MONASH University

# AUTONOMY AND PREGNANCY

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## Abstract

The title of the thesis is *Autonomy and Pregnancy*. Its main aim is to evaluate the extent to which pregnant women's rights to reproductive autonomy are protected or restricted under the law and its application. The laws regulating abortion and applying to the refusal of and consent to medical treatment were selected for analysis. The thesis focusses on the laws of those jurisdictions whose legal heritage is predominantly English and/or Western European.

The thesis identifies the meaning(s) of autonomy and then outlines a theoretical framework, informed by Drucilla Cornell's work, which is adopted here because it gives an insight into the practical aspects of the exercise of autonomy and pregnancy. It also considers the concept of legal personhood focussing on both the common law's adherence to the *born alive rule* and the advent of *foetal protection laws*.

An examination of the legal regulation of abortion indicated that there is not necessarily a correlation between the letter of the law and access to a timely safe abortion. It followed that there were factors, other than the law, which operated to impinge upon the exercise of autonomy. The impact of stigma upon access was evident. Other features were: governmental policy and health funding; the monopoly of the medical profession over the provision of reproductive services; the ability of medical professionals to withhold services; and, the activities, sometimes violent, of anti-abortion proponents in their war against women who decide to seek an abortion.

Stigmatisation and other matters which hindered access to abortion were also relevant when addressing the autonomous rights of women who decide to continue with their pregnancy. It is well established that all legal persons have the right to bodily integrity. This protection is enshrined in the laws on assault and battery and their equivalents in each jurisdiction. With limited exceptions, any medical treatment even that which involves the least touching without consent, will render the perpetrator liable under the law.

The right to refuse medical treatment is a fundamental right of all competent persons. The importance of the right is emphasised by the reluctance of the courts to allow

exceptions or place limitations upon the right. Unfortunately, there were several cases where the courts overrode the decision of a pregnant woman to refuse or withdraw her consent to medical treatment.

It was concluded that women who are pregnant have severe and unjustified limitations placed upon their autonomy. It is the pregnant woman who is best situated to make decisions in respect of abortion or medical treatment.

## Declaration

This thesis is an original work of my research and contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

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Date:16th September 2020

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## Table of Contents

# CHAPTER 1 INTRODUCTION, OVERVIEW AND STRUCTURE

## I INTRODUCTION

The title of this thesis is *Autonomy and Pregnancy.* The main aim of the thesis is to evaluate the extent to which pregnant women's rights to reproductive autonomy are protected or restricted under the law and its application. The main hypothesis of the thesis is that pregnant women's rights to reproductive autonomy are insufficiently protected and overly restricted under the law and its operation.

Part II of this chapter provides an overview of the thesis, background to the selection of the topic of this research and the main and subsidiary research questions which test the hypothesis. It includes the reasons for the choice of content and jurisdictions. Part III provides a brief synopsis of the material contained in the remaining chapters.

## II THESIS OVERVIEW

### A Research — Overview and Background

Women as legal persons are autonomous and entitled to be treated as equivalent with all other legal persons. The main question which the thesis addresses is: To what extent are pregnant women's rights to reproductive autonomy protected or restricted under the laws and their application? The subsidiary research questions are as follows:

i Does being pregnant alter the legal recognition of women's right to autonomy and its operation under the laws, and if so how?

ii What are the roles of the legal and medical professions in promoting or diminishing pregnant women's right to autonomy?

iii To what extent does the view taken about, and the status accorded to, the foetus have an impact upon pregnant women's autonomy?[1]

1 In its simplest form '[t]o be a legal person is to be the subject of rights and duties', Bryant Smith, 'Legal Personality' (1928) 37 *Yale Law Journal* 283. The foetus does not have legal personhood which is acquired by being born alive. Most jurisdictions have legislation which grant rights for specific purposes such as inheritance laws but the rights are contingent upon being born alive. Increasingly there has been legislation enacted for the purpose of protecting the foetus but they do not grant the foetus the full rights or status of

iv What factors, other than the recognition of 'foetal personhood',[2] promote or undermine the pregnant woman's right to autonomy?[3]

## B Background

Autonomy is a fundamental human right of all legal persons irrespective of national status, colour, race, caste, religion, belief, sexual identity, social and/or economic status or other identifying factor or attribute.[4] Reproductive autonomy is one aspect of the overall entitlement to autonomy. Nelson defines it as 'the ability to be self-determining and to act on one's own values in making decisions about reproduction'.[5] Reproduction includes issues 'from contraception to abortion; from cloning to sex selection of the embryo for implantation'[6] and 'before conception to the consequences of birthing techniques.[7] In simple terms reproductive autonomy is 'having the power to decide about and control matters associated with contraceptive use, pregnancy and childbearing'.[8] All persons have an entitlement to reproductive autonomy be it an

legal personhood. See Erin Nelson, *Law Policy and Reproductive Autonomy* (Oxford and Portland, Oregon; 2013) 114-115; Nevertheless, granting the foetus some rights without endowing it with legal personhood creates anomalies where the pregnant woman's rights as a full legal person are subordinated to the interests of the foetus. This is illogical and undermines the very basis of legal personhood because it can make the rights of the legal person inferior to those of a non-legal person See Chapter 5.

2 'Legal Personhood' is used in respect of the foetus here as a shorthand for the goal of the anti-abortion proponents and others who seek legal rights for the foetus. Legal personhood and legal personality are used interchangeably here.

3 Autonomy means -self-rule, self and self-determination; Put simply the concept of autonomy embodies the right to live our lives as we so wish and without undue interference.

