientious objection should be allowed to trump a request for abortion services and situations where it should not. While my proposal may not resolve existing disagreements in relation to conscientious objection and abortion, I aim to achieve three things. Firstly, some of the arguments that will be developed to criticise existing abortion legislation may explain why many health professionals object to participating in the provision of some abortion services, and the proposed alternative may inspire them to reconsider their refusals. Secondly, I hope that those who show little understanding of the views of health professionals with conscientious objections to providing abortion services, especially those who think that there should be no such thing as a right to conscientious objection, might come to understand why some health professionals object to providing some abortion services. It may become clear that some objections are not based on trivial considerations, yet on what Wicclair has referred to as "core values in medicine", such as a belief in the great moral significance of all human life.²³ Finally, I hope that my proposal will provide a new perspective that will stimulate further discussion and revision of abortion legislation, both in England and Wales as well as elsewhere.

3. How should abortion legislation in England and Wales be modified?

Firstly, whereas the Universal Declaration of Human Rights and the European Convention on Human Rights have proclaimed that, respectively, "everyone has the right to life" and "everyone's right to life shall be protected by law", I take issue with the fact that the law in England and Wales – as well as the law in many

²¹ Hill [2010] p. 347, 349.

²² House of Commons' Science and Technology Committee [2007] Vol I: para. 101. See also Lee, Clements, Ingham, et al. [2004].

²³ Wicclair [2000] p. 217.

other countries – does not apply this notion to unborn human beings.²⁴ Rather, the basic premise from which I start – which I have developed elsewhere – is that unborn human beings should be given the *prima facie* legal right to life from the moment of conception.²⁵ This is the logical consequence of the view that no morally relevant distinction should be made between a zygote, a two week old fetus, and a newborn child. Few contemporary scholars in England and Wales appear to adopt this view. A possible exception is John Mason, a scholar based at the University of Edinburgh, who has made the vague claims that he supports "fetal rights" and that "there is no logical reason to accord" unborn human beings "a different respect based on" their "age" or on the basis of different "stages in fetal development".²⁶ One reason why many scholars might oppose the attribution of the right to life to unborn human beings may relate to the perception that, should this view be adopted, all abortions should be objected to. For example, in their report on stem cell research, the House of Lords' Select Committee expressed the view that "if an embryo had full human rights it would be inconsistent to do anything that had the effect of destroying it".²⁷ Later on, I shall challenge this view, arguing that even those who adopt a pro-life position should not be allowed to object to providing some abortion services.

Secondly, it has been claimed that "only a ruthless hard-liner or an extreme religious bigot could now seriously argue that women ought to be forced by law

²⁴ Universal Declaration of Human Rights, art. 3; European Convention on Human Rights, art. 2. For an example of how the courts have decided not to apply this notion to unborn human beings, see Paton [1979].

²⁵ Deckers [2005] pp. 251-271.

²⁶ Mason [2007] pp. 16-17. Mason is, however, inconsistent with this position, by arguing also that "it is at the point of implantation that meaningful human life begins" (p. 17). He arrives at this conclusion by means of a flawed argument. Mason claims that the pre-implantation embryo has no future unless it adopts the uterine environment. While it is true that the early embryo needs to implant in order to develop, Mason draws an analogy between the natural process whereby embryos inside women's bodies implant and the situation in which in vitro embryos find themselves. A crucial difference is thereby ignored, as only the latter require the intervention of an external agent to realise their capacity to implant by being transferred into the female body. Mason then claims that their not being in the right place for further development should count against their having acquired full moral status. Yet it is hard to see how this should count against embryos conceived inside women's bodies, who – as a matter of speaking – only need to travel to the next room. With regard to in vitro embryos, many people who adopt a pro-life stance would argue that they are already valuable for what they are, irrespective of whether or not they will be allowed the chance to develop valuable futures. Moreover, unlike an implanted embryo, a newborn child is like an in vitro embryo in the sense that – to use the words of Mason – "left undisturbed, its only destiny is death" (p. 17). Therefore, the sheer fact that both require active decisions from their carers to develop their potential can hardly be used as a reason for giving them less respect compared with implanted embryos.

