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Conscience, abortion, & jurisdiction*

> [T]he game of jurisdiction acts to perform a kind of ethnomethodological miracle…, and the consumers of legal decisions are kept from asking: how should problem X or Y be governed in the first place?
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> M. Valverde, *Chronotopes of Law: Jurisdiction, Scale and Governance* (Routledge, 2015), 86.

Section 1: Introduction

Conscientious objection to activities that are required by law has achieved a particular place in contemporary law and culture. Lawyers, political theorists, ethicists, and others have debated how we best negotiate the tensions that can exist between professional obligations and private beliefs.[1] They have devised models that aim to accommodate difference and yet keep it bounded.[2] Conscientious objection to provision of abortion care has been a particular focus of these discussions. Section 4 of the Abortion Act 1967 provides, with qualifications, that 'no person shall be under any duty, whether by contract or any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection'.[3] The meaning and scope of this provision was most recently considered by the Supreme Court in the case of *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68.[4] This litigation provoked debate and academic commentary that for us evidences the clear tensions that exist in current regulation of conscientious objection to provision of certain medical treatments.[5]

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[1] See, for example, 'Special Issue: Conscience and Proper Medical Treatment' (2015) 23 (2) *Medical Law Review*.

[2] For recent attempts at this see Lori Kantymir, Carolyn McLeod, 'Justification for Conscientious Exemptions in Health Care' (2014) 28(1) *Bioethics* 16; Sara Fovargue, Mary Neal, 'In good conscience: Conscience-based exemptions and proper medical treatment.' (2015) 23(2) *Medical Law Review* 221.

[3] Abortion Act 1967, s 4 [hereafter section 4]

[4] *NHS* of *Greater Glasgow Health Board v Doogan and another* [2014] UKSC 68. [Hereafter *Doogan and Wood*] Two Scottish midwives working as 'Labour Ward Co-ordinators' wished to use section 4 to protect their refusal to be involved with the 'delegation, supervision, and support' of patients and nurses who had participated in termination of pregnancy. Their employer, Greater Glasgow and Clyde NHS Trust, objected. The parties to the litigation had agreed a list of 13 tasks that Labour Ward Coordinators may be asked to undertake related to termination of pregnancy [see para 39]. While it was accepted by both sides that certain activities properly fell within the scope of section 4 there was disagreement over whether 'delegating, supervising and/or supporting staff to participate in and provide care to patients throughout the termination process', more administrative aspects of their role, should qualify under section 4. The Supreme Court decision, handed down in December 2014, found that 'delegation, supervision, and support' were not proximate enough to the termination procedure to constitute 'participation' for the purposes of section 4 protection.

[5] See for example Mary Neal, 'Commentary: The Scope of the Conscience-based Exemption in Section 4(1) of the Abortion Act 1967: *Doogan and Wood v NHS Greater Glasgow and Clyde Health Board* [2013] CSIH 36.' (2014) 22 *Medical Law Review* 409; Chris Cowley, 'Conscientious objection in

Responding to this, in this article we draw on theoretical work on 'jurisdiction' to provide an account of what is embedded in claims to conscience and what the effects of such claims are. We focus specifically on refusals of abortion care and section 4, although our concerns extend to the wider landscape and impact of conscience claims. The consideration of conscientious objection presented here is not intended as an argument against conscientious objection, and we are keen to emphasise this. Rather, we problematize and politicise the explicit articulation of 'a right' to conscientious objection under section 4 and the necessity of statutory protections for this 'right'. We illustrate the way in which the lens of 'jurisdiction' sheds light on how we might understand the role for law in this area.

Legal scholars working across a range of fields have explored the utility of jurisdiction as an analytical lens.[6] Much of this work has been provoked by the governance studies of Mariana Valverde, who has defined jurisdiction as the 'governance of legal governance'.[7] Our consideration of conscientious objection considers both law and medicine as modes of governance and uses jurisdiction as a means of understanding and addressing the relationship between these sites. We are interested in the interplay of law and medicine and the process whereby law authorised medicine to manage abortion decision-making.[8] To do this we draw on sociological work on the professions as well as work by Valverde and others who have turned their attention to legal jurisdiction.[9] Bringing together professional and legal jurisdiction – and recognising the overlaps between the two - we engage an articulation of jurisdiction that is underpinned by a broader concern with authority and power.

Typically, legal discussions of conscientious objection - shaped and constrained by mainstream ethical theories – centre on the rights and obligations of individual service providers and tend to delist the structural and the political. The argument presented here is, in part, a response to this. As Chris MacDonald argues, existing approaches that emphasize the individual decision-making of health care professionals will always be inadequate: 'a more satisfying perspective on healthcare

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healthcare and the duty to refer' (2017) 43 *Journal of Medical Ethics* 207; Shaun Harmon, 'Abortion and conscientious objection: Doogan – A missed opportunity for an instructive rights-based analysis' (2016) *Medical Law International* 1; Ruth Fletcher, 'Conscientious Objection, Harm Reduction and Abortion Care' In Donnelly Mary. Murray, Claire (eds). *Ethical and Legal Debates in Irish Healthcare: Confronting Complexities.* (Manchester: Manchester University Press, 2016) 24-40

[6] Sheryl N. Hamilton, 'Thinking Through Chronotope: Reading and Working with Mariana Valverde's Chronotopes of Law: Jurisdiction, Scale, and Governance' (2016) 31(1) *Canadian Journal of Law and Society/Revue Canadienne Droit et Société* 125; Cedric Ryngaert, 'Territory in the Law of Jurisdiction: Imagining Alternatives'. In: Kuijer M., Werner W. (eds) *Netherlands Yearbook of International Law 2016. Netherlands Yearbook of International Law, vol 47* (The Hague: Asser Press, 2017) 49-82; Jess Mant and Julie Wallbank, 'The mysterious case of disappearing family law and the shrinking vulnerable subject: The shifting sands of family law's jurisdiction' (2017) 26(5) *Social & Legal Studies* 629; Chris Dietz, 'Jurisdiction in trans health' (2020) 47(1) *Journal of Law and Society* 60.

[7] Mariana Valverde, 'Jurisdiction and Scale: Legal "Technicalities" As Resources for Theory' (2009) 18(2) *Social & Legal Studies* 139, 141

[8] Mariana Valverde, *Chronotopes of Law: Jurisdiction, Scale and Governance* (Routledge, 2015), 86.

[9] *Ibid.*

ethics must shift attention to the social relations and institutions that distribute power.' [10] A jurisdictional lens helps to focus on the distribution of power and we argue that section 4, and the broader jurisdictional settlement it is part of, is only intelligible as part of a critical reading of medicine's relationship with abortion law reform.[11] In so doing, we evidence the importance of, and case for, historically informed ethico-legal enquiry.[12] As John Harrington notes, historicising legal studies can counter the trend to 'abstraction and a-contextuality' in law generally and medical law specifically under the influence of bioethics.[13]

We evaluate the evolution of the meaning of conscience with regard to the provision of abortion care in English Medical Law. *R v Bourne* [1938] 3 All ER 615 is the beginning point for a critical evaluation of what it means to be a conscientious practitioner.[14] The case concerns the unsuccessful prosecution of a doctor, Aleck Bourne, charged with unlawfully procuring a miscarriage under s. 59 of the Offences Against the Person Act 1861.[15] Bourne's attitude to law's ability to limit clinical discretion illustrates the way in which the medical profession's exclusive – jurisdictional - claim over abortion care emerged.[16] Conscience in this situation is cast as *professional jurisdiction*. Bourne's actions challenge the legitimacy of law to interfere with clinical decision-making, both generally and in the specific instance when a doctor seeks to do his or her best for a patient unencumbered by legal strictures or prohibitions.[17] His actions are also illustrative of the way in which the performance of 'conscience' is facilitated by, and to some extent reliant on, the power he has as an establishment figure.

