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Chapter 1

Introduction

1.1 An overview

Traditionally, the abortion debate has focused on the status of the fetus and the decisions available to pregnant women.

More recently, a progressive call to de-medicalise, meaning to reduce the involvement of healthcare professionals in abortion processes, has also been emerging and been implemented in law and policy. This monograph addresses the phenomenon of de-medicalisation and brings forth a different and novel narrative. It claims that it is time to focus on the decision-making process and to call for a process of revised, instead of reduced, medicalisation. I hence claim here that the abortion debate has neglected the crucial component of the decision-making process, particularly of patients' right to informed consent (IC). The latter (IC), I claim, is built on not only

patient's autonomy alone, but also medical partnership. In this sense, the key general contribution of my work stands in the claim that IC is the tool that can foster bridges of dialogue within the doctor-patient relationship in the abortion context. It is hence crucial to better work on the doctor-patient dynamics, since this is the core place where IC should unfold. As a result, focusing primarily on England and Wales, while also suggesting broader international examples, I propose legal and policy changes to foster a process of revised medicalisation that values and safeguards both patients' and medical voices through the principles of authentic autonomy and medical partnership.¹

1.1.1 Why is informed consent important in the abortion context?

¹ See Chapter 3 and 4 for a reflection on these principles.

Informed consent entails a patient's right to have disclosed information concerning risks, benefits, and alternatives. The relevance of this right, I claim, should be the common thread that unites every patient's journey, no matter which medical context they find themselves in. Abortion, too, should be no exception. However, the safeguarding of IC has often been jeopardised by soft and hard law approaches. Using England and Wales as a case study, I shed light on the current status quo: The abortion legal and ethical landscape provides little weight to the decision-making process in the context of abortion. I argue that this is closely connected with an ongoing process of reduction of medical involvement (de-medicalisation). The latter has significantly reduced, in the specific context of abortion, the opportunities for a process of support and information disclosure to be unpacked within the doctor-patient relationship.

De-medicalisation and IC, I claim, are at odds with each other in the context of abortion. This is firstly because there is a crucial connection between IC and the doctor-patient relationship. IC is tied to doctors' duty of information disclosure and is clearly a process that starts unfolding within a medical encounter. Secondly, because the reduction of medical involvement undermines the principles of medical partnership and authentic autonomy, which I derive from the UK Supreme Court judgment in *Montgomery v Lanarkshire Health Board*.² These principles, as I will show in Chapter 3 and 4, require that voice is given to both medical and patients' expertise and voices in a relational approach.

I use the UK Supreme Court judgment in *Montgomery* to ground a nuanced interpretation of the above-mentioned two principles that I believe should guide the IC context

² [2015] UKSC 11.

widely considered, and should support a process of revised medicalisation, instead of de-medicalisation. In Chapter 3 and 4, I present my interpretation of the principles of medical partnership and authentic autonomy. The principle of medical partnership proposes, as a way forward, a model of revised medicalisation, one that positively reframes the interaction with clinicians and tackles the phenomenon of progressive reduction of medical involvement in the context of abortion. This principle focuses on the importance of communication, dialogue, and informative support as key aspects for more fruitful opportunities of collaboration via medical encounters. I then also propose a thick concept of authentic autonomy that claims that women's autonomy is not only built on a recognition of their agency, but also an understanding and minimisation of possible decisional vulnerabilities (e.g. risk of patients' abandonment) together with a recognition of the

plurality of interests at stake in the abortion context (e.g. women's health, fetus's and prospective father's interests).

In a nutshell, if it's true, as I believe it is, that IC is a patient's right whose relevance applies across the healthcare sector, abortion should not be treated as an exception. IC, understood through the lenses of these two principles, can (and should) be the place where bridges of dialogue are built. Women's voices and clinicians' voices can indeed meet where a space for an open, truthful, and honest dialogue is fostered.

What follows in my analysis is the importance of fostering legal and policy changes that would give space to such reframed ethical approach (Chapter 5 to 7,). In Chapters 5 and 6, I explore possible changes for the context of England and Wales. I analyse two contexts: the law on abortion (i.e. Abortion Act 1967 [AA], Offence Against the Person Act 1861 [OAPA], Infant Life Preservation Act 1929 [ILPA]) and

the law of negligence. As far as the law on abortion is concerned, I suggest the inclusion of a consent clause within the AA as the optimal way to value the approach proposed within the current criminal law framework. In light of the proposed legal change, I then explore the context of the law of negligence and suggest ways by which courts can further develop the meaning of the materiality test of information disclosure. The latter helps highlight the inherent limitations of the law of negligence, while also safeguarding the principles of medical partnership and authentic autonomy. Chapter 5 then focuses on the policy implications of my proposed approach. It offers a thorough look at current professional guidelines in England and Wales.³ I focus on

³ Examples of generalised guidelines include: GMC, Decision making and consent (2020, as amended 2024), online available at: <https://www.gmc-uk.org/>

specialised guidelines⁴ to analyse (a) the role of medical encounter(s) in the abortion context and the impact of de-

[/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf](#) (accessed 12th March 2025).

⁴ Examples of specialised guidelines include: NICE, ‘Abortion Care’ (2019), available online at:

<https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693> (accessed 8th June 2024); RCOG ‘The Care of Women Requesting Induced Abortion’ (2011 as updated 2022), available online at:

https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf (accessed 8th June 2024).

RCOG, ‘Termination of Pregnancy for Fetal Abnormality’ (2010), available online at:

<https://www.rcog.org.uk/globalassets/documents/guidelines/te>

medicalisation for the safeguarding of IC; and (b) the complementary role of wider non-medical staff (e.g. counsellors) in enhancing support during and beyond the decision-making process. I then propose ways in which such guidelines can be amended to better safeguard my proposed approach. In particular, clarity on the content of the disclosure process together with recouped clinical involvement and wider forms of support (e.g. counsellors) are suggested as crucial ways to safeguard authentic autonomy and medical partnership in the abortion context.

