

The curate, a cleft palate and ideological closure in the Abortion Act 1967 – time to reconsider the relationship between doctors and the abortion decision.

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Summary

'This article suggests that the recent case of *Jepson v The Chief Constable of West Mercia Police Constabulary* [2003] EWHC 3318 provides a timely invitation to reflect upon the degree to which the law on abortion inappropriately elevates the role of doctors in the abortion decision. The author argues that there is an identifiable ideological closure operative in abortion law, the roots of which lie in the conceptual foundations of the Abortion Act 1967 itself, particularly viewed through the lens of the 1966 Second Reading Debate when the House of Commons had the opportunity to consider the question most broadly and freely. She suggests that neither women's rights nor potential foetal rights received adequate consideration in the framing of the Abortion Act 1967 and that the over-medicalisation of the issue, evident then and arguably present in the *Jepson* case, is now ripe for challenge. She suggests the analytical utility of a rights-based analysis of abortion, while advocating the careful contextualisation of that analytical approach within the complex social realities of abortion. She suggests that abortion is an inadequately met challenge for law makers and suggests that the time is now ripe for renewed public debate.'

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Introduction

A Church of England curate recently created a stir in the media by challenging the lawfulness of a late⁽¹⁾ abortion (*Jepson v The Chief Constable of West Mercia Police Constabulary* [2003] EWHC 3318). Ms Jepson had been reading through the abortion statistics for 2001 when she came across the abortion which had been carried out on a foetus of more than 24 weeks gestation, in the Birmingham area. The foetus had been diagnosed as suffering from a bilateral cleft lip and palate, and the abortion had been carried out under the Abortion Act 1967. Section 1(1)(d) permits abortion if two registered medical practitioners are of the opinion, formed in good faith, that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.⁽²⁾ Ms Jepson (who was born with a significant facial abnormality - later remedied by surgery) argues that a cleft lip and palate cannot amount to a serious handicap within the meaning of the section and that the abortion was therefore unlawful. Although the Chief Constable of West Mercia Constabulary is re-investigating the case, Ms Jepson intends to seek judicial clarification of the law.⁽³⁾ She has argued that:

1. 'seriously handicapped' in s 1(1)(d) of the Abortion Act 1967 has to be understood by reference to the remediability of the condition;
2. a cleft lip and palate does not constitute serious handicap within the meaning of the section;
3. the foetus at 24 weeks gestation and greater has a right to life pursuant to Article 2 of the European Convention on Human Rights, which is only subject to the competing Article 2 right of the mother;
4. s 1(1)(d) of the Abortion Act 1967 is incompatible with Articles 2,3,8 and 14 of the European Convention on Human Rights.

As Mr Justice Jackson suggests in his judgment granting permission to proceed with a claim for judicial review, the case raises serious issues of law and issues of public

importance. It is for this reason that Ms Jepson plans to seek clarification of the law, by which she means, presumably, clarification of the meaning of 'serious handicap'.

Arguably, one issue raised by implication is the degree to which abortion is under the sole control of the medical profession. It is notable in the case report on *Jepson* that Silber J's initial refusal to grant permission to apply for judicial review was based largely on the police use of evidence from the medical profession. The evidence in question was a letter from Miss Mellows, the Vice President of the Royal College of Obstetricians and Gynaecologists. She asserted, in that letter, that the correct procedure had been followed (two signatures) and, further, that the abortion had been carried out under the 'serious handicap' provision. She acknowledged that there is no precise definition of 'serious handicap' and that the decision was therefore for the 'practitioner to make in consultation with the parents and other interested parties'. She then stated that 'experts' in the condition had been involved in the decision with the parents. The barrister representing Ms Jepson contended that Miss Mellows's letter was flawed by three errors of law, the first of which is of most significance for present purposes. Counsel for Ms Jepson argued that the medical practitioners who signed the certificate erred in law when they took into account the views of the parents involved. If this is the case it suggests that the Abortion Act grants the power to control abortion solely to the medical profession, especially the practitioners whose advice is sought by a woman seeking termination. One implication of this is that if doctors think an abortion is a good (or bad) idea then others must simply defer to their technical expertise and accept their opinion. Medical opinion, in other words, is to operate as a kind of closure. Further, as reflected in the judgment of Silber J, deference to this closure can even extend to medical views of the legality of an abortion. In combination, the law, in form and practice, may inappropriately 'medicalise' abortion.

Any reductive⁽⁴⁾ medicalisation of abortion will tend to recast the complex ethical dilemmas involved as questions of medical judgement, first and foremost. The *Jepson* case implicitly raises the question of how far this is acceptable in a more rights-conscious age. It is a question that cuts both ways in relation to the abortion debate, which may not be quite what Joanna Jepson intends. It is likely that any reductive medicalisation of the abortion question will result in an incipient denigration of the rights of *both* women and the unborn.