More recent debates on conscience predominantly focus on the extent to which physicians should be facilitated in their decision to refuse to provide certain sorts of medical care.[18] In these scenarios, addressed below, there is no jurisdictional claim

[10] Chris MacDonald, 'Relational Professional Autonomy', (2002) 11(3) *Cambridge Quarterly of Health Care Ethics* 282

[11] See also Michael Thomson, 'Abortion Law and Professional Boundaries' (2013) 22 *Social & Legal Studies* 191; and Sheelagh McGuinness and Michael Thomson, 'Medicine and Abortion Law: Complicating the Reforming Professions' (2015) 23(2) *Medical Law Review* 177

[12] Duncan Wilson. 'What can History do for Bioethics' (2013) 27(4) *Bioethics* 215

[13] John Harrington, 'Time and space in Medical Law: Building on Valvrde's Chronotopes of Law*'* (2015) 23(3) *Feminist Legal Studies* 361 at 362; Wilson 2013 (n 12)

[14] *Rex v Bourne* [1938] 3 All ER 615 at 617 [Hereafter *Bourne*]

[15] For detailed analysis of this case see Barbara Brookes, Paul Roth, '*Rex v Bourne* and the medicalization of abortion'. In Michael P Clark, *Legal Medicine in History. (*Cambridge University Press, 1994) 314: 315; Lois Bibbings, 'R v Bourne: commentary' in S Smith, et al., (eds), *Ethical judgments: re-writing medical law* (Oxford: Hart Publishing, 2017)

[16] Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (Chicago: The University of Chicago Press, 1988)

[17] Thomas Gieryn, 'Boundary-work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists' (1983) 48(6) *American Sociological Review* 781; See further on this Thomson 2013 (n 11); McGuinness & Thomson 2015 (n 11)

[18] We acknowledge that there is an extensive body of work on conscientious commitment which rejects this frame – see Bernard Dickens, 'The Scope and Limits of Conscientious Objection' (2000) 71(1) *International Journal of Gynaecology & Obstetrics* 71; Lisa Harris, 'The Moral Agency of Abortion Providers: Conscientious Provision, Dangertalk and the Lived Experience of Doing Stigmatized Work'

over a particular practice or attempt to pre-empt law. Yet these cases are still illustrative of the relationship between power and conscience. Conscience in these situations is usually cast as *personal jurisdiction*. Conscience is understood as protecting moral integrity. Paying attention to the changing meaning of conscience and the 'game of jurisdiction' allows us to better understand processes of governance that are shaped by professional interests; including, the articulation of legal subjects and legal relations. [19]

We argue that legitimating narratives on conscience and section 4 seek to secure two seemingly contradictory positions. Thus these narratives seek to ground the morally ambivalent place of abortion in the medical imaginary whilst, at the same time, enabling a defence of abortion provision as an area of (largely) unfettered medical practice. We seek to reorient thinking on section 4, grounding the clause squarely in the politics of 'task areas', professional domains, market control, and claims of epistemological authority. Jonathan Montgomery has argued that statutory conscience clauses belong to 'the messy politics of professional boundary work'[20] and we see the clause as emblematic of law's 'extraordinary' treatment of abortion. [21] Thus, it aligns with what Caroline Corbin describes as "abortion exceptionalism"; that is, the way in which when it comes to abortion 'normal legal doctrine does not apply'.[22] In this case, the standard approach to accommodating conscientious beliefs in the context of employment is not enough.

Failure to understand section 4 as a mechanism for bolstering medical epistemological privilege, and thus jurisdiction, undermines the important identity-defining features of abortion and perpetuates a gendered cost of conscience. Turning to the *jurisdiction of conscience* helps us to begin to articulate a fuller and more productive understanding of the relationship between law, medicine, and conscience. Such analysis highlights the transformation of how we understand the place of conscience. To date, the burgeoning academic and policy literature on refusal to provide abortion care, and objection more generally, has not been addressed in these terms. Specifically, there has been a failure to address the questions of power that are embedded in the discourses and practices of conscientious objection. This article aims to unsettle and reorientate academic and policy debate in this area. To do so, we start by providing an outline and critique of dominant strands within the contemporary conscientious objection debate. In doing so, we foreground important limitations in such debate.

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in Lori d'Agincourt-Canning and Carolyn Ells (eds) *Ethical Issues in Women's Healthcare: Practice and Policy* (OUP, 2019); Bernard Dickens, 'The Right to Conscience' in Cook, Erdman and Dickens (eds) *Abortion Law in Transnational Perspective: Cases and Controversies* (Penn, 2014); Lisa Harris, 'Recognizing Conscience in Abortion Provision' (2012) 367 *New England Journal of Medicine* 981-983.

[19] Valverde 2009, (n7) 139

[20] Jonathan Montgomery, 'Conscientious Objection: Personal and Professional Ethics in the Public Square' (2015) 23(2) *Medical Law Review* 200, 220

[21] Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Oxford; Hart, 2001) 111

[22] Caroline Corbin, 2014. 'Abortion Distortions' (2014) 71(2) *Washington and Lee Law Review* 1175, 1176

Section 2: The contours and limitations of contemporary understandings of objection

It is often argued that conscientious beliefs are integral to an individual's sense of self. When an individual makes a claim of conscience they are making a statement about who they are: 'appeals to conscience can be understood as efforts to preserve or maintain moral integrity'.[23] Claims of conscience vary in form. They often, although not necessarily, engage religious beliefs and can exist at individual or group level.[24] A claim of conscience is generally a claim of withdrawal from general social and legal norms or expectations: 'Not me, or at least not in my name, goes the cry'.[25] Claims are premised on the assessment of what is acceptable for oneself. In making this assessment the individual is not expressing the view that the offending behaviour is one that others should avoid, rather 'the objector refuses to comply with an obligation on the ground that it would be wrong for him to do so'.[26] In professional settings, however, claims of conscience necessarily move beyond a statement about what is acceptable to self in their impact on third parties. Statutory protections of conscientious objection in these circumstances are therefore not simply a mechanism by which the objecting clinicians exempt themselves from what would otherwise be expected. Instead they become a way of perpetuating certain social norms of acceptability.[27] Thus, Douglas NeJaime and Reva Siegel argue '[i]n seeking an exemption, a claimant need not withdraw but instead can employ the [religious] objection to criticize norms governing the entire community.'[28] As such, accommodating claims 'may not settle conflict, as many contend. Instead, claims for [religious] exemption can provide a way to continue conflict over community-wide norms in a new form.'[29] Here the authors highlight two problems. First, rather than being an issue of personal morality or personal integrity, conscience clauses become a way of criticising the behaviour of others. Secondly, conscience clauses perpetuate the belief that particular practices are controversial and as noted by Cathleen Kaveny take the following form: 'A decent society ought to ban abortions but at the very least, it ought to protect those morally courageous doctors who refuse to perform it'.[30] As such it is important to note that even the declaration of an objection is not neutral.

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[23] Mark Wicclair, 'Conscientious objection in medicine' (2000) 14 *Bioethics* 205

[24] As Dan Brock summarises: 'conscience' [is] an individual's faculty for making moral judgments together with a commitment to acting on them. For many persons, their consciences are deeply informed by their religious beliefs and commitments, but there is no necessary connection between conscience and religion since many non-religious persons are equally possessed of moral commitments and consciences. Dan W Brock, 'Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?' (2008) 29 *Theoretical Medicine and Bioethics* 187, 188.

[25] Timothy Macklem, *Independence of Mind* (Oxford: Oxford University Press, 2006) 69.

[26] *Ibid.*

[27] Douglas Nejaime, Reva Siegel, 'Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics' (2015) 124 *Yale Law Journal* 2516

[28] *Ibid*., 2552

[29] *Ibid.*, 2553

[30] As cited *Ibid*., 2555

Contemporary statutory protections can be seen as requiring a particular identifiable group of individuals, those seeking a termination of pregnancy, to bear the burden of the religious or moral convictions of another, those who think abortion is never permissible. For some, like Macklem or NeJaime and Siegel, this moves the objection beyond the sphere of 'not in my name' in an important way as it prevents others from accessing legally permissible services.[31] As such we need to be mindful of the impact of conscientious protections on these third parties. DeJaime and Siegel identify two broad categories of harm to third parties that might arise: "material" harms and "dignitary" harms.[32] In what follows we focus on both categories of harm. This counters the assumption that it is only within the sphere of conscientious objection that dignitary harms arise and that the key issue with abortion is to reduce material harms by ensuring access. Such an approach overlooks the broader point that abortion is also an integrity right and infringement of this right has the potential for dignitary harm.[33]

Conscience clauses have the potential to cause dignitary harms and morally implicate a range of individuals beyond the holder of the conscientious belief. Arguments that seek to justify conscientious objection by reference to particular "questionable" practices are problematic to the extent that they situate the locus of conscience not solely within the individual but also within the activity. This gives rise to the possibility that all those involved in that activity become tainted with the *ethical doubt* it engages and generates. As such 'some citizens are singled out to bear significant costs of another's religious exercise'.[34] Consistent with this, arguments that seek to justify conscientious exemptions by treating abortion as morally questionable or a marginal medical activity are also problematic. Provoked, in part, by the passage of the *Doogan and Woods* litigation through the UK courts, Sara Fovargue and Mary Neal suggest three necessary limits on any framework for legal protection of a conscientious objection: that the conscientious belief be genuine, that clinicians have a duty to refer, and the objection pertains to a treatment whose status as 'proper medical treatment' is contested or liminal.[35] Fovargue and Neal accept abortion is a lawful medical procedure but draw on the work of Wicclair and use the framework 'proper medical treatment' to argue that:

> Where the status of a treatment or procedure is clearly within or without accepted medical practice, there is no need for CBEs [conscience based exemptions]. CBEs belong only at the margins of proper medical treatment where the status of the treatment is contested. A treatment may occupy liminal status because, despite being lawful, it is 'morally controversial and contentious'.[36]

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[31] Macklem, (n 25) 70; NeJaime & Siegel 2015 (n 27)
[32] NeJaime & Siegel 2015 (n 23)
[33] Elizabeth Procheska, 'Abortion and conscientious objection: what about human rights?' https://ukhumanrightsblog.com/2013/05/22/comment-abortion-and-contentious-objection-what-about-human-rights-elizabeth-prochaska/ (Accessed July 30th 2019)
[34] NeJaime & Siegel 2015 (n 27) 2521
[35] Fovargue & Neal 2015 (n 2) 227
[36] *Ibid.,* 229

Arguments like this are problematic. Using a justification of ethical doubt to invoke a framework that perpetuates this very ethical doubt is circular reasoning. Shaunnagh Dorsett and Shaun McVeigh observe that 'the repertoires of jurisdictional practice craft the figure of the legal person.'[37] Section 4 – cast as *personal jurisdiction* - helps to craft particular legal subjectivities for both the woman who may seek a termination of pregnancy and the doctors she may approach. It furthers the idea that abortion is never intrinsically acceptable, and expressed as conscience it frames this as ethical doubt. It further challenges the morality of the woman seeking the abortion and helps to justify the position where she has no 'right' to such care. Thus, even even though abortion is the most common medical or surgical procedure in the UK, with one in three women accessing abortion care by the time they reach the age of 45,[38] Section 4, and the legal mechanism adopted whereby doctors govern access to abortion as an exception to the criminal law, recursively narrates a female subject of law that justifies paternalism and fails to recognise bodily integrity, autonomy, and self-determination.

