An Exploration of How Current Legislations Restrict Women's Access to Abortion Services in England

Caitlin Day

Abstract

Despite scholarly and public criticism, under the current legislative framework, abortion remains criminalised in England and offenders could be subject to life imprisonment. This article seeks to contribute to scholarly debate on the design and impacts of the Abortion Act 1967, by providing a comprehensive review on how the current legislative framework restricts access to abortion services. This article argues that the discretionary power granted to doctors by the Abortion Act, the criminalisation of abortion and the stigma stemming from it, and the lack of effective oversight of the conscientious objection mechanism have significantly restricted access to abortion services in England by imposing multiple barriers. The article concludes by considering how two proposed law reforms, namely decriminalisation of abortion and abortion-on-request, could potentially render abortion services more accessible in England.

1 Introduction

While a survey shows that as many as 69% of respondents believe that abortion is legal, [1] abortion has in fact always been and remains a criminal offence in England ever since the introduction of The Offences Against the Person Act (OAPA) 1861, under which offenders are subject to life imprisonment.[2] In 1939, following the judgment in *R v Bourne*,[3] a legal exception was created whereby if the pregnancy would make a woman a 'physical or mental wreck', the procurement of abortion would not constitute a criminal offence.

In the absence of a national health service in the 1930s, the legal exception had led to several doctors in England interpreting this exception very liberally and charging women high fees for private abortions,[4] essentially turning the legal exception into a tool which doctors could use to legally justify performing abortions on women who were willing to pay high fees. Consequently, this created a large class divide between wealthy women and working-class women, with the latter who could not afford to pay the high fees for private legal abortions being forced to seek illegal abortions associated with high mortality rates.[5]

To combat these problems and expand access to abortion, in 1967 a private member's bill (PMB), now known as the Abortion Act 1967 (Abortion Act), was passed, providing doctors with four legal grounds for performing abortion procedures without constituting criminal offences. [6] However, the legal grounds specified in the Abortion Act do not translate into a right to abortion. Instead, abortion remains criminalised with the harshest of sentences.

From 2014 to 2022, at least seventeen women have been investigated by the police for having had abortions[7] and since 2022, at least six women have been awaiting criminal trial for offences

[1] BBC, 'Anne Robinson on her abortion "black doom"' *BBC* (London, 11 October 2017) < https://www.bbc.co.uk/news/uk-41565851> accessed 12 June 2024.
[2] Offences against the Person Act 1861 s 58.
[3] *R. v Bourne* [1939] 1 KB 687; [1938] 3 All ER 615, 694 (Macnaghten J).
[4] Emily Jackson, *Medical Law: Text, Cases, and Materials* (6 edn, OUP 2022) 773.
[5] Ibid 773.
[6] Abortion Act 1967 s 1.
[7] Charlotte Proudman, 'Think Abortion is Legal in Great Britain? Ask the Two Women Currently Facing Life Sentences' *The Guardian* (London, 19 August 2022) <www.theguardian.com/commentisfree/2022/aug/19/abortion-legal-great-britain-women-life-sentences-roe-v-wade> accessed 12 January 2023.

under the OAPA.[8] Furthermore, with the conditions laid out in the Abortion Act, women face multiple barriers and restrictions when they seek an abortion, raising questions over the accessibility of abortion services under the current legislative framework.

Despite keen scholarly and public debates, the accessibility of abortion services under the current legislative framework, in particular how the Abortion Act and the OAPA restrict access to abortion services, has been under-researched in current literature. 'Access' is given its literal meaning and refers to whether a woman can obtain an abortion. To contribute to current scholarly and public debates, this article will highlight the barriers imposed by the current abortion laws and argue that the discretionary power granted to doctors by the Abortion Act, the criminalisation of abortion and the stigma it generates, and the lack of effective oversight of the conscientious objection (CO) mechanism, have significantly restricted access to abortion services in England.

This article is structured as follows: first, the Abortion Act will be reviewed to examine how it restricts access to abortion services and argues that subjecting access to multiple disproportionate interferences and a liberal interpretation of the Act is not a sufficient governing mechanism. Second, it explores the societal perception of abortion to analyse how through criminalisation, abortion has been stigmatised, which subsequently impacts access. The purpose of criminal law will also be evaluated to argue that governing abortion within the criminal law framework is unjustified. Third, the use of the CO mechanism by doctors, which provides doctors with the right to object to abortion treatment,[9] and the lack of effective oversight thereof, will be reviewed to assess their consequences on the accessibility of abortion services. A key focus here will be the power dynamic between doctors and their patients and the intersection between the criminalisation of abortion and the CO mechanism. Finally, this article will discuss how the current legislative framework could be restructured through two proposed reforms, namely the decriminalisation of abortion and abortion-on-request, and evaluate if and how these proposed reforms could remove the current barriers to accessing abortion services.

[8] Zoe Williams, 'The Women Being Prosecuted in Great Britain for Abortions: Her Confidentiality Was Completely Destroyed' *The Guardian* (London, 10 November 2023) <www.theguardian.com/world/2023/nov/10/the-women-being-prosecuted-in-great-britain-for-abortions-her-confidentiality-was-completely-destroyed> accessed 3 February 2024.
[9] Abortion Act 1967 s 4.

2 How Does the Abortion Act Restrict Access to Abortion Services?

2.1 The Four Legal Grounds for Obtaining Abortion do not Translate into a Right to Abortion

Most women in England access an abortion under a liberal interpretation of the Abortion Act, leading to the statue being described as 'harmless legal fiction'.[10] Under section 1(1)(a) of the Abortion Act, a pregnancy can legally be terminated if there is a greater risk of harm to the woman's 'physical or mental health' as compared to continuing the pregnancy.[11] Calkin argues that this clause is interpreted very liberally, effectively enabling abortion-on-request.[12] A key reason for this is that it is statistically safer to have an abortion at any early gestation than to carry a pregnancy to full-term,[13] meaning abortions at early gestations can always be justified on this ground. Some would read the Abortion Act as offering no restrictions since there appears to be a loophole which women will almost always satisfy, at least at early gestations. The British Pregnancy Advisory Services (BPAS) stated that while the Abortion Act grants doctors a gatekeeping role with 'a great deal of latitude' in deciding whether a woman may have an abortion, such broad discretion for authorising abortions does not translate into a right to abortion on demand.[14]

The same legislation which currently provides access to abortion services on certain grounds could easily be used to restrict access,[15] rendering the Abortion Act a dual-edged sword. The Abortion Act does not include an entitlement to access an abortion nor does it require that a liberal interpretation guides medical practices. This means that access to abortion services and exemption from criminalisation currently depends on the latitude with which two doctors apply and interpret the risks imposed by the pregnancy to the woman's physical or mental health,[16]

[10] Emily Jackson, 'Abortion, Autonomy and Prenatal Diagnosis' (2000) 9 Social and Legal Studies 467, 472.
[11] Abortion Act 1967 s 1(1)(a).
[12] Sydney Calkin and Ella Berny, 'Legal and Non-Legal Barriers to Abortion in Ireland and the United Kingdom' (2021) 5 The Journal of Medicine Access <https://journals.sagepub.com/doi/full/10.1177/23992026211040023> accessed 15 October 2022.
[13] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, MUP 2016) 404.
[14] British Pregnancy Advisory Service, 'Abortion Law in Great Britain' <https://www.bpas.org/our-cause/campaigns/briefings/abortion-law-in-great-britain/> accessed 12 June 2024.
[15] Lula Mecinska, Carolyne James and Kate Mukungu, 'Criminalization of Women Accessing Abortion and Enforced Mobility within the European Union and the United Kingdom' (2020) 30 Women & Criminal Justice 391, 394.
[16] Samantha Halliday, 'Protecting Human Dignity: Reframing the Abortion Debate to Respect the Dignity of Choice and Life' (2016) 13 (4) Contemporary Issues in Law 287, 304.

rather than being protected by a right to access abortion services enshrined in the law. Ward addresses how there is no explicit criteria by which doctors are bound[17] and the decision on whether to perform an abortion on justified grounds is within the doctors' sole discretion, implying that doctors could easily deny abortions and restrict access. This further highlights the fragility of access and the lack of protection provided as there is no guarantee that a woman would be able to have an abortion. Though in practice, women can access abortion services by invoking one of the four legal grounds, within the current legal framework, it is entirely possible that women can easily be denied access to abortion, which raises serious concerns for women.

