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Halliday, S (2016) Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life. *Contemporary Issues in Law*, 13 (4). pp. 287-322. ISSN: 1357-0374

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Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life

Introduction

Pregnancy is a unique state, involving as it does two distinct entities within one body. Throughout pregnancy the foetus is entirely dependent upon the pregnant woman and her actions and choices, such as the choice to drink excessive alcohol or smoke, may impact negatively upon the foetus. By the same token, pregnancy, whether or not it continues to term and culminates in a live birth, will inevitably change the life of the woman concerned, both physically and emotionally. In recent years the courts and the legislature in England and Wales have considered the nature of pregnancy and the pregnant woman's responsibilities in a number of contexts. Thus, for example, whilst the courts have failed to recognise that either the pregnant woman has a right to autonomy, or that the foetus has a right to life, they have nonetheless been prepared to recognise that a pregnant woman must be given full information about delivery methods and their risks,¹ that the right to conscientious objection must be narrowly construed in order to not constrain access to abortion,² that a woman may be subjected to a caesarean against her wishes where she lacks the capacity to decide for herself and such an intervention furthers her best interests;³ and that the foetus cannot be a victim of poisoning for the purposes of an award of criminal injuries compensation when the child, once born, suffers from foetal alcohol spectrum disorder due to its mother's excessive consumption of alcohol during pregnancy.⁴ In Parliament a number of attempts have been made to amend the Abortion Act 1967, notably to introduce independent counselling⁵ and to prohibit gender based abortion.⁶ Ostensibly these proposals have not been made for the purpose of protecting the foetus, but in the name of protecting women from making an ill-informed, unwise, or even a coerced decision.

Although reproductive decision-making is deeply personal, it is regulated in a way that other health and life choices are not. To some extent this reflects the public interest in the foetus, but the regulation of women during pregnancy, and of their decision-making, can be only partly explained on this basis. In the recent cases of court authorised obstetric intervention concerning women with a mental disorder, or a learning difficulty, courts have demonstrated an astonishing willingness to find that a caesarean delivery is required by the woman's best interests, with the primary component of those best interests being the achievement of the safe delivery of the 'child.'⁷ In many of those cases there has been a noticeable lack of support intended to facilitate the woman making delivery choices for herself, despite the fact that the Mental Capacity Act requires use to be made of supported decision-making (s.4(4))

¹ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

² *Greater Glasgow Health Board v Doogan & Wood* [2014] UKSC 68, [2015] AC 640.

³ *Re AA (Mental Capacity: Enforced Caesarean)* [2012] EWHC 4378 (COP), [2014] 2 FLR 237; *Re P* [2013] EWHC 4581 (COP); *Great Western Hospitals NHS Foundation Trust v AA, BB, CC & DD* [2014] EWHC 132 (Fam); *Royal Free NHS Foundation Trust v AB* (unreported, 31 January 2014); *The Mental Health Trust, The Acute Trust & The Council v DD & BC* [2014] EWCOP 11 (COP).

⁴ *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation) & Others* [2014] EWCA Civ 1554, [2015] 1 QB 459.

⁵ Proposed amendment to the Health and Social Care Bill, 2011, Nadine Dorries MP.

⁶ Abortion (Sex-Selection) Ten Minute Rule Bill, 2014, and proposed amendment to the Serious Crime Bill, 2015, Fiona Bruce MP.

⁷ See for example *Re AA* (note 3), per Mostyn J at 239; *Re P* (note 3), per Peter Jackson J at [17]; *The Mental Health Trust, The Acute Trust & The Council v DD & BC* (note 3), at [97].

MCA 2005), obligating the person determining the best interests to permit and encourage the individual concerned to participate, or to improve her ability to participate as fully as possible. By contrast the proposed women protective amendments to abortion law stress the need to support women in reaching a decision about abortion, not to support her decision, but to influence the way in which she makes it, to ensure that she will not regret her decision. Thus narratives of regret and guilt, and the need to protect women from such self-induced states, as well more generally from making an unwise, or irresponsible decision, dominate the jurisprudence of court authorised obstetric intervention and the political discourse about the regulation of abortion. This article focuses upon one of the proposed woman-protective amendments to the Abortion Act 1967, the proposed introduction of a requirement that women be offered independent counselling, arguing that the way in which a pregnant woman's decision-making, and indeed pregnant women themselves, are regulated is in need of reform.⁸ It sets out an alternative framework for viewing and regulating this unique biological state, where the woman effectively becomes a living matryoshka with another entity inside her own body, namely by reference to the protection of human dignity.

There is considerable support for the principle of human dignity at both a national and an international level, however there is no consensus upon the meaning of dignity, even at a national level. As discussed below, the concept of dignity is capable of multiple meanings – it can be seen to constrain choice, as for example in the French dwarf throwing case,⁹ whilst also being seen to support the free exercise of autonomy. It may be restricted in its application to persons extant, or may apply both prenatally to the foetus,¹⁰ or even after death to the extent that it protects the bodily integrity and even the reputation of the deceased.¹¹ In this article I review one of the recent challenges to abortion law and consider how dignity may be utilised to bolster both the woman's autonomy, but also to ensure that the dignity of prenatal life is respected. In doing so I will draw comparatively upon caselaw from Germany and the United States of America, considering the way in which the U.S. Supreme Court and the *Bundesverfassungsgericht* (German Federal Constitutional Court) have constructed human dignity in the abortion context, whilst recognising that some important cultural and political distinctions exist between the three jurisdictions. Ultimately it will be argued that reproductive exceptionalism must end and that restrictions upon reproductive decision-making should be viewed as impacting upon the woman's dignity. It is not simply a question of whether a woman has a right to access abortion, or indeed a duty to have a caesarean, but rather a broader view of the protection that dignity demands during pregnancy should be taken. Therefore, I argue that rather than focussing upon a right to elect an abortion, more emphasis is needed upon supporting the pregnant woman throughout pregnancy, upon respecting human dignity. Reframing the debate about reproductive decision-making in this manner will demand that her autonomous choices are respected, but also require that her autonomy be fostered/promoted and that she is enabled to participate in decision-making to the greatest extent possible.

A1. The guarantee of human dignity – a universal principle

The principle of human dignity has come to play an increasingly important role in the context of medical ethics and the law. At the supranational level, recognition of the inalienable right to human dignity and guarantees to protect it can be found in instruments including the

⁸ For a detailed analysis of the recent court authorised obstetric cases see S. Halliday *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention*, London: Routledge, 2016, chapter 2.

⁹ Conseil d'Etat, Ass., 27 October 1995, *Cne de Morsang-sur-Orge*, Dalloz Jur. 1995, p. 257.

¹⁰ *BVerfGE* 39, 1; *BVerfGE* 88, 203; *Vo v France* (2005) 40 E.H.R.R. 12.

¹¹ See for example the *Bundesverfassungsgericht's* Mephisto decision, *BVerfGE* 30, 173.

United Nation's Universal Declaration of Human Rights,¹² the Convention of the Elimination of All Forms of Discrimination against Women,¹³ the International Covenant on Civil and Political Rights¹⁴ and the Council of Europe's Convention on Human Rights and Biomedicine.¹⁵ Although the protection of human dignity is not explicitly mentioned in the European Convention on Human Rights, the European Court's jurisprudence leaves no doubt that dignity is protected under the Convention, indeed as the court held in *S.W. v The United Kingdom*, the essence of the convention is 'respect for human dignity and human freedom,'¹⁶ it is the central premise upon which the convention is built. Moreover, Art. 2 Lisbon Treaty emphasises the preeminent importance of dignity in EU law, stating 'The Union is founded on the [value] of respect for human dignity.'

At a national level such provisions guaranteeing human dignity can be found in constitutions, normally at the start, emphasising the centrality of the principle to the constitutional order; a prime example can be seen in the German constitution (the *Grundgesetz*, Basic Law): Art. 1 I GG states 'The dignity of human beings is inviolable. All state authority is under a duty to respect and protect it.'¹⁷ This article guarantees the protection of human dignity in a provision that is little more than a statement affirming the dignity of human beings, without attempting to elucidate the meaning of human dignity, or indeed the beneficiaries of the guarantee. Nevertheless, the *Bundesverfassungsgericht* (German Federal Constitutional Court) has described Art. 1 I GG as the 'supreme value in the *Grundgesetz*,'¹⁸ and it is probably best regarded as the preamble to the constitution itself and the lens through which the basic rights protected by the constitution (set out in Art.s 2 – 19 GG) should be viewed. As will be discussed below, the guaranteed protection of human dignity has played a pivotal role in the abortion jurisprudence of the *Bundesverfassungsgericht*, requiring that foetal life be protected from implantation, but simultaneously demanding respect for the woman's right to self-determination and bodily integrity.¹⁹

Notwithstanding the lack of any similar provision, in the United Kingdom and the United States of America references to human dignity can increasingly be seen in the case law and legislative debates, in relation to such disparate topics as the withdrawal of life-sustaining medical treatment and the right to marry for same-sex couples.²⁰ The courts in both jurisdictions have made reference to the principle, and indeed sought to uphold it, in a number of spheres of life. Thus, for example, in *Ghaidan v Godin-Mendoza*, Baroness Hale relied upon the concept of dignity in finding that s. 2(2) Rent Act 1977 should be interpreted to comply with the Convention, so that the defendant could succeed to the tenancy of his longstanding male partner.²¹ She emphasised that:

Democracy is founded on the principle that each individual has equal value. Treating some as automatically having less value than others not only causes pain and distress to that person but also violates his or her dignity as a human being. The essence of

¹² Preamble, Art.s 1, 22, 23 Universal Declaration of Human Rights.

¹³ Preamble Convention of the Elimination of All Forms of Discrimination against Women.

¹⁴ Preamble, Art. 10 International Covenant on Civil and Political Rights.

¹⁵ Preamble, Art. 1 Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.

¹⁶ 22 Nov. 1995, 47/1994/494/576, at para 44.

¹⁷ Unless otherwise stated, all translations are my own.

¹⁸ *BVerfGE* 6, 32, at 41.

¹⁹ *BVerfGE* 39, 1; 88, 203.

²⁰ See for example the second reading of the Marriage (Same Sex Couples) Bill, HL Deb 3 June 2013, vol 745, col 980 ff.

²¹ *Ghaidan v Godin-Mendoza* [2004] UKHL 30, [2004] 2 AC 557, per Baroness Hale, at [132].

the Convention, as has often been said, is respect for human dignity and human freedom.’²²

Similarly in *Roper v Simmons*,²³ holding the death penalty to be unconstitutional in the case of minors, Kennedy J referred to ‘the broad provisions to secure individual freedom and preserve human dignity’ in the U.S. constitution, arguing that ‘These doctrines and guarantees are central to the American experience and remain essential to our present-day self-definition and national identity.’²⁴

2. Competing conceptions of dignity

Notwithstanding the absence of a specific provision asserting the protection of human dignity, the European Court of Human Rights and courts on both sides of the Atlantic have accepted that the protection of human dignity forms a core principle within the law. Nevertheless, there is no consensus on what the protection of human dignity requires. The concept of dignity is capable of bearing multiple meanings and, recognising that it can be used as both a sword and a shield, Deryck Beyleveld and Roger Brownsword offer two competing constructions of dignity, namely dignity as empowerment and dignity as constraint.²⁵ Conceptualising dignity as empowerment recognises the manner in which it can be used to support choice, to reinforce autonomy. It is this construction of dignity that has enjoyed significant success in the context of end of life decision-making where it has been utilised by those seeking to promote assisted dying as a more publicly acceptable synonym for autonomy. Thus reference is made to ‘dignity in dying’ based upon compassion and choice, indeed the titles given to the American assisted dying Acts (the ‘Death with Dignity Acts’ of Oregon and Washington, and Vermont’s ‘Patient Choice at the End of Life Act’) demonstrate the key role now attributed to dignity as a vehicle for choice.²⁶ Significant progress has been made by those seeking to legalise assisted dying in the United States of America by reframing the issue as a right to die with dignity, rather than a right to euthanasia.

Jeremy Waldren has argued that ‘dignity has to function as a normative idea: it is the idea of a certain status that ought to be accredited to all persons and taken seriously in the way they are ruled.’²⁷ Such a construction of dignity would be consistent with Deryck Beyleveld and Roger Brownsword’s concept of dignity as constraint. It provides a symbolic expression of the inherent value of human life and requires that all life be treated with respect, but not that life be preserved in all circumstances. In Germany at least, dignity has been held to impose a duty upon the state to protect prenatal life; in its first abortion decision the *Bundesverfassungsgericht* emphasised that ‘Where human life exists, human dignity is present; whether the bearer is aware of this dignity and knows how to preserve it himself is not decisive. The potential capabilities present from the beginning of human existence suffice to establish human dignity.’²⁸ Thus by endowing prenatal life with dignity, the woman’s autonomy may be constrained, reflecting the communitarian nature of dignity. As Christian Starck explains, ‘Human dignity does not mean unlimited self-determination, but self-

²² Ibid.