At the same time as we see the 'variegated mechanisms of jurisdiction'[39] craft a familiar woman of law, the Act supports the image of the doctor as morally trustworthy, supporting historic notions of veracity and good character that were essential to early occupational development and ongoing advancement.[40] Further, the specific provision for conscientious objection clearly engages the idea of moral deliberation. In terms of crafting the legal person, there is a narrow ascription of moral reasoning. This supports the relationship whereby abortion remains governed by the criminal law but doctors provide ethical and clinical judgement that validates the procedure in limited circumstances. This, of course, also relates to how the legal person operates as 'a jurisdictional devise, creating and ordering legal relations.'[41]

If we return to the idea that conscience claims can play an important role in affirming identity, we would assert that abortion and its role in the control of reproduction are importantly identity affirming in a way that is neglected. Quite often in academic commentary on conscientious objection to abortion care much time is spent considering what conscience is and how it should be assessed.[42] Less time is spent asking the question of why abortion is important and how this importance should be weighed against protection of conscience. Instead there is a tendency to invoke an unspecified metric assuming conscience is an issue of dignity or integrity whereas abortion can be reduced to a question of material harm, i.e.

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[37] Shaunnagh Dorsett and Shaun McVeigh *Jurisdiction.* (London: Routledge, 2012) 81.
[38] Abortion Care: Our Responsibility 2017 https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/spring-2017/abortion-care-services.pdf (accessed 19 August 2019)
[39] Valverde 2009 (n 15) 40
[40] Michael Thomson, *Reproducing narrative: Gender, Reproduction and the Law.* (Dartmouth Publishing Co Ltd, 1998)
[41] *Ibid.,* 95
[42] See for example Mary Neal and Sara Fovargue, 'Conscience and Agent-Integrity: A Defence of Conscience-Based Exemptions in the Health Care Context' (2016) 24(1) Medical Law Review 544.

access to a resource (care). We wish to take a step back and ask whether indeed there is an identifiable scale here and, if so, what legal framework best facilitates balancing the interests of both parties. In doing this we ask not just what does conscience mean but also what does abortion mean. We wish to show that abortion care should also be understood as being important in an identity affirming way, as summarised by Drucilla Cornell:

> Abortion … clearly involves the deepest recesses of one's being. Such a decision is obviously personality defining and a clear candidate for protection by any meaningful concept of conscience. Yet … the right to abortion demands actualization, not just expression.[43]

Abortion should be conceptualised as particularly important engaging both dignity and integrity. We follow Cornell's frame to advocate a rights based approach that balances the interests of those with a conscientious objection against the interests of those in need of an abortion and in doing so reject the idea that rights theory is necessarily embedded in 'an essentially masculinist ontology'.[44] We endorse a sex equality framework for how we should regulate abortion, and indeed reproduction more generally.[45] On this account, the legal framework should be sensitive to the distribution of burdens of reproduction by virtue of sexual difference and laws should not 'entrench or aggravate' the burdens that arise by virtue of difference by restricting 'women's bodily autonomy and life opportunities'.[46] Given this we must be cognisant of the fact that 'material' and 'dignitary' harms can be exacerbated when they are based on or perpetuate social norms of subjugation.[47] Cornell, summarises the importance of abortion as follows:

> the stake in the debate over abortion is whether or not women will be allowed to achieve the minimum conditions of individuation. If they are not allowed the right to abortion, they will not be allowed to engage in the process of bodily integration that is the very basis of the legal person.[48]

Abortion is integral to the recognition of selfhood. The denial of abortion or it's marginalisation within a legal framework has serious consequences for women's perception of themselves as part of the political community. As Cornell argues: 'women are not only denied the choice to have or not have an abortion, but deprived of the fundamental process of imagining their own bodily integration'.[49] For

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[43] Drucilla Cornell, *At the Heart of Freedom*, (Princeton University Press, 1998) 204

[44] See further Lisa Smyth, 'Feminism and Abortion Politics: Choice, Rights, and Reproductive Freedom' (2002) 25 *Women's Studies International Forum* 335.

[45] Reva Siegel, 'Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression.' (2007) 56(4) *Emory Law Journal* 815

[46] Siegel 2007 (n45) 816

[47] NeJaime and Siegel 2015 (n 27), 2527

[48] Drucilla Cornell, *The Imaginary Domain: Abortion Pornography and Sexual Harassment (*Routledge: 2015) 82

[49] *Ibid.,*

Cornell personhood is understood by reference to individuation, and the ability to imagine oneself over time. Lack of abortion is an infringement of bodily integrity.[50] She further argues that:

> The denial of the right to abortion should be understood as a serious symbolic assault on a woman's sense of self precisely because it thwarts the projection of bodily integration and places the woman's body in the hands and imaginings of others who would deny her coherence by separating her womb from her self.[51]

Cornell emphasises the importance of legal frameworks that permit abortion. The ability to control our reproductive futures is fundamentally important and decision-making in this area is identity affirming. Any limitations on the ability to make decisions of this kind will impact this.[52] Statutory clauses, like Section 4, further embed abortion as something which is bestowed on women rather than something to which they are entitled to by narrating a narrow conception of the rights holder. Further, as detailed below, they preclude any attempt of balancing competing rights. As such, the potential for serious dignitary harm to both women seeking abortion care and clinicians who provide this care is an important frame through which to assess existing and proposed frameworks for objection.[53]

This is the backdrop against which we focus on the politics of conscience as read through section 4, a provision that we contend marked a significant but neglected watershed in the relationship between doctor and patient. In addressing the question of conscientious objection through a historically informed jurisdictional analysis the merits and legitimacy of section 4 are called in to question. Our critique of section 4 is not just directed at its continued presence and operation, but also at the recent moves to translate or transplant the provision to other areas of practice. We have seen this, for example, in proposals before Parliament (Westminster[54] and Holyrood[55]) to legalise physician-assisted suicide and in Nuala O'Loan's 2017 Private Member's Bill which sought to expand the range of statutory protections for refusal to provide certain forms of medical care.[56] As Elen Stokes argues, 'the use of existing provisions to regulate a new area carries its own operational and ideological baggage'.[57] Any attempt at replicating such provisions is problematic because 'the

[50] For more recent accounts of bodily integrity that incorporate both physical and psychological features see Marie Fox and Michael Thomson, 'Bodily integrity, embodiment, and the regulation of parental action' (2017) 44(4) *Journal of Law & Society* 501; and Jonathan Herring, Jesse Wall, 'The nature and significance of the right to bodily integrity' (2017) 76 *Cambridge Law Journal* 566.
[51] Cornell 2015 (n48) 38
[52] See also Fox and Thomson (n 50) 501.
[53] It was suggested to us that it could be argued that 'dignitary harm' is too nebulous a threshold of harm. However, we suggest that it is no more nebulous that the importance of 'conscience' as a threshold for restricting abortion.
[54] Assisted Dying Bill 2016 HL Bill 25
[55] Assisted Suicide (Scotland) Bill 2013 SP Bill 40
[56] Conscientious Objection (Medical Activities) Bill [HL] 2015-2016 HL Bill 26
[57] Elen Stokes, 'Nanotechnology and the Products of Inherited Regulation' (2012) 39(1) *Journal of Law and Society* 93, 94

presumed application of existing measures … entails more than the replication of regulatory requirements. It also involves the transmission of traditions and assumptions, inbuilt in the regulatory regime'.[58] In this regard, our analysis highlights the relationships of power 'inbuilt' in section 4.