2.2 Empowering Doctors as Gatekeepers reinforces Patriarchal Notions

The legality and accessibility of an abortion rests upon the approval and confirmation of two doctors,[18] even if objectively a ground has been satisfied. This is a central argument against claims that abortion is in practice available on-request,[19] as doctors are granted sole discretion and are empowered as gatekeepers. This provides doctors with an unjustified degree of power[20] which is not held over any other medical procedures.

By placing the decision within the doctors' hands, women are left powerless and are forced to attempt to persuade doctors that they satisfy the requirements outlined in the Abortion Act. This usually involves the woman having to portray themselves as weak and desperate,[21] to gain sympathy, and to convince the doctors, which can be humiliating. This is exacerbated by the need to convince two doctors instead of just one.[22]

A stark power imbalance is present between the woman and the doctors. Doctors already enjoy an elevated status in society and the Abortion Act grants them even more power and control. Women are taken out of the decision-making process with the belief that doctors are best

[17] Abigail Ward, 'If a Woman's Personhood Is Truly Represented by the Law, Then She Must Also Be the Ultimate Source of Both the Decision to Abort and the Meaning given to that Decision. A Discussion with Reference to UK Abortion Law' (2016) Bristol Law Review 113, 116.
[18] Abortion Act 1967 s 1(1).
[19] Jane O'Neill, "'Abortion Games": The Negotiation of Termination Decisions in Post-1967 Britain' (2019) 104 (359) History (London) 169, 171.
[20] Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (1st edn, Hart Publishing 2001) 86.
[21] Yunjiao Liu, 'Medical Gatekeeping and Access to Abortion: Opening the Floodgate or Embracing Patient Autonomy?' (2010) 10 Manchester Review of Law Crime & Ethics 121, 124.
[22] Ward (n 17) 116.

positioned to assess the eligibility of women to get legal abortions, which impedes accessibility as women cannot access an abortion without first impressing two doctors.

The gendered nature of abortion must be addressed here. Placing doctors in control is a clear reflection of the prevailing societal attitudes when the Act was passed, as evidenced by parliamentary debates where women were considered unstable and helpless.[23] The Act was never formulated to empower women.

Attitudes towards women and their rights have altered since the 1960s and though women are now considered legal persons, as evidenced by the Equality Act,[24] such recognition for women's rights has not been reflected in abortion law. The abortion clauses reinforce the patriarchal notion that women are unfit to make their own decisions,[25] disempowering women in society as they are not awarded the same level of bodily autonomy as men, defined as the ability to make their own choices regarding their bodies.[26]

Instead, women are forced to conform to the patriarchal stereotype of being weak and vulnerable when they persuade doctors to grant them a legal abortion. This works to ensure that women do not feel 'entitled'.[27] The design of the Act disempowers women as they are not free to make the decision on procuring an abortion though the decision concerns their own bodies. Furthermore, Priaulx addresses how accessible abortions need to be made if women are to be released from patriarchal control.[28] This implies that while doctors are gatekeepers, women are not empowered because the Act operates to maintain control over women.

Evidence suggests that the two-doctor requirement is opposed by doctors themselves,[29] implying that doctors do not intend to exploit the discretionary power granted to them. Nevertheless, this power is still bestowed in doctors, providing them with control over women's bodies and the possibility to abuse this power should they wish to.

[23] Ellie Lee, 'Tensions in the Regulation of Abortion in Britain' (2003) 20 Journal of Law and Society 532, 535.
[24] Equality Act 2010.
[25] Lee (n 23) 535.
[26] Jackson (n 4) 209.
[27] Jackson (n 20) 82.
[28] Nicky Priaulx, 'The Social Life of Abortion Law: On Personal and Political Pedagogy' (2017) 25(1) Medical Law Review 73, 91.
[29] Ellie Lee, Sally Sheldon and Jan Macvarish, 'The 1967 Abortion Act Fifty Years On: Abortion, Medical Authority and the Law Revisited' (2018) 212 Social Science & Medicine 26, 29.

2.3 Women cannot access Abortion Services at a Later Stage of Pregnancy

A further barrier is the twenty-four-week gestation limit whereby an abortion can only be performed up until this point,[30] unless the woman's life is at risk,[31] or the foetus would suffer from 'physical or mental abnormalities'.[32] Many academics argue that this has little practical impact, as evidence shows that eighty-nine percent of abortions are performed within the first ten weeks of pregnancy, with only one percent of abortions performed at twenty weeks.[33] As such, Jackson argues that the Act functions to make all abortions under twenty-four weeks lawful,[34] and that the time limit does not impact accessibility. This could in theory suggest the gestation limit is over-generous considering the proportion of abortions performed several weeks before the limit, implying access would not be compromised if an even tighter limit was imposed.

However, it is imperative to look beyond the statistics and question why most women have early-gestation abortions. Simply because most abortions take place during the first trimester does not mean that this is the only period during which women want abortions. Instead, it is likely to be the result of the lack of accessibility of second-trimester abortions.

There is evidence suggesting that the way doctors judge whether an abortion should be granted has created an earlier gestation limit in practice. For example, doctors might deny abortion requests during the second trimester due to advancements in neonatal medicine and foetal viability at later gestations.[35] Therefore, it is more likely that women would be denied access to abortion during the second trimester.[36] This was demonstrated in *Saxby v Morgan*[37] whereby the complainant's doctor refused to perform an abortion, citing that the procedure would be too advanced, though the complainant was only nineteen-weeks pregnant, five-weeks within the

[30] Abortion Act 1967 s 1(1)(a).
[31] Abortion Act 1967 s 1(1)(c).
[32] Abortion Act 1967 s 1(1)(d).
[33] Office for Health Improvement & Disparities, 'Abortion Statistics, England and Wales: 2021' (*GOV.UK*, 30 January 2023) <www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021#contents> accessed 15 February 2023.
[34] Jackson (n 10) 470.
[35] John Wyatt, 'Medical Paternalism and the Fetus' (2001) 27 Journal of Medical Ethics ii15, ii17.
[36] Jackson (n 20) 75.
[37] *Saxby v Morgan* [1997] 4 WLUK 304, [1997] PIQR P531.

legal limit of obtaining an abortion. This presents a real danger to women who might not discover their pregnancy until later, for example, because of irregular menstrual cycles.[38] Access is therefore dependent upon the discretion of doctors, notwithstanding the seemingly generous limit, and provides a possible explanation for why the statistics show a high proportion of first-trimester abortions.