²⁷ House of Lords' Select Committee [2002] para. 4.23.

to continue with pregnancies that were likely to result in the birth of a severely handicapped child".²⁸ While I have no ambition to be regarded as either of these, my view, with reference to paragraph 1 (d) of section 37 of the Human Fertilisation and Embryology Act 1990, is that abortions should no longer be allowed on the basis of the possibility that there might be "a substantial risk" that the fetus would be "seriously handicapped".²⁹ I come to this conclusion because allowing abortions on the ground that the fetus might be "seriously handicapped" provides a legal justification for discrimination against 'disabled' fetuses.³⁰ I can find no good reason why people born with 'disabilities' should lack the right to life that we normally grant to more 'able' people. By analogy, it is not clear why 'disabled' fetuses should be granted fewer moral entitlements than more 'able' fetuses.

I shall briefly consider two common objections against this position. Firstly, some might argue that the reason why we should allow the abortion of 'disabled' fetuses is to avoid imposing unjustifiable burdens on those who would need to look after them should they be born, rather than the fact that they are 'disabled'.³¹ The problem with this view is that it is not clear why 'disabled' fetuses should be allowed to be discriminated against on the basis of the view that caring for them might be too burdensome. While those who become 'disabled' later on in life are often treated as inferior compared to those who are perceived to be more 'able', those who defend the rights of 'disabled' people have often defended the view that they should be regarded as persons with equal rights, in spite of the fact that they might need more support from other people. If their claims are valid – which I think they are – I fail to see why discrimination against 'disabled' fetuses should be allowed on the basis of the fact that they might require more help.

A second objection is that this position ignores the possibility that the life of a 'disabled' child may be so miserable as a result of the nature of the 'disability' that it would be better for the child not to be born with that condition in the first place. This is what is alleged in what have been called 'wrongful life' claims.³² Sev-

²⁸ Simms [1998] p. 7.

²⁹ Human Fertilisation and Embryology Act 1990, s.37 para. 1 (d).

³⁰ The quotation marks used around the word 'disabled' refer to the well-documented controversy about what 'disability' actually is. See for example Scott [2005] p. 394.

³¹ Ann Furedi, for example, has claimed that a woman who is pregnant with a "disabled" fetus is like "an animal caught in a trap". See Furedi [1998] p. 168. In many countries, damages can be awarded to those suffering from negligence resulting in the birth of a disabled child. This is what is alleged in what have been called 'wrongful birth' claims. The first case documented in the British legal literature is Salih [1990].

³² The first English case was the case of Mary McKay, which was heard in the Court of Appeal in 1982, whose claim of negligence rested on the fact that she had been born as a severely disabled child following a failure to detect rubella infection in her mother's blood sample during her preg-

eral legal scholars have shown support for this view, including Rosamund Scott, who claims that, while "someone with strongly 'pro-life' views would disagree ... it is not in the interests of a foetus who would develop Tay-Sachs as a born child to be born", and that aborting the lives of those who would experience "a very great degree of suffering" if they were born should be "legitimate", perhaps even "morally required".³³ In response, it must be recognised that the same reasoning would justify the killing of children after birth whose lives are deemed to be too miserable to be considered worthwhile. Indeed, if the emphasis is placed on measuring the nature and degree of a child's 'disability' and associated misery, such a position would logically require that the scope for killing 'disabled' young children should even be greater compared to the scope for killing 'disabled' fetuses. This would give recognition to the fact that, in many situations, the nature and degree of a fetus's 'disability' cannot be assessed satisfactorily before the child is born – at least if the assumption is made that it can be assessed with a reasonable degree of accuracy at all. The question must be asked if the killing of such children and fetuses either to end (what others perceive to be) their miserable lives or to prevent them from becoming miserable should trump their *prima facie* right to life. While I do not deny that some fetuses and children may experience a lot of pain in their short lives, I do not agree with the view that others should be allowed to kill them on the basis of their view that their lives are not worth living.³⁴ Therefore, it is my view that the second objection fails as well.

Thirdly, abortions on fetuses who could survive outside the womb – sometimes referred to as 'viable' fetuses – should no longer be allowed. Since they are morally equivalent with the killing of newborn children, I find that such abortions are deeply problematic. When there are no developmental differences between two fetuses, it is hard to understand why (even on a 'gradualist' account of moral status) it should be acceptable to give one the right to life as soon as it has left the womb, while it should also be acceptable to kill the other provided the killing oc-

nancy. The claim was unsuccessful. See McKay [1982]. A case which came to the Court of Appeal in The Hague and which was successful upon appeal in the Hoge Raad of the Netherlands was the case of Kelly Molenaar, who was born with a severe chromosomal disorder following a midwife's failure to provide appropriate information in relation to amniocentesis. See LJN [2005]. See also Sheldon, [2005].