It is then in Chapter 7, that I delve into a comparative analysis aimed at outlining possible ways in which the suggested legal and policy changes can operate also in a wider international context, particularly looking at European

[terminationpregnancyreport18may2010.pdf](#) (accessed 8th June 2024).

countries.⁵ The core aim is to highlight the wider reach of my argument, beyond my case study. After an overview analysis of how European countries have embraced the role of clinicians in the abortion context, I particularly focus on two of them, namely France and Italy. These countries have been chosen since they have strongly valued patients' right to IC while failing to fully implement it in the context of abortion. It is indeed the case that while these countries have differed in

⁵ For an overview of the European regulation of abortion after COVID-19, see Moreau C, Shankar M, Glasier A, Cameron S, Gemzell D, 'Abortion Regulation in Europe in the Era of COVID-19: A Spectrum of Policy Responses' (2021), *BMJ Sexual & Reproductive Health*, 47:e14; Bojovic N, Stanislijevic J, Giunti G, 'The Impact of COVID-19 on Abortion Access: Insights from the European Union and the United Kingdom' (2021), *Health Policy*, issue 7, 841–858.

embracing forms of de-medicalisation,⁶ they have both failed to achieve the goal of safeguarding IC. Through this chapter I ultimately offer reasons why the suggestions formulated for the context of England and Wales are also significant for a wider European context. Ultimately, I demonstrate that the existence of forms of reduction of medical involvement negatively affects IC in the specific context of abortion. The way ahead should hence be marked by rebalancing the contribution of doctors and patients as partners, not as antagonists where one voice trumps the other. Revised

⁶ For an overview of how these three countries have embraced a process of de-medicalisation, see Moreau C, Shankar M, et al., ‘Abortion Regulation in Europe in the Era of COVID-19: A Spectrum of Policy Responses’(2021), *BMJ Sexual & Reproductive Health*, vol. 47, 1–8.

medicalisation, I suggest, can and should be a tool to build bridges of dialogue and support in the abortion context.

1.2 Geographical context

This monograph is predominantly, though not exclusively, centred around a specific geographical context, here offered as a case study: the legal and ethical framework concerning the medical encounter for abortion in England and Wales. The key reason for this geographical approach also stands in a claim made in Chapters 4 and 5 that legal experts and policymakers should develop a revised ethical and legal approach in England and Wales. In light of recent and positive legal developments within the IC case law, which emphasise the necessity to safeguard patients' decision-making process in partnership with clinicians, my book answers the question of how this could affect the broader ethical and legal landscape concerning the medical encounter in this geographical context. It is my hope that my two

proposed principles, derived from the IC context, will help shape this discourse.

This approach is then be used as a standpoint to support a broader application of some of the considerations outlined also across the devolved nations of the United Kingdom and beyond. In this vein, in Chapter 7 I zoom out of my case study to explore a wider European context and test the wider significance of my claims. Ultimately, whilst my monograph is tailored to the England and Wales context to enable detailed consideration of case law and professional guidelines, through Chapter 7 I show that the findings and principles have a wider international significance. A process of revised medicalisation, through the principles of autonomy and medical partnership, is a roadmap not only for England and Wales, but also for those countries that are considering revising their legal and ethical landscape in the context of abortion and the medical encounter.

1.3 Legal context in England and Wales

The current legal framework⁷ surrounding abortion in England and Wales comprises three interlinked pieces of legislation that form part of a detailed analysis throughout this book.

Firstly, the Offence Against the Person Act 1861⁸ (OAPA), ss. 58–59, considers as criminal offences to ‘procure her own miscarriage’ or to procure it to a third party. In particular, according to s. 58, ‘every woman, being with a child’ who intentionally procures a miscarriage to herself or a

⁷ As it currently stands in July 2024. See for a historical account of the evolution of abortion law in England and Wales; M Brazier, ‘The not yet born child’, in M Brazier (ed), *Law and Healing* (Manchester, UK: Manchester University Press, 2023) 146–164

⁸ ss. 58–59.

third party shall be guilty of an offence. Furthermore, according to s. 59 it is a criminal offence, namely misdemeanour, to indirectly collaborate into an unlawful abortion, procuring or supplying drugs or other noxious thing. S. 60 refers to the offence of concealment of birth, to which a penalty of up to 2 years imprisonment is connected.

Secondly, the Infant Life (Preservation) Act 1929⁹ (ILPA), frames a criminal offence for the destruction of a child capable of being born alive. In particular, according to s. 1 the criminal offence of felony arises when someone intentionally ‘destroy[s] the life of a child capable of being born alive’, that is to say causes the death of a viable child. In 1990, s. 37(4)¹⁰ Human Fertilisation and Embryology Act

⁹ ss. 1(1)–1(2).

¹⁰ ‘No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who

1990 amended s. 5(1) of the AA, whereby no crime is committed under the ILPA by a registered medical practitioner (RMP) who terminates pregnancy in accordance with the provision of the AA.

Thirdly, the AA, sets out a list of legal defences to the offences listed above for an abortion to be legally carried out in England and Wales. According to s. 1, abortion is legal when two RMPs ‘are of the opinion formed in good faith’¹¹ that the circumstances follow under one of the listed defences.

The AA sets up three main legal defences:

(1) Risk to women’s health: According to s.

1(1)(a) when a pregnancy ‘has not exceeded its

terminates a pregnancy in accordance with the provisions of this Act.’

¹¹ The involvement of two RMPs is not required only in case of emergency (s. 1(1)(4) AA).

twenty-fourth week¹² and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family'. Furthermore, according to s. 1(2) account may be taken of the woman's actual or reasonably foreseeable environment as a

¹² The Court of Appeal, in *British Pregnancy Advisory Service, R (on the application of) v The Secretary of State for Health and Social Care* [2020] EWCA Civ 355 (10 March 2020), has recently determined the meaning of 'the pregnancy has not exceeded its twenty-fourth week' in section 1(1)(a) AA 1967, holding that it is when the woman is 24 weeks + 0 days pregnant, rather than, as argued by the appellants, 24 + 1.

ground for a legal abortion. This sets what has been commonly phrased as the so-called social ground defence for a legal abortion.