The medicalisation of abortion is no recent innovation or departure from a previous trend – and it will be argued here that the issues raised by the *Jepson* case reflect the conceptual foundations of the Abortion Act 1967. An examination of those foundations reveals both the way in which abortion was medicalised and the related tendency to uncritically elevate medical opinion. The *Jepson* case issues a timely invitation to reflect upon an incipient ideological closure operative in British abortion law.

In the late 1960's, when popular demands for the legalisation of abortion reached their height, Parliament was given the opportunity for a wide-ranging debate on the subject. The most revealing debate is the second reading of the then Medical Termination of Pregnancy Bill in the House of Commons. This 1966 debate was the parliamentary stage at which MPs could speak to the matter in broadest principle. The second major debate, in June 1967, was naturally more narrowly focussed on the text before the House, and largely concerned the medical administration of abortion. That debate

presupposed, therefore, certain answers to questions of principle, the opportunity for the free addressing of which was given, pre-eminently, in the 1966 debate.

From a rights-aware perspective, the 1966 debate is unsatisfying. What emerges most clearly is the influence of the medical profession's strong concern to protect both its professional autonomy and control over the abortion decision. An examination of the 1966 debate in particular reveals a relative absence of sustained or careful discussion of the rights of fetuses or women.

It is clear that abortion is a procedure available to the medical profession, and that the foundations of the 1967 Act were laid in the context of a therapeutic exception to the criminal law. However, it is one thing to recognise abortion as a medical procedure – it is another thing entirely for a legislative assembly to recast complex social, ethical and legal questions as medical ones. The following analysis explores the possibility that Parliament did just that.

Medicalising the impetus for the Bill

The initial movement for abortion law reform does not seem to have come from the medical profession. John Keown, in his book, *Abortion, Doctors and the Law* (1988), reveals that the Abortion Law Reform Association (ALRA) (a pro-abortion rights organisation) was instrumental in stimulating the reform movement. However, it seems that abortion was recast during the debates as a medical rather than a rights issue, and it is also clear from Keown's research that the views of the ALRA were almost completely sidelined by the intense involvement of the medical bodies in lobbying Mr David Steel MP (Keown, 1988:85).

One key argument made to support the reform of abortion law was the need for clarification of the law in the interests of the medical profession. Mr Steel, in the 1966 debate, made the claim that there was 'total uncertainty about the exact legal position' (*Hansard* HC Deb vol 732 col 1070 (22 July 1966)), and that the abortion decision was left to the judgement of individual practitioners without adequate guidance from the law as to the grounds upon which such decisions could lawfully be made. Speakers on both sides of the debate described the need for clarification of the law as compelling.⁽⁵⁾ However, two questions emerge with regard to the credibility of this argument. The first concerns the accuracy of the claim that the law was unclear. The second concerns the eventual reality of the 1967 Act and its true effect on the role of medical judgement in the context of the abortion decision.

At the time of the 1966 debate the most noted interpretation of the law was *R v Bourne* ([1939] 1 KB 687) a case concerning the termination of a pregnancy resulting from the rape of a fourteen year old girl.⁽⁶⁾ Keown has suggested that *Bourne* was an important but conservative exposition of the law. He argues that the pre-*Bourne* movement in the common law towards a less restrictive approach to therapeutic abortion already reflected the underlying reality of medical practice, despite widespread representations to the contrary (Keown 1988: 60). Such representations, however, formed a significant part of the argumentative foundation for law reform in the House of Commons in 1966 - despite the *Bourne* guidelines for practitioners, and despite subsequent cases developing the *Bourne* approach.

Keown has argued that, even in the period from the late eighteenth century to the *Bourne* case, despite the absence of a therapeutic proviso in the criminal anti-abortion law, abortion operations were not only performed, but indications for the procedure were expanded by the medical profession. Doctors, moreover, faced no real risk of prosecution, provided that they abided by their professional ethics. (Keown 1988: 78). The *Bourne* case meant that, 'in 1938, after the law was challenged by a member of the medical establishment ... legal theory [was] unequivocally brought more into line with the realities of clinical practice' (Keown 1988: 83). Keown's evidence indicates that the law at the time of the debates was neither uncertain nor unduly burdensome to the profession. It would, therefore, be more accurate to say that the law was not so much *unclear* as *uncodified* at the time of the 1966 debate.

Thus, it is untrue that the law prior to the 1967 Abortion Act was unclear, that doctors performed abortions without adequate guidance, or that they were particularly vulnerable to prosecution. On the contrary, the evidence suggests that the practice of the medical profession was well established (Keown 1988 78-79) and that the application of the law did not in any way militate against, compromise or overburden the medical profession in relation to the practice of therapeutic abortion.^[7] Thus, it seems that the demand for certainty in the law was somewhat synthetic.