³³ Scott [2005] pp. 395-396.

³⁴ However, it is my view that there may be situations where treatment must be withheld or withdrawn. See also Nuffield Council on Bioethics [2006]. I agree with the Council's position regarding newborn children by holding the view that, while withholding or withdrawing treatment may be justified in some situations, actively ending a life that is regarded as "intolerable" cannot be justified.

curs before the fetus has left the womb. If the ground on which a termination of a pregnancy is requested when it involves a fetus who could survive outside the womb is recognised as legitimate, the termination should occur without the fetus being killed so that the fetus can be given the same standard of care that is provided to other prematurely born babies. Exceptions to this rule should only be made in situations where there would be a significant risk of death or serious, lasting harm if methods aimed at birth were used rather than methods aimed at killing.

Fourthly, fetuses who are approaching the stage of being able to live outside their mother's womb should not normally be allowed to be aborted unless the abortion "is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman", as stipulated in the Abortion Act 1967.³⁵ For cases where abortion is needed to save women's lives, women should be given a positive right to abortion services and – as is currently the case – appropriately qualified health professionals should not be allowed to object to providing such services. This view does not stem from the conviction that the woman's status is greater than the fetus's, yet from the conviction that it is better to save one life rather than to risk losing both. What must also weigh in the balance is the fact that the woman has responsibilities and emotions (such as, for example, fear of death) which the fetus does not have. While these factors must also be taken into consideration when there is no significant risk of death, yet a risk of "grave permanent injury" to the woman's health, I find that it is more difficult to decide how such situations should be resolved. Since I am unsure about whether or not it is acceptable to kill a fetus "to prevent grave permanent injury" to a woman's health, I do not agree with the current legal position which does not allow health professionals the right to conscientious objection in such situations. At the same time, I have developed the point elsewhere that some abortions "to prevent grave permanent injury" to a pregnant woman's health may be justifiable.³⁶ While I do not wish to labour on this point here, I think it is reasonable – where a woman becomes pregnant without having consented voluntarily to intercourse or at a time when it was not known that sexual intercourse could lead to pregnancy – to take into account that in such situations there is no chance that the possibility of becoming pregnant could have been accepted freely. While such pregnancies might be associated with very traumatic experiences if they are unwanted, I take it that – despite John Mason and Graeme Laurie's contention – it is

³⁵ Abortion Act 1967, s. 4 para. 2. See also Human Fertilisation and Embryology Act 1990, s. 37 para. 1 (d).

³⁶ Deckers [2007].

by no means "obvious that the mental health of a woman who is carrying an unwanted pregnancy must suffer more damage if she is forced to carry her fetus than it would" if "she were relieved of her burden".³⁷ Either way, the argument could be made that women should not be expected to continue with a pregnancy when they have not had the chance to accept exposing themselves to the possibility of becoming pregnant. The crucial question is whether the benefits of terminating such pregnancies outweigh the costs. The benefits might be measured mainly in terms of an anticipated improvement in mental health and of being relieved from the responsibility of supporting someone one has never chosen to care for, while the costs might be measured mainly in terms of the killing of a human being and the possibility that further distress may be suffered by the woman and by others involved.

Some health professionals might argue that they should not be expected to help women to terminate such pregnancies, as they might deem that the costs outweigh the benefits. If there is a significant degree of controversy about how this calculus should be resolved, my view is that the views of those health professionals who object should be respected. If too many object, the argument could be made that allowing them to refuse involvement with the provision of an abortion in such situations would be indefensible on the basis that it would increase the burden on the pregnant woman concerned, as well as on health professionals who do not object to providing help in such situations. However, I am not convinced by this argument. The possibility that many might object would indicate that there is a significant degree of controversy amongst health professionals over the question if such abortions are ethical. Since the culture of medicine – and perhaps especially of obstetrics and gynaecology – might be aligned more with the beliefs of those who have relatively few objections than with the beliefs of others, public controversy might be even greater at times when many health professionals are at odds with one another. Therefore, if a significant degree of controversy exists over the question if abortions should be offered to women who find themselves in situations like these, I believe that the right to object in such situations should not be overridden. Should it be decided democratically that the degree of controversy is insufficient to warrant belief that the benefits of doing so outweigh the costs, I believe that it would then be appropriate to remove the health professional's right to object. At the present time, many health professionals in England and Wales adopt the view that abortions "to prevent grave permanent injury" to