(2) Risk of grave permanent injury and risk to life:

According to s. 1(1)(b) an abortion can be legally carried out when it 'is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman'; or s. 1(1)(c) 'that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated'.

(3) Fetal abnormality: According to s. 1(1)(d) a further legal defence arises when 'there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'.

Through this monograph, I particularly focus on the relationship between the AA, as the central piece of abortion legislation to date, and the domestic legal and ethical framework surrounding IC.

1.4 An overview of the approach chosen:

The medical encounter, the IC literature, and the ‘how-approach’

The core of my argument is built around the ethical and legal considerations surrounding the medical encounter and the informative process that starts in this context. I hence look at the decision-making process in the context of the medical arena and more specifically in the context of abortion. The following sections explain in turn the meaning of (1) the medical encounter and (2) the ‘how-approach’, namely the heart of the approach I propose. I distinguish my ‘how-approach’ from a pure ‘how-question’, as a general focus on

the decision-making process in the abortion context. This analysis is aimed at clarifying and offering a preliminary justification of key aspects of my proposed approach.

1.4.1 The medical encounter in the abortion context

The medical encounter is here defined as the place where the doctor-patient¹³ interaction unfolds. Though IC does not exclude concurrent forms of access to information through

¹³ It is worth noting that through this monograph I use interchangeably the words *doctors* and *clinicians*. The term *registered medical practitioner* (RMP) is also adopted to mirror the terminology used within the current formulation of the AA. The main focus of the monograph, and of a proposed revised medicalisation, is primarily on an exploration of their role (i.e. RMPs/doctors/clinicians), while not excluding the importance of wider healthcare professionals.

non-medical means (e.g. telemedicine, or via access to the internet, or personal knowledge), I claim here that this still holds as the core of the IC process. The extent of the interaction and its relevance will surely vary, depending on the unique patients' circumstances and patients' desire or not to engage, but the relevance of the interaction per se or, better said, the access to the interaction, I believe still holds true. I argue this is important across the healthcare sector and hence also within the abortion context. However, erosion of the relevance of such encounter has been gradually brought into place. Using England and Wales as a case study, the legal landscape to date shows that it is not a statutory requirement for either of the two RMPs to have personally seen or examined a woman, although RMPs remain in charge of the

procedure throughout.¹⁴ Yet, this encounter with RMPs is a key link in the chain of support that can be offered to women in the abortion context. Crucially, as I argue also further in this chapter and in Chapter 2, its relevance has been neglected at the domestic level, triggering ‘a domino’ negative effect on the decision-making process.

When an unplanned pregnancy arises, women seeking a legal abortion in England and Wales are required, in line with AA, to receive medical approval from two RMPs.¹⁵ Those clinicians are asked to assess in good faith that one of the conditions listed in the Act is satisfied. The medical

¹⁴ See on this point, *R v (Christian Concern) v SSHSC* at [35–39] [2020] EWCA Civ 1329, making reference to the judgment in *Royal College of Nursing v Department of Health and Social Security* [1981] AC 800.

¹⁵ s. 1(1)(a) AA.

encounter with an RMP, while not a statutory requirement, can happen in either a National Health Service (NHS) facility or, more likely as statistics show,¹⁶ in a private abortion clinic. These contexts, or class of places, although necessarily different (the latter is characterised by the practice of abortion-related services alone, and the former has a wider spectrum of medical activities) are both subject to the same

¹⁶ At the time of writing the latest statistics show that abortions are more likely to be operated via NHS-funded abortion clinics. See: Department of Health and Social Care, ‘Abortion Statistics England and Wales: 2022’, available online at: <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2022/abortion-statistics-england-and-wales-2022> (accessed 20th March 2025).

legal and policy framework and are worthy of analysis.¹⁷

¹⁷ Both contexts are subject to the same legal (i.e. AA) and policy framework (i.e. generalised and specialist professional guidelines). As far as the Care Quality Commission (CQC) is concerned, the independent regulator of health and social care in England, it should be outlined that: (1) Regulation 20, applies to both NHS and non-NHS facilities and sets the regulatory requirements to abortion for providers; see CQC, ‘Regulation 20: Requirements Relating to Termination of Pregnancies’ (2009), available online at:

<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-requirements-relating-termination>

(accessed 8th June 2024); (2) Regulation 11, broadly regulating the consent standards applies to both NHS and non-NHS providers; see CQC, ‘Regulation 11: Need for Consent’ (2014), available online at:

<https://www.cqc.org.uk/guidance-providers/regulations->

[enforcement/regulation-11-need-consent](https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent) (accessed 8th June

2024). (3) The inspection frameworks are outlined in two different documents, yet the standards required specifically concerning the consent process are convergent; see for NHS acute hospitals, that is to say NHS abortion providers, CQC, ‘Inspection Framework: NHS Acute Hospitals’ (2018), available online at:

https://www.cqc.org.uk/sites/default/files/20180706_9001228

[_Additional_service_Gynaecology_and_Termination_of_Pre](https://www.cqc.org.uk/sites/default/files/20180706_9001228)

[gnancy_framework_v2.pdf](https://www.cqc.org.uk/sites/default/files/20180706_9001228) (accessed 8th June 2024), E6, 36;

CQC’s inspection framework for non-NHS abortion providers, that is to say private abortion clinics, is outlined in: CQC, ‘Inspection Framework: Independent Acute Hospitals (and Single Specialties) Termination of Pregnancy’ (2020), available online at:

Additionally, and as it is further clarified later in this chapter,¹⁸ the introduction of ‘home’ as a class of places where an early term medical abortion can happen, has also opened up the doors to the use of virtual consultations (telemedicine) and of de-medicalisation practices.

Beyond the possible encounter with the RMP(s), there

https://www.cqc.org.uk/sites/default/files/20191219_IH_TOP_inspection_framework_v6.pdf (accessed 8th June 2024), E6,

31. It should be noted that the Care Inspectorate Wales, the independent regulator of health and social care in Wales, does not set any inspection framework specifically for termination of pregnancy providers. See on this point: Care Inspectorate Wales (CIW), ‘Who We Inspect’, available online at:

<https://careinspectorate.wales/providing-a-care-service/our-inspections> (accessed 8th June 2024).