It is also essential to consider if there is a medically justified reason for the gestation limit being set at twenty-four weeks. Research from the Royal College of Obstetricians and Gynaecologists (RCOG) found that abortions at later gestations did result in an increased risk of morbidity, but crucially this increase was not of statistical significance.[39] Furthermore, this research was conducted almost forty years ago. Medical development may have further reduced the morbidity risks. This implies that further research on the safety of second-trimester abortions is required to investigate if this can justify doctors refusing to perform abortion procedures during the second trimester. This may subsequently demonstrate that imposing the twenty-four-week limit is medically justified and is necessary from a medical point of view. Nevertheless, if doctors refuse to perform abortions at earlier gestations within the legal limit, this still shows that abortions in England are not as accessible as they are initially assumed to be.

If doctors refuse to perform an abortion even though it is within the twenty-four-week legal limit, younger women would be disproportionately disadvantaged. Teenagers are one and a half times more likely to seek an abortion after thirteen weeks[40] out of worries and therefore delay making an appointment.[41] Such data is not routinely published within abortion statistics, making it challenging to draw up-to-date conclusions. Nevertheless, teenagers are potentially the age group that would be the most detrimentally impacted by an unwanted pregnancy, as they are likely to still be in education and do not have adequate resources to raise a child. Kobayashi further argues how accessing an abortion is highly critical in shaping teenagers'

[38] Roger Ingham and others, 'Reasons for Second Trimester Abortions in England and Wales' (2008) 16(31) Reproductive Health Matters 18, 24.
[39] The Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists, 'Induced abortion operations and their early sequelae' (1985) 35 Journal of the Royal College of General Practitioners 175.
[40] Social Exclusion Unit, *Teenage Pregnancy* (Cm 4342, 1999) para 8.14.
[41] Ellie Lee, 'Young Women, Pregnancy, and Abortion in Britain: A Discussion of Law "In Practice"' (2004) 18(3) International Journal of Law, Policy and the Family 283, 285.

futures.[42] This emphasises the need for accessible abortions to help young women secure their futures.

2.4 Reinforcing the Class Divide

Socio-economic factors also constitute access barriers.[43] A high level of knowledge about how the Abortion Act operates is required to challenge a doctor's refusal to perform an abortion.[44] Many women lack the knowledge that they have a right to seek a second opinion and instead interpret an initial denial as ineligibility.[45] Generally, affluent women are more likely to hold a full appreciation of their rights as a patient and understand the Abortion Act.[46] They are therefore more likely to seek a second opinion if their request is initially rejected and convince doctors that they meet the legal grounds specified in the Abortion Act. This further amplifies the power and discretion doctors hold over women from lower socio-economic groups who might not possess the knowledge required to challenge doctors' decisions or ask for a second opinion, and therefore go without the abortion they need.

Because of the design of the Act, women are forced to seek ways around it if their initial request is rejected and those without sufficient knowledge about the Act are not equipped to do so effectively. A reason for the enactment of the Abortion Act was to eliminate the class divide between affluent women who could afford to pay for an abortion and women from working-class backgrounds whose only option was an unsafe backstreet abortion.[47] It is clear to see this disparity in access is still present, albeit in a different form, because of the design of the Act. This has been referred to as the 'modern manifestation of backstreet abortions'[48] which the Act was designed to eliminate, showing how by being too restrictive, the Act is not fulfilling its purpose.

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[42] Alicja Kobayashi and Madeline Thomas, 'Does Access to Abortion Vary Across the UK?' (*Economic Observatory*, 5 October 2022) <www.economicsobservatory.com/does-access-to-abortion-vary-across-the-uk> accessed 4 January 2023.
[43] Elizabeth Chloe Romanis and Jordan A Parsons, 'Legal and Policy Responses to the Delivery of Abortion Care During COVID-19' (2020) 151(3) International journal of gynecology and obstetrics 479, 480.
[44] Liu (n 21) 130.
[45] Jackson (n 20) 86.
[46] O'Neill (n 19) 178.
[47] Jackson (n 4) 773.
[48] Emily Ottley, 'Abortion on Request: A Desirable Response to the Criminalisation of Abortion in England and Wales?' (2020) 11 King's Student Law Review 54, 55.

2.5 Early Medical Abortion (EMA) does not remove all Barriers to access Abortion

In 2022, the measure launched during the COVID pandemic that permits early medical abortion (EMA) pills to be taken at home following a remote consultation with doctors[49] became a permanent amendment. This provides a glimmer of hope that abortion legislation is starting to be reformed to make abortion more accessible by breaking down the barriers which previously existed. This development contrasts with Mecniska's argument that the law does not reflect recent medical developments in abortion care.[50]

As women can take the EMA medication at a time most convenient to them,[51] they are able to work around other commitments, minimising the impacts their abortion has on their routines. For instance, women might no longer need to take time off work as they can now plan to take the medication during their day off, reducing the financial impacts of having an abortion. Furthermore, the barrier of having to travel to a clinic is removed. This increased control given to women[52] makes abortion more accessible. Abortion rates peaked in 2021,[53] which was possibly a result of the increased accessibility of abortion with the home use of EMA. Yet, it must be noted that the pandemic brought high levels of financial and job uncertainty, which may also explain why more women sought an abortion,[54] as they felt unable to have children in the given circumstances. It will be interesting to see if this increase continues to measure and if this was a result of the new EMA rules, or the implications of the pandemic.

Yet, it must be noted that EMAs are not accessible for all women. Acquiring EMAs relies on having access to the 'internet or a private telephone'.[55] Complications are therefore present for women in controlling relationships who cannot talk freely on the phone or have their calls monitored. This means the advantages provided by EMAs are not universally present and many

[49] Health and Care Act 2022 s 178(4).
[50] Mecinska, James and Mukungu (n 15) 394.
[51] Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79(2) Modern Law Review 283, 311.
[52] Sally Sheldon, 'The Medical Framework and Early Abortion in the UK: How Can a State Control Swallowing?' in Rebecca J Cook, Joanna N Erdman and Bernard M Dickens (eds), *Abortion Law in Transnational Perspective* (University of Pennsylvania Press 2014) 192–193.
[53] Office for Health Improvement & Disparities (n 33).
[54] BPAS, 'BPAS Comment Re: Abortion Statistics 2021' (*BPAS*, 21 June 2022) <www.bpas.org/about-bpas/press-office/press-releases/#:~:text=%E2%80%9CThe%20pandemic%2C%20and%20the%20policies,continuing%20or%20ending%20a%20pregnancy> accessed 15 February 2023.
[55] Romanis (n 43) 482.

women may still be left with significant barriers to overcome. Furthermore, EMAs have not removed the barriers imposed by the Abortion Act.[56] Accessing EMAs is still contingent on approval by two doctors, which is a gruelling barrier to overcome and fails to remove the gatekeeping role doctors play. In addition, EMAs are only available for pregnancy of up to ten weeks,[57] meaning this is not an option for second trimester abortions. Although the new EMA regulations hold the potential to reduce certain barriers and make abortion more accessible, this has not gone far enough for abortion to be accessible for all women.

3 How Does the Criminalisation of Abortion Stigmatise and Restrict Access?

By governing abortion within the criminal framework,[58] abortion is portrayed as inherently wrong, which has implications on the societal perception of abortion. With the so-called 'abortion stigma',[59] negative attributes are given to women seeking termination, labelling them as 'inferior' to the 'ideals of womanhood'.[60] The link between abortion stigma and its implications on access is vastly overlooked. Besides, the criminalisation of abortion further intensifies its stigmatisation, which in turn restricts access to abortion.