³⁷ Mason, Laurie [2006] p. 145.

a pregnant woman's health are justifiable. On this basis, I would suggest that, while health professionals should be allowed to refuse to carry out abortions in such situations, they should not be allowed to refuse referring women to others who can provide the abortion.

Fifthly, all else being equal, there should be slightly more scope for the abortion of at least some younger fetuses. The risk of a pregnancy being experienced as traumatic for the reasons mentioned before may be greater the further the pregnancy is removed from the potential moment of birth. The moment of birth is relevant as it marks the moment when the fetus is no longer reliant exclusively on the mother's body. Therefore, even if a child had been created without the woman's consent to intercourse, infanticide would be morally wrong, since society should make sure that a born child does not depend exclusively on the mother for support. However, because a younger fetus is reliant exclusively on the body of their mother for a longer time compared to an older fetus, women who have become pregnant without having consented to sexual intercourse and who struggle to cope early on in their pregnancies may be more likely to sustain "grave permanent injury" compared to women who have fewer problems early on, yet struggle to cope later on in their pregnancies. The latter group are closer to the point of no longer being 'singled out', the moment when the fetus could be born to live, having developed the capacity to live outside their mother's body. While women from both groups might feel equally strongly that they wish to terminate their pregnancies, it is my view that health professionals are more justified in the carrying out of abortions on women who are in the early stages of pregnancy when they are at greater risk of sustaining "grave permanent injury".

In addition, there is another reason why at least some early abortions can be justified more easily: while both early as well as late abortions require the involvement of third parties, the nature of this involvement can be different. Some early abortions, for example so-called 'medical abortions', could be carried out by the women themselves. While this possibility does not absolve those who provide the 'medicine' from responsibility, direct responsibility lies with the proximate cause, that is, the person who carries out the abortion. While abortions that are carried out by third parties need to satisfy the consciences of the women involved as well as the consciences of the third parties, abortions that are not carried out by third parties do not require the same level of justification from them. By analogy, there may be situations where parents do not agree with their children's choices, but would still find it acceptable to facilitate their children in the making of those choices. Or, to use another analogy, while a weapons manufacturer can be held

accountable for what happens with the weapons he produces, the primary responsibility lies with the people who use them.

Sixthly, we should rid ourselves of the present legal anomaly whereby women are allowed to choose to use contraceptives which can have an abortifacient effect, but are not allowed to choose to have what is legally defined as an abortion unless either one or two medical practitioners agree that the woman's request satisfies a legally recognised ground. A report by the House of Commons' Science and Technology Committee has recommended having "the requirement for two doctors' signatures removed".³⁸ However, since I subscribe to the view that all human life is precious, I find the view that women should be allowed to decide unilaterally to have an abortion unacceptable. I do not agree with the view, expressed by Ellie Lee, that leaving the ultimate choice with the health professionals "degrades women", at least for those abortions that require to be carried out by health professionals and that one should be allowed to object to.³⁹ Irrespective of whether or not the abortion is carried out by health professionals, it is my view that – other than in emergency situations to save the woman's life – it should be required that, apart from the health professional(s) carrying out the abortion, two people agree with the woman, in a meeting or 'pregnancy counselling' session involving the three parties, that the ground on which the abortion is requested is legitimate. Apart from increasing the chance of the fetus being adequately protected, such an arrangement might help to lighten the burden on the pregnant woman, thus helping her to come to terms with the decision, whatever decision is made. It might also help the health professionals who carry out the abortion to decide whether or not to go along with the decision reached in the pregnancy counselling meeting(s), especially when they doubt the legitimacy of the ground on which the abortion was requested.⁴⁰ The structure of such pregnancy counselling meetings will be discussed when I make my final point. For now, I conclude that, if the assumption is made that very young human beings ought to have the *prima facie* right to life, it is not appropriate to leave the decision of whether or not to kill them entirely to the discretion of one person.