²³ 125 S Ct 1183 (2005).

²⁴ Ibid, at 1200.

²⁵ D. Beyleveld & R. Brownsword, *Human Dignity in Bioethics and Biolaw*, Oxford: OUP, 2001.

²⁶ S. Halliday ‘Comparative reflections upon the Assisted Dying Bill 2013: A plea for a more European approach’ (2013) 13 *Medical Law International* 135, at 141.

²⁷ J. Waldron ‘How Law Protects Dignity’ (2012) 71 *Cambridge Law Journal* 200, at 202.

²⁸ *BVerfGE* 39, 1, at 41.

determination which is exercised on the basis that everyone – not simply the person claiming the right to self-determination—is of value in his or her own right.’²⁹

Dignity does not however merely require that all life be valued and protected, it also incorporates an element of equal treatment. Both Jeremy Waldren and James Whitman have argued that dignity has occasioned a ‘levelling up’, requiring that the degree of respect and level of treatment previously only accorded to nobility be afforded to all persons,³⁰ and Baroness Hale certainly gave voice to this argument in *Ghaidan*.³¹ In the reproductive context, whilst the foetus has benefitted from such levelling up, it is suggested that pregnant women have had no such boost in relation to their perceived decisional capacity. As Ann Oakley explained, the overwhelming view that emerged from her study of the medical care of pregnant women was that ‘pregnant women were themselves deficient: they lacked the necessary intelligence, foresight, education, or responsibility to see that the only proper pathway to successful motherhood was the one repeatedly surveyed by medical expertise.’³² Whilst Oakley’s study was conducted during the early 1980s, the inability of women to make reproductive decisions without guidance continues to dominate the discourse. As will be considered below, women’s decision-making is subject to supervision and amendment and is treated as suspect and incompetent wherever it is inconsistent with the idealised standards of maternity.

The European Court of Human Rights recognised the synthesis of dignity with autonomy in *Pretty*,³³ but the courts in England and Wales have also placed reliance upon ‘dignity’ in cases where the individual concerned lacks the ability to make an autonomous choice. As Munby J emphasised in *Burke*,³⁴ ‘It is not just the sentient or self-conscious who have dignity interests protected by the law.’ In cases where the individual is incapable of making a choice (either contemporaneously, or through the implementation of an anticipatory decision) dignity can clearly not operate as empowerment, however the courts regularly refer to the notion that an individual lacking capacity to decide for herself should be permitted to ‘die with dignity.’ Acknowledging this, Munby J stressed:

The invocation of the dignity of the patient in the form of a declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the law's and of society's recognition of our humanity and of human dignity as something fundamental.³⁵

There is a significant difference between a court granting a declaration that treatment may be withheld, or withdrawn, to allow a patient lacking capacity to die with dignity, and respecting

²⁹ C. Starck, ‘The Religious and Philosophical Background of Human Dignity and its Place in Modern Constitutions,’ in D.Kretzmer and E. Klein (eds) *The Concept of Human Dignity in Human Rights Discourse*, Kluwer Law International, 2002, 179, at 181.

³⁰ See for example J. Waldron, ‘Dignity and Rank: In Memory of Gregory Vlastos’ (2007) 2 *Archives Européennes de Sociologie* 201, at 215 ff; J. Whitman, *Harsh Justice: Criminal Punishment and the Widening Divide Between America and Europe*, Oxford:OUP, 2003.

³¹ *Ghaidan v Godin-Mendoza* (note 21), at [132].

³² A. Oakley, *The Captured Womb: a History of the Medical Care of Pregnant Women*, Oxford: Basil Blackwell, 1984, at 72.

³³ *Pretty v United Kingdom* (2002) 35 EHRR 1, at [65].

³⁴ *R (Burke) v General Medical Council* [2004] EWHC 1879 (Admin); [2005] QB 424, at [58].

³⁵ *R (A, B, X and Y) v East Sussex CC and the Disability Rights Commission (No 2)* [2003] EWHC 167 (Admin), (2003) 6 CCLR 194, at [86].

a patient's refusal of life-sustaining treatment as in the case of Ms B.³⁶ Whilst the latter may properly be characterised as dignity as empowerment, the former demonstrates the conceptualisation of dignity as constraint, restraining healthcare professionals from prolonging life (or as the Law Lord's referred to Antony Bland's state, his existence³⁷) for the sake of life. As Lord Hoffmann made clear in *Bland* autonomy and dignity may be complementary, rather than synonymous:

In my view the choice which the law makes must reassure people that the courts do have full respect for life, but that they do not pursue the principle to the point at which it has become almost empty of any real content and when it involves the sacrifice of other important values such as human dignity and freedom of choice.³⁸

Thus the courts have stressed that the protection of human dignity may override the importance of the sanctity of life, even where the patient has not made any choice concerning (non)treatment as in the case of *Bland*. In this construction of dignity as constraint, stress is laid not upon personal choice, but upon the inherent dignity of life, emphasising the distance between human dignity (where the life must be perceived as having some value, to the individual or at an abstract level) and the sanctity of life. Thus although the guarantee of human dignity expresses respect for life, it will not always require the preservation of a specific life, particularly where so doing would significantly impact upon the dignity and rights of another, a key consideration in the context of reproductive decision-making.

3. Dignity in the reproductive context

The tension between the multiple and often competing conceptions of dignity is particularly apparent in the reproductive context where human dignity may require the protection of both the woman's rights to bodily integrity and self-determination, as well as the protection of foetal life. Although the English courts have not recognised that the foetus has a right to life, or that the pregnant woman has a right to autonomy in respect of choosing an abortion at any stage of the pregnancy,³⁹ a number of superior courts have addressed these rights by reference to human dignity. For example, the Hungarian Constitutional Court found that dignity was engaged in the regulation of abortion, holding: 'Among the rights to be weighed against the state's duty to give increased protection to foetal life, the mother's right to self-determination – as part of the right to human dignity – is the most important one.'⁴⁰ By contrast the *Bundesverfassungsgericht* found that the regulation of abortion impacts upon both the dignity of the pregnant woman and foetal life and was significantly less inclined to prioritise the woman's right to self-determination as will be considered below.

Emphasising the conceptualisation of dignity as liberty, Joseph Raz wrote 'Respecting human dignity entails treating humans as persons capable of planning and plotting their future. Thus respecting people's dignity includes respecting their autonomy, their right to control their future.'⁴¹ This formulation echoes that adopted by Wilson J in *R v Morgentaler* where she

³⁶ *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).

³⁷ See for example *Airedale NHS Trust v Bland* [1993] AC 789, at 856, per Lord Keith.

³⁸ *Airedale NHS Trust v Bland* [1993] AC 789, at 830.

³⁹ *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276, per George Baker P, at 279.

⁴⁰ Decision 48/1998 (IX.23) AB, para 3(b), quoted in C. McCrudden, 'Human Dignity and Judicial Interpretation of Human Rights,' (2008) 19(4) *EJIL* 655, at 689. For an excellent comparison of the use of dignity in relation to abortion by the German and Hungarian constitutional courts see C. Dupré, *Importing the Law in Post-communist Transitions: The Hungarian Constitutional Court and the Right to Human Dignity*, Oxford: Hart, 2003.

⁴¹ J. Raz, *The Authority of Law: Essays on Law and Morality*, 2nd edn, Oxford: OUP, 2009, at 221.

stressed that human dignity underpins the Canadian Charter of Rights and Freedoms⁴² and that ‘the right to reproduce or not to reproduce ... is properly perceived as an integral part of modern woman's struggle to assert her dignity and worth as a human being.’⁴³ She emphasised that the limitations upon access to abortion imposed by s. 251 Criminal Code undermined not only a woman’s autonomy, but also her bodily integrity, that the pregnant woman ‘is truly being treated as a means - a means to an end which she does not desire but over which she has no control. She is the passive recipient of a decision made by others as to whether her body is to be used to nurture a new life. Can there be anything that comports less with human dignity and self-respect?’⁴⁴ Thus conceived dignity is more broadly defined than autonomy, it encompasses the right to bodily integrity and reflects Immanuel Kant’s second categorical imperative, the principle that persons should not be instrumentalised, that they should be an end in themselves, and not a means to an end.⁴⁵

The synthesis of dignity with autonomy is clearly evident in the American abortion jurisprudence, where the Supreme Court has relied upon the concept of dignity to reject limitations upon the woman’s right to choose an abortion prior to viability. Writing for the majority in *Planned Parenthood of Southeastern Pennsylvania v Casey*, O’Connor J expressed this notion in the following terms:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.⁴⁶

The plurality’s formulation of dignity, based upon autonomy and the construction of personhood through choices, had the effect of empowering women, reinforcing a pregnant woman’s claim to self-determination. Similarly, Stevens J, concurring in part and dissenting in part, stated, ‘The authority to make such traumatic and yet empowering decisions is an element of basic human dignity. As the joint opinion so eloquently demonstrates, a woman's decision to terminate her pregnancy is nothing less than a matter of conscience.’⁴⁷

Thus in *Casey* the Supreme Court adopted a conception of dignity that focussed upon personal choice and recognising women’s agency. However, the limits of that personal choice are particularly clear in the American context, where the right to elect a pre-viability abortion must be distinguished from the question of a woman’s ability to access abortion. As the Supreme Court has made clear on a number of occasions, there is no requirement that states facilitate access to abortion.⁴⁸ Moreover, as the plurality recognised in *Casey*, a woman is entitled to make the ultimate decision to have an abortion, but the state can seek to manage, or influence that decision provided that in so doing it does not impose an undue burden upon her ability to elect a pre-viability abortion.⁴⁹ For example, in that case the

⁴² *R v Morgentaler* [1988] 1 S.C.R. 30, Canadian Supreme Court, Wilson J (concurring), at 165ff

⁴³ *Ibid*, at 172.

⁴⁴ *Ibid* at 173.

⁴⁵ I. Kant, ‘Grundlegung zur Metaphysik der Sitten,’ in J. Timmermann (ed), *Sammlung Philosophie*, Göttingen: Vandenhoeck & Ruprecht, 2004, vol. 3, at 44, Rn. 49.

⁴⁶ *Planned Parenthood of Southeastern Pennsylvania et al v Casey* 505 U.S. 833 (1992), at 851.

⁴⁷ *Ibid*, at 916.

⁴⁸ See for example *Harris v McRae* 448 US 297 (1980); *Rust v Sullivan* 500 US 173 (1991); *Webster v Reproductive Health Services* 492 U.S. 490 (1989).

⁴⁹ *Planned Parenthood of Southeastern Pennsylvania et al v Casey* (note 46), at 877.

plurality upheld the Pennsylvanian measures such as an informed consent requirement whereby the woman's consent will only be considered voluntary and informed if at least 24 hours before the abortion was performed the doctor had provided information about the nature and health risks of the abortion procedure and childbirth, told her the probable gestational age of the foetus and informed her of the availability of printed materials from the state describing the foetus and providing information about alternatives to abortion (including adoption) and the availability of financial assistance available for medical care during pregnancy and childbirth. The plurality stressed that this requirement does not impose an undue burden upon the woman's right to elect a pre-viability abortion noting that 'the right protected by Roe is a right to decide to terminate a pregnancy free of undue interference by the state. Because the informed consent requirement facilitates the wise exercise of that right, it cannot be classified as an interference with ...[or] an undue burden on that right.'⁵⁰ Of course complying with such an informed consent requirement will delay the performance of an abortion, requiring two separate visits to the abortion clinic and thereby subjecting women to running the gauntlet of abortion protesters at least twice, increasing the cost of abortion (particularly if the woman has to travel a long distance to access abortion) and requiring her to take more time off work or from her other commitments. Nevertheless, the court considered that these factors would not render the mandatory waiting period and informed consent requirement an undue burden upon her ability to choose an abortion and therefore upheld the requirement.⁵¹ Thus considered, the negative aspect of the woman's right to choose abortion is evident – practical restrictions upon her ability to exercise that right render it illusory for those of limited means.