3.1 Role of Criminal Law

A key role of criminal law is to deter others from committing criminal acts out of fear of repercussions. Parsons asserts that criminal law functions for social control and integration[61] by punishing individuals for going against socially accepted standards, which in turn facilitates the normalisation of desired behaviours.[62] By this logic, by governing abortion within the criminal system, women are deterred from seeking an abortion out of fear of criminal consequences, which reduces women's ability to access an abortion as criminalisation generates this fear barrier. It is essential to consider how widespread the knowledge is that

[56] Adelyn LM Wilson, 'The Health and Care Act 2022: Inserting Telemedicine into the Abortion Act 1967' (2023) 31 Modern Law Review 158, 161.
[57] Health and Care Act 2022 s 178(4).
[58] Offences against the Person Act 1861 s 58.
[59] Alison Norris and others, 'Abortion Stigma, A Reconceptualization of Constituents, Causes and Consequences' (2011) 21 Women's health issues S49.
[60] Anuradha Kumar, Leila Hessini and Ellen MH Mitchell, 'Conceptualising Abortion Stigma' (2009) 11(6) Culture, Health & Sexuality 625, 628.
[61] Talcott Parsons, 'The Law and Social Control' in William M Evan (ed), *Law and Sociology: Exploratory Essays* (Free Press of Glencoe 1962) 58.
[62] Ibid.

abortion is a criminal offence in England. Research shows that only 13% of individuals knew that abortion was a criminal offence,[63] suggesting that fear of prosecution is not a key factor of consideration when a woman seeks an abortion, implying the deterrence function is not being achieved. This means that criminalising abortion does not achieve the rationales and purposes of criminal law.

The aforementioned research was conducted in 2017 and figures might be outdated. There has been extensive media coverage on the legality of abortion since its decriminalisation in Northern Ireland[64] and the overturning of *Roe v Wade*[65] is likely to have raised awareness on the criminal status of abortion. Nevertheless, this still provides a valuable insight into how well the criminalisation of abortion is known.

According to Mill's harm principle,[66] the power of criminal law is only justified when criminalisation prevents harm to others.[67] This is supported by the Sentencing Act[68] whereby the court must consider 'the protection of the public'[69] when determining sentences. If this argument is applied to abortion, imposing criminal sanctions on women seeking an abortion is a disproportionate use of power. Denying a woman a safe abortion by trained professionals will not protect her from harm, but will instead exacerbate the harm as women have reported to resort to any means to terminate an unwanted pregnancy.[70] The Abortion Act was enacted to reduce instances of women obtaining unsafe backstreet abortions,[71] which arguably has not been completely eradicated and therefore, it remains in question how the law is protecting women when it functions to restrict their access to abortion services and criminalises them for seeking an abortion. Unregulated abortions are conducted without proper medical attention and resources and have a higher mortality rate.[72] Governing abortion under the criminal law framework results in increased harm to women, which is contrary to the harm principle that aims at justifying the use of criminal sanctions.

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[63] BBC (n1).
[64] The Abortion (Northern Ireland) Regulations 2020.
[65] *Roe v Wade* 410 US 113 (1973).
[66] John Stuart Mill, *On Liberty and Other Essays* (Introduction and Notes by John Gray (ed), OUP 1998) 11.
[67] Ibid 12.
[68] Sentencing Act 2020 s 57.
[69] Sentencing Act 2020 s 57(2)(d).
[70] Christian Fiala and Joyce H Arthur, "'Dishonourable Disobedience"—Why Refusal to Treat in Reproductive Healthcare is not Conscientious Objection' (2014) 1 Woman, Psychosomatic Gynaecology and Obstetrics 12, 18.
[71] Jackson (n 4) 774.
[72] Fiona de Londras and others, 'The Impact of Criminalisation on Abortion-Related Outcomes: A Synthesis of Legal and Health Evidence' (2022) 7 BMJ Global Health 1, 7.

Views that foetuses are human beings could arguably justify criminal sanctions. Marquis compares abortion to murder and depriving the unborn foetus of its future,[73] which could justify the use of criminal law as it seeks to protect foetuses from harm. However, it must be considered that there is a lack of consensus surrounding whether a foetus is considered a human being. Therefore, instead of taking for granted the argument that foetuses are human beings, other viewpoints should also be considered when developing abortion laws. Marquis' argument and the harm principle are only valid if one believes that foetuses are human beings. A full exploration of the pro-life versus pro-choice debate is outside the scope of this article as this is not directly linked to the accessibility of abortion services and therefore will not be explored any further. However, it is important not to assume that the argument that foetuses are human beings is a definitive fact when determining whether abortion should be criminalised.

3.2 Criminalisation reinforces Social Stigma around Abortion

It is important to evaluate the societal perception of abortion to assess how the criminalisation of abortion has shaped such perceptions and how such perceptions in turn affects access to abortion services. A survey shows that 34% of respondents do not support an abortion when a woman does not want a child.[74] Pro-life protests outside abortion clinics[75] show that unfavourable perceptions of abortion still exist. The portrayal of these views, especially when they receive extensive media coverage,[76] creates the potential to influence societal perception on abortion. The criminal law framework governing abortion reinforces and even justifies anti-abortion perceptions, as criminal law paints a picture of what behaviours are desirable.

Criminalising abortion also creates a 'chilling effect'[77] that influences women's perception of their ability to access an abortion. This chilling effect makes abortion seem 'morally

[73] Don Marquis, 'Why Abortion is Immoral' (1989) 86(4) Journal of Philosophy 183, 192.
[74] Alison Park and Rebecca Rhead, 'Personal relationships: Changing attitudes towards sex, marriage and parenthood' in Park, A., Bryson, C., Clery, E., Curtice, J. and Phillips, M. (eds) *British Social Attitudes: the 30th Report* (NatCen Social Research, 2013), available at <https://natcen.ac.uk/sites/default/files/2023-08/bsa30_personal_relationships_final.pdf> accessed 14 June 2024.
[75] *Dulgheriu v Ealing LBC* [2019] EWCA Civ 1490; [2020] 1 WLR 609.
[76] Priaulx (n 28) 87.
[77] Mecinska, James and Mukungu (n 15) 391.

questionable',[78] as women might think that if they seek an abortion, they would be doing something inherently wrong[79] as the criminal law framework differentiates abortion from all other medical procedures[80] and leads to the abortion stigma. Besides, by threatening the possibility of life imprisonment, women are deterred from seeking an abortion out of fear of prosecution. This can result in women carrying an unwanted pregnancy or resorting to unsafe methods of termination.[81] As such, it is clear to see how the chilling effect has constituted a substantial barrier to accessing abortion services.

From another perspective, Cook explains how abortion stigma impacts access by creating two types of stigma.[82] First, a 'perceived stigma' is generated whereby women are concerned with how other people will react.[83] This can cause worry and anxiety for many women and results in them either delaying accessing abortion services as they hesitate about whether an abortion is right for them or avoiding seeking an abortion altogether. Delaying an abortion can result in women passing the statutory time limit and there is evidence suggesting that women are more likely to be denied an abortion at a later gestation,[84] as explained at length earlier. It is crucial for women to feel comfortable accessing abortion services to avoid their request being denied at a later stage. This shows how, by criminalising abortion, a perceived stigma is generated, which in turn imposes a barrier for women to overcome.