Section 3: Abortion, Conscience, and the Medical Profession

Underpinning our analysis is an understanding of jurisdiction as *epistemological authority:* the claim to the authority of a particular knowledge field that allows judgment. Jurisdiction as epistemological authority underpins all other jurisdictional forms. In this section we consider *professional jurisdiction*. The processes of professionalisation are dependent on successful claims to epistemological authority. With the co-evolution of the medical profession and abortion law, we see the relationship between epistemological authority and professional jurisdiction. Our focus is on the relationship between jurisdiction and the articulation of (medico-)legal subjects and relations. We see this as a key part of the 'how' of governance that the 'ethnomethodological miracle' of jurisdiction makes invisible. At the same time, attending to these features responds to Valverde's call to consider both the 'governance mood' and the 'affective and aesthetic dimensions' of jurisdictional arrangements.[59]

The role of the medical profession in abortion law reform has been widely documented.[60] Here we focus specifically on the role of claims to conscience within this. We look at the effects of the jurisdictional ordering of conscience that we see in the emergence of section 4 and its immediate operation. Jurisdictional analysis has largely been preoccupied with territories and sovereigns, with the 'sorting out of territories simultaneously sort[ing] out authorities'. [61] Yet, jurisdiction also 'differentiates and organizes' the *what* of governance, and 'most importantly because of its relative invisibility, the "how" of governance'. Questions of governance often 'end up being settled indirectly and without dialogue, as a result of the allocation of powers to different jurisdictions with distinct institutional habits and logics of governance'.[62] The picture painted is a complicated one; distinguishing conscience from clinical judgment is nigh on impossible and indeed attempts to do so risk being artificial and potentially misleading. This is illustrated by starting with the story of Aleck Bourne, a prominent obstetrician and gynaecologist who worked in London in the early part of the twentieth-century.

[58] *Ibid.*, 101
[59] Valverde 2015 (n8) 78
[60] John Keown, *Abortion Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982, (*Cambridge University Press 2009); Brookes and Roth (n 15) 314; Sally Sheldon, *Beyond Control: Medical Power, Women and Abortion Law* (Pluto Press, 1997)
[61] Valverde 2009 (n 7) 144.
[62] Valverde 2015 (n 8) 85

Bourne was Cambridge educated, and held a number of prestigious hospital posts, served as a military doctor, and upon his return from war started a well-known consultancy practice on Harley Street.[63] In 1938 he found himself before the Criminal Court for performing a termination on a 14-year-old girl who was pregnant after being raped by a group of soldiers. Brookes and Roth summarise the situation thus:

> Bourne's confidence in his reputation, in the justice of the case, and in public support, was such that he was willing openly to test the law; an action which, if resulting in conviction, would have meant the automatic removal of his right to practise and the end to an illustrious career.[64]

What prompted Bourne to perform this operation was a view that doctors must be allowed to provide that care which they believed to be clinically indicated. Bourne wished to challenge law's capacity to circumscribe or dictate his medical practice to him. Bourne's journey to, and through, the criminal court is indicative of the longstanding negotiation or 'turf war' – evident since the latter part of the eighteenth-century – between medicine and law over jurisdictional control of abortion.[65] As Valverde notes, 'jurisdiction is sometimes openly contested in disputes whose legal resolution then determines what kind of governance, what mode of power/knowledge, will be used'.[66]

Bourne was eventually acquitted and, although it was not enacted until some 30 years later, the Abortion Act 1967 enshrines many features of this case, for example, the necessity of two doctors stating that an abortion is necessary, an instance of the 'golden rule' of 'colleague control'.[67] The case also has an interesting legacy for how we might understand conscientious objection. It seems from his summing up that McNaughton J had some sympathy with Bourne's view on authority and medical discretion. He clearly respected Bourne's professional status as a man of the 'highest skill' and distinguished his ability to perform abortions where he believes them to be necessary from cases 'performed by a person of no skill, with no medical qualifications, and there is no pretence that it is done for the preservation of the mother's life'.[68] According to McNaughton '[i]t is obvious that that defence [of medical necessity] could not be available to the professional abortionist'.[69] Here McNaughton seems to endorse Bourne's view that there are areas of medical practice which are not subject to the ordinary authority of law. However, McNaughton moves beyond this to comment on the extent to which medical discretion could ever be legitimately trumped by individual conscience. He states that to provide care in circumstances like those outlined in the case before him is not

[63] see Plarr's Lives of the Fellows – Aleck William Bourne, http://livesonline.rcseng.ac.uk/biogs/E006328b.htm accessed 7 January 2019
[64] Brookes & Roth (n 15), 314
[65] See for example Keown (n 60); Sheldon (n 60)
[66] Valverde 2015 (n 8), 87
[67] Abbott 1988 (n 16) 2
[68] *Bourne* (n 14) 617
[69] *Bourne* (n 14) 618

simply a matter of discretion but rather one of duty, the dereliction of which should be subject to legal sanction:

> [T]here are people who, from what are said to be religious reasons, object to the operation being performed at all, in any circumstances. … [A] person who holds such an opinion ought not to be a doctor practising in that branch of medicine, for, if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of some religious opinion, and the woman died, he would be in grave peril of being brought before this court on a charge of manslaughter by negligence. He would have no better defence than would a person who, again for some religious reason, refused to call in a doctor to attend his child, where a doctor could have been called in and the life of the child saved. If the father, for a so-called religious reason, refused to call in a doctor, he also would be answerable to the criminal law for the death of his child.

Here McNaughton J deftly refutes any understanding of 'personal' conscience as having the capacity to trump professional obligations. Indeed, there are echoes of this limitation in section 4 of the Abortion Act, a point we will return to. For now we highlight the tension that exists between the different claims of conscience and the legal response. We find support for the notion of conscience as *professional jurisdiction*; that is accepting Bourne's exercise of clinical judgment. However, McNaughton does not seem to find persuasive the notion that conscience as *personal jurisdiction* could trump professional legal obligations. Legitimate conscientious deliberation appears here to be at the level of professional obligations rather than personal decision-making that may run counter to professional expectations or standards.[70] Medicine as a 'governing institution' is hybrid and complex, and as Valverde notes, authorities 'can use different gazes at different times – or even at the same time.'[71] As such, conflicts between medicine and law may be motivated by both perceptions of what is in the best interests of patients and simultaneously the boundary-work necessary to maintain professional jurisdiction.

As *Bourne* illustrates, the history of medicine's engagement with abortion law reform is a history of the profession seeking professional jurisdiction, but then also defending the boundaries of that jurisdiction. The constant within this has been medicine's claim to the authority to talk the truth about abortion – epistemological authority - and thus to define the limits of the legal and the ethical. This brings us to our third jurisdictional frame; that of *legal jurisdiction*. The relationship between medicine and law is complicated, as the history of abortion law evidences. At

[70] See for example Zuzana Deans, 'Might a Conscience Clause be used for non-moral or prejudiced reasons?' (2016) 42 *Journal of Medical Ethics* 76; Stephen Smith 'Individualised claims of conscience, clinical judgement and best interests' (2018) 26 (1) *Health Care Analysis* 26 (1) 81-93.
[71] Valverde 2009 (n 7), 142.

different times we see both jurisdictional conflict and medico-legal alliances. As Valverde advises, analysis must attend to the pluralism of regulatory systems:

> A sociolegal study of specific jurisdictional struggles has to be attentive to the legal lines of force but also integrate a careful consideration of the relevant non-legal and quasi-legal vectors of governance….[72]

Reading Bourne's understanding of medical discretion as integral to professional conscience alongside McNaughton J's warning that personal viewpoints should be trumped by professional obligations provides a complicated and nuanced picture for how we might understand conscience and abortion care. While clearly embedded in a question of professional jurisdiction and control, it seems to us to suggest a picture of conscience that aligns more with discourses of 'conscientious commitment' than 'conscientious objection'. Conscientious commitment is often reduced to a commitment to provide legally permissible but morally controversial medical services. However, as Bernard Dickens describes, '[c]onscientiously committed practitioners often need courage to act against prevailing legal, religious, and even medical orthodoxy, following the honourable medical ethic of placing patients' interests above their own'.[73] Understood in this way the conscientiously committed practitioner is one who is not necessarily bound by law but rather is prepared to transcend both law and personal beliefs in order to serve the *interests of their patients*.[74]

Contemporary accounts of section 4 generally accord with the incomplete characterisation of the legislation solely as a compromise.[75] As Valverde writes, 'particular claims about history are often crucial elements in jurisdiction's game'.[76] For example Lady Hale in *Doogan and Woods* sees section 4 as a relic of the political compromise necessary to achieve law reform:

> The conscience clause was the *quid pro quo* for a law designed to enable the health care profession to offer a lawful, safe and accessible service to women who would previously have had to go elsewhere.[77]

However, demarcating the sides between which this barter takes place is not entirely straightforward. David Steel had initially considered the inclusion of such a clause in his Medical Termination of Pregnancy Bill but ultimately decided, following consultation with lobbyists and medical professionals, that such a clause was not necessary.[78] However, following reflection with Catholic semenarians he changed his

[72] Valverde 2015 (n 8). 83
[73] Bernard Dickens, 'Conscientious Commitment' (2008) 371(9620) The Lancet 1240, 1241
[74] See further Carol Joffe, *Doctors of Conscience: The Struggle to Provide Abortion Before and After Roe V. Wade* (Beacon Press, 1996); Bernard Dickens, 'The art of medicine: Conscientious commitment' (2008) 371(9620) *The Lancet* 1240-1.
[75] For a criticism of this view see, McGuinness and Thomson 2015 (n 11)
[76] Valverde 2009 (n 7).
[77] *Doogan and Wood* (n 4) [para 27]
[78] Barbara Brookes, *Abortion in England 1900-1967* (Routledge, 2013) 154

mind. The clause was jointly drafted by Steel and vehemently anti-abortion Parliamentarian and key opponent of the proposed legislation, Norman St John Stevas MP.[79] St John Stevas had made clear from the earliest stages that he objected on principle to the content of Steel's Bill. However, as Hindell and Simms note, 'it seemed he was aware that abortion was a cause whose hour had come'.[80] He summarised his view of the necessity of a specific protection of conscientious objection as follows:

> [T]he conscience Clause…, I think we would all agree, is a very important part of the Bill. Perhaps the one point which commanded almost universal agreement in Committee and on Report was that there should be a conscience Clause of some kind in the Bill to protect those who have conscientious objection, on whatever grounds, in taking part in abortion operations.[81]

An examination of the Parliamentary debates from the time evidences a complicated picture of the extent to which a specific statutory protection of conscience was actually considered necessary. There are a number of strands of argumentation which provide the contours for how we might understand the emergence of section 4. For some the clause was important so as to protect those, for example Catholic, doctors and nurses who were opposed to abortion. However, linked to this it could be argued that the insertion of a conscience clause was an effort to restrict the scope of the Medical Termination of Pregnancy Bill by those, like St John Stevas, who had broader anti-abortion concerns. Although the wording of a draft clause was initially agreed in the later commons debates Steel and St John Stevas disagreed on the final detail, particularly on the obligation to treat in emergency situations.[82] As such it could be argued that the 'aim' is a strategic one aimed at limiting any liberalising effect of the reform.[83] In addition, and as we have detailed elsewhere, the medical establishment were at best reticent about the need to reform the law on abortion.[84] It is clear from their engagement with the reform process that a key concern can be understood in terms of professional jurisdiction; that is, preserving clinical control and clinical freedom in all aspects of medical practice.[85]

In the debates on the introduction of the conscience clause conflicting views emerged about the extent to which a clinician could ever be 'forced' to provide abortion care. Indeed, often the focus of the debate was on nurses as it was felt that they may not have sufficient power or status to recuse themselves from practices

[79] Malcolm Potts, Peter Diggory, and John Peel, *Abortion* (Cambridge University Press, 1977) 295
[80] Keith Hindell, Madeleine Simms, *Abortion Law Reformed* (Peter Owen 1971) 164
[81] St. John-Stevas HC Deb 25 October 1967 vol 751 cc1737-80.
[82] HC Deb 25 October 1967 vol 751 cc1737-80.
[83] Using conscience clauses in this way is sometime referred to as 'obstruction' – see further Fletcher 2016 (n5) 24-40.
[84] McGuinness & Thomson 2015 (n 11) 177-199
[85] *Ibid.*

they found objectionable.[86] This tension in viewpoints, which can be understood - like *Bourne* - as about professional jurisdiction provides an illustration of our arguments. Here, what is being resisted is not only patients' demands but also encroachment by lawyers on clinical discretion and decision-making. We see the protection of professional jurisdiction against outside powers - including legislatures – who are attempting to encroach upon medicine's 'task area' and authority.[87]

In the wake of enactment there was almost immediate concern about section 4. In order to respond to general concerns about the workings of the Abortion Act 1967, Sir Keith Joseph, then Secretary of State for Social Services, established an enquiry into the working of the Act chaired by Justice Elizabeth Lane in 1971.[88] The Lane Committee's terms of reference were to review the 'workings of the Abortion Act and not … the principles that underlie it'.[89] With section 4 two concerns are immediately evident and intertwined: that clinicians were being pressured into providing abortions and also that clinicians who exercised conscientious objections would be discriminated against. Consider the following excerpt from the evidence of the RCOG to Lane:

> Whether registrars who are asked by their seniors to terminate pregnancy do so because they believe it is right or because they are under orders, is unknown. There is, however, clearly a danger that concern for their future advancement could override their own convictions.[90]

Further concerns of those who felt that section 4 was not providing adequate protection of 'conscientious' practitioners also include complaints of advertisements for posts specifically excluding from application those who have a conscientious objection to abortion.[91] An alternative complaint regarding the operation of section 4 is evident from the evidence of the Birmingham Pregnancy Advisory Service which states:

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[86] See for example the comments of Mr Bernard Braine MP who stated that he 'favoured the conscience Clause in the first place much less on behalf of doctors than of nurses, if only because, unlike the former, nurses are part of a team and in the operating theatre take their orders directly from a doctor. It was not surprising that the Royal College of Nurses, the Royal College of Midwives and, I think, also the Association of Hospital Matrons, asked for the provision of a clearly drafted conscience Clause in order to safeguard the position of nurses. This was not merely because of circumstances whether the consciences of nurses might conflict with the duties they were called upon to perform but to obviate any deterrent effect the Bill might have upon nursing recruitment'. at HC Deb 13 July 1967 vol 750 c1323

[87] Thomson 2013 (n 11) 191

[88] Lane Committee on the Working of the Abortion Act, 1971 – 1974. See further Ashley Wivel 'Abortion Policy and Politics on the Lane Committee of Enquiry, 1971-1974' (1998) 11 *Social History of Medicine* 109-135.

[89] Report of the Committee on the Working of the Abortion Act (April 1974) (Cmnd. 5579) vol. 1, p.1 [Hereafter Lane Report]

[90] As reported in Kemp, John. 28th April 1972. Abortion 'Duress' on Doctors *The Daily Telegraph* 2

[91] TLT Lewis, 'The Abortion Act' (1969) 25 Br Med J 241.

> While the conscience clause properly respects the difficulties of the 'conservative' wing of the medical profession, it enables them also to obstruct the equally sincere endeavours of the 'liberal' wing (and of the majority of the doctors somewhere in between) to arrange abortions which they judge to be necessary. Rights in theory exercisable under the Abortion Act – doctors' rights as well as patients' rights – cannot be made fully effective without organised effort to enable the less conservative doctors to act according to their conscience in recommending and obtaining abortions for qualified patients.[92]

In their evidence BPAS detail cases of women who had attended their clinic after being turned away by their own doctors, or being turned away by hospital consultants having been referred by their own GPs.[93] The Lane Report clearly acknowledged the importance of protecting doctor's claims of conscientious objection. However, they also recognised this must be balanced against a woman's interest in receiving appropriate and timely health care. As such they recommended doctors should be open with their patients about when their refusal to provide care resulted from a conscientious belief.[94] The Report also suggested that these patients be given information about where they might be able to access abortion care.[95]

In summary, it is clear that those who argued for the clause had mixed motives. For some it was an attempt to restrict the scope of the Act and for others it was important because of the strongly held personal beliefs of some doctors. However, in its operation we see a dominant concern emerge whereby section 4 becomes a mechanism for maintaining control over the abortion decision-making process. Section 4 is then both a mechanism for maintaining power and also for protecting individual beliefs.[96] It results from the intermingling of the desire to maintain clinical control of the abortion decision-making process with broader anti-abortion aims.[97]

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[92] 'Provision of Abortion: Whose Responsibility?' [BPAS: Memorandum submitted to the official Committee on the Working of the Abortion Act, December 1971] p.15 (Emphasis in the original).
[93] *Ibid* Appendix C
[94] It is interesting to note that the obligation to disclose conscientious objection was included in an earlier draft Abortion Bill drafted by Glanville Williams. However, this was then omitted from the Bills that got as far as being discussed in Parliament. See Bernard Dickens, *Abortion and the Law* (MacGibbon & Kee, London; 1966) 143. We thank Sally Sheldon for drawing our attention to this.
[95] Lane Report (n 89). Similar concerns regarding the operation of Section 4 were also evident in a report of the Social Services Committee 'Abortion Act 1967: 'Conscience Clause'', see Abortion Act 1967: 'Conscience Clause' (Tenth Report Social Services Committee) (Session 1989-1990) (17th October 1990).
[96] It is interesting to note that the Guidance of the Medical Defence Union published in 1968 states without qualification that it is not expected that doctors wishing to claim a conscientious objection would need to meet a similar threshold to those exercising such an objection in the military sphere. See *Memoranda on the Abortion Act1967 and the Abortion Regulations 1968* (London, Medical Defence Union, 1968) Part 1: Memorandum on the Abortion Act 1967, 9. On comparison with the military see Kate Greasley, *Arguments about Abortion: Personhood, Morality, and Law* (Oxford University Press, Oxford; 2017) 251-2.
[97] A good example of this entanglement is the statements of Mr Norman Wylie MP HC Deb 13 July 1967 vol 750 c1317

In the final section we examine the consequences of different frameworks for protecting conscientious objection; that is, the 'how' of jurisdiction. So far we have sought to detail how conscience has been differently articulated in the context of abortion care. These articulations have shifted in terms of both jurisdiction and scale. Our focus has been jurisdiction and how it appears apolitical; affecting its 'ethnomethodological miracle'.[98] Scale – a function of jurisdiction – contributes to this, appearing as a 'politically neutral technical choice.'[99] The politics of governance is again obfuscated as tasks are assigned as part of a seemingly technical exercise to forms of governance of different scale (e.g. parish, municipality, domestic, transnational, or international). In this, the question of scale is central to the broader 'game of jursdiction' – 'deciding who governs where effectively decides how governance will happen.'[100] Valverde provides the following example, which also illustrates the way scale and jurisdiction overlap:

> If a decision is made – by a court of appeal, by a legislature, or by an international body – that a certain entity, say, a supply of fish, is indeed located in a certain space (say, Canadian territorial waters rather than international waters) then the answers to the … key questions of governance will generally flow in a certain direction…. [J]urisdictional assemblages have a strong path dependence. If the fish are deemed to be Canadian, then the logics of "natural resources" will certainly be deployed to govern them, but the political consequences of unemployment in East Coast fishing villages will also be taken into account….[101]

As this example illustrates, different methods or logics of governance take place at different scales enabling 'quite heterogeneous modes of governance carried out by different assemblages to co-exist without a great deal of overt conflict'.[102] Attending to jurisdiction as the 'governance of legal governance' therefore necessitates that we be mindful of the different scales at which governance (legal and regulatory) works. In this, scale provides a means through which to surface technicalities of governance, but also the broader 'sorting and separating' of jurisdiction.[103] This is illustrated in our mapping of how conscience has been articulated differently in the history we have addressed so far.