The construction of dignity as empowerment is subjective, prioritising individual values, rather than seeking to establish a universal human dignity. However, as Deryck Beyleveld and Roger Brownsword recognise, dignity can also operate to deny individual choice when constructed as constraint. The U.S. Supreme Court adopted a very different interpretation of dignity in *Gonzales v Carhart*⁵² where it upheld the Partial Birth Abortion Ban Act. Having provided an extremely graphic and emotive description of how a so-called 'partial birth' abortion is performed, the majority of the Supreme Court recognised that dignity is engaged in relation to the foetus' life as well as the woman's choices. Thus, upholding the constitutionality of the Partial Birth Abortion Ban Act Kennedy J stated that it 'expresses respect for the dignity of human life.'⁵³ Unfortunately, he failed to develop his analysis of dignity as life and gave no explicit consideration to the dignity of the pregnant woman. Kennedy J emphasised the need for a woman's decision to abort to be fully informed, the purpose of the information being to protect women from the seemingly inevitable regret that some women will feel after choosing to undergo an abortion.⁵⁴ However, as Reva Siegel argues, the suggestion that women should be protected from making a decision that they will later regret is a very different view to the conception of dignity as equality and autonomy set out in *Casey*.⁵⁵ Given that the Act contains no exception safeguarding the health of the woman, it is suggested that Kennedy's understanding of dignity can at best be characterised as one-sided. Moreover, the conclusion that the Act expresses respect for the dignity of human life is somewhat surprising when one considers that the legislation prohibits a

⁵⁰ Ibid, at 887.

⁵¹ At 885ff.

⁵² 127 S.Ct. 1610, at 1633 (2007).

⁵³ Ibid, at 1633

⁵⁴ Ibid at 1634.

⁵⁵ R.B. Siegel 'Dignity and sexuality: Claims on dignity in transnational debates over abortion and same-sex marriage' (2012) 10 (2) *I.Con* 355, at 368.

particular method of procuring an abortion, rather than the termination of pregnancy itself, suggesting that the respect expressed is extremely limited in nature. Indeed, given that the focus of the prohibition is upon the method utilised to procure an abortion, the only constraint would appear to be upon medical practice.

4. The German compromise: the protection of dignity, life and liberty interests in the regulation of abortion

Whilst the U.S. Supreme Court and the Hungarian Constitutional Court have primarily adopted a conception of dignity focused upon choice and recognising a woman's agency in relation to abortion, the German *Bundesverfassungsgericht* linked the protection of human dignity to both the woman's right to self-determination and the foetal right to life, conceptualising dignity as both liberty (in the sense of decisional autonomy promoted in *Casey*) and constraint, in so far as it requires the woman's liberty interests to be restrained in order to protect the foetus. The court has twice found abortion legislation to be unconstitutional and thus invalid, in decisions handed down shortly after the U.S Supreme Court decided *Roe* and *Casey*.⁵⁶ Despite the proximity in time, the German decisions differ significantly from their U.S. counterparts, holding that the constitutional guarantee of human dignity, and the right to life, apply to the foetus in and of itself.⁵⁷

The right to life is guaranteed by Art. 2 II s.1 GG, protecting the physical-biological existence of human beings.⁵⁸ Unlike the Irish constitution⁵⁹ the German constitution does not expressly state that the right to life applies to prenatal life, but the legislative history of the *Grundgesetz* demonstrates that the legislature intended the right to life to apply prior to birth⁶⁰ and the judges in each of the abortion decisions were unanimous in holding that the right to life is not limited to life extant, stating 'The protection of human existence from state interference would be incomplete if it did not include the preliminary stage of "completed life," prenatal life.'⁶¹ Indeed, as Rupp-v.-Brünneck and Simon JJ point out in their dissenting opinion, the question is not *whether*, but *how* the right applies to the foetus.⁶² Although the *Bundesverfassungsgericht* recognised that the pregnant woman's rights to life and bodily integrity, to personality and her dignity are engaged, it held that she owes a duty to her foetus throughout pregnancy, a duty to continue the pregnancy to full term.⁶³ That being the case, her rights must be curtailed to the extent necessary to protect the foetus, unless her choice to terminate the pregnancy can be justified. As the court stressed, in all but the most serious situations a woman's failure to continue the pregnancy will not be capable of justification and thus must be categorised as unlawful.⁶⁴

⁵⁶ *BVerfGE* 39, 1 (1975); 88, 203 (1993).

⁵⁷ Abortion I: *BVerfGE* 39, 1, at 1, headnote 1; Abortion II: *BVerfGE* 88, 203, at 252. Cf *Roe v Wade* 410 US 113 (1973), per Blackmun J at 158.

⁵⁸ H. Schulze-Fielitz, in H. Dreier, *Grundgesetz Kommentar*, 2nd edn, Tübingen: Mohr Siebeck, 2004 Art. 2 II, Rn. 25.

⁵⁹ Art. 40.3.3° Irish constitution states 'The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right. ...'. Noticeably the only conflicting right relevant in the Irish context is the woman's own right to life, her right to self-determination cannot be weighed against the foetal right to life, *Attorney General v X* [1992] IRLM 401.

⁶⁰ For a comprehensive account of the parliamentary debates see R.Beckmann, 'Der Parlamentarische Rat und das "keimende Leben"' (2008) 47(4) *Der Staat* 551.

⁶¹ *BVerfGE* 39, 1, at 37.

⁶² *BVerfGE* 39, 1, at 68.

⁶³ *BVerfGE* 39, 1, at 44; 88, 203, at 253.

⁶⁴ *BVerfGE* 39, 1, at 48ff; 88, 203, at 255ff..

A fundamental difference in approach in the American and German constitutional philosophies can be readily discerned in the abortion jurisprudence. The U.S Supreme Court recognised that the state had an interest in prenatal life and that it could (should it so choose) intervene to protect that interest from the beginning of the third trimester (in *Roe*), or throughout pregnancy provided that in doing so the state did not pose an undue burden upon the woman's right to elect a previability abortion (in *Casey*). By contrast, the *Bundesverfassungsgericht* held that the foetus is protected by both the right to life and the constitutional guarantee of human dignity and that the state is under a duty to take positive action to protect foetal life from implantation onwards. It stated 'The state's duty to protect is comprehensive. Self-evidently it does not only prohibit direct state interference in the developing life, but also requires the state to take a stance protecting and promoting this life, ... above all, to protect it from unlawful interference from others.'⁶⁵ Therefore, the *Bundesverfassungsgericht* recognised that the state has an affirmative duty to protect and promote foetal life, including protecting the foetus from the pregnant woman herself.⁶⁶

Thus, two years after the U.S. Supreme Court had emphasised the liberty of the individual and the limits of state action infringing upon the exercise of that liberty in *Casey*, the German court stressed the communitarian nature of rights, emphasising that pregnancy involves a '*Zweiheit in Einheit*' (duality in unity), rather than merely a pregnant woman and underlining the social and relational aspects of pregnancy.⁶⁷ Whilst the U.S Supreme Court found that the foetus is not a person within the meaning of the constitution,⁶⁸ the *Bundesverfassungsgericht* recognised that the right to life applies to prenatal life, holding that the foetus is an independent legally protected value (*Rechtsgut*) that 'does not develop into a human being, but as a human being.'⁶⁹ In seeking to reconcile the conflicting rights of the woman and the duty to protect foetal life, the court attributed a pivotal role to the protection of human dignity, holding in Abortion I that in weighing the conflicting constitutional values reference must be made to their relationship with the protection of human dignity, the epicentre of the constitutional value system.⁷⁰ Nevertheless, the court adopted a very one-dimensional view of dignity in the first decision, adopting the formulation of dignity as restraint by stressing that the protection of dignity requires the protection of human life, and that such protection will outweigh the woman's right to self-determination throughout the pregnancy.⁷¹ It failed to consider the impact of dignity on the weight to be accorded to her right to self-determination. In Abortion II the *Bundesverfassungsgericht* emphasised the link between human dignity and the consequent duty to protect foetal life,⁷² stressing that 'where human life exists, human dignity is accorded to it.'⁷³ The court described the right to life 'as the most elementary and inalienable right derived from human dignity,'⁷⁴ and emphasised

⁶⁵ *BVerfGE* 39, 1, at 42.

⁶⁶ *BVerfGE* 39, 1, at 42; 88, 203, at 255.

⁶⁷ *BVerfGE* 88, 203, at 253; cf. *BVerfGE* 39, 1 at 42 stressing the separateness of the foetus and the pregnant woman. For an interesting analysis of the juxtaposition between the communitarian and individualist stances of the two courts see C. McCrudden (note 40).

⁶⁸ *Roe v Wade* (note 57), at 157.

⁶⁹ *BVerfGE* 88, 203, at 252; 39, 1, at 37.

⁷⁰ *BVerfGE* 39, 1, at 43, citing *BVerfGE* 35, 202, at 225.

⁷¹ *BVerfGE* 39, 1, at 43.

⁷² *BVerfGE* 88, 203, at 251ff. In Abortion II the court held that the protection of human dignity was the source of the state's duty to protect foetal life, with the measure of that protection being derived from Art. 2 II GG, this is an important shift from the position it took in Abortion I, where the protection of human dignity was viewed as a parallel source of support for the state's duty, *BVerfGE* 39,1, at 51.

⁷³ *BVerfGE* 88, 203, at 252.

⁷⁴ *BVerfGE* 88, 203, at 252.

that ‘The duty to protect prenatal life is based upon individual life, not just on human life in general. Compliance [with the duty] is a fundamental condition of orderly cohabitation in the state.’⁷⁵ The court’s finding that the foetus benefits from the guarantee of human dignity remains controversial, not least because it failed to explain why the existence of prenatal life will in and of itself will automatically engage the protection of human dignity. As Horst Dreier argues ‘Life is the *condition sine qua non* not the *sine per quam* for the applicability of Art. 1 I GG.’⁷⁶ Nevertheless, it is suggested that Jörn Ipsen is correct to argue that the foetus is protected by the guarantee of human dignity operating as an objective fundamental constitutional principle, rather than at a subjective level, with the foetus a designated holder of human dignity.⁷⁷ In this manner the foetus’ prospective dignity interest can be protected, without endowing the foetus with rights.

The German constitution expressly recognises that the right to life is not absolute,⁷⁸ but human dignity is guaranteed as inviolable (*unantastbar*), it is an absolute value, the infringement of which cannot be justified in any circumstance.⁷⁹ If dignity is construed as life, it constitutes a trump card⁸⁰ for those seeking to prohibit abortion, but the termination of pregnancy *per se* is not necessarily contrary to human dignity, rather in order to establish a breach of Art. 1 I GG, it must be demonstrated that the extinguishing of foetal life is contrary to human dignity in the context in which it takes place. For example, gender-based abortion for the purpose of family balancing rather than on medical grounds, could be found to be contrary to human dignity, but it is the motivating factor, rather than the termination of foetal life, that makes it so.⁸¹ It is submitted that in recognising the symbiotic nature of the relationship between the right to life and the guarantee of human dignity, the *Bundesverfassungsgericht* underlined the significance of the right to life within the hierarchy of fundamental rights and the need for restraint in abrogating that right,⁸² it also broadened the scope of available protection substantially, permitting itself significantly more leeway to determine that the abortion legislation in question was unconstitutional.

In both decisions the *Bundesverfassungsgericht* held that the foetus is protected by the guarantee of human dignity and adopted a duty driven conception of dignity, imposing a duty to protect foetal life upon the state and a duty to carry the pregnancy to term upon the woman. Inevitably this formulation of the state’s protective duty will prioritise the protection of foetal life over the woman’s liberty interests. Nevertheless, the *Bundesverfassungsgericht* stressed that ‘the dignity of a human being lies in its very existence’ and that it applies to prenatal life *as well as* life extant.⁸³ The significance of the second factor should not be overlooked – whilst the state has a duty to respect and protect the dignity of the foetus, it is

⁷⁵ *BVerfGE* 88, 203, at 252.

⁷⁶ H. Dreier, ‘Menschenwürdegarantie und Schwangerschaftsabbruch’ (1995) 24 *Die öffentliche Verwaltung* 1036, at 1037.

⁷⁷ J. Ipsen, ‘Der „verfassungsrechtliche Status“ des Embryos in vitro: Anmerkungen zu einer aktuellen Debatte’ (2001) *Juristen Zeitung* 989, at 992 f..

⁷⁸ The right to life may be infringed pursuant to statute, Art. 2 III GG.

⁷⁹ H. Dreier, in H. Dreier (note 58), Art. 1 I, Rn. 44, but cf. M. Baldus, ‘Menschenwürdegarantie und Absolutheitsthese Zwischenbericht zu einer zukunftsweisenden Debatte’ (2011) 134(4) *Archiv des öffentlichen Rechts* 529.

⁸⁰ See also H. Dreier *Bioethik: Politik und Verfassung*, Tübingen: Mohr Siebeck, 2013, at 25; J. Isensee, ‘Menschenwürde: die säkulare Gesellschaft auf der Suche nach dem Absoluten’ (2006) 131(2) *Archiv des öffentlichen Rechts* 173, at 194.