In addition, criminalising abortion results in 'internalised stigma' whereby the connotations associated with abortion are incorporated into a women's perception of herself.[85] This produces feelings of 'guilt or shame'[86] after receiving an abortion. This can prevent women from accessing an abortion again in the future if they require one to avoid these negative feelings. This is amplified by the criminal law framework which reinforces the idea that abortion is wrong,[87] making women feel guilty. Therefore, criminalisation results in women developing

[78] BMA's Medical Ethics Committee, 'Decriminalisation of Abortion: A Discussion Paper from the BMA' (*BMA*, 2017) 28 <https://www.bma.org.uk/media/1142/bma-paper-on-the-decriminalisation-of-abortion-february-2017.pdf> accessed 4 June 2023.
[79] Ottley (n 48) 58.
[80] Swara Saraiya, 'Conceiving Criminality: An Evaluation of Abortion Decriminalization Reform in New York and Greater Britain' (2018) 57 (1) Columbia journal of transitional law 174, 204.
[81] Ottley (n 48) 55.
[82] Rebecca J Cook, 'Stigmatized Meanings of Criminal Abortion Law' in Cook, Erdman and Dickens (n 52) 354.
[83] Ibid 355.
[84] Jackson (n 20) 75.
[85] Cook (n 82) 355.
[86] Kristen M Shellenberg and others, 'Social Stigma and Disclosure about Induced Abortion: Results from an Exploratory Study' (2011) 6 Global Public Health S111, S114.
[87] Saraiya (n 80) 204.

damaging perceptions of themselves and their behaviour, which in a way reduces access by making vulnerable women feel guilty about their actions.

3.3 Criminalisation of Doctors performing Abortions

Potentially resulting from the abortion stigma, insufficient education and training is provided to medical students with several medical schools providing less than two hours of clinical teaching on abortion procedures.[88] This stands in contrast to the eight teaching hours that cover the ethical-legal aspects of abortion,[89] which reinforces abortion as an ethical topic rather than a common medical procedure. This could contribute to the anti-abortion beliefs amongst medical students, which discourage them from choosing a speciality where they would be continually faced with abortion requests.

Furthermore, abortion is not a mandatory part of obstetrics and gynaecology (OBGYN) training in England, showing yet again the lack of education related to abortion provided throughout a doctor's career.[90] The lack of attention and importance given to abortion procedures during medical school reinforces the stigma around abortion,[91] though abortion is one of the most common procedures for women with one in three women having had an abortion.[92]

Research conducted in 2008 supports the view that there is a perpetuation of anti-abortion beliefs among medical students.[93] Some of the participating medical students in the UK thought that abortion was morally wrong when considering the rights of the foetus.[94] It is possible that since the research was conducted attitudes towards abortion in this context have changed given the increase in abortion rates.[95] However, the cohort of students participating in the research

[88] Catriona Rennison and others, 'Abortion Education in UK Medical Schools: A Survey of Medical Educators' (2022) 48(3) BMJ Sexual and reproductive health 6.
[89] Ibid.
[90] Sheelagh McGuinness, 'A Guerrilla Strategy for a Pro-Life England' (2015) 7(2) Law, innovation and technology 283, 307.
[91] Joy Hodkinson and Marina Politis, 'Abortion Teaching Must Empower Medical Students and Doctors to Advocate for Reproductive Justice' (2022) 378 BMJ 1.
[92] Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36(2) Oxford journal of legal studies 334, 344.
[93] R Gleeson and others, 'Medical Students' Attitudes Towards Abortion: A UK Study' (2008) 34(11) Journal of medical ethics 783, 784.
[94] Ibid.
[95] Office for Health Improvement & Disparities (n 33).

would now be practising doctors who operate today while possibly holding those same anti-abortion beliefs.

Doctors' worries that they could be subject to criminal prosecution since they operate within questionable limits of discretion[96] constitute another access barrier. Lee found evidence of fear and insecurities among doctors regarding the threat of prosecution they could face.[97] This supports the argument that by criminalising doctors for performing abortion, they may be reluctant to perform the medical procedure, hence further restricting access to abortion.

However, there has only been one reported case since the enactment of the Abortion Act where a doctor has been prosecuted under the Act.[98] This potentially implies that doctors' fears of prosecution might be exaggerated as the possibility of them being investigated is exceptionally slim. Nevertheless, doctors' fears should not be dismissed, especially considering that some MPs are now pushing for doctors to face prosecution regarding abortion services, including for paperwork inaccuracies.[99] The existence of such initiatives, may help explain why doctors are fearful and reluctant to provide an abortion. Furthermore, the possibility of prosecution could further deter junior doctors from specialising in OBGYN.

It is possible that a woman may be denied an abortion due to the doctor being fearful that they would be prosecuted if they were investigated, constituting yet another barrier to accessing abortions. This could result in women turning to unsafe methods of termination or being forced to carry an unwanted pregnancy. The law should not induce fear in doctors nor force women to adopt unsafe methods. Rather, women who meet the criteria under the Act[100] should be able to access an abortion. By criminalising abortion, the Abortion Act does not achieve its intended purposes.

4 Does the Conscientious Objection Mechanism Restrict Access?

[96] Liu (n 21) 127.
[97] Lee, Sheldon and Macvarish (n 29) 31.
[98] *R v Smith (John Anthony James)* [1973] 1 WLR 1510; [1974] 1 All ER 376.
[99] Liu (n 21) 133.
[100] Abortion Act 1967 s 1(1).

The Abortion Act provides doctors with the right to refuse to carry out an abortion if they hold a conscientious objection.[101] This is when the doctors' own beliefs and values conflict with the proposed treatment and they therefore refrain from performing the procedure.[102]

Though the World Health Organisation recognises that CO reduces the standard of abortion care,[103] limited literature has focused on the impacts CO has on access to abortion. In fact, CO presents another barrier to access abortion by reducing the number of doctors willing to perform abortion procedures, reinforcing the power imbalance between doctors and patients, and rendering abortion an ethical issue rather than a medical procedure.

4.1 CO shrinks the Pool of Providers of Abortion Services

Conscientious objection provides a way for doctors to avoid being stigmatised and discriminated against within their profession for performing certain procedures, which in some cases can result in violent threats against them.[104] Instead of being used to exercise genuine conscience, CO can be invoked as a convenient tool[105] to prevent these negative consequences. In the case of abortion, invoking CO in such a way would reduce the number of doctors willing to perform an abortion. If there are fewer willing doctors, abortion services are stretched further, which can cause delays. Delays can push women over the legal time limit, as previously discussed, meaning they can no longer access a legal abortion. Women might then resort to seeking dangerous illegal abortions that carry a higher mortality rate[106] and face the risk of prosecution. Moreover, doctors are more likely to object to abortions at later gestations.[107] This means that if a woman's appointment is delayed, it would be possible that she would encounter an objecting doctor, which would impede her access to abortion services.

[101] Abortion Act 1967 s 4(1).
[102] General Medical Council, 'Personal Beliefs and Medical Practice' (*GMC*, 7 April 2020) <www.gmc-uk.org/professional-standards/professional-standards-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice> accessed 15 February 2023.
[103] World Health Organisation, 'Safe Abortion: Technical and Policy Guidance for Health Systems' (*WHO*, 2015) <https://iris.who.int/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf> accessed 24 January 2023.
[104] Leila Hessini, 'A Learning Agenda for Abortion Stigma: Recommendations from the Bellagio Expert Group Meeting' (2014) 54 Women & Health 617, 618.
[105] Fiala and Arthur (n 70) 17.
[106] de Londras and others (n 72) 7.
[107] Ingham and others (n 38) 20.

There is recent evidence suggesting that the lack of abortion providers due to doctors holding CO, means that junior doctors have limited learning opportunities.[108] These consequences have already been explored earlier and the same implications apply here.