Given the fact that the pre-existing law seems neither uncertain nor unduly limiting, it is likely that the argument for certainty was politically driven. This interpretation is supported by Mr Kevin McNamara MP in the 1966 debate. He quoted from a report prepared by the Royal College of Obstetricians and Gynaecologists (RCOG) in which the College argued that those seeking major changes in the law governing abortion in Britain failed to appreciate that medical practice was not seriously hampered by the law as it stood (*Hansard* HC Deb vol 732 col 1125 (22 July 1966)).

Keown records an intriguing fact about the difference in approach taken by different medical bodies - reflected in the part of the RCOG report that Mr McNamara referred to. 'A survey of the opinions of the major medical bodies reveals that none opposed reform as such, although those whose task it was to perform abortions, the gynaecologists, were less enthusiastic for reform than their colleagues in other areas of practice. The profession was, however, firmly opposed to any reform that compromised clinical freedom either by taking the final decision out of the hands of the medical attendant or by specifying the conditions for abortion too exactly.' (Keown 1988: 87).

Thus it seems that the movement for reform was instigated by campaigners concerned for women's abortion rights, and that these interests were submerged beneath medical professional interests by Parliament, under lobbying pressure from the medical profession. It is reasonable to suggest that rather than clarification of the law the true effect of the proposed reform lay closer to achieving a statutory extension of medical control over abortion.

As we have noted, Mr Steel presented himself as concerned to lift the burden of responsibility for the abortion decision from individual doctors. However, this basis for reform is revealed as largely chimeric by the effect of the Abortion Act 1967 itself. The Act arguably places a more profound responsibility on the profession by extending the medical indications for abortion to include social factors. Thus, the argument about lifting the burden of responsibility from the medical profession is not entirely reflected in

the eventual realities of the Abortion Act. This tends to undermine the justificatory status that the argument might otherwise have had. It also further reveals the extent to which women's rights claims were sidelined. The ALRA had campaigned for an explicit right to abortion on social grounds. The sublimation of social grounds beneath an expanded set of medical criteria for abortion meant that the role of the doctor was likewise expanded. The Abortion Act, as we shall see, places far greater responsibility for the control of the abortion decision on the shoulders of doctors than previously, and in the process, recasts social indications for abortion as medical ones.

In tracing the way in which this happened, the way in which the opinions of the medical profession were elevated in the course of the debates, so that their voice, as it were, muted the voices of those concerned for female reproductive autonomy, will also be noted.

Medicalising the debate on the Bill

The reductive characterisation of abortion as almost completely a medical issue, and the consequent consolidation of medical control of abortion, is mirrored by a very high degree of argumentative deference accorded by the House to medical expertise and opinion. In the 1966 debate, in which MPs could freely address the abortion question in its broadest social and moral terms there is a notable degree of relatively uncritical deference to members of the medical profession. The extent to which their opinion was canvassed and used in the arguments during the debate is marked,⁽⁸⁾ and this argumentative deference seems to have been a mechanism (conscious or unconscious) for the devolution of legislative responsibility for a deeply complex social and moral question to the medical profession.

In the 1966 debate, the main reasons for according deference to medical opinion appear to be founded on two considerations: the degree to which the issue is central to medical ethics, and medical expertise.

The first argument for according deference to medical opinion turned upon the realisation that abortion, in the words of Mr Deedes, MP for Ashford, 'goes so close to the heart of medical ethics' (*Hansard* HC Deb vol 732, col 1092 (22 July 1966)) such that it was seen as both wise and necessary to bring the profession into account. Certainly, any legislation that goes to the heart of an ethically fraught professional practice should be enacted with the closest possible attention to the best available professional opinion. However, it is less clear that the profession should be allowed to sway the legislature on matters beyond their professional competence. In particular, should the opinions of doctors on the social complexities giving rise to the demand for abortion have been quite as uncritically accepted? Over-emphasising the opinions of doctors inappropriately can suppress important questions of principle, leave social complexities incompletely addressed, and mask the genuine necessity for a thoughtful and multi-faceted response to complex social issues beneath a medical short cut.