⁸¹ See also M. Herdegen, in T. Maunz / G. Dürig, *Grundgesetz-Kommentar*, München: C.H.Beck, 70. Ergänzungslieferung, 2013, Art. 1 I Rn. 112.

⁸² See also U. Steiner, *Der Schutz des Lebens durch das Grundgesetz*, Berlin: Walter de Gruyter, 1991, at 13.

⁸³ *BVerfGE* 88, 203, at 267, my emphasis.

equally obliged to respect and protect the woman's dignity and not to treat her as a mere uterine environment. Therefore, in the second abortion decision the *Bundesverfassungsgericht* recognised that the woman's dignity and liberty interests must also be protected, necessitating a proportionate solution that sufficiently protects foetal life, without disproportionately restricting the woman's right to self-determination.⁸⁴

In the first decision the majority held that the minimum level of protection required for the foetus could only be provided by the use of the criminal law, whilst the dissenting judges argued that better alternatives to criminal sanctions exist and would be more likely to persuade her to continue the pregnancy, thereby affording the foetus greater protection.⁸⁵ One of the significant shifts between the first and second decisions is that the majority in the latter accepted this argument, moving from a duty to protect the foetus that categorised the woman as an aggressor, to a conception that framed her as a collaborator, as someone whose cooperation is essential in safeguarding the foetus.⁸⁶ Consistent with its first decision, the *Bundesverfassungsgericht* held that abortion may be justified in circumstances where it would be unreasonable to impose a duty to continue the pregnancy, for example where a medical, criminological or embryopathic indication would justify termination. However, it also held that absent a justificatory indication, a woman could elect to terminate the pregnancy throughout the first trimester, provided that she underwent counselling designed to encourage women to continue their pregnancies. Thus the court found that the state could provide the requisite minimum of protection of foetal life by requiring that the woman undergo pro-life counselling, by providing support (such as child care facilities) for bringing up children, and by continuing to designate non-justified abortion as unlawful (but not punishable) throughout pregnancy. In relation to the woman's rights, the court found that such counselling (which would not require the counsellor to approve the woman's reasons for wanting a termination) would comply with the duty to respect the woman's dignity.⁸⁷

The counselling now enshrined in § 219 StGB forms an integral part of the protection of foetal life and is compulsory in the case of all abortions that cannot be justified by either the medical or the criminological indication (§ 218a II, III StGB).⁸⁸ Designated as 'pregnancy conflict counselling' the normative goal of the counselling is to encourage women to continue their pregnancy. The *quid pro quo* is that a woman can exercise her right to self-determination and elect an abortion without requiring the approval of any other individual (including a doctor) within twelve weeks, provided that she undergoes the mandatory counselling and at least three days pass between the counselling and the performance of the abortion, (§ 218a I StGB). The counselling is designed to assist her to reach a 'responsible and conscientious' decision about terminating the pregnancy. Clearly the imposition of such a requirement treats women as less able to make a responsible decision without external assistance and there would appear to be little dignity in being forced to undergo compulsory pro-life counselling, to be told that the foetus has a right to life and that if you have a termination you will act unlawfully, but will not be punished. As Mahrenholz and Sommer JJ (dissenting) pointed out, the label 'unlawful' contributes nothing to the state's protection of

⁸⁴ *BVerfGE* 88, 203, at 254 ff.

⁸⁵ *BVerfGE* 39, 1, at 79.

⁸⁶ *BVerfGE* 88, 203, at 266.

⁸⁷ *BVerfGE* 88, 203, at 265ff.

⁸⁸ The court did recognise that an embryopathically indicated abortion could be justified, but that indication has been subsumed within the medical indication, § 218a II StGB by taking account of the woman's current and future circumstances.

unborn life.⁸⁹ The stigma of abortion remains, women are labelled lawbreakers, and the practical impact is that the direct costs of the counselling based abortion will not be covered by healthcare insurance, although the states are required to fund abortions where the woman's income falls below a certain level.⁹⁰ Nevertheless, provided women jump through the counselling hoop they are able to elect an abortion without having to gain a third party's approval, in direct contrast to the regulation of abortion in England and Wales, where the doctor plays the role of gatekeeper, determining when an abortion is permissible within the terms of the Abortion Act 1967, and women have no more than the ability to request an abortion.

B: Who decides?

By focusing upon dignity, the question of who decides to terminate a pregnancy can be framed in terms of personal choice, as an inherently private matter. However, framing abortion in such a manner would necessitate a break with the underlying philosophy of the Abortion Act 1967, namely that women are incapable of making a decision to terminate a pregnancy without the guiding hand of a responsible, professional, a registered medical practitioner. Indeed, one of the aspects of the regulation of abortion in England and Wales that sets it apart from that adopted in the majority of Europe and the U.S.A. is the medicalised model of abortion that continues to dominate the legislative landscape. In this section I outline the manner in which the Abortion Act 1967 conceptualises the role of medical professionals in determining the legitimacy of abortion on a case by case basis, whilst rejecting the moral agency of women to make the decision to terminate, rather than continue, a pregnancy. Thereafter I focus upon the shift in the debate that has occurred that, whilst continuing to stress the vulnerability of women, now portrays her as in need of protection from, rather than by, the doctor. Finally I consider one of the proposed 'women protective' amendments, the introduction of a requirement that all women seeking an abortion be offered independent counselling, and then draw upon the German law to suggest a way in which abortion can be framed as a matter for personal choice (respecting the woman's dignity and self-determination), whilst protecting the dignity of foetal life, through the use of counselling.

1. Framing abortion as a matter of medical opinion

Passed at a time of great social change that saw suicide decriminalised by the Suicide Act 1962 and homosexual acts in private between men over the age of 21 decriminalised by the Sexual Offences Act 1967, the Abortion Act 1967 was not a great liberalising measure. It failed to empower women to elect to terminate a pregnancy at any time during the pregnancy, instead framing abortion as a medical matter and prioritising medical opinion. The Act built upon the common law in emphasising that only registered medical practitioners are capable of performing a lawful abortion, and indeed of agreeing that an abortion would be legitimate in the circumstances. In *R v Bourne* Macnaughten J distinguished between the respectable medical professional, a skilled man, performing an abortion free of charge and in the belief that 'he ought, in the performance of his duty as a member of a profession devoted to the alleviation of human suffering, to do it,' and the abortionist, 'a woman without any medical

⁸⁹ *BVerfGE* 88, 203, at 348.

⁹⁰ The level is set on an annual basis, for example, in 2015 a woman would not be expected to pay for a counselling based abortion if her net monthly income was less than 1,075 €, with additional allowances of 254 € per child (so that a woman with 2 children would qualify for financial assistance if her income were less than 1583 €) and for rents of over 351 €; additionally certain groups will automatically qualify for financial assistance, including recipients of unemployment benefit, a vocational training award, or asylum seekers benefit, see § 19 SchKG. Indicated abortions will be covered by statutory health insurance.

skill or medical qualifications' who performed the same act for money.⁹¹ Moreover, he stressed that the woman, a 16 year old rape victim, was 'a normal, decent girl brought up in a normal, decent way,' rather than someone who was feeble-minded or had a 'prostitute mind.'⁹² As Sally Sheldon has demonstrated the construction of women seeking abortion played a significant role in the parliamentary debates where three images of femininity can be observed – the woman as minor, victim and mother.⁹³ Within the debates women who wish to terminate their pregnancies are clearly portrayed as aberrant, as failing to fulfil their potential and their natural role; as Sheldon argues, they were classed either as the 'emotionally weak, unstable (even suicidal) victim of her desperate social circumstances,' or a 'selfish, irrational child.'⁹⁴ By contrast, the registered medical practitioners were described in wholesome terms, being responsible, mature, professional men able to make dispassionate, objective decisions; experts able to consider the woman's request for a termination and determine its legitimacy.

The parliamentary debates that culminated in the enactment of the Abortion Act 1967 make it clear that the reforms were not intended to give women the right to elect an abortion, but rather to preserve clinical judgement, establishing doctors as the gatekeepers to lawful abortion. As David Steel, the promoter of the Bill stated, 'We are leaving to the medical profession what members of that profession consider and have represented to us that they, and they alone, have every right and qualification to determine and that it is not for Parliament to tie their hands.'⁹⁵ This view clearly reflects the conclusion of the British Medical Association's Special Committee on therapeutic abortion that 'the ultimate decision to advise termination of pregnancy rests with the doctors in charge of the case and, subject to the conditions laid down to safeguard the security of the pre-viable foetus, the law should not seek to influence this decision by further defining the degree of risk which must be present before termination can be regarded as lawful.'⁹⁶

A similar stance was adopted in *Roe v Wade* when the U.S Supreme Court held that during the first trimester, 'the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.'⁹⁷ Thus the right to elect an abortion protected by the right to privacy, as defined in *Roe*, consisted of a right to elect abortion *in consultation with her doctor*, rather than the woman's right to elect an abortion *per se*.⁹⁸ As Blackmun J stated 'The abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.'⁹⁹ In this way professional judgment was protected and prioritised. On both sides of the Atlantic reform of the law relating to abortion occurred against the backdrop of recognising and preserving medical discretion in the decision-making process. The result is that medical paradigms dominate the discourse at all levels – pregnancy is defined as a medical condition, abortion as a medical procedure, to be performed by a medical professional in a medical setting. As Laura Woliver has pointed out,

⁹¹ [1939] 1 K.B. 687, at 689-690.

⁹² *Ibid* at 694 - 5.

⁹³ S. Sheldon, *Beyond Control: Medical Power and Abortion Law*, London: Pluto Press, 1997, at 35.

⁹⁴ S. Sheldon 'Who is the mother to make the judgment? The construction of woman in English abortion law.' (1993) 1(1) *Feminist Legal Studies* 3, at 6.

⁹⁵ David Steel MP HC Deb 29 June 1967 vol 749, col 900.

⁹⁶ 'Therapeutic abortion: Report by BMA Special Committee' [1966] 2 *British Medical Journal* 40, at 44.

⁹⁷ *Roe v Wade* (note 57), at 164.

⁹⁸ See also R.B. Siegel 'Dignity and sexuality: Claims on dignity in transnational debates over abortion and same-sex marriage' (2012) 10 (2) *I.Con* 355, at 361.

⁹⁹ *Roe v Wade* (note 57), at 166.

The naturalness of pregnancy and childbirth has been transformed into an illness, an unnatural condition, with an assumption of risk to fetal and maternal health that only the medical profession can rectify and control. Shifting control from the pregnant woman to doctors and other medical professionals brings with it increased power of ‘experts’ at the expense of women. Experts define social issues in the arcane language of their professions, limiting the terms of debate and popular involvement.¹⁰⁰

Undoubtedly medical expertise is desirable in relation to the performance of an abortion, but by framing abortion as a medical matter the law also makes the decision as to whether or not an abortion is permissible a matter for doctors, ignoring the broader social context in which such decisions are made. The impact of medical approval is particularly clear in the current German law whereby the applicability of both the medical and criminological indications (§ 218a II, III StGB) fall to be determined by a doctor and will result in the abortion being classified as ‘not unlawful,’ whilst abortions based upon counselling (rather than an independent verification of the justifiable nature of the abortion by a doctor) are classified as unlawful, but not punishable.¹⁰¹

As Ellie Lee points out, access to abortion is easy in England and Wales, but that is the result of the ways in which doctors interpret the law, rather than a recognition of the woman’s right to elect an abortion, even during the very early stages of pregnancy.¹⁰² As Hale LJ has so clearly stated ‘The availability of legal abortion depends upon the opinions of others.’¹⁰³ Thus, the law as framed by the Abortion Act 1967 depends upon the professional integrity of the medical profession, it does not, for example, permit abortion in the case of rape,¹⁰⁴ rather the broadly drafted medico-social indication permits an abortion to be performed where two doctors form the opinion in good faith that it would be safer for the woman’s physical, or mental health, for the pregnancy to be terminated than if she were to continue the pregnancy.¹⁰⁵ Clearly, the fact that she is pregnant as a result of rape is a relevant factor in determining the risk to the woman’s mental or physical health, but that calculation is left to doctors. In this way, the Abortion Act 1967 prioritises medical opinion, rather than the woman’s wishes; at no stage in the parliamentary debates during the 1960s was there any recognition that a woman should be permitted to exercise her autonomy, to elect an abortion, a view that persisted when the Abortion Act 1967 was amended in 1990 by the Human Fertilisation and Embryology Act. By contrast, just 2 years later in *Casey*, the U.S Supreme Court recognised that a woman’s right to autonomy and dignity, together with her right to equality, required that she be able to elect a pre-viability abortion.¹⁰⁶ Despite referring to

¹⁰⁰ L.R. Woliver, *The Political Geographies of Pregnancy*, Urbana: University of Illinois Press, 2002, at 30.