In *Bourne*, we read conscience as primarily the protection of professional discretion, here the scale is the individual exercising their judgement in the context of professional obligations. In terms of the Parliamentary emergence of section 4, whilst we see this as again a complicated governance picture, we foreground the provision as part of the broader legislative 'turf war' that was motivated, in part, by

[98] Valverde 2015 (n 8)
[99] Valverde 2009 (n7) 141.
[100] Ibid., 145.
[101] Ibid., at 144.
[102] Ibid., at 141. For a discussion and illustration of this point, see D Cowan, C Hunter, and H Pawson, 'Jurisdiction and scale: Rent arrears, social housing, and human rights' *Journal of Law and Society* (2012) 269-95
[103] Ibid.

concerns to maintain abortion as a question of medical authority and discretion. The scalar dimension here is at the professional level. In returning now to the broader overview of contemporary conscience in health care that we started with, we see conscience located at the level of personal jurisdiction, untethered to the question of professional obligations. In this most recent 'scal[ing] and rescaling'[104] of conscience, it is understood as a claim to personal authority over actions in the context of public obligations.

Section 4: Jurisdiction and Scale - The expansion of Conscience Based Exemptions

Section 4 extends law's 'extraordinary treatment'[105] of abortion as legal jurisdiction seeks to allow a space for personal jurisdiction. This has multiple, and at times profound effects on a number of lawful relations including the relationship between doctor and patient, between profession and state, and between state, woman, and doctor. Perhaps most immediately, the provision contributes to abortion being positioned as a moral question in a way that rewrites the relationship between doctor and patient. Excepting the Human Fertilisation and Embryology Act,[106] statute law provides no other instance where a doctor may object to meeting a clinical need of a patient. Dame Joan Vickers, supporting the clause, nevertheless recognised this exceptionality in the context of traditional medical practice and ethics:

> It is quite wrong for any doctor to put his ethical reasons before the consideration of his patient, but I suppose that this would be the only case in which we would refuse an operation on those grounds.[107]

This 'abortion exceptionalism' is never fully explained or justified and it is left as part of legal and medical *common sense*. With the advent of what has been described as 'conscience creep'[108] it is arguable that the effects of this initial breaching of the responsibility and ethic of care that Vickers acknowledges, has had enduring and escalating effects.

In her analysis of the evolution of conscience clauses in the US Elizabeth Sepper distinguishes between first-generation clauses, which are narrow and focus on particular groups of practitioners' ability to withdraw from a limited range of activities, and second-generation clauses that broaden the scope of conscience protections to include a wider range of individuals and activities.[109] As we go on to show, this analysis is also apposite in analysing English law. However, it is first worth stressing how far understandings have moved from the articulation of conscience

[104] Cowan et al. (n102) 275.
[105] See Jackson 2001 (n 21)
[106] Human Fertilisation and Embryology Act 1990, s.38
[107] Dame Joan Vickers HC Deb 22 July 1966 vol 732 cc1112
[108] Julie D. Cantor, 'Conscientious Objection Gone Awry: Restoring Selfless Professionalism in Medicine' (2009) 360 *New England Journal of Medicine* 1484, 1485
[109] Elizabeth Sepper, 'Taking Conscience Seriously' (2012) 98 *Virginia Law Review* 1501.

with professional duties and obligations that we read in *Bourne*. We now see conscience hobbled to mean little more than the rights of some individuals to withdraw from providing certain types of care. Conscience has become a question of personal jurisdiction. Conscience in health care can, of course, be much richer than this. As Shaw and Downie observe, whilst some may object to service provision

> … other practitioners feel equally conscientiously motivated to provide services such as abortion, by which patients can express their autonomy and achieve optimal health. The latter practitioners may equally feel harmed by having to compensate for colleagues' conscience-related service delays or obstruction, potentially creating unmanageable patient caseloads and/or rendering care more difficult, risky, or costly.[110]

In the context of thinking about conscience differently, there is value in turning to Montgomery's consideration of conscience in health care where he characterises statutory provision as anomalous, rooted 'in very specific settlements between society and health professions, whose legitimacy is historically contingent.'[111] Addressing conscience, Montgomery foregrounds not conflicting value systems, but *good faith*.[112] For Montgomery, the conscience that defines health care is the conscience found in the conscientious exercise of professional responsibilities, conscientious reasoning, and the conscientious exercise of discretion.[113] Contemporary expressions of conscience are understood as stemming from an expression of individual moral integrity. Here conscience is understood as a form of *personal jurisdiction*, arguably that which McNaughton cautioned against (something that becomes clearer the more extreme the claim, for example the refusal to refer or refusal to treat in emergencies). Here we argue that the governance of contemporary expressions of conscience transpose the deference afforded to professionals to define the boundaries of their own professional practice into a protection of individual conscientious beliefs - a claim to personal authority over actions in the context of public obligations.[114] Such conscience claims involve a call to law rather than a pre-emption of it.

Section 4 seeks to enable health care practitioners to withdraw themselves from participation in abortion care. What constitutes 'participation' in the context of

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[110] Jacquelyn Shaw, Jocelyn Downie, 'Welcome to the Wild, Wild North: Conscientious Objection Policies Governing Canada's Medical, Nursing, Pharmacy, and Dental Professions.' (2014) 28(1) *Bioethics* 33, 45. Shaw and Downie also refer to Justice Bertha Wilson's judgement in the Supreme Court of Canadian Justice that recognised that women may well have committed, considered and conscience-based reasons for requesting a termination. As Justice Wilson stated: '[F]or the state to take sides on the issue of abortion… is not only to endorse but also to enforce… one conscientiously-held view at the expense of another. It is to deny freedom of conscience to some, to treat them as a means to an end to deprive them of their 'essential humanity'.' *R v Morgentaler* [1988] S.C.J. No. 1 para 249, 253.

[111] Montgomery 2015 (n 20) 200-220.

[112] *Ibid.,* 225

[113] See also Stephen Smith, 'A bridge too far: Individualised claims of conscience' (2015) 23 *Medical Law Review* 283-302.

[114] See Montgomery 2015 (n 20) 200-220

conscientious objection has been subject to litigation on two occasions.[115] In addition subsequent caselaw clarifies that objecting physicians must refer patients to other willing providers.[116] An attempt to circumscribe the potentially disruptive effects of section 4 on the provision of healthcare is also evidenced by the obligation to refer in the NHS contract.[117] Beyond how this section operates in terms of day-to-day clinical practice it is also important to take account of how the provision operates in employment and education practices; this is something that tends to be over looked in the literature on conscientious objection.[118] Addressing this returns us to Valverde's attention to the importance of legal technicalities and the need to be both 'inside and outside law, simultaneously technical and theoretical, legal and socio-legal.'[119] It is also a clear question of jurisdiction and scale, as she writes, 'deciding who governs where effectively decides how governance will happen.[120]

The Health Service Guideline on 'Appointment of doctors to hospital posts: termination of pregnancy', issued in 1994, places limits on when and how conscientious objection may be taken into account in the recruitment process.[121] Particular criticisms include career grade posts should only mention the need to provide abortions if 'adequate services for termination of pregnancy [within the NHS/trust] would not otherwise be available.'[122] The BMA clarify this as meaning 'career posts that had little content other than termination of pregnancy'.[123] Further, questions about abortion can only be asked at interview stage if this has been detailed in the job description. For training grade posts 'no reference to abortion should be included in the job advertisement or job description, and applicants