During the debate, it was clear that medical professionals had strong views concerning abortion as a solution to social problems. Dr John Dunwoody MP, for example, openly states that his support for the Bill is not primarily based on medical but on social grounds, and continues, '[t]his is a piece of social legislation rather than medical

legislation' (*Hansard* HC Deb vol 732 col 1099 (22 July 1966)). The problematic nature of relying on medical opinion as the basis for social legislation did not go unnoticed. Sir John Hobson MP, for example, objected to clause 1(c) of the 1966 Bill, the clause permitting abortion directly upon social grounds. He was clearly uncomfortable with the approach taken by Dr Dunwoody and expressed doubt about the acceptability of committing 'to the hands of doctors decisions on social and economic problems which are to be solved by the termination of prospective life' (*Hansard* HC Deb vol 732 col 1135 (22 July 1966)). To the response made by Mr Charles Pannell MP that Dr Dunwoody did not want to solve social and economic problems so much as to solve, as a doctor, the impact of a social or economic problem upon his patient, Sir John Dobson remained unconvinced. He even doubted that this interpretation presented a justifiable position. He argued, '[t]he paragraph gives *carte blanche* to doctors to apply in individual cases pretty well whatever views they may take on difficult questions and I do not think that it is right to place on the medical profession generally the right to take these decisions'. (*Hansard* HC Deb vol 732 cols 1137-1138 (22 July 1966)).

The removal of clause 1(c) (the social clause) from the final legislation might appear to endorse the concern expressed by Sir John Dobson, but in fact the opposite is true. By sublimating the social factors under a definitionally expanded medical criterion the social basis for abortion was inevitably placed under medical control, and further from the reproductive autonomy claims of women seeking abortion on social grounds (Keown 1988: 100). This medicalisation of the social grounds for abortion, moreover, raises the very real possibility that Parliament inappropriately devolved responsibility to the medical profession to solve complex social and ethical problems through the expedient device of renaming them as medical ones. This, combined with a high degree of deference to medical opinion in the debates, reflects the way in which the abortion question was moved further from the claims of those interested in women's rights. Keown argues that 'the opinions expressed were not confined to strictly medical questions, such as the methods and dangers of abortion, but included recommendations on the desirability of reform, the appropriate scope of the Bill, and the wording of particular provisions. Equally significantly, the bulk of these recommendations were accepted.' (Keown 1988:108-109).

Relying on research conducted by Hindell and Simms (1971) Keown records that the influence of the British Medical Association (BMA) in particular, and the Scottish gynaecologist Sir Dugald Baird, were decisive in the removal of clause 1(c), the social clause, from the Bill. What emerges from the research evidence is a picture of Mr Steel moving further away from the recommendations of the ALRA, for whom the social clause was the only significant reform in the Bill, and instead adopting the recommendations of the medical profession. By dropping the social clause and clause 1(d) (the clause relating to hard cases such as rape) at the Committee Stage of the Bill, as Hindell and Simms put it: Mr Steel 'seemed to accept the main arguments of the BMA and the RCOG and to sacrifice the heart of the Bill' (Hindell and Simms 1971: 177).

Significantly, Keown records that, in his statement accompanying the relevant amendment, Mr Steel acknowledged the influence of these medical bodies in framing his new clause 1(a), included at the expense of clauses 1(c) and 1(d). In moving the amendment, Mr Steel argued that it was wrong to give the impression that the social and medical indications were distinct, and that most abortions, legal or illegal, were performed for social reasons. The charade of fitting them into other categories should be

abandoned ((1966-1967) X Parl Deb, HC Standing Cttee F, 108-109 – quoted in Keown 1988: 99). One would expect, on the basis of this argument, that the social clause might openly have been retained. Yet, it was dropped in favour of expanded medical grounds for abortion in clause 1(a). The purported reasoning behind these developments is particularly interesting. Clause 1(a), as amended, now included much broader and less clearly specified indications for therapeutic abortion: the doctor could now take into account a woman's total environment, actual or reasonably foreseeable, in determining the level of risk of injury to her health. Thus, despite removal of the social clause, the medical profession retained as much scope for permitting a social basis for abortion as if the clause had been retained, simply by an extension of the definition of the medical grounds for abortion to include social considerations.

The arguments for the removal of clause 1(d) (the hard cases clause) were based on arguments made by the RCOG and the BMA that such a clause 'might mislead women into thinking that abortion would automatically be granted in the circumstances it specified' (Keown 1988: 100). This overt protection of medical autonomy eschews any wording that might conceivably give women a right to abortion in certain circumstances. The real burden the profession sought to avoid, it seems, was having fetters placed upon its autonomy (*Hansard* HC Deb Vol 749 col 900 (29 June 1967) Mr David Steel MP).

Thus, the Bill as it finally emerged entrenched the traditional autonomy of the medical profession. Keown records that '[o]ne aspect of the profession's successful defence of its autonomy was the recommendation that doctors should not be required to make judgements on matters beyond their expertise; that the indications for abortion should be "medical" not "social".' (Keown 1988: 109). It is suggested that this conclusion is radically incorrect. What the profession in fact achieved was a successful defence of its autonomy by extending the meaning of 'medical' to *include* the 'social'.