¹⁰¹ § 218a I StGB.

¹⁰² E. Lee ‘Reinventing abortion as a social problem: “Postabortion syndrome” in the United States and Britain’ in J. Best (ed) *How claims spread: cross-national diffusion of social problems*, New York: Aldine de Gruyter, 2001, 39, at 43.

¹⁰³ *Parkinson v St James & Seacroft University Hospital NHS Trust* [2002] QB 266, [2001] EWCA Civ 530, at [66].

¹⁰⁴ Cf the second indication set out in the German Penal Code: § 218a III StGB [The termination of pregnancy carried out by a doctor with the consent of the pregnant woman is not unlawful] ‘in the case of a termination of pregnancy, which is performed by a doctor with the consent of the pregnant woman, if in medical opinion an unlawful act in the sense of §§176 - 179 Penal Code [sexual offences] has been committed against the pregnant woman, compelling reasons lead to the assumption that the pregnancy is a result of the act, and that not more than twelve weeks have passed since conception.’

¹⁰⁵ S. 1(1)(a) Abortion Act 1967.

¹⁰⁶ *Planned Parenthood of Southeastern Pennsylvania et al v Casey* (note 46).

upholding and reaffirming the ‘essential’ holding of *Roe*, the court stressed the woman’s right to choose a pre-viability abortion, rather than her need to cooperate with her doctor.¹⁰⁷

Thus a significant shift in terms of recognising a woman’s decisional capacity and her role within society occurred in *Casey*. Similarly, in its second abortion decision the *Bundesverfassungsgericht* clearly distanced itself from its earlier stance regarding maternal duties. In its first decision the court spoke of motherhood as a woman’s natural role, clearly viewing those seeking an abortion as aberrant ‘because they are not willing to accept the accompanying sacrifices [of pregnancy] and the natural maternal duties.’¹⁰⁸ That a woman should have a duty to continue a pregnancy to term was regarded self-evident, whilst the state’s duty to protect foetal life required it to attempt to reawaken the maternal protective instinct that all women were considered to have.¹⁰⁹ Such a view of women and their role both on their own terms, but also within society, stood in stark contrast to that propounded in the German Democratic Republic where early abortion was freely available, lawful and without charge from 1972, three years before the *Bundesverfassungsgericht* delivered its first decision. The preamble to the GDR’s Act Relating to the Interruption of Pregnancy 1972 emphasised that access to abortion is an integral part of women’s equality and that the responsibility for the decision whether to continue a pregnancy or not must rest with the woman concerned, stating: ‘The equality of women in education and career, marriage and family requires that the woman can decide herself about whether to continue a pregnancy to term.’¹¹⁰

Following Germany unification the German legislature was charged with introducing uniform criminal law provisions regulating abortion to replace those that existed in East and West Germany, whilst guaranteeing the protection of foetal life to a greater extent than was the case in either part of Germany.¹¹¹ The resultant legislation, the *Schwangeren-und Familienhilfegesetz* (SFHG)¹¹² formed the focus of the *Bundesverfassungsgericht*’s second abortion decision.¹¹³ The court adopted a rather more enlightened view of the role of women and stressed that the woman and the foetus should not be framed as adversaries, but rather that the state should view the woman herself as a source of protection for the foetus and attempt to persuade her to continue the pregnancy. Although the court did not go so far as the U.S. Supreme Court in holding that the pregnant woman’s right to self-determination will encompass a right to elect a pre-viability abortion, in a significant change the *Bundesverfassungsgericht* recognised that she could opt for an abortion within the first twelve weeks of pregnancy without requiring the legitimising effect of a doctor’s approval. The *quid pro quo* was that she would have to undergo compulsory pro-life counselling at least three days before the procedure. Whilst counselling-based abortions continue to bear the label ‘unlawful’, neither the woman, nor the doctor will incur criminal liability. By contrast, the Abortion Act 1967 continues to require the signature of two doctors, certifying in good faith that one of the indications set out in s. 1(1) is fulfilled in order for those involved to be exempt from liability for procuring a miscarriage under ss.58, 59 Offences

¹⁰⁷ *Ibid* at 746, 878f.

¹⁰⁸ *BVerfGE* 39, 1, at 55.

¹⁰⁹ *BVerfGE* 39, 1, at 45.

¹¹⁰ *Gesetz über die Unterbrechung der Schwangerschaft* 9.3.1972, GBl DDR 1972 I, S.89.

¹¹¹ Art.31 IV *Einigungsvertrag* (Treaty on the Establishment of German Unity) 31.8.1990, BGBl. II 889.

¹¹² 27.7.1992, BGBl. I, 1398.

¹¹³ The *Bundesverfassungsgericht* struck down the SFHG and following the second Abortion decision the German legislature introduced a new amendment to the Penal Code (StGB), effectively codifying the *Bundesverfassungsgerichts*’s decision by introducing a regulatory system combining the counselling and indication models, *Schwangeren –und Familienhilfe- Änderungsgesetz* (SFHÄndG).

Against the Persons Act 1861. As the Science and Technology Committee found, this requirement does not ‘safeguard women or doctors in any meaningful way, or [serve] any other useful purpose.’¹¹⁴ It recommended the removal of the requirement, yet almost ten years later it persists, more than twenty years after the Supreme Court recognised the moral agency of women in America, emphasising the pregnant woman’s right to autonomy and dignity, rather than the need for her to cooperate with a doctor. This requirement for medical approval continues to set England and Wales apart from the U.S.A and most of Europe and is particularly surprising given the increased debate about the need to protect women from doctors in the context of abortion.

2. The demonization of medical professionals and calls for women-protective measures

As Sally Sheldon has convincingly argued, abortion lost its high political profile in England and Wales due to the fact that regulation ‘has increasingly shifted from the political realm into the private sphere, where it has been constructed as a matter for the discretion of the medical profession. This recodification as a technical problem to be discussed by experts ... has defused the most fierce debates around abortion and has militated against any attempt to radically reform the law.’¹¹⁵ Thus framing abortion as a medical issue has avoided the politically charged debate about abortion that dominates American politics and judicial appointments. However, more recently the trust in doctors that underpinned the parliamentary debates appears to have waned; doctors (or at least those who perform abortions) are no longer characterised as a safe pair of hands and increasingly calls are being made on both sides of the Atlantic for women to have a ‘right to know,’ suggesting that doctors conceal information about abortion, taking advantage of, rather than protecting, vulnerable women. For example, in *Gonzales v Carhart* the U.S Supreme Court referred to ‘abortion doctors’ (rather than simply doctors, or even gynaecologists) in holding that ‘The law need not give abortion doctors unfettered choice in the course of their medical practice,’¹¹⁶ a marked change in attitude from that prevailing in *Roe v Wade* where the court stressed the importance of maintaining professional autonomy.¹¹⁷ Similarly derogatory references can be found in the debates accompanying the more recent proposed amendments to the law regulating abortion in England and Wales. For example, Nadine Dorries MP has argued that the National Institute for Clinical Excellence should draw up guidance relating to abortion, rather than the Royal College of Obstetricians and Gynaecologists on the basis that RCOG members are ‘all abortionists. They earn their livings from abortions.’¹¹⁸

The parliamentary debates that accompanied the Abortion Act 1967 characterised women as vulnerable and in need of support, with doctors portrayed as the source of that support and the people best able to take a dispassionate, responsible view of the situation in determining whether abortion is the appropriate solution in the circumstances. More recently however, anti-choice actors have sought to problematise abortion, subverting the arguments used to permit abortion by emphasising women’s vulnerability not as a reason to permit abortion, but rather as a need to intervene to protect women from predatory doctors who think only of the profit to be made from abortion. Thus the Abortion Act 1967 has been the subject of attack

¹¹⁴ Science and Technology Committee *Scientific Developments Relating to the Abortion Act 1967* (HC 2006-07, 1045 –I), at [99].

¹¹⁵ S. Sheldon (note 93), at 3.

¹¹⁶ *Gonzales v Carhart* (note 52), at 1636.

¹¹⁷ *Roe v Wade* (note 57), at 166.

¹¹⁸ <<http://www.theguardian.com/politics/2011/aug/06/nadine-dorries-abortion-sex-education>>

on a number of occasions, with campaigners attempting to amend the Act by restricting access to abortion in the name of protecting women. Whilst many of these amendments have continued to stress the vulnerability of women seeking an abortion, the language relating to the doctor has changed, characterising ‘him’ as a scheming abortionist seeking to perform as many abortions as possible.¹¹⁹ This was particularly clear in the Dorries/Fields’ amendment to the Health and Social Care (HSC) Bill that would have required all women to be offered advice, information or counselling services by an independent body, defined as a body that does not provide, or have a financial interest in the provision of abortion, or a statutory body. The effect of this would have been to bar the registered charities (primarily Marie Stopes and the British Pregnancy Advisory Service) that perform a large proportion of abortions in England and Wales from providing these services.¹²⁰ Throughout the debate Dorries argued that it is essential that the counselling is not provided by the abortion provider, arguing

If anybody in this House were to take out a mortgage today, the person who sold them the mortgage would have to refer them elsewhere for independent advice. ... I wonder why we feel it is appropriate that organisations that take £60 million a year of taxpayers’ money and are paid to carry out abortions give advice on the procedure. ... If an organisation is paid that much for abortions, where is the incentive to reduce them?¹²¹

It is suggested that there is a significant difference between the purchase of a financial product (often the source of commission for the seller) and consent to a medical procedure, performed free at the point of delivery, at the request of the woman. As Diane Abbott so incisively quipped, ‘They imply that those men and women are involved in some sort of grotesque piecework. It is almost as though they were paid per abortion.’¹²² Whilst this was a clear attempt to undermine trust in the medical profession, it is suggested that this is not merely a reflection of the less elevated position occupied by doctors in society during the twenty-first century, but rather that terms such as ‘abortionist’, applied to medical professionals, rather than back street operators as in *Bourne*, are being used in order to reclaim the political and moral aspects of the abortion decision, to argue that the decision to terminate a pregnancy cannot be left to doctors to determine in good faith without a significantly greater degree of external control. Noticeably those seeking to amend the law did not suggest that a woman should be able to decide to terminate a pregnancy without medical approval, they merely argued that she should be offered ‘independent’ counselling.

A similar motivation to rein in doctors can be seen to underlie Fiona Bruce MP’s amendment to the Serious Crime Bill 2015. As a result of a sting operation in 2012 by the Daily Telegraph,¹²³ the Crown Prosecution Service were asked to consider bringing criminal charges against two doctors who appeared to have been willing to authorise an abortion on the basis of gender. The woman involved was eight weeks pregnant and presented claiming to have had a test that showed she was having a girl and to have previously had a foetal loss at 22 weeks due to chromosomal abnormality. Reacting to the sting operation the then Secretary of State for Health, Andrew Lansley wrote a piece entitled ‘Health professionals must not think they know better than the law’ and stated ‘Carrying out an abortion on the

¹¹⁹ See also F. Amery, ‘Solving the “Woman Problem” in British Abortion Politics: A Contextualised Account’ (2014) *British Journal of Politics and International Relations* 1, at 9-10.

¹²⁰ In 2014 67% of abortions in England and Wales were performed in approved independent sector places under NHS contract, *Abortion Statistics, England and Wales: 2014, 2015*, table 2.

¹²¹ HC Deb 7 September 2011, vol 532, cols 376 – 8.

¹²² *Ibid*, col 380.