¹⁸ Section 1.4.2.3.

are also forms of complementary and subsequent medical (e.g. nurses) and non-medical support (e.g. through counselling sessions) that are also relevant. It is possible, for instance, that prior to an encounter with an RMP, an encounter with a general practitioner (GP) has already happened. Although this is rare, in light of the use of self-referral practices whereby women self-refer themselves straightforwardly to an abortion facility, this is still a theoretical possibility. It is also more likely that previous abortion-related encounters have happened, especially when a serious risk of a fetal abnormality arises. Furthermore, subsequent involvement of wider medical professionals, like nurses or social workers and counsellors, can also be a possibility. However, the existence of both prior and subsequent forms of support is an additional component that should be built upon and not in lieu of the involvement of RMP(s), in this case. RMPs are the first link in the chain of

support whose relevance can sustain also wider medical involvements.

The medical encounter is framed here as the foundation without which the structure of the whole decision-making process, and hence of IC, is at risk of being jeopardised. Through this book, I analyse how the encounter with RMPs should unfold to best safeguard what is later shown to be the ‘how-approach’ and concepts of medical partnership and authentic autonomy in this context.

1.4.2 From the ‘how-question’ to the ‘how-approach’

In light of the foundational relevance of the medical encounter, as a space where IC can unfold, through this book I suggest that the abortion context should embrace what I call the ‘how-approach’. In order to understand the meaning attached to this proposed approach, a preliminary distinction should be made here between the ‘how-question’ and the

proposed ‘how-approach’. The ‘how-question’ deals with how a decision about abortion is reached. It encompasses both the process concerning circumstances where the pregnancy is ‘unplanned’ or ‘not welcomed’ from the moment when it is discovered,¹⁹ and/or circumstances where there is a later

¹⁹ The phenomenon of unplanned pregnancies is also statistically significant; in the latest 2018 report, in England 45% of pregnancies were unplanned or ambivalent. See on this point: Public Health England, ‘Health Matters: Reproductive Health and Pregnancy Planning’ (2018), available online at:

<https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning#resources>

(accessed 8th June 2024). These data can be also combined with the statistics around conception (i.e. data that gathers

change in perspective due to previously unknown events, as for instance in the case of a diagnosis of fetal abnormality. The ‘how-approach’ constitutes the particular way in which I propose to answer the ‘how-question’. This ‘how- approach’ will be built upon two key principles, namely medical partnership and authentic autonomy, as I derive and reinterpret from IC case law. The medical encounter in the

both childbirth and abortion notification) showing that in 2018 the conception rate had decreased for the 11th year in a row, with a percentage of conception resulting in abortions constantly increasing. See the latest release: Office for National Statistics, ‘Conceptions in England and Wales, Main Points’ (2020), available online at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018> (accessed 8th June 2024).

abortion context, I claim, should be better reflective of these principles, as bedrocks upon which the dialogue between doctors and patients should unfold.

1.4.2.1 The ‘how-question’ and the informed consent literature

The ‘how-question’ asks ‘how a decision concerning an abortion unfolds’. This question is predominantly derived here from the IC scholarship, which emphasises how disclosure of information and decision-making dynamics between patients and clinicians occur. It should be clarified at the outset that in law reference to the decision-making process inevitably includes the safeguarding of ‘valid consent’ and ‘informed consent’ as two separate, yet interrelated, key legal aspects. They are ‘separate’ because they set, amongst others, different standards of information disclosure. Crucially, a failure to obtain a *valid* consent can result in criminal assault and a battery, whereas a failure to obtain *informed* consent

can result in negligence.²⁰ Yet they can be ‘interrelated’

²⁰ It should be clarified that the safeguarding of the former (valid consent) does not necessarily coincide with the latter (informed consent). As Cave has also clarified: ‘Informed consent is not necessarily valid (if it is not voluntary or capacitous) and consent that is valid is not necessarily adequately informed. This flows from the different informational thresholds that apply in battery and negligence.’ See on this point: Cave E, ‘Valid Consent’ (2021), *Journal of Medical Ethics*, vol. 47(12), e31. See also Chapter 2 on tort law approaches in Section 4. This book focuses on how to strengthen the IC process in the context of abortion. In this respect, it explores (1) how the safeguarding of a valid consent within the AA can be ameliorated (as the baseline approach); (2) how the safeguarding of informed consent can

because the valid consent, with its narrow standard of disclosure, can constitute the basis for the safeguarding or the neglect of informed consent (IC), which requires more extensive information disclosure. My focus is on IC. A reflection on how to strengthen the consent process is included in subsequent chapters insofar as this can serve as a baseline for the safeguarding of IC and of the ‘how-approach’.

Informed consent is a crucial concept in healthcare ethics whereby clinicians embark on a partnership process of information disclosure aimed at fostering an autonomous

be strengthened in common law and professional guidelines.

See also on this point Chapters 5 and 6.

patient decision. Faden and Beauchamp²¹ have claimed that IC has two distinct and general uses. The first use claims that it is a ‘form of autonomous authorisation by a patient or subject’²² whereby a clinician is protected from liability. The second use amounts to a series of rules and policy governing the IC process itself. It can be stated that ultimately IC is at the same time both a ‘safety net’ for medical professionals and a ‘process’ oriented, amongst others, towards equipping

²¹ R R Faden, T L Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986) 274–283

²² T L Beauchamp, J L Childress, *Principles of Biomedical Ethics*, (Oxford: Oxford University Press, 2019) 119

the patients to better safeguard their autonomy.²³

Beauchamp and Childress²⁴ have framed IC as a series of key legal requirements.²⁵ Firstly, they claim that two preconditions need to be in place, namely that the patient has competence and that the decision is voluntary. The same authors also broke down the information disclosure into (a) the disclosure of information has to be in line with a legal standard, and (b) there should be a recommendation of a plan

²³ Further chapters 3 and 4 clarify how these principles of partnership and autonomy can inform the chosen field of research.