4 International Covenant on Political and Civil Rights (First adopted19 December 1966, came into force 23 March 1976) 999 UNTS, 171, Arts 17, 23.

5 Nelson (n 1) 2.

6 Jonathan Herring, *Medical Law and Ethics* (Oxford University Press, Seventh ed, 2018, Eighth ed, 2020) 371, 370 – 374; this includes birthing methods and consequences see

7 Elizabeth Chloe Romanis, 'Why the Elective Caesarean Lottery is Ethically Impermissible (2019) 27 *Health Care Analysis* 249, 251.

8 U D Upadhyay et al, 'Development and validation of a Reproductive Autonomy Scale' (2014) 45 (1) *Studies in Family Planning* 19, 20.

entitlement to procreate or not to procreate or other aspect of reproduction. Women are not the only persons who have entitlement to reproductive autonomy.

The impact of pregnancy on women's autonomy is a global issue which has received a great deal of attention in the first two decades of the 21st Century. It is relevant on a national, intranational and international level. Worldwide, women, irrespective of who they are or where they live may face reproductive decisions. Nevertheless, not all women may be able to reproduce and not all women will want to reproduce. The actual experience of pregnancy and the ability to exercise autonomy will differ between women due to various factors including the country in which they live, being of a particular nationality or being stateless, being of a race, caste or of colour, culture, gender or sexual identification, socio-economic status, and a variety of other factors.[9] Such factors ought not but do operate in a manner which impedes the exercise of the autonomy of the person. Pregnancy, like any other characteristic, ought not to be used as reason to deny a woman the right to autonomy.

It is argued here that the restriction on the autonomy of a woman cannot be justified because she is pregnant. In many countries, at this point in time, reproductive autonomy is regarded as a fundamental human right but one which women are not always able to exercise. This raises questions as to how and why the law affects women's autonomy and how legal systems seek to regulate reproduction.

Although recognising the global nature of autonomy during pregnancy the research and argument have been restricted to Australia, the United Kingdom (UK) the Republic of Ireland (Ireland), Canada, New Zealand (NZ) and the United States of America (USA).[10] They were selected because of their common English heritage and their continuing economic, cultural and political ties.[11] The origins of their legal systems are to be found in the English common law. They apply similar legal principles. On a very general level of abstraction they have much in common. However, differences become apparent when considering the detail of the right to reproductive autonomy in any particular

9 Khiara M Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (University of California Press, 2011) (USA);

10 It is noted that not all jurisdictions are covered in each chapter — they are included to the extent necessary to analyse the topic covered and support or contradict the thesis.

11 The English common law tradition has been influential on the laws of many other countries.

jurisdiction. There were also commonalities which informed the research and provided some interesting material from which to assess women's right to autonomy at all stages of pregnancy.

As stated above 'reproductive autonomy' raises a number of complex issues. Three of these have been selected for research and analysis because they reflect core issues which may arise during pregnancy. They are the right to a legal abortion,[12] the ability to access medical treatment,[13] and the right to consent to or to refuse medical treatment.[14] These topics provide the basis of discussion for the central chapters of the thesis.

The findings in each chapter combine to provide support for a conclusion that women's autonomous rights have already been, and potentially may be further, undermined through regulation defined by the status of pregnancy. The analysis of the law indicated that, laws which regulate women by focussing upon the status of pregnancy create and perpetuate the myth of a conflict between the woman and her foetus and divert attention from the need to view her pregnancy as part of as an aspect of her overall health and well-being. Further the autonomy of the woman is not guaranteed, irrespective of whether or not the foetus is granted legal rights. This suggested that there are factors, other than foetal rights, which militate against the autonomy of pregnant women.

The status of the foetus in each of the jurisdictions provides an appropriate starting point for answering the research questions detailed above. The willingness to impose restrictions on the autonomy of pregnant women is more pronounced in those jurisdictions which recognised the foetus as having legally protected rights than in those jurisdictions which did not accord legal rights to the foetus before birth. Nevertheless, in the latter, it was evident that pregnant women had limitations placed upon the exercise of their autonomy. This indicated that, although important, viewing the foetus as if it were a legal person did not completely explain why being pregnant impacted upon women's autonomy. Therefore, it was necessary to be aware of other factors which impacted upon autonomy. A consideration of the topics revealed various legal and non-legal influences which operated to determine the extent and content of pregnant

12 Chapter 3 – The Legal Regulation of Abortion.

13 Chapter 4 – Access to Legal Terminations.

14 Chapter 5 – Medical Treatment – Consent and Refusal.

women's theoretical or actual autonomy. This in turn added to the degree of complexity in both analysing the material and reaching a conclusion. In brief, the overall conclusion drawn is that the autonomy of all women, not only pregnant women, is at risk from a failure to address abortion as a health matter, from the granting of legal rights to the foetus, from intervention compelling unwanted medical treatment, and from other dynamics which control (pregnant) women.[15]

Fundamental to addressing the thesis question is the underlying importance of history in providing a background to the existing laws regulating pregnancy. History contributes to an appreciation: that birth and birth control was historically important and continues to be so; of how control of reproduction came under the auspices of Church,[16] State and 'medical profession';[17] of why abortion became entrenched as a crime in the modern Western world; of why bodily integrity is valued and protected; of why abortion remains a highly controversial topic; and why it remains important to women's reproductive autonomy.[18]

Integral to the medicalisation of pregnancy and hence the autonomy of pregnant women is the changing nature and role of what is referred to here as the 'medical profession'. It is useful to explain several meanings and how it is used in considering the current laws in respect of reproductive autonomy. The definition of 'medical profession' has changed

15 See Chapter 6 – Findings and Implications.

16 R Radford Ruether, 'Women, Reproductive Rights and the Catholic Church' (2008) 16 (2) *Feminist Theology* 184; Sandra McAvoy, 'The Catholic Church and Fertility Control in Ireland: the making of a dystopian regime' in Eds Catherine Conlon, Sinead Kennedy and Aideen Quilty, *The Abortion Papers Ireland Volume 2* (ATTIC Press, 2015) 62.