One might argue that the medical profession would have controlled the application of the social clause in any case. However, it is problematic for the social basis for abortion to be sublimated under a medical definition. It appears further to disguise the ethically problematic nature of doctors deciding the abortion question on social grounds. The re-characterisation of the social basis for abortion as a medical question damages the integrity of the abortion debate and eclipses question of women's rights. With regard to the former, it inappropriately reduces social factors to medical ones, thus evading difficult and important issues concerning the morality and adequacy of abortion as a solution to social problems. With regard to the latter, it moves any possibility of a social basis for abortion further from women's rights claims, placing the abortion decision further under medical control.

The undoubted involvement of social factors in health (and the expansion of the modern concept of health to reflect this) (*Hansard* HC Deb vol 732 col 1114 (22 July 1966) (Dr David Owen MP)) supports neither a medical professional monopoly over 'social medicine' nor the medical expansionism achieved in the 1967 Act. It would have been more imaginative and responsible for Parliament to question the inevitability of the modern dominance of the medical profession over 'social health', and to confine doctors to a more focussed, technical role congruent with their expertise and training. Wider responsibility for the social issues implicated could be met by a legislature taking bold social initiatives, and by appropriate delegation to other state and non-state agencies,

including community-based initiatives. What seems to emerge is a picture of inappropriate delegation – a reductive medicalisation. It is hard to resist the impression that the resulting 1967 Act reflects a deeply impoverished approach to the abortion question.

From simple medicalisation to the complexity of rights-talk

The medicalisation of abortion, and the high degree of deference to the medical profession in the very formation of the law, arguably reduced the scope for serious systematic consideration either of female reproductive autonomy rights, or, indeed, the potential rights of the foetus. The nature of the state's interest in the question was, likewise, not addressed in any systematic manner. Women's rights and potential foetal rights were both diminished in the process of framing the British abortion law.

It should be clear from what has already been said that women's rights were sublimated beneath a concern for medical professional autonomy. Interestingly, despite the work of the ALRA, which publicly promoted the view that 'every woman has a right to an abortion and every child has a right to be born wanted', the issue of the rights of women to abortion featured surprisingly little in the 1966 debate. The strongest characterisation of the 'women's rights' position was attributed to the ALRA by Mr St John-Stevas, for example, who, despite his admission that two conflicting rights exist, then concentrated almost entirely on discussing the rights of the unborn child with no real consideration of the rights of women (*Hansard* HC Deb vol 732 col 1155ff (22 July 1966)). Throughout the debate as a whole women's rights received scant treatment and were depreciated through a lack of thorough consideration. Mr Kevin McNamara revealed the likeliest reason when he asked: 'where does the medical profession stand if women in certain circumstances can claim abortion as of a right, as they could under the Bill?' (*Hansard* HC Deb vol 732 col 1127 (22 July 1966)). Thus, women's rights were eclipsed by considerations of medical autonomy and control. We have seen that the lobby supporting female reproductive self-determination was sidelined by the lobbying activities of the medical establishment. The dropping of the social clause, and the hard cases clause (of which the most obvious is rape) of the Bill in favour of an expanded medical definition effectively moved the abortion decision further from the rights-demands of women.

Moving to the potential rights of the foetus, in the 1966 debate the right to life argument appears in three main forms: in terms of lack of safeguards, the sanctity of life and quality of life.

The first two arguments appear in the wording of an amendment proposed by Mr Wells. The amendment sought to refuse Second Reading to the Bill on the grounds that, inter alia, it contained 'no adequate safeguard against the destruction of potentially healthy babies, and undermines respect for the sanctity of human life, which is fundamental to British law'. (*Hansard* HC Deb vol 732 col 1080 (22 July 1966)). Even here, however, there was a noticeable eugenic exception to the application of the sanctity of life principle, an exception repeatedly assumed by pro-life speakers. Yet, if a eugenic exception to the sanctity of life principle is to be so readily conceded by those who defend the sanctity of life principle it needs to be made clear why the intrinsic humanity

of a handicapped child counts for less than that of a healthy child. As importantly, the question of the basis upon which the distinction between such unborn children should be made needs clarifying and defending.

Part of the answer may lie in the third life-based argument raised in 1966, that of quality of life. The quality of life argument emerged most explicitly in the context of discussions of the eugenic basis for abortion - particularly by speakers supporting clause 1(b) of the bill, which proposed to permit abortion where there was a substantial risk that the child be seriously handicapped. Quality of life arguments, however, can cut both ways. Mrs Jill Knight (who had repeatedly stressed the need to avoid the destruction of healthy babies - an implied eugenic concession) answered the eugenic argument by urging caution in judging the quality of life of the 'deformed' seeking to raise a quality of life defence of the unborn 'spastic child' (*Hansard HC Deb vol 732 col 1073 (22 July 1966)*).