²⁴ T L Beauchamp, J L Childress, *Principles of Biomedical Ethics*, (Oxford: Oxford University Press, 2019) 120

²⁵ In the England and Wales scenario, these can be summed up in the requirements of legal capacity as enshrined in the Mental Capacity Act 2005, ss. 1–3.

and a process that fosters understanding. Altogether, this process is aimed at not only authorising a legal medical intervention on someone's body, but also helping the patient reach a final personal decision.

However, this ethical understanding of IC has been crucially neglected²⁶ in the political, doctrinal, and normative debates surrounding abortion, particularly within England and Wales. The political debate has predominantly directed its attention to either an analysis of women as decision makers, which is later phrased as the 'who-question', or an abortion as the termination of unborn life, which is later phrased as the 'what-question'. However, little weight has been given to a 'how-question', that is to say to the decision-making process. The doctrinal and normative debates, I further argue, have also neglected this question. In Chapter 2, I claim that the

²⁶ For further analysis, see Chapter 2, Section 3.

Abortion Act (AA), as the main legislative tool in this context, although recognising the involvement of medical professionals during the medical encounter,²⁷ gives insufficient weight to this approach. A pervasive political and normative movement to reduce medical professional involvement in abortion decision-making also undermines their contribution.²⁸ Wider legal tools derived from the law of tort can only partially help tackle this phenomenon. Additionally, professional guidelines are but a starting point for this phenomenon to be addressed.

The importance of addressing the ‘how-question’ also well fits the claim purported by professional guidelines. In England and Wales, the National Institute for Health and Care

²⁷ s. 1(1)(a) AA.

²⁸ See Chapter 2 for an account of a process of de-medicalisation (Section 2.3).

Excellence (NICE) Guidelines 2019 on Abortion Care state that ‘improving information provision would benefit all women who are having an abortion’.²⁹ This has led NICE 2019 to provide recommendations ‘that could apply to everyone’.³⁰ In other words, an information-oriented discourse can benefit women regardless of the reasons that might draw them (or not) towards an abortion. The ‘how-

²⁹ NICE, ‘Abortion Care’ (2019), available online at:

[https://www.nice.org.uk/guidance/ng140/resources/abortion-](https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693)

[care-pdf-66141773098693](https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693) (accessed 8th June 2024), 30. See

also: NICE, ‘Abortion Care (2019), [B] Information Needs of Women Undergoing An Abortion’, available online at:

[https://www.nice.org.uk/guidance/ng140/evidence/b-](https://www.nice.org.uk/guidance/ng140/evidence/b-information-needs-of-women-undergoing-an-abortion-pdf-6905052974)

[information-needs-of-women-undergoing-an-abortion-pdf-](https://www.nice.org.uk/guidance/ng140/evidence/b-information-needs-of-women-undergoing-an-abortion-pdf-6905052974)

[6905052974](https://www.nice.org.uk/guidance/ng140/evidence/b-information-needs-of-women-undergoing-an-abortion-pdf-6905052974) (accessed 8th June 2024).

³⁰ NICE, ‘Abortion Care’ (2019), 30.

question' matters.

1.4.2.2 The 'how-approach'

The 'how-question' asks 'how a decision concerning an abortion unfolds', the 'how-approach' is my proposed response to this, which is thoroughly unpacked in Chapter 3 and 4. There I argue that the response lies in two principles: medical partnership and authentic autonomy. The principle of medical partnership calls for an approach oriented towards dialogue, communication, and support between women and RMPs, which seeks to strike a balance between clinical expertise and patients' needs and values. The principle of authentic autonomy highlights the crucial relevance of the time spent in an information-sharing process for the safeguarding of women's autonomy as this offers the opportunity to be supported during the decision-making process.

As I show in Chapter 2, common law in England and

Wales has been slow to embrace ethical principles on the importance of patient autonomy and medical partnership when information is disclosed in the context of medical decision-making more widely. It has neglected the ‘how-question’ as a general focus on the decision-making process. However, since the Supreme Court decision of *Montgomery* in 2015, a patient-centred approach has been more firmly adopted. I hence argue that abortion has not kept up with these developments, and a change in approach is needed. This is a claim that holds true also internationally, particularly in those countries³¹ where the general relevance of IC in law has not been coupled with a concurrent relevance of IC in the abortion context and the medical encounter.

The voice and expertise of both doctors and patients should find room in the way in which we understand IC and

³¹ See Chapter 7.

hence through a focus on how the journey of disclosure of information unfolds. Abortion decision-making process matters too.

1.4.2.3 The ‘how-approach’ and the role of RMPs

The ‘how-approach’ I am proposing is an expression of a revised medicalisation of the abortion context, that is to say, of the desire of reshaping rather than reducing the involvement of clinicians. The medical encounter between women and RMPs is of crucial relevance for a disclosure process to unfold and for the safeguarding of the principles of medical partnership and authentic autonomy. In proposing a revised medicalisation of the abortion context, the ‘how-approach’ will spur contention, given the current movement

for the progressive reduction of medical involvement,³²
coupled with the current push towards the rapidity of the

³² See on this point: E C Romanis, A Mullock, J A Parsons, 'The Excessive Regulation of Early Abortion Medication in the UK: The Case for Reform' (2021), *Medical Law Review*, 30(1), 4; S Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016), *The Modern Law Review*, vol. 79(2), 283; S Sheldon, 'How Can a State Control Swallowing? The Home Use of Abortion Pills in Ireland' (2016), *Reproductive Health Matters*, vol. 24(48), 90. For a wider analysis of the challenges purported by a process of reduction of medical involvement (de-medicalisation), see Chapter 2, Section 2.3.2.

process and self-referral practices,³³ in both England and Wales and across Europe. It is hence important to clarify the multifaceted nature of decision-making surrounding abortion and set out the rationale behind the proposed approach.

The decision-making process³⁴ concerning abortion

³³ This means that women can bypass the involvement of GPs and self-refer themselves to an abortion clinic without a prior GP encounter/referral.