17 John M Riddle, *Contraception and Abortion from the Ancient World to the Renaissance* (Harvard University Press, 1992); Sheena Meredith*, Policing Pregnancy: The Law and Ethics of Obstetric Conflic*t (Taylor & Francis Group, 2005); Sally Sheldon, 'Subject Only To the Attitude of the Surgeon Concerned: The Judicial Protection of Medical Discretion'(1996) 5 (1) *Social & Legal Studies* 95, 96-97.

18 Judith Orr, 'Abortion: As Old as Humanity' in *Abortion Wars: The Fight for Reproductive Rights* 41-66. (Bristol: Bristol University Press, 2017) 42 – 66; Jennifer Elisa Veninga, 'Feminism and the Pro-Life/Pro-Choice Debated in *Feminism and Religion: How Faiths View Women and Their Rights*, edited by Michele A Paludi, and J Harold Ellens, (ABC-CLIO, LLC, 2016. ProQuest Ebook Central) 249-62.

throughout history and its meaning changes according to the era and context in which it is being used.

David Coburn has suggested.

> Professionals are assumed to be experts in an applied field and are generally of high income, prestige, and social position. … Medicine is often referred to as the archetype profession because it exemplifies the professional ideals of expertise, an altruistic rather than self-interest orientation, high work autonomy, and occupational self- government.[19]

The practice of medicine, including abortion, can be traced to Ancient Times[20] and was entrenched in the craft guilds of the Middle Ages[21] but the identification of a 'medical profession' and regulation by the state did not occur until the 19th Century with supervision of abortion and medicalisation of pregnancy becoming entrenched during the 20th Century.[22] The relatively recent increase in medical knowledge and technological advancement has meant that the 'medical profession' no longer refers solely to doctors, physicians or surgeons but includes a wide variety of persons who work in occupations which are medially focussed or related. As a result legislation regulating health and medical services has been neither uniform nor consistent. There has also been a trend towards using the term 'healthcare professional' rather than 'medical professional'. In Australia for example the legislation which regulates health including medicine is ambiguous. This is particularly apparent when considering the laws on abortion discussed in Chapter 3.[23] Throughout the thesis the term 'medical

19 David Coburn, (2015) 15 (2) *International Encyclopedia of the Social & Behavioral Sciences* 92.

20 0rr, (n 18).

21 Coburn (n19) 92.

22 Ibid.

23 For example, under the *Health Act 1993* (ACT) provides that a 'doctor' must perform an abortion but does not define 'doctor' which is defined in the *Legislation Act 2001*(ACT) as a person who is registered under the *Health Practitioner Regulation National Law* (ACT) wherein the health professional is defined as practicing in a recognised and accredited health profession. Which may include medical or nursing. What is important is not the classification but rather the qualifications. Thus a nurse practitioner may be accredited and registered to perform abortions and therefore come within the category of doctor for

profession' will be used generally to refer to accredited and registered medical practitioners including nurses, nurse practitioners, midwives, psychiatrists, sonographers, chemists etc, and may include hospital and medical administrations.[24] The meaning of 'medical profession' changes depending on the context in which it is used throughout the thesis.

History demonstrates that entrenched acceptance of the ideology and practices of patriarchy, including misogynistic attitudes to and stereotyping of women, remain identifiable in western society. Thus, history may help explain why it continues to be difficult for women to achieve true equality and exercise their autonomy.[25] History shows that it is the mandate of law and social reform to secure autonomy for its citizens, including pregnant women. The right to control what happens to one's body is ongoing as history, past and present, demonstrates.[26]

## III STRUCTURE

The thesis is divided into six chapters as follows:

Chapter 1 Introduction

Chapter 2 Theoretical Underpinnings

Chapter 3 The Legal Regulation of Abortion

Chapter 4 Access to Legal Terminations

Chapter 5 Medical Treatment — Consent and Refusal

Chapter 6 Findings and Implications

What follows is a summary of the content of chapters two to six.

### A Chapter 2 Theoretical Underpinnings

Chapter 2 identifies the major theoretical concepts and provides a framework in which to situate the practical issues discussed in the subsequent chapters. The interrelated concepts draw together the topics to identify the extent to which being pregnant impacts upon women's autonomy. Following a brief introduction, Part II identifies the

the purposes of abortion.

24 See *Health Practitioner Regulation National Law* for each state and Territory of Australia.

25 Michele A Paludi, 'Introduction' in Paludi (n18).

26 Judith Orr, *Abortion Wars* (n 15).

meaning(s) of autonomy and then outlines a theoretical framework, informed by Drucilla Cornell's work,[27] which is adopted here because it gives an insight into, and has relevance to, the practical aspects of the exercise of autonomy and pregnancy. Part III considers the concept of legal personhood and its relevance to the autonomy of the pregnant woman. It focusses upon the common law's adherence to the *born alive rule*[28] which states that the rights of the foetus are contingent upon s/he being born alive. It considers an alternate approach which asserts that personhood occurs sometime before birth and as early as conception. As a result, the foetus has legal rights and given legal protection.[29] The latter approach describes and thereby recognises the foetus as a 'legal person' without applying the *born alive rule*.[30] Part IV examines the ways in which the relationship between the woman and her foetus is constructed and how this may be used to the detriment of women's autonomy.