In addition to the other consequences of inadequate training explored above, a concern arises in relation to CO specifically because regardless of whether a doctor holds CO, they are still required to perform an abortion if the woman's life is at risk.[109] If a doctor has insufficient training in performing abortions due to holding CO, it may interfere with their ability to save a woman's life in emergencies. From this perspective, not only is the lack of training for doctors impacting accessibility, it is also threatening the lives of women who would die without a safe abortion, such as those with ruptured ectopic pregnancies. Ideally, abortion and OBGYN training should be a mandatory part of a medical school's curriculum to ensure women's safety.

Furthermore, many junior doctors are discouraged from performing abortions due to the fear that they will be stigmatised.[110] This poses serious concerns for the future of abortion services[111] whereby access could become even more restricted as fewer doctors choose to specialise in OBGYN and those who do then claim CO to avoid stigmatisation. In other words, allowing CO reduces the quantity of abortion providers and operates to dissuade doctors from performing an abortion whenever concerns over stigmatisation arise.

A key example of how CO can reduce the pool of providers is shown in Italy where 71% of OBGYN are registered as holding CO.[112] This has had severe consequences on accessibility as many women are forced to travel to find a willing doctor,[113] or to continue the pregnancy unwillingly. This has occurred despite abortion being governed by a seemingly liberal law, showing yet again the importance of examining beyond the letter of the law to analyse how

[108] Jasmine Meredith Davis, Casey Michelle Haining and Louise Anne Keogh, 'A Narrative Literature Review of the Impact of Conscientious Objection by Health Professionals on Women's Access to Worldwide 2013– 2021' (2022) 17(9) Global Public Health 2190, 2199.
[109] Abortion Act 1967 s 4(2).
[110] Fiona de Londras and others, 'The Impact of "Conscientious Objection" on Abortion-Related Outcomes: A Synthesis of Legal and Health Evidence' (2023) 129 Health Policy 1, 9.
[111] Sophie LM Strickland, 'Conscientious Objection in Medical Students: A Questionnaire Survey' (2011) 38 Journal of medical ethics 22, 24.
[112] Tommaso Authorino, Francesco Mattioli and Letizia Mencarini, 'The Impact of Gynaecologists' Conscientious Objection on Abortion Access' (2020) 87 Social Science Research 1.
[113] Daniel Rodger and Bruce P Blackshaw, 'Quotas: Enabling Conscientious Objection to Coexist within Abortion Access' (2021) 29 Health Care Analysis 154, 158.

accessible abortion is in practice. The lack of safeguards to prevent CO from being abused endangers the availability and access to abortion.

The example of Italy demonstrates the possibility of CO becoming so widespread it completely undermines access to abortion which could potentially also manifest in England.[114] However, it must be noted that Italy is heavily influenced by Catholicism,[115] which includes a belief that abortion is equivalent to murder,[116] and which might explain why a significant number of doctors hold CO. In contrast, England is becoming more secular with an increasing percentage of individuals not following any religion,[117] implying religious beliefs might not be as influential. Nonetheless, Authorino found that the rate of doctors holding CO is disproportionately high compared to the rate of people having religious beliefs in Italy,[118] suggesting that religious beliefs may not be the only factor for claiming CO. Arguably, as discussed earlier, the associated social implications and fear of stigmatisation in performing abortion offer a plausible explanation for CO being more widespread.

4.2 The potential Abuse of Conscientious Objection

A CO can be misused when appropriate safeguarding measures are lacking.[119] If a regulatory framework was put in place with strict guidance regarding when CO could be used, doctors would not be able to misuse their power. Use of CO should be limited to instances when doctors have a genuine claim. Without an effective oversight mechanism, CO becomes 'impossible' to manage[120] and doctors can continue to abuse it. Therefore, there is a need to strengthen the oversight mechanism governing CO to ensure that it is invoked only when a genuine objection exists.

It remains to be discussed as to which regulations should be implemented and the form they might take. For example, would doctors be subjected to civil or criminal proceedings if they

[114] Fiala and Arthur (n 70) 15.
[115] Rachel Anne Fenton, 'Catholic Doctrine Versus Women's Rights: The New Italian Law on Assisted Reproduction' (2006) 14(1) Medical Law Review 73, 75–76.
[116] Francesca Minerva, 'Conscientious Objection, Complicity in Wrongdoing, and a Not-so-Moderate Approach' (2017) 26(1) Cambridge Quarterly of Healthcare Ethics 109, 111.
[117] Census 2021, 'Religion, England and Wales: Census 2021' (*Office for National Statistics*, 29 November 2022) <www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/bulletins/religionenglandandwales/census2021> accessed 12 January 2023.
[118] Authorino Mattioli and Mencarini (n 112) 5–6.
[119] Brooke R Johnson Jr and others, 'Conscientious Objection to Provision of Legal Abortion Care' (2013) 123 International Journal of Gynecology & Obstetrics S60.
[120] Fiala and Arthur (n 70) 13.

are found to be abusing CO? The Council of Europe found that abuses of CO are mainly a result of insufficient 'oversight mechanisms',[121] supporting the need for a stronger regulatory system. Although this report was conducted over thirteen years ago, which suggests that it might lack temporal validity, there have been no further regulatory changes or evidence thereof in practice. This demonstrates the need for stricter regulations to prevent CO from being misused when it comes to performing abortion procedures.

Doctors are required to refer patients to other practitioners when they decline to perform an abortion, as held in *Barr v Matthews*[122] and stated in the General Medical Council's (GMC) guidance.[123] This could mitigate the implications of encountering an objecting doctor because being referred to another doctor implies that women can still access an abortion and that abortion is not necessarily medically an incorrect course of action. Nonetheless, according to Londras' study, most research evidence suggested 'an inconsistent and fragmented approach to referrals where conscientious objection is invoked'.[124] This could potentially be attributed to doctors feeling that by referring, they still hold moral responsibility.[125] This will have implications for women who are left without a referral and therefore cannot access an abortion. Crucially, however, Londras failed to review any English studies, which leaves open the question of how effective the referral requirement is in England in practice.

4.3 CO renders Abortion an Ethical Question rather than a Medical Procedure

Allowing CO impedes access to abortion by reinforcing the idea that abortion is ethically questionable by adding 'ethical doubt'[126] around the procedure. A CO poses abortion as a moral question when CO is specified as a legitimate ground for doctors to refuse to perform an abortion, casting ethical doubts over the procedure. This entrenches abortion within an ethical,

[121] Council of Europe Parliamentary Assembly, 'Women's Access to Lawful Medical Care: The Problem of Unregulated Use of Conscientious Objection' (*Council of Europe*, 2010) <https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=12506&lang=en> accessed 3 February 2023.
[122] *Barr v Matthews* [1999] 3 WLUK 382; (2000) 52 BMLR 217 (227) (Alliott J).
[123] General Medical Council (n 102).
[124] de Londras and others (n 110) 7.
[125] Udo Schuklenk, 'Conscientious Objection in medicine: Private Ideological Convictions must not Supercede Public Service Obligations' (2015) 29(5) Bioethics ii.
[126] Sheelagh McGuinness, 'Conscience, Abortion and Jurisdiction' (2020) 40(4) Oxford journal of legal studies 819, 825.

rather than a medical framework, despite abortion being one of the most common female medical procedures.[127]

In other words, invoking CO treats abortion as an ethical issue rather than a medical procedure. This is demonstrated by most academics focusing on the ethical basis underpinning CO[128] as opposed to exploring its practical implications in the context of delivering abortion services. By questioning the moral nature of abortion, the societal perception that abortion is problematic is reinforced. This leads to stigma around abortion as the legislation validates the ethical nature of abortion by allowing doctors to invoke CO to avoid performing abortion. This impacts access by dissuading women from seeking an abortion out of fears that they will be stigmatised and marked differently,[129] as previously explained. Revoking CO in abortion procedures would help reposition abortion away from the ethical framework.