³⁴ For further analysis of the decision-making process concerning abortion, see: S Rowlands, 'The Decision to Opt for Abortion' (2008), *Journal of Family Planning and Reproductive Health Care*, vol. 34(3) 175, where she unpacks five steps that characterise the decision-making process, namely: '1) the acknowledgement of the pregnancy; 2) formulation of options: to continue the pregnancy and keep the baby, to continue the pregnancy and offer the baby for

adoption or to undergo abortion; 3) selection of continuation of the pregnancy or abortion by a balancing exercise; 4) commitment to the chosen outcome; 5) adherence to the decision'. See also Kero in her reflection on the variety of psychosocial factors in women requesting abortion: A Kero, 'Psychosocial Factors in Women Requesting Abortion', in S Rowlands, *Abortion Care* (Cambridge: Cambridge University Press, 2014) 34–40 Brauer et al.'s an empirical study on the variety of experiences faced by women with an unintended pregnancy in the Netherlands showing a different degree of complexity and difficulties during the decision-making process that can also affect the aftermath of the decision itself. M Brauer, J van Ditzhuijzen, H Boeije, C van Nijnatten, 'Understanding Decision-Making and Decision Difficulty in Women with an Unintended Pregnancy in the Netherlands' (2019), *Qualitative Health Research*, vol. 29(8), 1084

involves a variety of interconnected components that merge medical and non-medical aspects. Starting from the medical component, abortion is a medical intervention³⁵ that terminates an existent pregnancy, which is inevitably associated with the importance of outlining connected medical risks, benefits, and possible alternatives. However,

³⁵ This is surely not an uncontested interpretation. For a critical analysis of the extent to which abortion has a ‘medical’ connotation, see: M Neal, ‘Locating Lawful Abortion on the Spectrum of Proper Medical Treatment’, in S Fovargue, A Mullock (eds), *The Legitimacy of Medical Treatment* (Oxon, UK: Routledge, 2016) 124–141. The interpretation given here of abortion as a medical intervention focuses, narrowly, on the nature of an abortion, while also acknowledging that the reasoning behind a decision to abort is not solely medical in nature.

the reasons affecting the decision-making process are not solely medical. Research has shown that factors influencing the outcome of an unplanned pregnancy are often multifaceted³⁶ and can vary depending on age,³⁷ stage of

³⁶ See for a broad account of women's reasons for seeking an abortion: S Chae, S Dessi, M Crowell, G Sedgh, 'Reasons Why Women Have Induced Abortions: A Synbook of Findings from 14 Countries' (2017), *Contraception*, vol. 96(233), 234–236E Coast, A H Norris, A M Moore, E Freeman, 'Trajectories of Women's Abortion-Related Care: A Conceptual Framework' (2018), *Social Science & Medicine*, vol. 200(199), 202205

³⁷ See on the under-18 abortion experience: E Lee, 'Young Women, Pregnancy and Abortion in Britain: A Discussion of Law in Practice' (2004), *International Journal of Law Policy and the Family*, vol. 18(283), 286, 289–296

pregnancy,³⁸ pregnancy circumstances, and broader socio-economic factors. Biggs et al.,³⁹ in a US study, isolated 35

³⁸ See on factors influencing second trimester abortion in England and Wales: R Ingham, E Lee, S J Clements, N Stone, 'Reasons for Second Trimester Abortions in England and Wales' (2008), *Reproductive Health Matters*, vol. 16, 18

³⁹ M A Biggs, H Gould, D G Foster, 'Understanding Why Women Seek Abortion in the US' (2013), *BMC Women's Health*, vol. 13(29), 1, 6For a further wider analysis of decision-making factors, see: J Pereira, R Pires, M C Canavarro, 'Decision-Making Trajectories Leading to Termination of an Unplanned Pregnancy: Specificities Among Adolescent and Adult Women' (2019), *Journal of Reproductive and Infant Psychology*, vol. 37(3), 242, 248, 251This empirical study showed in particular that adult women more frequently were 'not considering pregnancy

possible themes that led women towards the decision to abort; they then categorised these under a final set of 11 overarching

continuation, concealed the decision from their family and reported economic reasons for abortion; or considering its continuation but were pressured into abortion by their partners' (Pereira et al., 242). The decision-making process and the consent process appear to be more complex when a suspect of fetal abnormality arises. A 2018 empirical study on patient's perception of a prenatal diagnosis of fetal cardiac pathology and the reason to continue or terminate a pregnancy highlighted the greater complexity of the decision-making process and the importance of seeking informed consent in a timely manner. See: G A Tayeh, J M Joaunnic, F Mansour, A Kesrouani, E Attieh, 'Complexity of Consenting for Medical Termination of Pregnancy: Prospective and Longitudinal Study in Paris' (2018), *BMC Medical Ethics*, vol. 19(33), 1

themes, which are here summarised as follows: (1) not financially prepared; (2) not the right time for a baby; (3) partner-related reasons (e.g. poor or lack of a relationship); (4) need to focus on other children; (5) interferes with future opportunity (e.g. work or education related); (6) not emotionally or mentally prepared; (7) health-related reasons (e.g. concerns for her own health or the health of the fetus); (8) want a better life for the baby than she could provide; (9) not independent or mature enough for a baby; (10) influences from family or friends; (11) don't want the baby or to place the baby for adoption. It is clear that many of these rationales are not medical in nature.

Kumar, in an empirical study of 21 women in the London area who had undergone an abortion, highlighted similar themes like 'inability to care for a child (for financial reasons or because they felt too young to provide a stable environment), commitment to finishing their education, or

lack of family and partner support'.⁴⁰ The results were also similar in a 2011 Australian empirical research study on women's abortion experience, which found that many women perceive abortion as a possible difficult 'solution' to a 'problem'. According to this study, the nature of the problem lies in the pregnancy itself and in the challenges arising from it. The challenges that women can experience are, according to this study, 'related to themselves [women], the potential child, existing children, their sexual partners and other significant relationships, and economic constraints'.⁴¹ These

⁴⁰ U Kumar, 'Decision-Making and Referral Prior to Abortion: A Qualitative Study of Women's Experiences' (2004), *Journal of Family Planning and Reproductive Health Care*, vol. 30(1), 51, 52

⁴¹ M Kirkman, H Rowe, A Hardiman, D Rosenthal, 'Abortion Is a Difficult Solution to a Problem: A Discursive Analysis of

studies indicate that an unwanted pregnancy usually has a highly personal component, because, for example, it happens at the ‘wrong’ time or in the ‘wrong’ circumstances, like the absence of a stable relationship, which affects women’s willingness to take responsibility for a child.