### B Chapter 3 The Legal Regulation of Abortion

Whether or not and when to have children is considered an important reproductive right. It is contingent upon the ability and the opportunity to conceive, prevent conception and/or terminate a pregnancy. In the broader context of autonomy, reproductive rights would include matters which are relevant to the choice being exercised. These include access to family planning, financial assistance, adequate health care, in vitro fertilisation programmes, embryonic transplants and any appropriate medical technology which could result in a healthy pregnancy and/or a timely safe abortion.[31] For the purpose of addressing the hypothesis the focus is on the manner in

27 See Drucilla Cornell, *The Imaginary Domain: Abortion, Pornography & Sexual Harassment* (Routledge, 1995).

28 *In the UK, Australia, Canada and NZ.*

29 As evident in many states of the USA.

30 See Michele Goodwin, 'Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront' (2014) 102 (4) *California Law Review* 781, 787–780; see eg, the *Unborn Victims of Violence Act of 2004* (Public Law 108-212) US which states that the 'child in utero' is 'a member of the species Homo sapiens, at any stage of development, who is carried in the womb'.

31 Catherine Kenny, 'Abortion — A Reproductive Right' in Heather Widdows, Itziar Alkorta Idiakez and Aitziber Emaldi Cirión (ed) *Women's Reproductive Rights* (Palgrave Macmillan, 2006) 17; Hille Haker, 'Reproductive Rights in the Twenty-First Century' in Heather

which the laws considered here impact upon women's autonomy in terminating or to continuing with a pregnancy.

The extent to which a pregnant woman has a legal right to an abortion is the focus of this chapter. Part II examines the legal regulation of abortion in the jurisdictions considered in the thesis. Part III compares, contrasts and critiques the abortion regimes adopted. Part IV identifies the concepts used and the other factors, which have contributed to the regulatory framework of abortion in these jurisdictions and the impact which this has had upon the autonomous rights of women in general and pregnant women in particular.

The laws considered here have their origins in English common law.[32] Consequently, an understanding of the laws of abortion in each of the jurisdictions may be enhanced through an examination of the history of abortion law in England which, from at least 1803 was a criminal offence.[33] Abortion remains located within the criminal law [34] and remains a criminal offence unless it comes within the criteria for lawful abortions in the *Abortion Law Act 1967.*[35] History engenders questions about, as well as explanations of, a broad range of matters not normally identified as being within the purview of the criminal law. The areas have impacted upon the shaping and operation of abortion laws in various countries and include: constitutional law, family law, health law, morality, contraception, family planning, inheritance, individual autonomy, international law,

Widdows, Itziar Alkorta Idiakez and Aitziber Emaldi Cirión (ed) *Women's Reproductive Rights* (Palgrave Macmillan, 2006) 167; UN, International Conference on Population and Development and Platform for Action, Cairo, Egypt September, 1994; Ch 7.2 – 7.3; UN, Fourth World Conference on Women, Beijing, China September 1995.

32 See Gerard Casey, *Born Alive: The Legal Status of the Unborn Child in England and the USA* (Barry Rose Law Publishers, 2005) Chapters 2–6.

33 *Lord Ellenborough's Act of 1803* (UK) 43 Geo 3, c 58 (also called the *Miscarriage of Women Act).*

34 See Casey, *Born Alive, (n 32);* John V Barry, 'The Law of Therapeutic Abortion' (1938) 3 *Medico-Legal Society of Victoria: Medico-Legal Society Proceedings* 211, 21217; Louis Waller, 'Any Reasonable Creature in Being' (1987) 13 *Monash University Law Review* 37–8; Kirsten L Savell, 'Is the "Born Alive" Rule Outdated and Indefensible?' (2006) 28 *Sydney Law Review* 625.

35 *Abortion Act 1967* (UK) c 87 abortions which are not in accordance with this Act remain criminal offences.

human rights law, economics, sociology, and politics.[36] The aims of the chapter are to outline and analyse the laws of abortion as they impact upon women's right to autonomy.

### C Chapter 4 Access to Legal Terminations

Chapter 4 analyses some of the factors which may hinder or prevent pregnant women from implementing a decision not to continue with a pregnancy. Part A considers the legal framework in which the laws of abortion operate and argues that there is not necessarily a correlation between the letter of the law and access to abortion. Part B considers the interrelationship between governmental policy, law making and funding and their impact upon access to abortion. Part C examines the important role of the medical profession as the law's proxy in the regulation of abortion. It argues that the medical profession is the 'gate keeper' of and has a monopoly over the provision of termination services. It also addresses the issue of allowing medical professionals to refuse to participate in the provision of termination procedures. Part D considers the broader issue of the impact of stigma upon accessing an abortion. Part E considers the manner in which those groups which are anti-abortion attempt to prevent abortion by impeding physical access to institutions which provide reproductive services.

### D Chapter 5 Medical Treatment – Consent and Refusal

This chapter analyses the use of the laws relating to consent to or refusal of medical treatment in a manner which may impinge upon the autonomy of pregnant women. Part II analyses the general legal principles applicable to consent to and refusal of medical treatment in the context of their applicability to all legal persons.[37] Part III considers some exemplars in which judicial intervention has been sought to override the refusal of medical treatment (such as caesarean sections and blood transfusions) by pregnant women and considers the reasons for doing so. An analysis of the cases indicated that pregnancy was an important factor in the outcome of the cases and the resulting negative impact upon women's autonomy.