Mr Kevin McNamara took an ardent pro-life stance, challenging the eugenic clause on several grounds that closely foreshadow *Jepson*. He raised the difficulties of delineating a eugenic abortion; the difficulties of diagnosis in early pregnancy; and the 'more important question' of the foetus itself and the impossibility of judging the quality of life it might enjoy - even as a handicapped person (*Hansard HC Deb vol 732 col 1128 (22 July 1966)*). None of these questions, it seems, was adequately answered.[\(9\)](#)

Given that neither the rights of women, or of the foetus, were adequately discussed during the debate, it is no surprise that the 1966 debate reflects a distinct reluctance truly to engage with the thorny question of foetal status in relation to women's sexual autonomy rights. The full potential interests of the foetus were simply never weighed against the rights of the woman. The thorny nature of the problem, combined with the absence of any developed rights-aware culture and the campaigning influence of the medical profession, conflated, it seems, to produce a medicalised side-step. Thus, *Jepson* raises questions that are entirely consistent with the distinctive closures operative in the conceptual structure of the Abortion Act 1967, revealingly exposed in its broad argumentative foundations.

Although the conceptual inadequacy of the foundations of British abortion law in the light of rights discourse is becoming apparent, it could be argued that rights discourse can be no less problematic. Rights are too easily conceived of atomistically, individualistically, in a way that can sublimate broader, more complex matrices of social interaction (Glendon 1991). Inappropriate closure of the abortion issue will inevitably occur if and when abortion as a complex social question is reduced to any one inappropriately elevated framework of approach - and that applies to rights as much as to the medicalisation identified above. However, notwithstanding this objection, it is suggested that there is a compelling *analytical* role for rights-based approaches to the abortion question. Rights-based reasoning, like medical opinion has an important role to play - so long as there is adequate contextualisation.

The abortion issue is often portrayed in terms of an irreconcilable polarisation between extremes, both in conceptual and in social terms. It is important to reflect on this briefly before proceeding, and to draw some distinctions between different kinds of polarity involved in the question, in order to suggest the usefulness of rights-based reasoning.

First, it is true to say that, unless we are willing, *a priori*, to privilege one side of the debate over the other, the abortion question involves an inescapable nexus between female reproductive autonomy interests and the future of the foetus. There is, therefore, a certain *analytical bi-polarity* in the issue. Without the foetus being present in a living woman's uterus it would not present its peculiarly intimate challenge to a woman's reproductive autonomy - it is precisely the biological location of the foetus that brings it into potential conflict with maternal autonomy interests. In order to dismiss this fundamental bi-polarity we would need to dismiss either the foetus or the autonomy interests of the woman. It is in part the fundamental analytical bi-polarity of the issue that suggests the analytical utility of a rights-based analysis. However, this analytical statement should be distinguished from both the assertion that the abortion *debate* is *necessarily* fundamentally polarised and irreconcilable and from any assertion concerning the inevitability of social polarisation between different worldview groups in relation to the abortion question.

In general terms, the public debate over abortion has to date been conceived of as a battle between two irreconcilable worldview positions. This goes beyond strict analytical bi-polarity to embrace an impassioned polarisation of the debate, often conceptualised as a fundamental polarity between two *extreme views*: abortion on demand opposed by denial of the validity of abortion in any situation.⁽¹⁰⁾ Related to this is the conception of the abortion question as an *insurmountable antithesis* between two competing rights-claims: the right of a woman to reproductive autonomy; and the right of a foetus to life. The fulcrum upon which these two apparently incommensurable claims pivot is the central question of the true status of the foetus, the other important issue raised by the *Jepson* case. (Ms Jepson seeks to assert that s 1(1)(d) of the Abortion Act 1967 is incompatible with Art 2 ECHR, a claim which directly raises the question of whether or not the foetus should be at any stage defined as a legal person capable of bearing rights.)

The status of the foetus, and the true nature of the pro-life claim, was explored by Ronald Dworkin in his book *Life's Dominion* (1993). Dworkin argues that the popular conception of the debate as inescapably polar is misconceived, being based on a 'widespread intellectual confusion' (Dworkin 1993: 10) – a confusion concerning the true meaning of the sanctity of life claim.

Dworkin suggests that the public debate over abortion has failed to recognise a vital distinction between two possible interpretations of the pro-life claim. The first interpretation understands the claim as being that human life begins at conception, and that, as the foetus has personhood from that moment, abortion is an assault on the sanctity of that individual human life and a violation of that individual human being's fundamental right not to be killed. This position presupposes and is derived from rights that all human beings, including foetuses, are assumed to have, and Dworkin labels it as the *derivative* objection to abortion. The second interpretation of the pro-life claim is radically different, and can be understood, Dworkin argues, to be a claim that abortion is wrong in principle because it disregards and insults the intrinsic value, the sacred character, of any stage or form of human life. He calls this the *detached* objection to abortion, as it 'does not depend on or presuppose any particular rights or interests' (Dworkin 1993: 11).