¹²³ H. Watt, C. Newell & Z. Khimji. ‘Abortion investigation: Available on demand – an abortion if it’s a boy you wanted,’ *Daily Telegraph*, 23 February 2012.

grounds of gender alone is in my view morally repugnant. It is also illegal.’¹²⁴ However, the CPS decided to take no further action and the Director of Public Prosecutions published fuller reasons for the decision not to prosecute. Keir Stamer pointed out that ‘the law does not, in terms, expressly prohibit gender-specific abortions; rather, it prohibits any abortion carried out without two medical practitioners having formed a view, in good faith, that the health risks (mental or physical) of continuance outweigh those of termination. This gives a wide discretion to doctors in assessing the health risks of a pregnant patient.’¹²⁵ Similarly the British Medical Association’s *Handbook of Ethics and Laws* stresses that ‘it is normally unethical to terminate a pregnancy on the grounds of fetal sex alone, except in cases of severe sex-linked disorders. ... [However] in some circumstances doctors may come to the conclusion that [the effect of the sex of the fetus on the woman’s situation and on her existing children] are so severe as to provide legal and ethical justification for a termination.’¹²⁶

In 2014 the Department of Health issued guidance emphasising that ‘Abortion on the grounds of gender alone is illegal,’¹²⁷ but Fiona Bruce MP felt that an explicit prohibition of sex-selective abortion was necessary and proposed a Ten Minute Bill, followed by an amendment to the Serious Crime Bill 2015 to achieve such clarity. She specifically addressed the need for the amendment in order to ensure that doctors did not continue to break the law, because ‘abortion providers and others, staggeringly, are still refusing to accept the Government’s interpretation of the law.’¹²⁸ Nevertheless, when questioned upon whether the amendment would preclude terminations for sex-linked conditions, Bruce argued that ‘We can trust our medical professionals *in that respect*. ... The ground for the abortion in such cases would be the genetic condition and not the sex of the child.’¹²⁹

Whilst the anti-choice movement traditionally speak in terms of protecting the foetus, a perceptible shift in the contours of the debate has occurred, as Reva Siegel argues, the justifications advanced for restricting abortion have moved from focusing upon the foetus, to gender-based justifications.¹³⁰ The amendments to the Abortion Act 1967 proposed in recent years, including the introduction of an offer of independent counselling and the prohibition of gender based abortion, are part of the so-called ‘neglected rhetorical strategy’ (NRS) promoted by anti-choice activists such as David Reardon. This strategy is based upon the argument that anti-choice campaigns should focus not merely on protecting the foetus, but also the woman, indeed Reardon characterises his stance as ‘pro-woman / pro-life,’ arguing:

For the purpose of passing restrictive laws to protect women from unwanted and/or dangerous abortions, it does not matter if people have a pro-life view. The ambivalent majority of people who are willing to tolerate abortion in ‘some cases’ are very likely to support informed consent legislation and abortion clinic regulations, for example, because these proposals are consistent with their desire to protect women. In some cases, it is not even necessary to convince people of abortion’s dangers. It is sufficient to simply raise enough doubts about abortion that they will refuse to actively oppose the proposed anti-abortion initiative. ... Converting these people to a pro-life view, where they respect life rather than simply fear abortion, is a second step... but it is not

¹²⁴ A. Lansley, ‘Health professionals must not think they know better than the law,’ *Daily Telegraph*, 24 February 2012.

¹²⁵ http://www.cps.gov.uk/news/latest_news/dpp_abortion_case_fuller_reasons/

¹²⁶ British Medical Association’s *Handbook of Ethics and Laws*, 2012, at 287.

¹²⁷ DoH, *Guidance in Relation to Requirements of the Abortion ACT 1967*, 2014, at para. 25.

¹²⁸ HC Deb 23 Feb 2015, vol 593, col 114; see also HC Deb 4 Nov 2014, vol 587, col 677.

¹²⁹ HC Deb 23 Feb 2015, vol 593, col 115, my emphasis.

¹³⁰ R. Siegel ‘The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions’ (2007) *University of Illinois. Law Review* 991, at 991.

necessary to the accomplishment of other good goals, such as the passage of laws that protect women from dangerous abortions and thereby dramatically reduce abortion rates.¹³¹

As Reardon makes clear, such amendments are not intended to prohibit abortion, they are incrementalist in nature and intended to restrict access to abortion, to make it harder, and particularly in the U.S context more expensive, to obtain. Noticeably advocates of such policies have adopted the rhetoric of choice; they build on earlier narratives accepting that women are in need of protection, speaking of empowering women to make an informed choice and about ensuring that women are not coerced into having an abortion. Women protective regulation has come to dominate the abortion landscape in the United States of America and has proved a particularly effective means of limiting access to abortion, but as Jennifer Hendricks argues, these arguments focussing upon the need to protect women 'are based on traditional, paternalistic views that women should be protected from poor decisions, or from coercion, by eliminating their choices rather than informing and empowering their decisions.'¹³² The regulatory and political landscape in the United States of America is very different to that in England and Wales, but the notion of a woman's right to know has also become a feature of the debates at Westminster. The recent proposed amendments to the Abortion Act 1967 can be seen to be part of the anti-choice agenda, to attack boundary issues in the name of protecting women and promoting gender equality, in order to reduce the availability of abortion incrementally.

Fiona Bruce MP's proposal that an explicit prohibition of sex-selective abortion be enacted was presented as a feminist amendment, an amendment necessary to give effect to equality, to protect women and female foetuses from abuse.¹³³ The dominant narratives found in the parliamentary debate of the proposed amendment are those stressing the vulnerability of women, the need to protect women from coercion to abort and the emphasis of 'otherness' – the problem of 'gendercide' was portrayed not as an English problem, rather it was a problem affecting women from Southern Asia living in England and Wales. Bruce called sex selective abortion 'a gross form of sex discrimination... the first and most fundamental form of violence against women and girls,' and suggested that nobody could object to banning such a practice.¹³⁴ She argued that women were suffering because of the lack of clarity in the law, and provided anecdotal evidence of women being forced to have an abortion to avoid giving birth to girl, or women who had been subjected to abuse after delivering a girl,¹³⁵ but none of the reports have been substantiated and it is difficult to see how the enactment of her amendment (criminalising sex selective abortions) would have helped to safeguard the women upon whom she focussed from abuse. As the Southall Black Sisters argued, the protection of women should be addressed by a safeguarding, not a criminal framework, and this practice needs to be considered within the broader context of gender discrimination, including domestic violence and honour based violence.¹³⁶ Similarly, Sally Sheldon has argued, if anything the cases referred to 'illustrate that fully respecting women's autonomy in

¹³¹ D. C. Reardon, 'A Defense of the Neglected Rhetorical Strategy (NRS)' (2002) 18(2) *Ethics Med.* 23-32.

¹³² J.S. Hendricks 'Body and Soul: Equality, Pregnancy, and the Unitary Right to Abortion' (2010) 45 *Harvard Civil Rights-Civil Liberties Law Review* 329, at 9.

¹³³ The proposed amendment stated 'Nothing in section 1 of the Abortion Act 1967 is to be interpreted as allowing a pregnancy to be terminated on the grounds of the sex of the unborn child.'

¹³⁴ HC Deb 23 Feb 2015, vol 593, col 114.

¹³⁵ 4 Nov 2014 : Column 677f

¹³⁶ 'SBS urges MPs to examine sex selective abortion within a safeguarding and not a criminal framework' <<http://www.southallblacksisters.org.uk/sbs-urges-mps-examine-sex-selective-abortion-within-safeguarding-criminal-framework/>>

this context requires not just robust consent procedures but also active commitment to securing the best possible conditions within which reproductive choice may be exercised.’¹³⁷ Notwithstanding the debate generated by this issue, it is questionable to what extent sex selective abortion occurs in England and Wales. Although Bruce’s amendment was defeated, an amendment was passed requiring the Secretary of State for Health to arrange for an assessment of the evidence of termination of pregnancy on the grounds of the sex of the foetus in England, Wales and Scotland.¹³⁸ The findings were published in August 2015, confirming early Department of Health statistical reports in finding that there is no systemic evidence for sex selective abortion.¹³⁹

Nadine Dorries’ proposal that doctors be obliged to offer women seeking abortion independent counselling gained significantly more traction and was similarly based upon both protecting and empowering women. Addressing the need for such counselling she wrote:

Doesn’t every woman have a right to know that the risk of pre-term delivery is increased in further pregnancy following an abortion? Doesn’t she have a right to know the statistics regarding mental health issues post abortion? Are women seeking an abortion not entitled to be treated in the same way as they would be if they were seeking any other type of operation? Should their consent not be fully informed? ...The fact is that I am pro-woman. I strongly object to the pro-choice mantra of the 1980s which as the advocate of a streamlined, conveyor belt, factory efficient, abortion process is now doing so much to damage so many women.¹⁴⁰

This statement echoes the rhetoric underlying the informed consent provisions that have been introduced at state level in much of the USA. That a woman should give her informed consent to abortion sounds eminently reasonable, it is of course a legal requirement that she does so and treatment provided without a sufficiently informed consent will constitute a trespass against the person. However, the content of informed consent in the abortion context is hotly contested, as is counselling as the vehicle for achieving such consent. Moreover, the demand for counselling and enhanced duties to inform can be seen to be part of the ‘awfulisation’ of abortion, constructing abortion as crisis and counselling as a crisis intervention to protect vulnerable women,¹⁴¹ or as a necessary measure to enable women to make a responsible decision.

3. Counselling as a tool to ensure the woman’s informed consent or equip her to make a responsible decision

There is nothing innovative in the proposal that women seeking abortion should have access to counselling, more than forty years ago the Lane Committee recommended:

A woman considering abortion should be able to discuss and explore her difficulties in an informal and unhurried manner. She should be told the nature of the operation

¹³⁷ S. Sheldon, ‘The Decriminalisation of Abortion: An Argument for Modernisation.’ Forthcoming, *Oxford Journal of Legal Studies*.

¹³⁸ S. 84 Serious Crime Act 2015.

¹³⁹ DoH *Assessment of termination of pregnancy on grounds of the sex of the foetus - Response to Serious Crime Act 2015*, 2015.

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456642/sex_selection_doc.pdf>

¹⁴⁰ Nadine Dorries MP: Britain’s abortion laws currently leave vulnerable women without the most basic support and help to which they should be entitled, 7/3/2011 <<http://www.conservativehome.com/platform/2011/03/nadine-dorries-mp-britains-abortion-laws-currently-leave-vulnerable-women-without-the-most-basic-sup.html>>.

¹⁴¹ See also L. Vincent ‘Shaking a hornets’ nest: pitfalls of abortion counselling in a secular constitutional order – a view from South Africa’ (2012) 14 *Culture, Health & Sexuality* 125, at 130.

(risks and alternatives). She should thus become more fully aware of the implications of the continuation, or alternatively the termination of her pregnancy and be helped to arrive at a wise and independent decision as to what her real wishes are.¹⁴²

However, the meaning of abortion counselling is contested.¹⁴³ As Sam Rowlands has documented, in the abortion context there is a distinction between the provision of information and decision counselling, where counselling engages primarily with the psychological and emotional aspects of the decision to continue the pregnancy or abort.¹⁴⁴ The former is clearly linked to the ability to give an informed consent and will require the healthcare professional to provide information about the procedure and any material risks, as well as satisfying herself that the woman has the capacity to consent to a termination and is doing so voluntarily. Decision counselling is very different in nature; it is available in England and Wales, however it is not routinely offered to women. Instead women are offered counselling upon request, or where the doctor believes that the woman requires additional support, for example where she is young, or where there is evidence of coercion. As previously mentioned, the Dorries/Fields amendment to the Health and Social Care Bill 2011 sought to introduce a requirement that all women be offered advice, information or counselling services by an independent body, thus excluding the largest providers of abortion in England and Wales from offering this service.¹⁴⁵ If a woman were required to go to another body for counselling, information and advice, as proposed, there would inevitably be further delay in accessing abortion, despite the policy consideration that early access to abortion should be achieved wherever possible.¹⁴⁶ Moreover, there is a need to ensure that information provided is accurate and evidence-based and not be intended to pressurise women into continuing the pregnancy; this would clearly be a cause for concern if women were to be offered counselling by a crisis pregnancy centre for example.¹⁴⁷ No evidence was put forward to suggest that there was a problem in the way that counselling was being provided during the parliamentary debate and in 2013 the Department of Health reported that the independent providers do offer counselling to all women, but that access is patchier in NHS hospitals with no counselling being available at all in some cases.¹⁴⁸ Thus, as in the case of Fiona Bruce's proposal, this would appear a rather contrived debate, proposing a solution to address a problem that does not seem to exist.¹⁴⁹

The notion that women should be put in the position to give a fully informed consent to abortion requires greater consideration. During the course of the debate it was never made

¹⁴² *Report of the Committee on the Working of the Abortion Act* (Cmd 5579, 1974), at para 292.

¹⁴³ For an excellent interdisciplinary review of the literature regarding abortion counselling see L. Hoggart 'Abortion Counselling in Britain: Understanding the Controversy' (2015) *Sociology Compass* 365.

¹⁴⁴ Sam Rowlands, 'The decision to opt for abortion' (2008) 34(3) *Journal of Family Planning and Reproductive Health Care* 175.

¹⁴⁵ In 2014 67% of abortions in England and Wales were performed in approved independent sector places under NHS contract, *Abortion Statistics, England and Wales: 2014, 2015*, table 2.

¹⁴⁶ Department of Health *A Framework for Sexual Health Improvement in England*, 2013, at 34; RCOG, *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7*, 2011, at 35.