This takes me to my seventh consideration. We should ban the use of all contraceptive pills and other contraceptive methods that have potential abortifa-

³⁸ House of Commons' Science and Technology Committee [2007] para. 99.

³⁹ Lee [1998] p. xiv.

⁴⁰ Incidentally, the view that one signature would be sufficient has also been opposed by those who adopt a 'pro-choice' position, for example by Des Spence who has argued that the requirement to have two signatures provides "a broader support" and "a balance and check" for the woman and "means that an onerous responsibility is shared between professionals" (See Spence [2007]).

cient effects, and reserve the use of (what are inaccurately called 'contraceptive') pills that are used after sexual intercourse and that aim to prevent implantation to situations that satisfy the legal grounds for abortion. This proposal differs significantly from the present situation, since 'contraceptive' methods with the ability to prevent implantation do not even require to fulfil any of the grounds on which abortion can be allowed. This is so because the Human Fertilisation and Embryology Act 1990 claims that, "for the purposes of this Act, a woman is not to be treated as carrying a child until the embryo has become implanted".⁴¹ Therefore, I understand that the Human Fertilisation and Embryology Act 1990's implicit assumption is that a termination of pregnancy can only occur to those who, "for the purposes of this Act", can be said to be "carrying a child". Since it is a widely held view that normal pregnancies (those which do not follow on from *ex utero* conception) start at conception, rather than at implantation, this is a piece of legal tinkering *par excellence*.

This leaves open the question if those who use birth-control methods that may prevent implantation can be found guilty of an offence under the Offences against the Person Act 1861 sections 58 and 59. The crime consists in the supply or use of any method used "with intent to procure the miscarriage of any woman, whether she be or not be with child".⁴² Mason and Laurie mention a case (*R. v. Dhingra*) where a judge (Wright at Birmingham Crown Court) dismissed a charge under this Act by arguing that a woman cannot be regarded as pregnant before the completion of implantation.⁴³ The same case is discussed by Kennedy and Grubb, who cite a number of other texts in support of this view, including a letter sent by the 1983 Attorney-General Michael Havers to the House of Commons. Interestingly, Havers uses what I have termed the "argument from probability" (or 'probability fallacy') to support his view that preventing implantation "does not constitute a criminal offence within either section 58 or 59 of the Offences against the Person Act 1861". Havers claims that, since there is a significant probability that early embryos may naturally fail to implant, it would not be appropriate to use the word "miscarriage ... to describe a failure to implant", and therefore one could not "procure a miscarriage" by preventing implantation.⁴⁴

⁴¹ Human Fertilisation and Embryology Act 1990, s. 2 para. 3.

⁴² Offences against the Person Act 1861, ss. 58-59.

⁴³ Mason, Laurie [2006] p. 155. Reference is made to *R* [1991] p. 5.

⁴⁴ Kennedy, Grubb [2000] p. 1413. Reference is made to 42 Parl Deb HC 238 at 239. Incidentally, Kennedy and Grubb do not seem to be aware of the fact that many, if not all, 'contraceptive' pills can also prevent implantation (p. 1410).

This account has serious legal and moral problems. Legally, it seems dubious, to say the least, to suggest that the way in which the legislators behind the Offences against the Person Act 1861 understood the word "miscarriage" was such that the term could not apply to the prevention of implantation of the early embryo.⁴⁵ And morally, Havers commits the probability fallacy by suggesting that, since the probability that an early embryo may naturally fail to implant might be high, the destruction of unimplanted embryos should be less problematic compared to the destruction of implanted embryos. The problem with this view is that it is not clear why, *ceteris paribus*, the destruction of those who have a low probability of surviving beyond a certain stage should, *ipso facto*, be more acceptable compared with the destruction of others.⁴⁶ In spite of these problems, Kennedy and Grubb proceed to claim that the views expressed by Havers and by Wright in the case of *Dhingra* "conform with a common-sense understanding of the word 'miscarriage'", and even that the view in section 2 paragraph 3 of the Human Fertilisation and Embryology Act 1990 "is highly persuasive when interpreting the scope of the 1861 Act".⁴⁷ More recently, the interpretation adopted by the judge in *Dhingra* was supported also by the High Court judge Munby in the more significant case of *Smeaton*.⁴⁸ Munby's judgment has been questioned by John Keown, who refers to an overwhelming body of evidence to argue that neither the view that the Offences against the Person Act 1861 prevents the concept of "miscarriage" from being applied to the pre-implantation embryo nor the view that – to use the words of Munby – there is "no substantial dispute" that the current meaning of "miscarriage" is the "termination of ... a post-implantation pregnancy" can be maintained.⁴⁹ While it is beyond the scope of this paper to examine Keown's legal evidence, my conviction that there is no morally relevant distinction between unimplanted and implanted embryos is sufficient to demand that the legally required revision of the law regarding the termination of pregnancy recognise that