36 These areas are neither mutually exclusive nor exhaustive.

37 See the discussion of women in Canada being recognised as civil and social persons in *Edwards v. Canada (Attorney General) 1929* CanLII 438 (UK JCPC) [1930] AC 124, [1930] DLR 98, 99 [Privy Council, UK] discussed in Chapter 2.

## E Chapter 6 Findings and Implications

This chapter analyses how the topics addressed related to the main hypothesis and the research questions. It identifies the findings in respect of the areas covered in each chapter and draws the conclusion that the autonomy of a woman is impinged upon by virtue of being pregnant. This is contrary to the expectation that women are to be treated as having full legal personhood and entitled to equivalent treatment under the law.

Further it was found that application of the laws which regulate the availability of and access to medical treatment (including abortion) retain identifiable remnants of stereotyping and attitudes which were overt throughout much of western history. Recognition of women as free and equal legal persons remains a continuing struggle, which raises questions as to how genuine equality is best achieved in the future.

# CHAPTER 2 THEORETICAL UNDERPINNINGS

*'Feminism has at its heart the demand that women be treated as free human beings.*[1]

## I INTRODUCTION

This chapter identifies the major theoretical concepts that are relevant to the practical issues discussed in the following chapters. These concepts are interrelated and provide a theoretical framework in which to analyse: the regulation of abortion; access to abortion; and the right to consent to and refuse medical treatment. The areas illustrate and identify the extent to which being pregnant impacts upon women's rights to autonomy. Part II commences by identifying the meaning(s) of autonomy and the relevance of the contribution of Drucilla Cornell to the theory of what it is to be a person and why all persons, including pregnant women have a right to equivalence or individuation. Part III considers the concept of legal personhood and its relevance to the autonomy of the pregnant woman. It focuses upon both the adherence to the *born alive rule*[2] and the advent of foetal personhood and protection laws.[3] Part IV examines the ways in which the relationship between the woman and her foetus are constructed. It indicates how the adoption of Cornell's theory provides a basis from which to argue that women's autonomy is best protected by a theory which respects the rights of women rights and in turn the best interests of the foetus.

## II AUTONOMY

### A Defining Autonomy

Put simply personal autonomy may be defined as 'the capacity to govern oneself'.[4] 'Autonomy' may be explained as: a legal, a philosophical, an ethical, a social, a political, an economic, and even an environmental ideal. It may be restricted to a specific 'ideal' such as 'legal autonomy' or it may be a hybrid or composite of several ideals, such as socio-political and moral autonomy. It encapsulates the idea of the desirability of directing one's life according to one's preferences, free from coercive actions by the state

1 Drucilla Cornell, *At the Heart of Freedom: Feminism, Sex and Equality* (Princeton University Press, 1998) 20.

2 *In the UK, Australia, Canada and NZ.*

3 As evident in the USA.

4 Brian H Bix, *A Dictionary of Legal Theory* (Oxford University Press, 2004) 15.

or others. When it is considered and discussed its meaning and usage is frequently assumed to be constant.[5] However, the reality is quite the opposite. There is no single definition or usage of the word autonomy.[6] Rather there are innumerable ways of explaining what it means.[7] Gerald Dworkin referred to it as a 'term of art'.[8] Of particular relevance to this thesis is its use in law as enacted and applied by the courts, in medical administration and practice, and in the broader socio-political context.

The term autonomy is derived from the ancient Greek word 'αυτονομια' (from 'αυτος [autos]—alone, νομος [nomos]—law) meaning 'self-government', 'self-law' and 'self-determination'.[9] Originally its use was predominantly political, expressing the sovereignty of the state rather than the self-determination of the individual.[10] In Ancient Athens free men participated in democratic governance, including all governmental tasks of law and decision making needed to govern the state. This was the ancient meaning of liberty or freedom, the freedom to engage in the democratic rule of the state. It was regarded as a positive freedom. On a social level there was pressure to conform and the liberty on an individual level was more restricted.

In 1818, Benjamin Constant in 'De la Libertés Ancients compare à celle des Modernes'[11] contended that the idea of freedom in ancient Greece was the opposite to that which applied in his era. At that time it was understood as 'freedom' to participate in group

5 This is an observation rather than a criticism. There are many writings which consider autonomy without discussing what they mean by that term, e g Samantha Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge, 2016).

6 Bix, (n 4) 15.

7 Alasdair Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge University Press, 2009) 9–29.

8 Gerald Dworkin *The Theory and Practice of Autonomy* (Cambridge University Press, 1986) 6; Carolyn McLeod, 'How to Distinguish Autonomy from Integrity' (2005) 35 *Canadian Journal of Philosophy* 107, 108.

9 Gerald Dworkin (n 8) 12.

10 Gerald Dworkin (n 8) 12-13.

11 Benjamin Constant, 'The Liberty of the Ancients compared with that of the Moderns in Benjamin Constant' *Political Writings* Trans and ed Bianca Fontana (Cambridge University Press, 1988)

governance.[12] He considered that the ancient world had no conception of what was meant by 'modern liberty'.

According to Constant

> Modern liberty means the freedom to do as one pleases within the framework of the rule of law, to hold beliefs as one sees fit, to be free of government interference so as to follow one's inclination and interest. Ancient liberty, however, meant something entirely different.[13]

Whether his view that there were two distinct categories of freedom, that is, ancient and modern, is accurate is open to question.[14] The bodily integrity and autonomous rights on an individual level are important rights and it is the responsibility of the state to protect these rights for its people.