[115] *Janaway v Salford Area Health Authority* [1989] AC 537; *Doogan and Wood* (n 4).
[116] Barr v Matthews (1999) 52 BMLR 217
[117] For England, see National Health Service (General Medical Services Contracts) Regulations 2004 (S.I. 2004/291), Sched 2(3)(2)(e) and clause 9.3.1(e) of the NHS England Standard General Medical Services Contract; for Scotland, see National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004 (S.S.I. 2004/116), Sched 3(3)(2)(e). It is important to note that while the duty to refer goes some way to addressing the 'material' harms which arise from conscientious objection they do not address the wider dignitary harm detailed above.
[118] See also Wendy Chavkin, Laurel Swerdlow, and Jocelyn Fifield, 'Regulation of Conscienctious Objection to Abortion: An International Comparative Multiple-CaseStudy' (2017) 19 Health and Human Rights Journal 55-67. See also Wivel (n 88).
[119] Valverde 2009 (n 7) at 154.
[120] Valverde 2009 (n 7)
[121] NHS Executive (1994) Appointment of doctors to hospital posts: termination of pregnancy, HSG(94) 39, DH, London. See also The National Health Service (Appointment of Consultants) Regulations: Good Practice Guidance (Department of Health, 2005) 2; *BMA views: The law and ethics of abortion* (British Medical Association, 2012) (updated 2014) https://www.bma.org.uk/media/1144/bma-view-on-the-law-and-ethics-of-abortion-october-2018.pdf accessed 7 January 2019.
[122] For criticisms see 'Memorandum from the Abortion Law Reform Association' https://publications.parliament.uk/pa/cm199899/cmselect/cmhealth/38/38ap62.htm accessed 7 January 2019 and 'Memorandum by Birth Control Trust' https://publications.parliament.uk/pa/cm199899/cmselect/cmhealth/38/38ap61.htm accessed 7 January 2019
[123] *Medical Ethics Today: The BMA's Handbook of Ethics and Law* (British Medical Association, 2012); *BMA views: The law and ethics of abortion* (British Medical Association, 2014) (updated 2018) https://www.bma.org.uk/media/1144/bma-view-on-the-law-and-ethics-of-abortion-october-2018.pdf accessed 7 January 2019.

should not be questioned about their attitude to termination of pregnancy prior to appointment'.[124] These restrictions potentially give rise to serious material harm and are particularly noteworthy given the current acknowledgement by organisations like the Royal College of Obstetricians and Gynaecologists that there is a lack of skills and training for abortion provision within the NHS.[125] A significant proportion of junior doctors are not being trained or gaining experience in this field although all doctors may be called upon at some time in their career to carry out abortions for obstetric reasons or in emergencies where a woman's life is endangered. This has a knock on effect that women with complex care needs, who can not be treated in the independent sector, may sometimes not be able to access care within the NHS and are thus forced to carry medically dangerous pregnancies to term.[126]

Outside of the employment and recruitment context it is also important to take account of the education context. The most recent BMA Guidance notes that medical students may be able to use section 4 to opt out of witnessing abortions.[127] In 2017 the Faculty of Sexual and Reproductive Health (FSRH) published 'Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception' under the threat of legal action by the Christian Medical Fellowship.[128] The guidance emphasises the importance of placing women at the centre of treatment but makes provision for those with objections to be able to still fulfil certain professional competencies.[129] This means that refusal to provide abortion is not just protected in the sphere of employment but additionally that individuals could potentially render themselves incompetent to perform a legally mandated procedure in emergency situations which are, of course, outside the reach of section 4.

As mentioned above the operation of section 4 was most recently litigated in

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[124] *Medical Ethics Today: The BMA's Handbook of Ethics and Law* (British Medical Association, 2012)

[125] See for example Abortion Care: Our responsibility https://www.rcog.org.uk/globalassets/documents/members/membership-news/og-magazine/spring-2017/abortion-care-services.pdf

[126] Alex Matthews-King, 'NHS pressures leave one woman a week unable to access abortion with no legal option other than childbirth, charity warns' (*The Independent*, 2018) https://www.independent.co.uk/news/health/hs-abortion-women-access-legal-option-childbirth-mothers-waiting-times-a8256096.html Accessed 7 January 2019

[127] 'Department of Health (now Department of Health and Social Care) correspondence shared with the BMA in the early 90s clarified that the conscientious objection clause can be used by medical students to opt out of witnessing abortions.' *BMA views: The law and ethics of abortion* (British Medical Association, 2012) (updated 2014) https://www.bma.org.uk/media/1144/bma-view-on-the-law-and-ethics-of-abortion-october-2018.pdf accessed 7 January 2019.

[128] Freedom of conscience for Christian medics after climb-down. (*The Christian Institute*, 2017) https://www.christian.org.uk/news/freedom-conscience-christian-medics-climb/; See also 'Briefing to accompany 'Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception' https://www.fsrh.org/documents/briefing-to-accompany-guidance-for-those-undertaking-or/ accessed January 19th 2019

[129] Asha Kasliwal, Jane Hatfield, 'Conscientious Objection in Sexual and Reproductive Health – a Guideline that Respects Diverse Views but Emphasises Patients' Rights' (2018) 44 BMJ 5-6.

Doogan and Wood, heard in the Supreme Court in November 2014.[130] The case and it's fallout provide an insight into the difficulties and tensions that coexist with the existence and operation of section 4. Two midwives working as 'Labour Ward Co-ordinators', a role that involved the 'delegation, supervision, and support' of patients and nursing staff who had participated in termination of pregnancy, wished to invoke section 4 in order to refuse to fulfil these duties. The Greater Glasgow & Clyde Health Board objected stating that their activities were not proximate enough to the termination procedure to qualify for protection under section 4. They further claimed that if the midwives claim were successful it would cause a level of administrative difficulty such as to pose a risk to patient care. In Scotland the termination of pregnancy after 18 weeks gestation often takes place in the labour ward.[131] Ultimately the midwives arguments for a wider reading of section 4 were rejected with the Supreme Court instead focusing on the question of whether the activities they wished to be exempted from constituted 'direct participation' in termination of pregnancy. Lady Hale opened her judgement by dispensing with 'Two Distractions': human rights arguments which were the main focus of the interveners submission and the wider impact on the abortion service.[132] Brian Napier QC, who was instructed by the Trust, felt that it was not necessary to read Article 9 into Section 4 as only Section 4(2) was qualified whereas Section 4(1) was unqualified and therefore unlike Article 9 in form and logic. This goes to the heart of our criticisms that Section 4 precludes rather than facilitates the operation of a framework which attempts to balance the interests of the competing parties.[133]

Subsequent to the decision in *Doogan and Wood* being handed down there has been a further attempt to extend the reach of Section 4 with potentially similar effect. Nuala O'Loan introduced a Private Members Bill, Conscientious Objection (Medical Activities) Bill, seeking to expand the range of statutory protections for refusal to provide certain forms of medical care.[134] The Bill contained all of the features that Sepper describes as being characteristic of 'second generation' conscience clauses.[135] Section 1 sets out three areas of medical practice that clinicians with a conscientious objection should not be under a duty to participate:

> (a) the withdrawal of life-sustaining treatment;
> (b) any activity under the provisions of the Human Fertilisation and Embryology Act 1990; or

[130] [2014] UKSC 68. See also *Janaway v Salford Area Health Authority* [1989] AC 537; *Barr v Matthews* (1999) 52 B.M.L.R 217.
[131] *Doogan and Wood* (n 4) [paras 12-17]
[132] *Doogan and Wood* (n 4) [paras 23 & 24]
[133] For a critical view of this failure to engage in a fulsome analysis of the rights of both parties see Harmon 2017 (n 5)
[134] Conscientious Objection (Medical Activities) Bill [HL] http://services.parliament.uk/bills/2015-16/conscientiousobjection.html. The 2017-2019 session of Parliament was prorogued which meant that Bill makes no further progress.
[135] Elizabeth Sepper, 'Doctoring discrimination in the same sex marriage debates' (2014) 89 Indiana Law Journal 703

(c) any activity under the provisions of the Abortion Act 1967[136]

As such, it broadens the range of activities that would be subject to statutory protections. However, it is really in Section 2 where it becomes apparent that this is a clear attempt to extend the scope of practices that a clinician can refuse to provide. The wording of the Bill reflected exactly the failed argument put forward in the case of *Doogan & Wood,* that is:

> "participating in an activity" includes any supervision, delegation, planning or supporting of staff in respect of that activity.[137]

The Bill broadened the scope of the protection afforded by Section 4 and had the potential to seriously impact the provision of certain sorts of medical care. This potential to impact care was heightened by the requirement outlined in Section 3 that:

> An employer (A) must not discriminate against or victimise an employee of A's (B) who makes use of the protections set out in this section.[138]

This wording was an attempt to enshrine in statute the current guidance outlined above. Importantly, however, there is no limitation on the protection against discrimination in an employment setting in order to facilitate the smooth running of a comprehensive service. As such and consistent with many clauses of this sort there is 'little or no effort to offset [it's] impact on third parties' beyond not being able to rely on section 4 in emergency situations.[139] Further, Section 3 is mistaken in framing conscientious objection as an issue of discrimination law. The Bill did not seek to protect a group's conscientious beliefs based on particular religious or moral views. Rather it sought to protect an individual's claim to refuse to provide certain services for unspecified conscientious beliefs which may be based on religious reasons or indeed no reasons at all as long as it was refusal to provide one of the specified services (locus of the claim is the activity). While discrimination law protects certain characteristics (locus of the claim is the person), of which religious beliefs are one, it does not provide protection for non-specified moral views on which this Bill is based.