⁴⁵ *Ibidem*, pp. 1410-1412: Indeed, Kennedy and Grubb refer to the sixth edition of 'Taylor's Principles and Practice of Medical Jurisprudence' as well as to early case law in countries other than England and Wales, which apply the concept of 'miscarriage' from the moment of conception onwards. The former explicitly puts this interpretation forward as the statutory definition of the Offences against the Person Act 1861, s. 58. Reference is made to Smith [1910] p. 142. More significantly, in a survey of all major obstetrical documents published in England between 1788 and 1910, I. J. Keown comes to the same conclusion. See Keown [1984].

⁴⁶ This point has been argued more fully in Deckers [2007]. Incidentally, the same fallacy is committed by Drife, who provided "evidence" as a medical expert in a more recent case. See *The Queen* [2002].

⁴⁷ Kennedy [2000] p. 1413.

⁴⁸ *The Queen* [2002].

⁴⁹ *Ibidem*, p. 351. See Keown [2005].

abortion applies to all women 'carrying a child', irrespective of whether or not the embryo has implanted.

My eighth concern relates to the issue of paternal rights and duties. Since the fetus' biological parents are causally responsible for the creation of the fetus, they are normally assumed to have a duty to take moral and legal responsibility. Yet all too frequently, women are left with the baby. Marie Fox, for example, has claimed that "the most common and problematic male response to an unwanted pregnancy continues to be an eschewal of any role, leaving the woman to cope alone".⁵⁰ More measures should be taken to hold biological fathers who consented to intercourse and knew of its possible consequences legally responsible for the upbringing of their children (unless a moral or legal contract has been made that this should be otherwise), so that women might feel less pressure to consider abortion. Women who consider abortion should be asked to invite the biological father to the formal pregnancy counselling session. His presence might not only help to assess if a termination would be legitimate, but might also make it easier for both partners to come to terms with the decision. In addition, Marie Fox has argued that it could encourage men to take their responsibilities in relation to family planning and child rearing more seriously.⁵¹ Whatever the view of the father may be, I do not think that the views of the father should be allowed to override the decision reached by the other parties in the pregnancy counselling session.⁵² This should be the case even in situations when women become pregnant after forcing men into having intercourse, since fathers do not carry the fetuses they conceive and are therefore not 'singled out' in the same way.

Finally, while I have argued that appropriately qualified health professionals should not be allowed to object to providing abortion services when there is a great risk to the pregnant woman's life, I also think that they should not be allowed to object to participating in pregnancy counselling meetings.⁵³ The purpose of these meetings should be to determine whether or not an abortion either must or may be carried out. These meetings might help not only to increase the chance that the correct decision is made, but also to provide support to the pregnant woman with what may be a very difficult decision. A legal framework should

⁵⁰ Fox [1998] p. 200.

⁵¹ *Ibidem*, p. 211.

⁵² This accords with the current legal situation, confirmed in Paton [1979].

⁵³ This proposal is more concrete than the General Medical Council's view that "where a patient who is awaiting or has undergone a termination of pregnancy needs medical care", doctors "have no legal or ethical right to refuse to provide it on grounds of a conscientious objection to the procedure". See General Medical Council [2008] para. 26.