In ancient times only male citizens had the right to participate in government. Women were not deemed appropriate to be formally involved in the affairs of the state. They had the status of citizen and had a role to play in the social, domestic and economic spheres. Even at this early stage in the development of the world and western democracy women were deemed citizens but were denied the full rights and obligations of civil and political personhood. The origins of the patriarchal society where women are deemed as lesser can be identified as being in existence at least in ancient Greece and most likely earlier.[15]

Constant considered that both ancient freedom and modern freedom ought to be used in combination. The reasons for this assertion was that the doctrine of freedom of the ancient world placed insufficient weight on individual rights and happiness. On the other hand, allowing individuals to pursue happiness as an end in itself would threaten social cohesion and abrogate the 'right to share in political power'.[16] Therefore, the two should exist in combination. The individual ought to have a right to freedom but must

12 Constant (n 11).

13 Ibid 310-11.

14 Julia Maskivker, 'Participation and Rights in Athenian Democracy: A Habermasian Approach' (2010) 15 (7) *The European Legacy* 855, 861.

15 Marlene LeGates, *In Their Time a History of Feminism in Western Society* (New York: Routledge, 2001) Chapter 1.yh

also support state governance. It was the role of government to protect the rights of the individual.[17]

Over time autonomy came to denote the ability of the state, its organisations and men generally to be involved in law making and self-regulating in western society. Women were excluded from the public and political arena. The laws as decided were given the role of protecting autonomy.[18] Some terms used to describe the entitlements of self-regulation were seen as akin to permission, freedom or licence.[19] Other perceptions of autonomy would claim that there is also an implication of 'some measure of self-restraint',[20] 'personal responsibility'[21] and 'ability to reason'.[22] Implicit is an understanding that the liberty of the subject is protected by law but is not absolute. The law protects the entitlement not to be subjected to unjustified interference by the state or others. Literally autonomy means self-rule.[23] A more contemporary view of autonomy is that it is not restricted to legal autonomy or the individual but is 'relational'.[24] Overall

16 Jeremy Jennings, 'Constant's Idea of Modern Liberty' in H Rosenblatt (Ed) *The Cambridge Companion to Constant* (Cambridge Companions to Philosophy), (Cambridge: Cambridge University Press, 2009) 69, 70.

17 Ibid.

18 Ibid.

19 Mortimer Sellers, 'An Introduction to the Value of Autonomy in Law' in Mortimer Sellers (ed) *Autonomy in the Law* (Springer, 2007) 1, 1–9.

20 Ibid.

21 Mason Cash, 'Extended Cognition, Personal Responsibility, and Relational Autonomy' (2010) 9 *Phenomenology and the Cognitive Sciences* 645; Sophia H Gilbert, David DeGrazia and Marion Danis, 'Ethics of Patient Activation: Exploring its Relation to Personal Responsibility, Autonomy and Health Disparities' (2017) *Journal of Medical Ethics* 670.

22 Joseph H Kupfer, Autonomy and Social Interaction (State University of New York Press, 1990) 42; Nicole Hassoun, 'Raz on the Right to Autonomy' (2014) 22 *European Journal of Philosophy* 96.

23 MacLean (n 7) 10.

24 'The term "relational autonomy", does not refer to a single unified conception of autonomy but is rather an umbrella term, designating a range of related perspectives', Catriona Mackenzie, and Natalie Stoljar, 'Introduction' in *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*, Eds Catriona Mackenzie, and Natalie Stoljar, (Oxford University Press, Incorporated, 2000) 4; Elizabeth Wicks, *The State and the Body:*

it may be said that the autonomy of person(s) may be understood as the attribute of an individual or group within the context of history, society, class, race, gender and other influences which impact upon their view of who they are and their capabilities. Some examples of the definition of autonomy illustrate that its meaning is both contextual and fluid.

In the context of medical practice and the autonomy of the patient,

> [a]utonomy is usually expressed as the right of competent adults to make informed decisions about their own medical care. The principle underlies the requirement to seek the consent or informed agreement of the patient before any investigation or treatment takes place.[25]

Wicks has defined 'bodily autonomy' as 'referring to the freedom to act upon choices made by a person with decision-making capacity which relate to the human body'.[26]

A final reference to the meaning of autonomy is to recognise its use in and connection to human rights law.[27]

> Human rights are rights that attach to human beings and function as moral guarantees in support of our claims towards the enjoyment of a minimally good life. In conceptual terms, human rights are themselves derivative of the concept of a right.[28]

The ideas of autonomy as outlined above indicate that they may be applied equally to all legal persons and that autonomy is an integral feature of personhood. Freedom during

*Legal Regulation of Bodily Autonomy* (Hart Publishing, 2016) 6; Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (Oxford University Press, 2011); Marina A L Oshana, *Personal Autonomy and Social Oppression* (Routledge, 2014); Marilyn Friedman, *Autonomy, Gender, Politics* (Oxford University Press, 2003); Maclean (n 7) 235.

25 British Medical Association, *2 Autonomy or Self Determination* (15 November 2016).

26 Elizabeth Wicks (n 24) 5.

27 Ibid 6; Nicole Hassoun, 'Human Rights, Needs, and Autonomy' (2008) *Carnegie Mellon University Research Showcase @ CMU* (online).

28 Internet Encyclopedia of Philosophy, *Human Rights: Philosophical Analysis of the Concept of Human Rights* (online); Elizabeth Wicks (n 24) 6; *Universal Declaration of Human Rights 1948* (online).

the Enlightenment was a right to the freedom of the individual. Constant argued that the two concepts could be used in conjunction with each of other.