The Bill attracted the support of a broad range of anti-abortion politicians and as such arguably was an example of what Nejaime and Siegel described as conscience claims serving 'larger law reform goals in "culture war" conflicts'.[140] It is hard not to view O'Loan's Bill as part of a broader anti-abortion agenda and as such we think it is important to assess the Bill not just against standards of how we protect

[136] Conscientious Objection (Medical Activities) Bill [HL] Section 1; https://publications.parliament.uk/pa/bills/lbill/2017-2019/0014/18014.pdf
[137] *Ibid*, Section 2
[138] *Ibid*, Section 3
[139] Abortion Act, section 4; NeJaime & Siegel, 2015 (n 27), 2542.
[140] NeJaime & Siegel 2015 (n 27), 2543

conscientious beliefs but also as part of the 'messy politics' of abortion law reform. As such, again drawing from Nejaime and Siegel:

> [L]awmakers might consider the message the government sends in furnishing an exemption. Context matters in assessing social meaning. Are there ways to accommodate religious persons without giving legal sanction to their view that other law-abiding citizens are sinning? If the government grants an accommodation, is the accommodation structured to block or amplify dissemination of religious claims about the sins of other citizens?[141]

O'Loan's Bill perpetuates the idea of certain practices being morally dubious and as such suggests that those who are involved in these activities are in some way tainted.[142] In this section we have emphasised the difficulty of Section 4 in practice and critiqued attempts to replicate section 4 in other areas of medical practice. This attempt to harness a flawed clause, with its associated problematic 'regulatory heritage', is based on a mistaken view that in the absence of such statutory provisions there is no legal protections for conscientious viewpoints. Ruth Fletcher has compelling argued for an account of conscientious objection that is in accordance with human rights norms.[143] We agree that such an approach provides a better framework for taking seriously the balancing of the interests of the different parties. Such an approach is premised on acceptance that an appropriate limit to expressions of conscience is the potential for third party harms.[144]

Section 5: Conclusions

A jurisdiction of conscience should engage the rights and dignity of the service user, or the 'collective conscience of the political or ethical community.'[145] At the moment, the impoverished understanding of conscience articulated in the Abortion Act represents the 'historically contingent'[146] reduction of professional autonomy and *professionalism* to the exercise of the personal autonomy of the health care worker. In other words, we need a more appropriate scale at which to see the exercise of conscience.

In this paper we do not seek to answer the question of the extent to which conscientious objection should be protected in law but rather to challenge some of

[141] NeJaime & Siegel 2015 (n 27) 2586

[142] Marginalising abortion in law and medical practice is part of broader anti-abortion strategising – see Sheelagh McGuinness 'A guerrilla strategy for a pro-life England' (2015) 7(2) *Law, Innovation and Technology* 283-314.

[143] Fletcher 2016 (n5) 24

[144] Douglas NeJaime and Reva Siegel, 'Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism' in Susanna Mancini & Michel Rosenfeld (eds.) *The Conscience Wars: Rethinking the Balance between Religion, Identity, and Equality* (Cambridge University Press 2017)

[145] McVeigh and Dorsett (n37) 95

[146] Sally Sheldon, Gayle Davis, Jane O'Neill, Clare Parker, 'The Abortion Act (1967): A biography' (2018) Legal Studies 1, 1

the legitimating narratives that have become associated with section 4 of the Abortion Act 1967 and to dispel the myth that statutory provisions are the only mechanism which can protect conscientious objection. Drawing on work on jurisdiction we have shown that this specific legal mechanism originated in a particular politico-legal context and cannot un-problematically be extended and duplicated to other areas of medical practice. In addressing this history, we respond to Valverde's directive that '[f]uture studies of the governance of governance will need to highlight and analyse the different "whens" of governance',[147] acknowledging that spatial analysis is strengthened by attention to temporality and history.[148]

In British abortion law there are currently multiple avenues for protecting claims of conscientious objection. We have focused here on the statutory protection of section 4. However, those like *Doogan and Wood* who fail to establish that their refusal meets the threshold of section 4 can pursue other avenues. As emphasised by Lady Hale, they could use the Equality Act 2010 to make a claim through an employment tribunal that their beliefs were not being reasonably accommodated in a workplace setting.[149] In addition, although they did not have purchase in *Doogan and Wood*, an objector could make a claim that requiring they undertake certain activities infringes their human rights as laid out in the Human Rights Act 1998.[150] Finally, many professional healthcare codes of practice contain protections for the conscientious objector.[151] These alternative strategies undermine the claims of those who suggest that section 4 is necessary to protect conscience claims and that in the absence of specific statutory protections there is no protection of conscience.

Those who advocate for such provisions are concerned with a particular sort of absolutist protection that statutory provisions like section 4 and those contained in O'Loan's Bill give rise to. For such people, conscience comes 'without cost'. However, provisions such as section 4 place the burden of an individual's conscientious beliefs solely on the shoulders of those in need of abortion and medical colleagues. Further, by attaching the protections to certain forms of medical care such statutory

[147] Valverde 2009 (n 7) 155.
[148] Ibid., at 154.
[149] *Doogan and Wood* (n 4) [para 24] See further Alasdair Henderson 'Conscientious objection to abortion: Catholic midwives lose in Supreme Court' https://ukhumanrightsblog.com/2014/12/28/conscientious-objection-to-abortion-catholic-midwives-lose-in-supreme-court/ (Accessed July 30th 2019)
[150] It is worth noting that there is existing European Human Rights jurisprudence on conscience and abortion, see *Grimmark v Sweden* [2020] (No 43726/17) and *Steen v Sweden* [2020] (No 62309/17). In *R.R. v. Poland*, Application No. 27617/04, Eur. Ct. H.R. (2011) para 206 it was held that the State must 'organize the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professional in the professional context does not prevent patients from obtaining access to services to which they are entitled under applicable legislation'. The European Court of Justice has also adopted this approach in *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy*, Complaint No. 87/2012, Decision on the Merits, March 10, 2014.
[151] See for example the General Medical Council's 'Personal Beliefs and Medical Practice' (Last updated November 2019) https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice (Access January 14th 2020)

provisions mistakenly identify the primary locus of the conscience claim in the activity rather than the individual.[152] Fletcher situates claims of conscientious objection within a broader context of legal obligations to provide health care. Any protection for derogation from provision must be narrowly drawn.[153] This is not to say that individuals should not be able to object if they wish, rather it is to say that if they do so they, not their colleague nor those in need of abortion, must bear the burden of their claim. Fletcher states:

> When abortion law recognises interests which may justify a termination of a pregnancy it is recognising interests which may be harmed by the exercise of conscientious objection.[154]

In this article we centre how changing articulations of conscience are involved in the jurisdictional scuffles and boundary-work between medicine and law in the context of securing and protecting legal jurisdiction. In this, the game of jurisdiction:

> … sorts competing powers and knowledges into ready-made, clearly separate pigeon-holes. An open-ended non-legalistic discussion about which type of governance is or is not appropriate in a given process is thus foreclosed.[155]

Following from this, governance studies have predominantly focused on questions of *who* governs *where*. This leaves important questions of *what* is governed and *how* they are governed under-explored. Yet, according to Valverde, 'jurisdictional assemblages have strong path dependence'.[156] By this she means that 'jurisdiction sorts the where, the who, the what, and the how of governance through a kind of chain reaction whereby if one question (where, who) is decided, then the answers to the other questions seem to follow automatically'.[157] As such, struggles over the where and the who of jurisdiction end up determining broader questions of power and authority. This can obfuscate the historical and political context within which the method of governance emerged:

> In general, for law to work smoothly, disputes about the substance and the qualitative features of governance have to be turned into seemingly mundane and technical questions about who has control over a particular spacetime (an inheritance, a quantity of lumber, a murder).[158]

[152] For an attempt to justify such an approach see Fovargue and Neal, 2015 (n 2); although note that in Neal and Fovargue 2016 (n 42) they seem to advocate for an account of conscience as integrity but suggest that limiting to certain practice acts as a further limit of conscience.
[153] Montgomery 2015 (n 20)
[154] Fletcher 2016 (n 5) 40
[155] Valverde 2015 (n 8) 85
[156] Valverde 2009 (n 7) 144
[157] Valverde 2009 (n 7) 143
[158] Valverde 2015 (n 8) 84

The game of jurisdiction has a 'quite magical power to depoliticize governance', it is 'the true anti-politics machine'.[159] In this article we have harnessed a jurisdictional approach to re-politicize conscientious objection and fully acknowledge the implications of objection for those in need of abortion care. Reading objection through a jurisdictional lens has helped to counter the depoliticization and decontextualization of the debates. Our attention to questions of scale within this jurisdictional analysis, and particularly the changing understanding of conscience, recognises the impact scale has on contestation: 'Scale demarcates the sites of social contest, the objects as well as the resolution of that contest.'[160] More generally, our analysis has foregrounded questions of power that are embedded within the discourses and practices of conscience and yet have been left unaddressed. In responding to this, we have highlighted the way in which medico-legal subjects and relations are crafted. In surfacing these questions and effects of power we seek to unsettle and reset the academic and policy debate in this area.

[159] Valverde 2015 (n 8) 84 citing Ferguson.

[160] Neil Smith 'Contours of a spatialized politics: Homeless vehicles and the production of geographical scale' (1992) 33 *Social Text* 54-81.