It is hence well possible that some of the questions that women can face specifically in the medical encounter(s) are also not strictly medical and can be future related: Do I want to be a parent? Or, do I want to be a parent of ‘this child’? For some women, what is at stake when it comes to an unplanned pregnancy is crucially the long-term responsibility connected to the raising of a child in general or to a ‘specific’ child when it comes to a child carrying the risk of disabilities.

Interviews with Women Considering Undergoing Abortion in Australia’ (2011), *Women’s Studies International Forum*, vol. 34, 121, 124.

Abortion is in this scenario perceived to be a potential solution to a parenting problem. An alternative set of questions are these: Can I be a parent? Can I be a parent for this child? If the first set of questions focuses more on the willingness or not to embrace the long-term responsibility connected to childbirth, this second set of questions puts more emphasis on the ‘capability’ of parenting in general or parenting a child with a disability. The ‘parenting questions’ might involve, as the studies mentioned above suggest, from lack of financial resources, to wrong timing because of age or existence of other children; the parenting questions can also encompass, I would add, lack of information and/or stereotypes concerning the raising of a child with a disability. And these can be addressed in the medical encounter through the IC channel.

On a closer analysis, these parenting questions, which can be broadly phrased as ‘social questions’, are strictly

interconnected with the medical ones. The questions of ‘parenting’ are closely related to, for instance, an analysis of the nature and the impact that an abortion—as the alternative option—can have on the health and well-being of women and also considering possible alternatives to it. It is therefore possible that some women might also ask themselves whether they are willing or not to take the responsibility connected with an abortion and whether there are any possible wider alternatives that they can brainstorm with their healthcare professionals. In this sense, the broader social relevance of these questions does not exclude clinical involvement, yet it requires, as it will be claimed below, that the encounter is adapted to take account of the breadth of the issues at stake.

Furthermore, for some women, abortion will not be a ‘neutral’ or ‘morally free’ option. They might consider that abortion would have moral implications since it terminates fetal life. For them abortion may not be an ‘easy’ option, and

when presenting for the medical encounter, they will require space, time, and support in a morally challenging situation. They might need to further consider alternative opportunities that can fit not only their unplanned pregnancy circumstances, but also their moral viewpoints.⁴²

⁴² A 2019 empirical study led by L Hoggart. L Hoggart, 'Moral Dilemmas and Abortion Decision-Making: Lessons Learnt from Abortion Research in England and Wales (2019), *Global Public Health*, vol. 14(1), 1 on young women and their moral dilemmas concerning the abortion decision-making in England and Wales highlighted the complexity of the decision-making process, where moral and personal (autonomy-related) components are often intertwined. Individual and moral understanding together with considerations of personal autonomy are hence closely interconnected. In Hoggart's perspective, this leads to moral

The difficulties in answering these questions, which merge medical, social, and moral aspects, are often exacerbated by further broader circumstances. Take for example the lack of a stable relationship and hence of partner support, which abortion statistics in England and Wales⁴³

relativism. This book is drawing upon this work only to show the various factors influencing the decision-making process that inevitably affect the content and modality of the medical encounter.

⁴³ At the time of writing, the latest England and Wales abortion statistics highlight that ‘82% of abortions in 2022 were for women whose marital status was given as single, a proportion that has remained roughly constant for the last 10 years. 51% were to women whose marital status was given as single with a partner. This proportion has remained similar in recent years’. See: DHSC, ‘Abortion Statistics, England and

have consistently and clearly reported to be a common trait for most women seeking an abortion, or the existence of abusive and/or instable relationship with their partners. These are some of the circumstances that can negatively impact women's decision-making and contribute to the feeling of lack of support and abandonment.⁴⁴

Wales: 2022', available online at:

<https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2022/abortion-statistics-england-and-wales-2022#key-points-in-2022> (accessed 8th June 2024).

⁴⁴ It should be clarified that the possible negative impact on women's well-being of poor relationship and social support in general is associated with not only pregnancies ending in abortions, but also those ending in childbirth. See on this point a 2017 research study: K Barton, M Redshaw, M A Quigley, C Carson, 'Unplanned Pregnancy and Subsequent

What is then the relevance at all of the medical encounter? Given the interconnection between the medical, social, and moral components, the temptation might be to consider the involvement of medical professionals as irrelevant or limited in this context. In other words, if women's needs are to be taken seriously, it might be argued that medical professionals are not best placed to address social questions or moral issues that women might have through an information disclosure process. Critics of the medicalised approach, I would anticipate, would argue that

Psychological Distress in Partnered Women: A Cross-Sectional Study of the Role of Relationship Quality and Wider Social Support' (2017), *BMC Pregnancy Childbirth*, vol. 17(1), 44This study suggests more broadly that both during and after the pregnancy, whether it results or not in an abortion, the existence of forms of support is vital.

abortion is best expressed and is empirically experienced as a private matter⁴⁵ where women can reach a decision before an encounter with a medical professional either alone or through discussion with those ‘who are emotionally close to them’.⁴⁶ I further address this issue in Chapter 2, where I unpack the push towards reduction of medical involvement (i.e. de-

⁴⁵ See on this point: E Lee, ‘Young Women, Pregnancy and Abortion in Britain: A Discussion of Law in Practice’ (2004), *International Journal of Law Policy and the Family*, vol. 18, 283, 295P Baraitser, S Morton, H Massil, ‘Decision-Making and Referral Prior to Abortion: A Qualitative Study of Women’s Experiences’ (2004), *Journal of Family Planning and Reproductive Health Care*, vol. 1, 5

⁴⁶ E Lee, ‘Young Women, Pregnancy and Abortion in Britain: A Discussion of Law in Practice’ (2004), *International Journal of Law Policy and the Family*, vol. 18, 283, 290

medicalisation). This push represents a tension that cannot be easily solved, yet forms of revised medicalisation are suggested as a possible way forward, particularly for the safeguard of the right to IC.