Central to this ideal view is that personhood applied to women in theory only. Full personhood did not exist for women.

In ancient Rome and Greece governance was the provenance of men but not women, slaves and aliens. During the intervening centuries between ancient civilisation and the Enlightenment of the 18th and 19th Centuries patriarchy was prominent in the development of the western society.[29] Women's rights to participate in government remained very limited and her subordinate role in society unquestioned.[30] Tim Stretton and Krista Kesselring noted that

> even as coverture explained the loss of a woman's rights when she married, it in turn had justifications that changed over time, with a wife variously understood to be the dependent subordinate of her husband or, indeed, to have become "one flesh" with him or one person at law, with his legal identity effectively erasing and replacing her own.[31]

The development of the English Common Law reflected and legitimised the idea that women were under significant disabilities which limited both their autonomy on both a political and private level.

By the 19th Century women of the western world women, both married and single were becoming increasingly active in promoting their rights to be allowed to participate in

29 Tim Stretton and Krista J Kesselring, *Married Women and the Law: Coverture in England and the Common Law World* (MQUP, 2013) 4.

30 Ibid 5 'legal arenas have long served as sites to set, contest, and make public the limits on women's rights to personal autonomy, physical integrity, property, citizenship, and custody over their children. Moreover, it was within marriage that the law most rigorously entrenched the subordination of women to men. Married women, not women in general, found themselves linked with "idiots" and minors in manifesting disabilities and deficiencies, deficiencies that in their case derived from law and culture rather than from "nature." While this much remained true for centuries, the ways in which law shaped the experiences of women who married changed over time. Changes occurred in conjunction with continuities; in England and then its colonies, this often happened around or within the distinctive common law concept of coverture.

31 Tim Stretton and Krista J Kesselring (n 29) 5.

governance and have their opinions heard because they were still effectively denied full political personhood.[32] Generally, they were unable to vote or to be members of a governmental body and their participation in the judicial system was restricted to the role on the 'matron jury'.[33]

For women who married the disadvantage of being female was compounded. As social beings they were entitled to be accorded autonomy but their rights were limited by the manner in which society was organised[34] and especially the common law doctrine of coverture.[35] During their minority and/or until they were married they were under the control of the male head of the family.[36] This was usually the father but if he had died then they were placed under the guardianship of another male or the courts. Under the common law women were not eligible for the role of guardianship;[37] that is, unless they had borne their children 'out of wedlock'.[38]. Upon marriage the husband and wife

32 Le Gates (n 15).

33 Defendants who were pregnant could escape the death penalty by 'pleading the belly'. A jury of matrons was empanelled to determine whether the woman was in fact pregnant. See Jane Bitomsky, 'The Jury of Matrons: Their Role in the Early Modern English Courtroom' (2019) 25 *Lilith: A Feminist History Journal* 4; Kevin Crosby, 'Abolishing Juries of Matrons' (2019) 39 (2) *Oxford Journal of Legal Studies* 259; Alex C Castles, *An Australian Legal History* (Sydney: Law Book, 1982) 61.

34 Lord Wilson, 'Out of his shadow: The long struggle of wives under English Law' *The High Sherriff of Oxfordshire's Annual Law* Lecture 9 October 2012, provides an interesting and comprehensive overview of the history of the disadvantages which attached to women upon marriage, including the Married *Womens Property Acts* and the *Matrimonial Causes Act* 1857.

35 Norma Basch, 'The Legal Fiction of Marital Unity in Nineteenth- Century America' (1979) 5 *Feminist Studies* 346, 347; C Bishop 'When Your Money Is Not Your Own: Coverture and Married Women in Business in Colonial New South Wales' (2015) 33 (1) *Law and History Review* 181; Tim Stretton and Krista J Kesselring (n 31) 4, 5.

36 Marlene LeGates (n 15) 1.

37 The law was an important disincentive for any wife to leave the marriage because he was entitled to the custody of the children; Lord Wilson, 'Out of his shadow' (n 34) 25.

38 Patricia Crawford, *Parents of Poor Children in England 1580-1800* (Oxford: Oxford University Press, 2010) Ch 1 & Ch 2. Thomas Nutt Levene and Samantha Williams (eds), *Illegitimacy in Britain, 1700– 1920* (Basingstoke, Palgrave Macmillan); *Adrian Wilson,*

became one person and that was the person of the husband.[39] In effect women became 'non-persons' for the purposes of the civil law.[40] This was the common law doctrine of coverture.[41] Married women were not allowed to own property in their own right.[42] In return he provided for her and was responsible for her protection. The husband was regarded as the head of the family and as such the wife and any children were under his control. The laws on marriage when put in legislative form, remained similar to the canon or Christian law, reinforced the rights of the husband and the subjection of the wife.[43] This continued until the late 19th Century when the *Married Women's Property Acts* were passed in the UK.[44] This allowed married women to enter into contracts, own property, make a valid will and to sue and be sued. However, it did little to accord

*Ritual and Conflict: The Social Relations of Childbirth in Early Modern England* (Taylor & Francis Group, 2013) Chapter 1.