¹⁴⁷ In 2014 a Daily Telegraph sting found that crisis pregnancy centres were providing false and misleading information, see E. Barnett et al "Abortion will make women child sex abusers" independent clinics warn' *Daily Telegraph*, 10 February 2014.

¹⁴⁸ Department of Health (note 146), at 35 – 36.

¹⁴⁹ The Dorries/Fields' amendment was rejected after a commitment was given to consult on voluntary independent counselling, but in October 2012, during a debate initiated by Dorries regarding the need to reduce the time limit for social abortions, Anna Soubry, Parliamentary Under-Secretary of State for Health, announced that the Government does not intend to undertake a separate consultation on counselling as there is no intention to change the law, HC Deb 31 Oct. 2012, vol 552, Col 92WH.

clear how advice, information and counselling services were to be distinguished from one another and Dorries appeared to conflate the three elements in talking about the need to protect vulnerable women and to ensure that the decision made is fully informed, arguing that the current system fails women.¹⁵⁰ Dorries has long campaigned for a woman's 'right to know,' indeed in the draft minority report to the Science and Technology Committee's Report on *Scientific Developments Relating to the Abortion Act 1967* which she co-authored, it was stated that

Given the evidence regarding upper limits and health complications for women, there should be new 'right to know' provisions so that women are given all the information they need about fetal development and pre-term birth. Women should also be informed with regard to the conflicting expert opinions regarding a link to breast cancer and should be given time to consider the options available – in order to empower women and enable them to make a fully informed choice.¹⁵¹

From this statement it is clear that she considers that an enhanced level of information will be required, over and above the standard requirement that doctors disclose all material risks.¹⁵² The question of what will constitute full information in the abortion context is contested, however the informed consent paradigm has been adopted at state level in much of the United States of America. In *Casey*, outlining its undue burden standard, the U.S. Supreme Court made it clear that the woman's exercise of her autonomy is not unfettered, but may be 'guided' by the state to ensure that a 'responsible' or 'wise' decision is made.¹⁵³ In so deciding, as Susan Appleton argues, the joint opinion of O'Connor, Kennedy and Souter JJ 'validated a portrait of women as incompetent decision-makers, dependent on the state to orchestrate their deliberation and provide relevant information.'¹⁵⁴ Since the Supreme Court's *volte-face*¹⁵⁵ women protective regulation has come to dominate the abortion landscape in the United States and has proved a particularly effective means of limiting access to abortion. Whilst there can be no doubt that a woman's consent to any medical procedure should be fully informed, it is the recognition in *Casey* that abortion specific informed consent may be required that is a significant cause for concern. The 'right to know' legislation that has been introduced in a number of states following *Casey* is not limited to evidence based risk assessments, instead duties to inform about manufactured risks, such as the risk of breast cancer and 'post-abortion syndrome' have been introduced in some states. For example, there is no scientific link between breast cancer and abortion,¹⁵⁶ but that has not prevented

¹⁵⁰ HC Deb 7 September 2011, vol 532, cols 373.

¹⁵¹ Science and Technology Committee (note 114), at 81.

¹⁵² *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, per Lord Kerr & Lord Reid, at [87].

¹⁵³ *Planned Parenthood of Southeastern Pennsylvania v Casey* (note 46), see for example at 885: 'The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly where the statute directs that important information become part of the background of the decision.'

¹⁵⁴ S.F. Appleton 'Gender, Abortion and travel after Roe's end' (2007) 51 *St Louis University Law Journal* 655, at 661.

¹⁵⁵ In *Planned Parenthood of Southeastern Pennsylvania et al v Casey* (note 46) the majority departed from its previous decisions in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U. S. 747, and *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U. S. 416 (*Akron I*), by upholding the informed consent requirement.

¹⁵⁶ See for example C.M. Braüner et al 'Induced abortion and breast cancer among parous women: a Danish cohort study' (2013) 92(6) *Acta Obstetrica et Gynecologica Scandinavica* 700; World Health Organization *Induced abortion does not increase breast cancer risk. Fact sheet No.240*. Geneva, WHO; 2002, <http://www.who.int/mediacentre/factsheets/fs240/en/>; ACOG Committee on Gynecologic Practice, 'ACOG Committee Opinion No. 434: induced abortion and breast cancer risk' (2009) 113 *Obstetrics & Gynecology* 1417–8; RCOG (n 146) at 42 f.

some U.S. states, requiring that women be told there ‘may’ be a link between breast cancer and abortion. Thus the Texas Woman’s Right to Know Act 2003 requires that women seeking abortion be informed of ‘the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer.’¹⁵⁷ Similarly there is no evidence to substantiate a link between abortion and mental illness,¹⁵⁸ but in *Gonzales v Carhart* Kennedy J posited:

Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The [Partial Birth Abortion Ban] Act recognizes this reality as well. Whether to have an abortion requires a difficult and painful moral decision. ... While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. .. Severe depression and loss of esteem can follow.¹⁵⁹

As Ginsburg J noted in her stinging dissent, in so doing the court invoked ‘an antiabortion shibboleth for which it concededly has no reliable evidence.’¹⁶⁰ Nevertheless, despite ample evidence that such a link does not exist,¹⁶¹ a number of states require women to be told of the link between abortion and psychological harm, for example South Dakota requires a doctor to inform the woman seeking an abortion of ‘all known medical risks of the procedure and statistically significant risk factors to which the pregnant woman would be subjected, including: (i) Depression and related psychological distress; (ii) Increased risk of suicide ideation and suicide.’¹⁶² South Dakota is not alone in requiring that women are given inaccurate, or misleading information in this respect, but it is difficult to see how obliging doctors to provide such information can be compatible with obtaining informed consent.

In *Gonzales v Carhart* Kennedy J explained that:

The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.¹⁶³

Thus it would appear that informed consent has a rather different meaning in the abortion context to that applicable to other medical procedures, requiring more than an accurate understanding of the risks and merits of the proposed procedure. Abortion exceptionalism, it would appear, requires that women are given additional guidance in order to equip them to make a responsible decision that they will not regret, a limitation that noticeably does not seem to apply to the decision to continue a pregnancy. As Ginsburg J argued, ‘This way of thinking reflects ancient notions about women’s place in the family and under the Constitution—ideas that have long since been discredited.’¹⁶⁴ The American experience clearly demonstrates the dangers of the informed consent paradigm in the abortion context. It

¹⁵⁷ Sec. 171.012. (1)(B)(iii) Texas Health and Safety Code.

¹⁵⁸ See for example National Collaborating Centre for Mental Health. *Induced abortion and mental health. A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors*, London: Academy of Medical Royal Colleges, 2011; RCOG (note 146) at 45 f; American Psychological Association Task Force on Mental Health and Abortion, *Report of the APA Task Force on Mental Health and Abortion*, Washington DC, 2008.

¹⁵⁹ *Gonzales v Carhart* (note 52), at 1634.

¹⁶⁰ *Ibid*, at 1648.

¹⁶¹ See note 127.

¹⁶² S.D. Codified Laws § 34-23A-10.1(e).

¹⁶³ *Gonzales v Carhart* (note 52), at 1634.

¹⁶⁴ *Ibid*, at 1649.

has allowed the state to require healthcare professionals to give information that may not be accurate and in some cases is calculated to mislead, it has permitted the state to mandate medical procedures that serve no medical purpose, but that increase the cost of abortions, the time taken to access abortion, and subject women to varying degrees of invasiveness. In all these cases the state can justify the requirements on the basis that it is protecting a woman's right to full information and that it is recognising the dignity of life in ensuring that she makes a well informed decision.

It is submitted that the level of information required to consent to an abortion should be the same as that required for any other medical procedure. Clearly that will require that the doctor informs the woman of how the abortion will be performed, but it is suggested that the level of detail suggested by Kennedy J in *Gonzales v Carhart* would be unnecessary.¹⁶⁵ Both the U.S Supreme Court and the *Bundesverfassungsgericht* have recognised that counselling need not be neutral, that the state can try to persuade a woman to continue the pregnancy, but information should be relevant and appropriate. On that basis it is difficult to justify requirements that women undergo an ultrasound scan and be given a detailed description of the foetal dimensions, presence of cardiac activity, and the presence of external members and internal organs as required in Texas in all cases except where the woman was the victim of a sexual assault, a minor or the foetus is handicapped.¹⁶⁶ The fact that women who have been raped are able to provide a voluntary and informed consent without such information would appear to confirm that the underlying purpose of such informed consent provisions is to stigmatise abortion and the women who exercise their right to elect a pre-viability abortion; to make access to abortion more difficult, more expensive, more time-consuming and more distressing, unless the woman is perceived to have a 'good' reason for seeking a termination. As Howard Minkoff has argued, 'Performing an angiogram before the placement of a stent is clearly an appropriate preoperative procedure, but legislators have not passed statutes to mandate it, and there certainly would be no support for a requirement that patients view the screen before consenting to the procedure,' the same principles should apply to informed consent in the abortion context.

The woman should be informed of the alternatives (both in terms of different procedures, but also in terms of continuing the pregnancy and adoption) and of the risks that apply to the procedure, but reference to full information should not be seen as justifying a duty to inform of hypothetical risks, or provide misleading information. The anti-choice movement has dedicated significant time and resources to developing a bank of literature investigating whether there might be a link between abortion and breast cancer, as well as whether abortion is psychologically damaging. Whilst both theories have been debunked at the highest levels, the continued re-researching of such links has produced a large body of literature that is 'premised on and perpetuates the pathologisation of abortion.'¹⁶⁷ During her speech Dorries made repeated reference to a recently published article by Priscilla Coleman¹⁶⁸ which claimed that the evidence 'revealed a moderate to highly increased risk of mental health problems after abortion,' a finding at odds with the Royal College of Psychiatrists' conclusion that 'Where studies control for whether or not the pregnancy was planned or wanted, there is no

¹⁶⁵ Above, text accompanying note 163.

¹⁶⁶ Sec. 171.012. (4)(5) Texas Health and Safety Code.

¹⁶⁷ M. Leask, 'Constructing women as mentally troubled: The political and performative effects of psychological studies on abortion and mental health', (2014) 28 *Women's Studies Journal* 74, at 75.

¹⁶⁸ P.K. Coleman 'Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009' (2011) 199(3) *British Journal of Psychiatry* 180.

evidence of elevated risk of mental health problems.’¹⁶⁹ Priscilla Coleman is a collaborator of David Reardon and her article has been widely discredited.¹⁷⁰ There is no evidence of a causal link between abortion and mental health problems, indeed the Academy of Medical Royal Colleges have advised ‘The rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth.’¹⁷¹ It is a source of deep concern that the sponsor of an amendment to require every woman be offered counselling by an independent body should accept such flawed research without question, even going so far as to dismiss the findings of the Royal College of Psychiatrists as outdated.¹⁷²

Much of Dorries’ arguments appear to relate to a need for counselling in the broader sense, involving a discussion of the woman’s feelings about abortion. Clearly such counselling will be indicated where the woman is ambivalent about her decision, but research suggests that most women do not want decision counselling, that they have in fact already made their decision when they request an abortion. In a recent study Charlotte Baron et al investigated the proportion of women presenting for a termination of pregnancy in Edinburgh who undergo pre-termination counselling and sought to evaluate their experience. Although this is a relatively small scale study its findings are consistent with those of earlier studies. The researchers found that only 9% of the women surveyed had undergone counselling and of those 18 women, 10 reported that the counselling had assisted them to make a decision. 85% of those who had not had counselling felt it was unnecessary because they were sure of their decision to have an abortion.¹⁷³

Counselling plays a pivotal role in enabling the German state to fulfil its duty to protect foetal life, it is the lynchpin of the current regulatory scheme and thus any woman who does not qualify for an abortion on the basis of either the medical, or the criminological indications will be required to undergo the mandatory counselling.¹⁷⁴ As the primary vehicle for fulfilling the state’s duty to protect foetal life the counselling cannot be merely informative,¹⁷⁵ thus the wording of § 219 StGB makes it very clear that the counselling is not neutral: ‘Counselling serves the protection of unborn life. It is to be led by the efforts to encourage the woman to continue the pregnancy and to show her perspectives for a life with the child; it should help her to make a responsible and conscientious decision...’

¹⁶⁹ Royal College of Psychiatrists *Induced Abortion and Mental Health*, 2011.

¹⁷⁰ See for example correspondence published under the title ‘Abortion and mental health: guidelines for proper scientific conduct ignored’ (2012) 200 *British Journal of Psychiatry* 74 – 79; National Collaborating Centre for Mental Health (note 158).

¹⁷¹ National Collaborating Centre for Mental Health (note 158), at 8; see also references above note 158.