therefore be developed to make sure that at least one of these meetings is organised for all women who demand an abortion. Apart from the pregnant woman, it is my view that at least two other people should be included, where one would be an appropriately qualified health professional. Health professionals specialised in mental health would be well-placed to assess if the possibility of becoming pregnant was chosen voluntarily at the time of intercourse and if continuing with the pregnancy might inflict 'grave permanent injury'. Some cases may also benefit from the help that could be provided by health professionals specialised in the art of determining if a pregnancy poses a great risk to the life of the pregnant woman. The involvement of someone who is not a health professional with sufficient knowledge of the law on abortion could help to make up for the potential power imbalance between the health professional and the pregnant woman, helping to ensure that all parties are heard –including, where appropriate, the father – and that the law has been understood correctly. The outcome of these assessments should be determined solely by the question if a legally recognised ground has been met, rather than by the question if any of the parties personally agree with the law.⁵⁴ If the latter option were allowed, we would allow people to put themselves above the law, which cannot be justified if the legitimacy of democracy – the political regime I favour – is valued at the same time.

While I hold the view that counsellors should not be allowed to refuse to refer someone for an abortion if this is what is desired by the pregnant woman and if they are beyond any reasonable doubt that any of the revised legal grounds for abortion has been satisfied, this must not be confused with situations where counsellors refuse to refer a woman because they hold the view that her situation does not satisfy a legally recognised ground. In such situations, their refusal is entirely legitimate, and – pace Savulescu – they should not be obliged to refer her to "other practitioners who take a different view of the law".⁵⁵ If Savulescu's view was defensible, it would imply that any service provider, for example, a climbing instructor, had a duty to refer a client keen to avoid health and safety legislation, say Miss Daredevil, to another instructor who held what Savulescu calls a "different" interpretation of the law in question; that is, to an instructor who was known to act unlawfully. Clearly, there should be no such duty. However, while I see no

⁵⁴ It is beyond the scope of this paper to give a detailed answer to the difficult question of what should be done if the different parties involved in the discussion disagree on the issue if a particular abortion request falls within the law. To guard against medical paternalism, I disagree with the ruling in *R [2005]* that there should be no duty to refer to the court in such cases. For an illuminating discussion, see Gurnham [2006].

⁵⁵ Savulescu [2006] p. 296.

reason why health professionals should refer their patients to those who adopt questionable legal interpretations, there is no doubt that health professionals who wish to invoke their limited right to conscientious objection should promptly refer women who satisfy any of the revised legal grounds to those who may be able to provide further help. Also, a referral for a fourth, or fifth (in cases where the father is included) opinion must be recommended in situations where pregnancy counsellors doubt if the patient's situation falls within the law. If an abortion request is recognised as legitimate, the woman may be able to carry out the abortion herself. If this is not possible or desirable, all appropriately qualified health professionals should be prepared to carry out the abortion where this is necessary to save the woman's life. In other situations, those who do not have a conscientious objection to providing the abortion should carry out the abortion. While this arrangement leaves open the possibility that an abortion is refused even in situations when pregnancy counsellors reach the decision that, legally, the abortion could be carried out, I think we must allow for this as it is important that those who are called upon to carry out abortions can approve of their own actions.

4. Conclusion

In this paper I have developed a proposal of how abortion legislation in England and Wales should be modified if it was informed by the view that all unborn human beings should be granted the *prima facie* right to life. I have argued that the current distinctions in the legal provisions for 'able' and 'disabled' fetuses as well as for 'implanted' and 'unimplanted' embryos cannot be maintained, and that greater protection of all human life must be enshrined into law. I have also contributed to recent discussions on health professionals' duty of care and the right to conscientious objection, which I discussed in relation to abortion. I have argued that there should only be a limited right to conscientious objection to participate in the provision of abortion services. There should be no right to object conscientiously to providing abortion services when there is a great risk that a pregnant woman's life might be lost should the pregnancy be continued, and no right to refuse pregnancy counselling and referral of those who satisfy any of the revised legal grounds.

It is my hope that, should abortion legislation be amended in accordance with this proposal, health professionals would provide those services that women should be entitled to, while the lives of unborn human beings would be granted greater protection. For several years now, around 200,000 legal abortions have taken place in England and Wales every year – the latest number being 189,100 for

the year 2009.⁵⁶ To this number we must add abortions on pre-implantation embryos which escape legal scrutiny because of the unacceptable legal definition of 'pregnancy'. It is my hope that this proposal will stimulate discussion to revise legislation in England and Wales to reduce this alarming rate, and that legislators here as well as elsewhere will be stimulated to reject the view that only born human beings should be bestowed with the right to life.

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