As developed in Chapter 3, my response is that there are unacceptable risks to considering abortion as a purely private matter and hence seeing de-medicalisation as the sole way ahead. Firstly, there is the risk that this understanding would lead towards delays in accessing support⁴⁷ when it is

⁴⁷ Lee and Ingham have conducted a research study that explored the reasons for late term abortions (E Lee, R Ingham, ‘Why do women present late for induced abortion’ (2010), *Best Practice & Research Clinical Obstetrics and Gynaecology*, vol. 24, 479) They claim that ‘delays’ might be due also to personal concerns that women might have about abortion. This study suggests, amongst others, that: ‘All

needed. Secondly, and fundamentally, it can also undermine the positive advisory role that a medical professional can play, which I argue is especially relevant to the medical encounter(s). The role of medical professionals, as is clarified throughout the book, is not to scrutinise women's reasoning or to reach a 'shared' in the sense of a mutually agreed decision between them, but to offer the opportunity of professional support based on its risks and benefits and possible alternatives (e.g. childbirth, adoption, fetal surgery).

women of reproductive age should be made aware they do not have to have reached a definite decision to discuss the possibility of abortion with a provider' (p. 487). This ultimately shows possible drawbacks of framing the decision-making process as entirely private since it can negatively impact also the time of gestation and possible delays in reaching out for advice.

My work therefore provides a different approach. It acknowledges the broadness of the factors influencing the decision-making process; however, it does not consider the reduction of medical involvement as the way forward. It highlights that clinical questions are inevitably interconnected with wider factors, but this should not be a reason to reduce the involvement of healthcare professionals, but to recalibrate and find better ways in which the parties can dialogue with one another. I hence focus on the positive role that medical professionals can and should play with the provision of informative support during and beyond the medical encounter(s). In this vein, the medical encounter is understood to be of key relevance because it can both ensure that scientifically accurate and relevant information is shared and also open up to wider forms of support when needed (e.g.

counselling services).⁴⁸

The ‘how-approach’ can hence contribute to the creation of what Coast et al., when providing a broad framework for the abortion context, phrased as a ‘knowledge environment’⁴⁹ where the availability of good quality

⁴⁸ It should be clarified that this does not overlook the possibility of unbalanced power dynamics between doctor and patients, yet it seeks to minimise these circumstances by offering a revised approach. See Chapter 3 and 4.

⁴⁹ E Coast, A H Norris, A M Moore, E Freeman, ‘Trajectories of Women’s Abortion-Related Care: A Conceptual Framework’ (2018), *Social Science & Medicine*, vol. 200, 199, 206 It should be also clarified that knowledge is here framed not only as an understanding of the law on abortion in general plus its policies and services [see on this point J Erdman, ‘The Global Abortion Policies Database: Knowledge

information can positively operate also through the support of medical professionals. This can lead to different outcomes in different circumstances. For instance, with those who already have made a decision, this might further substantiate their standpoints; for those who instead experience decisional vulnerabilities (e.g. lack of support, lack of awareness, feeling of being ‘without a choice’, sense of isolation-loneliness⁵⁰), it

as a Health Intervention’ (2017), *BMJ*, vol 8, 1 but, as Chapter 5 and 6 clarify, also on connected risks and possible alternatives. I have also explored the role of knowledge in the IC context in a journal article: C Milo, ‘The Role of Knowledge and Medical Involvement in the Context of Informed Consent: A Curse or a Blessing?’ (2022), *Medicine Health Care and Philosophy*, vol. 26(1), 49–54

⁵⁰ See, for instance, a Norwich study on women who are ambivalent on abortion and their experience of a sense of

can offer the opportunity of reflection and advice during the decision-making process. Additionally, my approach does not exclude, yet it will encourage, further forms of non-medical support (e.g. counselling services), when and if the circumstances will require. These forms of non-medical support should be seen as a complementary factor that builds upon rather than excludes the core relevance of the medical encounter.

Ultimately, the decision-making process as unfolding in the medical encounter(s) is key. Here the relevance of different forms of support can find a timely space: Since the

loneliness: M Kjelsvik, R J Tveit Sekse, A Litleré Moi, E M Aasen, C A Chesla, E Gjengedal, 'Women's Experiences When Unsure About Whether or Not to Have an Abortion in the First Trimester' (2018), *Health Care for Women International*, vol. 39(7), 784, 793

earliest stages, women will be offered the opportunity to have a space for reflection and support in a medical context. This is also because the ‘how-approach’ claims that the ability to reach a personal decision stands not only in the availability of a decision-making role or in an analysis of the content of the medical intervention in question and of its possible risks/benefits/alternatives, but also crucially in the weight given to what ‘lays in between’, that is to say the decision-making process here framed in a clinical context. The existence of a multifaceted nature of the decision-making process crucially does not call for de-medicalisation, but for a *revised* medicalisation.

1.5 Conclusion

There is a strict interconnection between the disclosure of information and the relationship that doctors and patients have. IC, rightly understood, is the product of both, giving voice to both doctors’ and patients’ expertise. It is crucial to

get the balance between these two contributions right, rather than excluding one contribution at the expense of the other. In the abortion context, the multifaceted nature of the decision about abortion, which can combine amongst other social, medical, and moral components, does not make abortion an exception to the relevance of IC and should not lead to a process of progressive erosion of the medical involvement. I claim that for an IC process to unfold, clinicians also have a positive contribution to make starting from the encounter with women. Through this book, I show that the ‘how-question’ has been given insufficient weight (Chapter 2-4), and that policy and lawmakers should devote more attention to a proposed ‘how-approach’ in the form of a revised medicalisation (Chapter 5-7), if positive and novel principles of partnership and authentic autonomy want to be safeguarded. Chapter 2, to which I now turn, starts outlining the England and Wales case study and the neglected focus on

a ‘how-question’ in this context. I hence claim that greater focus is needed on what lays between the decision maker and the final decision, namely the decision-making process and how the medical encounter can be a space of valuable support in this respect.