According to Dworkin, if the pro-life claim is carefully analysed it becomes apparent that no one actually argues as if they seriously believe the derivative claim - the pro-life argument is a detached claim. As a result, he believes, a careful balancing of the intrinsic value of life can be made – one which weighs and respects the mother's interests in her own sacred intrinsically valuable human life against the value of the foetus.

Dworkin's position appears to be descriptively defensible. However, its normative defensibility as an argument about how the abortion debate ought to be conducted is less certain. Dworkin's strategy is to exploit a descriptive point – the fact that most people do not take the derivative claim seriously, nor argue in fully derivative terms. He then suggests that the alternative, detached interpretation of the pro-life claim provides a sanctity of life value capable of applying equally to mother and unborn child and thereby seeks to provide a unitary framework within which the difficult abortion calculus can be made. The suggestion is that this avoids the interminable pessimistic polarisation within which the debate is usually conducted. However, Dworkin's argument dismisses the derivative claim on empirical grounds. His reliance on the fact that, in reality, we do not currently treat the foetus as a full person with legal rights and interests of its own cannot answer the normative question of whether the foetus *should* have legal rights and interests of its own. It seems important, in the interests of intellectual integrity and, arguably more importantly, inclusive public discourse and justice to groups holding deep convictions on foetal status, to address the derivative pro-life claim as a normative claim, rather than dismiss it with an argument based on a descriptive claim. Moreover, Dworkin's empirical justification for abandoning the derivative objection to abortion discounts one voice entirely – namely some of the religious opponents of abortion. Dworkin rightly concedes that their derivative claim, if taken seriously, would mean the proscription of abortion on the ground that it is murder. However, that is precisely the claim being made. Whilst the conclusion may be deeply unpalatable to some liberal cultures, this is no good reason to avoid facing the question *a priori*. Full respect for public discourse rights suggests that their claim should be squarely faced.

The present approach to foetal personhood involves arguing that, because a foetus is not a legal person for certain purposes contingent upon live birth, it cannot be a person for the purpose of determining whether it has a right not to be destroyed in the uterus. This approach contains an unsatisfying circularity of reasoning. Moreover, it could be argued that the foetus should be recognised as having interests that may be more impressively at stake than anyone else's in the abortion question. Perhaps, rather than re-characterising the derivative claim, consigning it to descriptive insignificance, or evading it with circular reasoning, we should answer the claim, adequately, applying careful analysis liberated from ideological closures. Perhaps it is time to give women's rights and potential foetal rights (including the derivative pro-life claim) much fuller consideration. In doing so, we could consciously use the analytical bi-polarity of rights as a device to avoid too early a dismissal of either claim.

Conclusion

Overall, Parliament's approach to the formation of abortion law was to avoid 'extremes' by re-characterising the issue and placing control over the abortion question in to the hands of the medical profession. It is suggested that a legacy of this is that abortion is an unmet challenge for British lawmakers. A more integral approach to the question than

that taken to date would entail addressing it much more openly and fully, in all its intricacy, as a rights issue – but also as much more than that.

The *Jepson* case raises important questions beyond the strict legal ambit of its claims. It suggests that the reductive medicalisation of abortion needs challenging from a rights-aware perspective, particularly perhaps in the interests of women. At the same time, it re-invites engagement with the difficult question of foetal status by implying that the central normative question posed by the derivative pro-life position remains unmet – namely - whether or not we should accord the foetus a right to life (at a certain stage of development in *Jepson*) *despite* the fact that we do not currently accord the foetus legal personhood.

There are undoubtedly moral and social issues of enormous complexity to consider. However, if women's rights considerations were given full force, if the potential rights claim of the foetus were adequately addressed, and if the deep social reasons for abortion were also examined, it might become possible to conceive of a more transformative political and legal response to abortion. Welfare and economic rights, the encouragement of male sexual responsibility, and the development of innovative community-based responses aimed at supporting and empowering women could all become live issues in the question, widening it to reflect its genuinely multi-faceted nature. In this context the incommensurability of the conflict between the rights of mother and unborn child, while conceptually challenging, could be minimised in terms of practical impact (even while being carefully addressed) by social and political initiatives designed to reduce demand for abortion by challenging the constrictive pressures so often experienced by women (Kenny 1986). Such an attempt at an integrative social approach might satisfy Dworkin's aim of moving away from the social pessimism of the polarisation involved in the question, but achieve it perhaps, without intellectual re-characterisations designed to avoid the full normative impact of the potential foetal claim.