The counterargument is that CO is necessary because abortion is in fact an ethical issue. Brock asserts that CO is justified as it is based on deeply held values which define a doctor's moral integrity and who they are.[130] The debate regarding whether CO has ethical support is outside the scope of this article. However, it must be noted that while the ethical dimension of abortion needs to be considered, this should not be the only ground that justifies restrictions on women's access to healthcare as the medical dimension of abortion should also be considered.

4.4 Invoking CO out of Fears of Criminal Consequences

It is essential to consider how criminalisation works alongside CO to further impede access to abortion. Criminalisation reinforces the negative stigma surrounding abortion, which explains why CO is invoked as this allows doctors to retreat from participating in a procedure with potentially severe criminal repercussions. Also, by framing abortion within both the ethical and criminal frameworks, the idea that abortion is problematic is reinstated[131] because both frameworks portray abortion as inherently wrong. The decriminalisation of abortion might reduce the instances where CO is invoked as abortion would then be given the same non-

[127] Sheldon (n 92) 344.
[128] Authorino, Mattioli and Mencarini (n 112) 2.
[129] Bruce G Link and Jo C Phelan, 'Conceptualizing Stigma' (2001) 27 Annual Review of Sociology 363, 367.
[130] Dan W Brock, 'Conscientious Refusal by Physicians and Pharmacists: Who is Obligated to do What, and Why? (2008) 29(3) Theoretical Medicine and Bioethics 187, 189.
[131] McGuinness (n 126) 825–826.

criminal standing as all other medical procedures, which could help eliminate the ethical doubts surrounding CO.

Furthermore, even where the grounds for an abortion are satisfied, the medical decision could still be scrutinised and investigated.[132] By governing abortion within the criminal framework, CO serves as a favourable option for doctors to protect themselves from prosecution and the burden of having to defend their decision at a criminal court. This incentivises doctors to use CO as a guaranteed method of avoiding criminal prosecution, especially considering that claims of CO currently go unchallenged. In other words, CO and criminalisation work in parallel to restrict women's access to abortion.

5 How Should Abortion be Governed to Increase Accessibility? Two Proposed Reforms

The OAPA and the Abortion Act restrict access to abortion services by granting discretionary power to doctors to decide whether the grounds for obtaining a legal abortion are met, criminalising abortion, and allowing doctors to use CO to reject abortion requests. Two proposed reforms will be considered to evaluate if and how these reforms could increase the accessibility of abortion services.

5.1 Decriminalisation of Abortion

The argument concerning how the criminalisation of abortion creates access barriers leads to the suggestion that to eliminate these barriers, abortion should be decriminalised. This is supported by multiple medical bodies including the British Medical Association (BMA).[133]

Decriminalisation would enhance access by mitigating the 'chilling effect'[134] criminalisation creates as the moral doubts cast by criminal law on abortion would be removed. Women would no longer be dissuaded from obtaining an abortion out of the fear that they would be stigmatised or prosecuted. Cardéna's research in Uruguay found that decriminalisation was a central factor

[132] Zoe L Tongue, 'On Conscientious Objection to Abortion: Questioning Mandatory Referral as Compromise in the International Human Rights Framework' (2022) 22(4) Medical Law International 349, 356.
[133] British Medical Association, 'The Law and Ethics of Abortion: BMA Views' (*BMA*, March 2023) <www.bma.org.uk/media/3307/bma-the-law-and-ethics-of-abortion-report-march-2023-final-web.pdf> accessed 2 April 2023.
[134] Mecinska, James and Mukungu (n 15) 391.

in shifting the negative perception of abortion and catalysing a change in the overall societal attitude towards abortion.[135] Therefore, decriminalising abortion is vital to improving accessibility of abortion services and necessary to eliminate access barriers by removing the negative connotations induced by criminalisation.

Decriminalisation might also reduce the instances CO is invoked when performing abortions by removing ethical doubts around abortion within the legal framework. This could result in fewer doctors invoking CO out of fear of criminalisation[136] by removing the criminal consequences following abortion and the stigma around it. This would make abortion more accessible by increasing the pool of abortion providers, which could help reduce instances of delays as more doctors would be available. Furthermore, this would also increase the likelihood that a woman's first consultation is with a willing doctor, making it less likely that she would be dissuaded by an objecting doctor. However, though abortion has been decriminalised in every Australian state, research shows evidence of pharmacists refusing to stock or dispense EMA pills as they hold CO.[137] This calls for the need to review the scope of CO and oversee its exercise. Arguably, decriminalising abortion could reduce the instances of CO being invoked, hence removing the current barriers on accessing abortion services.

Concerns have also been raised that if abortion was decriminalised, it would become deregulated and enter a 'legal vacuum',[138] which raises the argument that abortion should remain criminalised to ensure women's safety. However, redefining the criminal nature of abortion within legislations and regulating abortion practices are not the same issue. Besides, a 'web'[139] of civil and criminal frameworks are already in place to ensure abortions are regulated and safe. For example, actual bodily harm or grievous bodily harm offences covered by the OPA[140] could be used if a pregnancy is terminated without the woman's consent, demonstrating how further criminal sanctions do not provide any additional safety protection. No other medical procedure is subjected to the level of regulation as abortion. This implies

[135] Roosbelinda Cardénas and others, "'It's Something That Marks You": Abortion Stigma after Decriminalization in Uruguay' (2018) 15 Reproductive Health 1, 6.
[136] Tongue (n 132) 356.
[137] Rebekah Yeaun Lee, Rebekah Moles and Betty Chaar, 'Mifepristone (RU486) in Australian Pharmacies: The Ethical Practical Challenges' (2015) 91(1) Contraception 25, 27.
[138] Sheldon (n 92) 337.
[139] Jonathan Herring, Emily Jackson and Sally Sheldon, 'Would Decriminalisation Mean Deregulation?' in Sally Sheldon and Kaye Wellings (eds), *Decriminalising Abortion in the UK: What Would It Mean?* (1 edn, Bristol University Press 2020) 58.
[140] Offences Against the Person Act 1861 ss 47 and 20.

criminalising abortion is unnecessary and unjustified as this serves no safety purpose and instead works to limit access through imposing restrictions and inciting fear.

Legislative reforms decriminalising abortion have recently been proposed through a private member's bill (PMB) in the House of Commons. Diana Johnson (Labour) introduced the Abortion Bill,[141] seeking to decriminalise abortion by removing criminal liability of abortion performed up to twenty-four weeks of pregnancy. Unfortunately, this bill did not progress past its second reading due to the timing restraints of the PMB procedure.[142] Nevertheless, the bill received majority support during its first reading,[143] suggesting a parliamentary willingness to debate and potentially reform abortion law. This willingness is further supported by the recent decriminalisation of abortion in Northern Ireland,[144] leading to discussion around decriminalisation in other devolved nations[145] by demonstrating that decriminalisation is not a radical suggestion. This proposed reform offers a viable option for how abortion could be regulated and governed by decriminalising abortion and removing the stigma stemming from criminality and fear of prosecution.