¹⁷² HC Deb 7 September 2011, vol 532, col 387

¹⁷³ C. Baron, S. Cameron, A. Johnstone, ‘Do women seeking termination of pregnancy need pre-abortion counselling?’ (2015) 42 *Journal of Family Planning and Reproductive Health Care* 181, at 183. This confirms the findings of other studies including S.Brown ‘Is counselling necessary? Making the decision to have an abortion. A qualitative interview study’ (2013) 18(1) *European Journal of Contraception and Reproductive Health Care* 44; S.T.Cameron & A. Glasier ‘Identifying women in need of further discussion about the decision to have an abortion and eventual outcome’ (2013) 88 *Contraception* 128.

¹⁷⁴ In 2009 a specific form of counselling was introduced for abortions to be performed on the basis of foetal handicap under the first indication (§ 218 a II StGB), § 2 a SchKG, consideration of such counselling falls outside the scope of this article. Whilst counselling relating to an embryopathic abortion should provide full information, counselling provided for the purposes of § 219 StGB is intended to persuade the pregnant woman to continue the pregnancy and thus to protect foetal life.

¹⁷⁵ *BVerfGE* 88, 203, at 282.

Tellingly, § 219 StGB bears the title ‘Counselling of the pregnant woman in a crisis or conflict situation,’ emphasising the aberrant nature of abortion and reinforcing the narrative of abortion as crisis. Nevertheless, one of the key shifts underpinning its second abortion decision was the *Bundesverfassungsgericht*’s recognition that the state could better protect the foetus by working together with the pregnant woman, rather than treating her as an adversary.¹⁷⁶ This recognition underpins the counselling provision, both in terms of its rationale and the way in which counselling is made available to women. The purpose of counselling is to persuade the woman to continue the pregnancy rather than to assess the validity of her choice, as the court argued, if the woman can make her own decision, without having to seek the approval of anyone else, she is more likely to make a responsible and conscientious decision¹⁷⁷ and more likely to engage fully with counselling as she will not feel the need to demonstrate that she fulfils an abortion indication.¹⁷⁸ Thus although the normative goal of the counselling is to persuade women to continue the pregnancy, the counselling is outcome neutral. Whilst the court made it clear that a woman would be expected to share her reasons for seeking an abortion in order to enable the counsellor to more effectively support her in her decision-making,¹⁷⁹ there is no legal obligation to do so. Provided that the woman attends the counselling, the counsellor must provide her with a certificate of counselling enabling her to access an ‘unlawful’, but non-punishable abortion after three days have passed.¹⁸⁰ There is no scope for the counsellor to refuse to issue the certificate, or to delay issuing the certificate where that would preclude access to an abortion within the twelve week time limit.¹⁸¹

In fulfilling its duty to protect foetal life the state must ensure that counselling is accessible and effective in providing both support and information to the woman, thus the counselling is provided free of charge and the states must ensure that women are able to access abortion counselling in a state approved counselling centre near where they live and without delay.¹⁸² Counselling is provided by a variety of centres, ranging from religious based counselling centres to individual doctors, but centres must be approved by the state, must provide professional counselling and be able to work with other bodies providing support to women and children; they must also be economically and organisationally independent from abortion providers.¹⁸³ Although the German form of abortion counselling is designed to encourage the woman to continue her pregnancy, it is very different in nature to that mandated by many of the abortion specific informed consent laws that have been introduced in the USA. There is no requirement that the woman submit to an ultrasound and view the foetus, for example, nor does the state require that doctors provide scripted information to the pregnant women, regardless of whether that information is clinically relevant, or indeed accurate. Crucially, the German counselling is not intended to inform a woman’s consent to abortion, rather it is intended to support her decision-making. The counsellor may not be the doctor who performs the abortion and the counselling is entirely distinct from the provision of information relating to the abortion procedure and any risks involved, discussion of which falls to the treating doctor, §218 c II StGB. Instead the focus of the counselling is upon looking at ways in which the woman might be able to come to terms with continuing the

¹⁷⁶ *BVerfGE* 88, 203, at 266.

¹⁷⁷ *BVerfGE* 88, 203, at 268.

¹⁷⁸ *Ibid.*

¹⁷⁹ *BVerfGE* 88, 203, at 285, see also § 5 II SchKG.

¹⁸⁰ §219 II StGB.

¹⁸¹ § 7 SchKG.

¹⁸² §§ 6, 8, 9 SchKG.

¹⁸³ § 9 SchKG.

pregnancy. Thus the stress is laid upon supporting her and as the court emphasised, it is not enough to point out to the woman that support is available, instead the counsellor must proactively try to assist her to access support, whether that be financial aid, or housing assistance for example.¹⁸⁴

The counselling provision is central to the regulation of abortion in Germany, it permits women to make an autonomous decision, to elect an abortion within twelve weeks, without having to satisfy an indication, or convince another person that an abortion is permissible in the circumstances. Admittedly there is little dignity in being required to undergo counselling in order to be put in a position to make a responsible and conscientious decision. However, it is suggested that in fact the counselling is a minimally intrusive device that enables the woman to exercise her self-determination whilst simultaneously affording the foetus a (minimal) level of protection from implantation. Whilst the counselling requirement does demonstrate respect for life, its ability to protect foetal life is necessarily limited. Just as in other jurisdictions women will present for abortion having already made up their mind to have an abortion; there is no evidence to suggest that a significant number of women change their minds after counselling.¹⁸⁵ Nevertheless, the fact that the counselling must be accurate and result neutral, that it must be designed to show the possibilities to continue the pregnancy, demonstrates respect for the dignity of foetal life, without undermining the woman's dignity. It is a compromise that seeks to respect human dignity conceptualised as both choice and life. Neither conceptualisation is absolute, thus the woman's dignity demands that she be able to elect an early abortion, but she must make that decision against the background of the impact it will have on the foetus. Clearly an abortion will terminate the life of the foetus and therefore the state is entitled to demand that she takes account of that fact in making her decision and considering the alternatives. By the same token, the state is under a duty to provide support for pregnant women and families.

Conclusion

Somewhat paradoxically, it is clear that access to early abortion is largely unproblematic in England and Wales, although that is the result of the liberal manner in which doctors interpret the Abortion Act 1967. However, as Laura Woliver recognises 'Much abortion jurisprudence is a story about doctors and fetuses instead of women's lives, because the court often reasons about reproductive policies in physiological paradigms, framing regulation as state action concerning women's bodies rather than women's rights.'¹⁸⁶ In this way abortion regulation is framed in terms of what others can do to the pregnant woman, rather than what she can choose for herself; she is objectified, depersonified and reduced to little more than an ambulatory reproductive facility. The symbolic implications of medicalisation are extremely problematic – in England and Wales the law affords scant regard to the woman's choices, with any decisions being left to professionals and decisions being made on narrow physiological grounds. The American experience demonstrates that the risk of so-called 'women protective' legislation is not that abortion will be prohibited, but that through various limitations and restrictions it will become inaccessible to more and more people. Although the context in which abortion is provided is very different in England and Wales, with the majority of abortions and contraception being provided free at the point of delivery, recent legislative proposals have drawn upon the American experience, seeking to resolve problems

¹⁸⁴ §5 II, III SchKG.

¹⁸⁵ 96.4% of all abortions performed in Germany during 2014 were performed on the basis of the counselling provision, Statistisches Bundesamt, *Schwangerschaftsabbrüche: Fachserie 12, Reihe 3, 2014*, 2015 Wiesbaden.

¹⁸⁶ L.R. Woliver (note 100), at 93-4.

that simply do not exist in the English context by introducing incremental restrictions upon access to abortion in the name of protecting women.

It is suggested that the time has come to recognise the agency of women in England and Wales, that they are capable of making reproductive decisions for themselves without the need for a doctor's guiding hand. The decision to terminate a pregnancy must be one of the most difficult decisions any woman has to make, but as an individual, a person who is more than her reproductive capacity, she must be permitted to make that decision on her own terms, even if she may later come to regret the decision. The price of autonomy is that one must take responsibility for one's own decisions, good and bad. However, focussing upon a woman's right to autonomy, or her right to bodily integrity, necessarily only considers one part of the whole. The foetus that resides within her is not nothing, it is deserving of respect, and cannot simply be destroyed without further thought. In *Vo v France* the European Court of Human Rights once again considered the application of Art. 2 ECHR to the foetus. Although it failed to determine whether or not the foetus is a person for the purposes of the Art. 2 ECHR, the majority held that 'The potentiality of [the foetus] and its capacity to become a person ... require protection in the name of human dignity, without making it a "person" with the "right to life" for the purposes of Article 2.'¹⁸⁷ Thus the court clearly anticipated that dignity could protect the foetus, and in doing so could restrict individual choice.

The Abortion Act 1967 constructs women as patients seeking care, rather than as women choosing abortion. By locating the regulation of abortion within a framework of respect for dignity, it is possible to prioritise choice so that the woman's dignity, which necessarily includes respect for her autonomy and bodily integrity, is not subject to the whims of the medical profession. In this article I have argued that the issue of abortion should be reframed as a matter of the protection of human dignity, rather than as a conflict between the woman's right to autonomy and the life of the foetus. Drawing upon the German abortion jurisprudence I have suggested that dignity operates as a lens through which the woman's claim to autonomy and the interest in foetal life are best viewed, enabling the conflicting interests to be reconciled and simultaneously protecting foetal life and the woman's autonomy and bodily integrity. The protection of human dignity does not require that these interests be given an equal degree of protection throughout pregnancy and thus it is argued that at least during the first trimester a lower level of protection is demanded in respect of the foetal life, whilst the woman's right to autonomy and bodily integrity are given precedence. With increased gestation, dignity will require that the balance is adjusted, so that at the latest when the foetus becomes viable its life is prioritised over the woman's autonomy, albeit with exceptions for risks to her health and life.

No matter what stage of the pregnancy, a woman's choice to terminate a pregnancy is not made in a vacuum, it is dependent upon the context in which she decides. By emphasising the physiological process of pregnancy, the current focus of the law in England and Wales fails to take account of the social framework in which such choices are made. Although the German abortion decisions conceptualise abortion as a rights issue, the *Bundesverfassungsgericht* has framed the basic rights set out in the German constitution as communitarian, rather than individualistic, in focus, thus the individual is conceived as 'an autonomous person who develops freely within the social community.'¹⁸⁸ It is suggested that

¹⁸⁷ *Vo v France* (note 10), at para 84.

¹⁸⁸ *Mephisto decision*, 30 BVerfGE 173 (1971); see also *the life imprisonment decision*, 45 BVerfGE 187, 227.

this approach is correct; John Donne wrote, ‘no man is an island’ and respect for human dignity gives voice to this philosophy, it values the individual as a subject and not as a mere means to an end, but it also places the individual at the heart of the community. Although the construction of dignity as empowerment will necessarily prioritise the woman’s values, it is suggested that dignity will impact upon the exercise of autonomy, requiring that the woman take account of the wider consequences of her choice. That is not to say that her decisions should be restricted to those that will protect foetal life, but she must consider the foetus in making her decision. The state has an interest in, and a duty towards, the foetus, a duty to ensure respect for the dignity of human life. This does not mean that the preservation of foetal life must be maintained in all, or even most, circumstances, but it does require the foetus, as a living entity to be respected. One means of demonstrating such respect is to require that the woman undergo non-directive counselling intended to accurately inform her choice prior to having an abortion.

Abortion is a public health issue, it should not be a criminal matter and it is time that we move away from treating it as such. The German solution is not perfect, it is regrettable that the majority of the *Bundesverfassungsgericht* decided that an abortion based upon the counselling provision must continue to be stigmatised as ‘unlawful’, however the manner in which counselling has been used in order to protect human dignity represents a useful benchmark to which we can look for inspiration. Respect for human dignity requires that the woman’s choice is informed, that she takes account of the foetus in making that choice, and that the state facilitates not only the making of the choice through information, but also ensures that there is a real choice to be made. The choice is not merely to continue the pregnancy or not, her decision will continue to have an impact after birth, for the rest of the woman’s life. Therefore, the context in which that choice will operate must be acknowledged and further support must be provided to women and families, for example by providing subsidised childcare, paid parental leave and more general support for families in the case of those who wish to continue the pregnancy and funded abortion for those who do not. In balancing the woman’s interests with those of the foetus, it would appear fair to require that information be made available about alternatives to abortion, and even that she be asked to wait a few days to consider that information, provided that thereafter she is entitled to have an abortion without the need for two medical professionals to say that her choice can be justified by reference to an indication, and funded by the National Health Service. In sum her dignity requires that her choice, and her ability to make that choice, be both facilitated and respected by the state.