The normative challenge of foetal status is not best met by avoidance. Women's autonomy rights are not best served by an abortion law based on a reductive medicalised conception of the issue. The question of the rights at stake should be fully faced and debated with the analytical bi-polarity of the issue in mind – but not being allowed to occlude the complex, multi-layered issues implicated in the abortion dilemma. The important question of the appropriate role of the state in relation to the issue should also be openly and thoughtfully addressed. *Jepson* will never achieve all this, but the case does imply that we should challenge the devolution of such fraught complexities to the medical profession, and question the adequacy of leaving them to meet the complex social needs of women faced with such a difficult reproductive choice. The *Jepson* case provides a timely opportunity to reflect upon an incipient ideological closure operative in British abortion law.

Perhaps we can take the invitation offered by *Jepson* beyond its strict legal ambit and strive to understand the true nature of the competing rights and the socially complex factors involved in abortion as democratic partners in a society concerned both to empower women and to protect children. Perhaps the time has arrived for renewed public debate.

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APPENDIX: MEDICAL TERMINATION OF PREGNANCY BILL 1966

Mr Steel introduced the Medical Termination of Pregnancy Bill in 1966. The detailed proposals for clauses at the stage of second reading were outlined in his proposing speech. These provided that the medical termination of pregnancy could only be carried out on the opinion of two registered medical practitioners, whose opinion should be reached on the basis of the grounds contained in clause 1 of the Bill. That clause set out the grounds upon which a decision to terminate could be reached in four paragraphs:

- (a) that the continuance of the pregnancy would involve serious risk to the life or of grave injury to health, whether physical or mental, of the pregnant woman, whether before, at or after the birth of the child; or
- (b) that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; or
- (c) that the pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be; or
- (d) that the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape.

(1) 'Late' abortion means the abortion of a pregnancy that has exceeded 24 weeks gestation: s 1(1)(a) Abortion Act 1967.

(2) For an excellent discussion of the alleged justifications for s 1(1)(d) see S Sheldon and S Wilkinson, 'Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law?' (2001) 9 *Medical Law Review* 85.

(3) See www.telegraph.co.uk/news/main.jhtml?xml=news/2004/04/17/njep17.xml&sec (accessed 10 May 2004).

(4) 'Reductive' is used in this context to mean 'any explanation of a phenomenon or concept which elevates one aspect of it over others and makes a claim, explicit or implicit, to explanatory completeness. The phenomenon or concept in question is thereby 'reduced' to the aspect disproportionately elevated': Anna Grear, 'Theorising the Rainbow: The Puzzle of the Public-Private Divide', (2003) 9 *Res Publica* 169-194.

(5) *Hansard* HC Deb vol 732, col 1091 (Mr Deedes MP); col 1118 (Mr Angus Maude MP); col 1141 (Mr Roy Jenkins MP); col 1133 (Sir John Hobson MP) (22 July 1966).

(6) Macnaughten J, giving judgment, had ruled that, 'if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother' (at 694).

(7) As Keown states, 'abortion was induced for increasingly broad indications and decisions were no longer arrived at in the light of medical considerations alone... The Bourne case of 1938 did not, therefore, liberate medical discretion from an uncompromising law. In fact this was recognised by Bourne himself. Writing shortly after his trial he conceded that his aim had *not been to reform the law but to ensure its declaration*' (emphasis added) (at 79). Keown's interpretation of matters prior to the 1966/67 debates is borne out by the speech of Mr Kevin McNamara, the only MP to have argued that the law did not really need reform, despite the widely held perception in the House to the contrary: *Hansard* HC Deb vol 732 col 1125 (22 July 1966).

(8) *Hansard* HC Deb vol 732, col 1083 (Mrs Renee Short MP); col 1083 (Mr William Wells MP); col 1090 (Mr Edward Lyons MP); cols 1100 – 1104 (Mrs Jill Knight MP); cols 1109 – 1111 (Dame Joan Vickers MP); col 1113 (Dr David Owen MP); col 1122 (Mr Angus Maude MP); cols 1123- 1128 (Mr Kevin McNamara MP); cols 1128, 1134 (Sir John Hobson MP); cols 1148-1151 (Mr Leo Abse MP); col 1158 (Mrs Renee Short MP) (22 July 1966).

(9) Nor have they been since. Sheldon and Wilkinson, in their scrutiny of the main arguments for the special exception encapsulated in s 1(1)(d), that '[n]othing has happened to challenge Morgan's view, expressed ten years ago, that this ground of the Abortion Act has remained curiously lacking in sustained critical analysis': S Sheldon

and S Wilkinson, 'Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law?' (2001) 9 *Medical Law Review* 85 at 87.

[\(10\)](#) See *R v Bourne* [1939] 1 KB 687 at 29 where Macnaghten J characterises the issue in these terms. See also *Hansard* HC Deb 732 cols 1077-1078 (22 July 1966) where Mr David Steel MP characterised the debate as polarised in two ways: there were two main groups (the reformers and the Roman Catholics); and two extremist poles of opinion - the 'abortion on demand' position and the 'abortion is always wrong' position. (Mr Steel characterised the reformers as standing on middle ground)