However, certain elements of the proposed bill would still retain some access barriers. For instance, CO continues to be protected without proposals on strengthening its regulation mechanism to manage its use and ensure it is not abused. Besides, while Johnson did include a clause providing the Secretary of State with a duty to ensure women can access an abortion in a timely manner,[146] it did not specify details regarding how this would take shape. Without specifying such detail or putting in place more effective oversight mechanisms, doctors would still be able to use CO to avoid performing abortion, which would continue to restrict access to abortion. On the other hand, decriminalising abortion might reduce the incentive for doctors to invoke CO as CO would no longer be needed as a tool for doctors to protect themselves against a possible criminal conviction. This would result in CO only being used for its intended purpose

[141] Abortion HC Bill (2017–19) [276].
[142] Robert Brett Taylor and Adelyn LM Wilson, 'UK Abortion Law: Reform Proposals, Private Members' Bills, Devolution and the Role of the Courts' (2019) 82(1) Modern Law Review 71, 83.
[143] House of Commons, 'Abortion Division 244: held on Tuesday 23rd October 2018' (*UK Parliament*, 23 October 2018) <https://hansard.parliament.uk/Commons/2018-10-23/division/5ED9E03E-C55A-4EFC-8C73-86BFB3F7A2BA/Abortion?outputType=Names> accessed 3 March 2023.
[144] The Abortion (Northern Ireland) Regulations 2020.
[145] Sally Sheldon and others, "'Too Much, too Indigestible, too Fast?" The Decades of Struggle for Abortion Law Reform in Northern Ireland' (2020) 83(4) Modern Law Review 725, 796.
[146] Abortion HC Bill (2017–19) [276] s 3(1)(4).

of protecting the beliefs and genuine conscience of doctors. This could suggest that the need for stronger regulations governing the use of CO might not be as central to reforms as initially considered. Nevertheless, decriminalisation on its own would not remove the other access barriers imposed by the Abortion Act, including the sole discretion awarded to doctors. This suggests a more far-reaching reform might be required.

5.2 Abortion-on-Request

Another proposed reform to enhance accessibility to abortion services is enabling women to obtain an abortion upon their request.[147] This is a step further than decriminalisation as abortion-on-request would also remove doctors as gatekeepers and place the decision in the hands of women. Since women are the primary party impacted by an unwanted pregnancy, they are far better suited to make the decision regarding the termination[148] as opposed to a doctor who is only temporarily present in a woman's life and cannot possibly fully understand and appreciate the woman's personal circumstances. This would increase the accessibility of abortion services as the requirement of getting two doctors' approval would be removed. Furthermore, access would no longer hinge on a liberal interpretation of the Act as women would be able to access an abortion upon request, essentially protecting their right to abortion.

However, certain barriers which have been explored earlier would remain, including the gestation time limit. It is likely that a time limit would still be in place as this is seen in other jurisdictions that have similar laws, such as South Australia where the limit is set at twenty-two weeks.[149] This would still limit how accessible abortions are at later gestations. Furthermore, questions such as whether CO could be exercised and under which circumstances would need to be considered. Both these points demonstrate how the wider picture needs to be examined if abortion is to be governed by abortion-on-request to improve accessibility to abortion services.

Allowing abortion-on-request would also reposition abortion as a medical procedure, offering women increased bodily autonomy by respecting their sole decision to undergo an abortion. The shift from medical paternalism to patient-centeredness has been vastly documented in

[147] Ottley (n 48) 58.
[148] Sally Sheldon, 'A Missed Opportunity to Reform an Outdated Law' (2009) 4(1) Clinical Ethics 3, 4.
[149] Termination of Pregnancy Act 2021 (South Australia).

literature,[150] but this shift is yet to be seen in abortion practices because of the paternalistic assumptions underpinning the Abortion Act. The Act shows how women are given an inferior status within the law considering the limited control they are given over their own bodies. Abortion-on-request would mitigate the 'disempowering effect'[151] that being forced to gain doctors' approval generates, as doctors would no longer be in the position to judge a woman's decision.

Despite the shift to patient-centeredness, patients do not have the absolute right to receive any treatment they desire[152] and this is reflected within the GMC guidelines.[153] Adopting an abortion-on-request system would be against this established practice as women would be provided a right that does not exist for any other medical procedure. This would effectively flip the scales whereby abortion would become the most accessible medical procedure. However, Ottley asserts that abortion-on-request would not be 'irreconcilable with existing principles' as the presumption that a woman knows what is in her best interest in this situation would prevail.[154]

Arguably, though women understand their own circumstances and the social factors[155] surrounding their own abortion better than a doctor, as with other medical procedures, certain medical checks prior to the abortion would still be needed to ensure the safety of the woman instead of performing an abortion straight away after receiving a woman's request. In other words, it is contestable whether abortion should be treated differently from other medical procedures by being made available upon request. Furthermore, the recent legislative change in France providing women with an explicit right to access an abortion[156] could support the notion that an abortion-on-request system could align with existing medical practice and that there is space within the legislative framework for women to be afforded this right.

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[150] Sheldon (n 92) 345.
[151] Fran Amery, 'Solving the "Woman Problem" in British Abortion Politics: A Contextualised Account' (2015) 17(4) British journal of politics and international relations 551, 556.
[152] *R (Burke) v General Medical Council* [2005] EWCA Civ 1003 [31] (Lord Phillips MR).
[153] General Medical Council (n 102).
[154] Ottley (n 48) 67.
[155] Sheldon (n 148) 4.
[156] George Wright, 'France Makes Abortion a Constitutional Right' (*BBC News*, 4 March 2023) <https://www.bbc.co.uk/news/world-europe-68471568#:~:text=Parliamentarians%20voted%20to%20revise%20the,when%20the%20result%20was%20announced> accessed 4 June 2024.

In summary, decriminalisation might be the more practical reform to increase the accessibility of abortion services by aligning abortion with every other medical procedure in terms of their non-criminal nature within the current legal frameworks, hence reducing the stigma and fear of prosecution surrounding the procedure.

6 Conclusion

This article has assessed the accessibility of abortion services in England under the current legislative framework in three aspects: the conditions imposed by the Abortion Act, the stigmatisation created from criminalising abortion, and the unregulated use of CO. This article has shed light on the contrast between common misunderstandings of abortion accessibility[157] and the strict legislative framework which operates to restrict access to abortion. This article also highlights the potential danger posed to women when they do not have a right to access an abortion.

This article has shown how the Abortion Act and OAPA create barriers that limit access to abortion. The limitations imposed by the two acts intersect to exacerbate the barriers women face when accessing abortion services. A central issue highlighted is the power imbalance between doctors and patients when discretionary power is granted to doctors as gatekeepers under the current legislative framework. Multiple barriers are created through the conditions specified in the Abortion Act itself and from criminalising abortion, which incentivises doctors to invoke CO to avoid performing abortion even though it would mean forcing their beliefs onto vulnerable women by denying them access to abortion. For abortion to be accessible, all three aspects highlighted in the article must be addressed.

Two proposed reforms were discussed. While this article highlights the access barriers created by current abortion law, further research into the specifics of legislative reform and their implications is needed. This article contributes to current scholarly debate on abortion law and the potential reform thereof by analysing the accessibility of abortion services under the current framework in England. Academia plays a key role in highlighting these issues with the hope that progressive PMBs can regain momentum or encourage further debates in the Parliament. Progress has been made with reforms allowing at-home EMAs, the decriminalisation of

[157] BBC (n1).

abortion in Northern Ireland,[158] and France becoming the first country to provide women with a constitutional right to access an abortion. This offers a glimmer of hope that reform can be taken further, and abortion will become more accessible for future generations.

[158] The Abortion (Northern Ireland) Regulations 2020.