39 William Blackstone, *Commentaries on the Laws of England* Vol, I (1765) 442445.

40 Norma Basch (n 35) 354.

41 Ibid, for the development of the Anglo-American common law of coverture.

42 Allison Anna Tait, 'The Beginning of the End of Coverture: A Reappraisal of the Married Woman's Separate Estate' (2014) 26 *Yale Journal of Law* & F*eminism* 165, discusses how persons of wealth attempted to circumvent the laws of coverture; see also C Bishop (n 35) for an examination of how the principles of coverture were adapted to needs of colonial NSW. Cw Jenny Hocking and Laura Donati, 'Obscured but not Obscure: How History Ignored the Remarkable Story of Sarah Wills Howe' (2016) 7 (2) *The Journal of the European Association for Studies of Australia* 58 which showed that law frequently adapted to fit different circumstances. The manner in which coverture operated to the advantage of free wom``en married to convicts unintentionally operated in the favour of the women, 58-59, 61-62.

43 See Kelly Hager, 'Chipping Away at Coverture: The *Matrimonial Causes Act of 1857*' in BRANCH: Britain, Representation and Nineteenth-Century History (Ed) Dino Franco Felluga (online).

44 See also *Married Women's Property Act 1883* (Tas); *Married Women's Property Act 1883-4* (SA); *Married Women's Property Act 1884* (Vic); *Married Women's Property Act 1892* (WA); *Married Women's Property Act 1890* (Qld); *Married Women's Property Act 1893* (NSW).

women equality with men in the commercial or political arena.[45] They still lacked the commercial network and economic means of using them.[46]

Unfortunately, marriage and coverture did not protect the wife from the husband. She could be held liable for crimes which she committed independently of her husband. The criminal law protected her against all assailants. However, it was difficult to prosecute a husband for offences against the wife's person. He had the right to her consortium.

It was not until the middle to late 20th Century that a woman had the right to refuse her consent to marital sexual intercourse.[47] Marriage was regarded as a type of contract by which the woman was deemed to have agreed to sexual intercourse with her husband. She could not withdraw her consent and thereby could not be a victim where a husband had intercourse with her and without her consent. [48].

It was extremely difficult for a woman, who felt trapped in her marriage, to leave her husband. Divorce was only available through an Act of Parliament until 1857, when the *Matrimonial Causes Act* was passed. Prior to that the Ecclesiastical courts had jurisdiction over matrimonial matters and did not recognise divorce. It was possible for them to grant an order of *a mensa a thoro* which had the effect of allowing a legal separation, but re-marriage was not permitted.[49]

After the passage of the *Matrimonial Causes Act* divorce was removed from the jurisdiction of the ecclesiastical courts and became a civil matter. The grounds on which a wife could obtain a divorce from her husband were more onerous than the grounds on which the husband could divorce the wife.[50]

45 For a feminist account of the position of woman and concept of the freedom of contract from the 17th Century until the penultimate decade of the 20th Century, see Carole Pateman, *The Sexual Contract* (Polity Press, 1991) Ch 6 '*Feminism and the Marriage Contract*' 238.

46 Ibid.

47 In UK see *R v R* [1991] 4 All ER 481.

48 In Australia, see *R v L* [1991] HCA 48; (1991) 174 CLR 379 at 390 per Mason CJ, Deane and Toohey JJ, 405 Dawson J; *PGA v The Queen* [2012] HCA 21.

49 Anthony Dickey, *Family Law*, (Thomson Reuters (Professional) Australia Pty Limited, 2013) Chapters 1 and 2.

50 Cf Canada see Thomas J Abernathy Jr and Margaret E Arcus, 'The Law and Divorce in Canada' (1977) 26 (4) *The Family and the Law* 409.

The legal disabilities of married women were apparent in the Anglo-American and Commonwealth legal systems as they had evolved. The judicial adherence to the ineligibility of women for public office combined with the unquestioning commitment to patriarchy perpetuated the subjugation of women.

By the mid 19th Century the sustained efforts of challenging the status quo and calling for fundamental changes were beginning to have an impact.[51] Not all women were willing to accept limitations on their personhood.[52] JS Mill,[53] considered it was time that women be included in governance.[54] It would appear that activism was becoming more organised and more vocal.

> The eruption of feminism onto the political stage during the revolutionary age is such a critical moment in women's history that it has tended to obscure antecedent developments. But what one 1793 journalist dubbed 'the new field of

51 See Andrew Pyle (ed), *The Subjection of Women: contemporary responses to John Stuart Mill*, (Thoemmes Press, England; 1995) for different perspectives and attitudes to the role of women at that time; see in particular Margaret Oliphant, 'Mill on the Subjection of Women' in Andrew Pyle *The Subjection of Women* 109 and Sheldon Amos, 'The Subjection of Women' in Andrew Pyle, *The Subjection of Women* 141.

52 Throughout history there have been women who refused to conform to their roles. We know of some of these but there were many more who remain hidden in history. John Willis, *Women of History; the Lives of Women Who in All Ages, All Lands and in All Womanly Occupations Have Won Fame and Put Their Imprint on the World's History* (JC Winston Co, c1913) (online); Simone de Beauvoir, *Feminist Writings: Feminist Writings* (ed) Margaret A Simons and Marybeth Timmermann (University of Illinois Press, 2015) (online); Sheila Rowbotham, *Hidden from History: Rediscovering Women in History from the 17th Century to the Present* (New York: Pantheon, 1974).

53 John Stuart Mill, 'Speech: On the Admission of Women to the Electoral' House of Commons, 20 May 1867 in John Stuart Mill, *The Collected Works of John Stuart Mill, Volume XXVIII - Public and Parliamentary Speeches* - November 1868 (online); See John Stuart Mill, *The Subjection of Women* (Early Modern Texts, 2017); Stefan Collini, 'JS Mill on the Subjection of Women' (1984) 34 *History Today* 34

54 Tim Stretton and Krista J Kesselring (n 29) 3-5; In NZ eg, male politicians including John Hall, Robert Stout, William Fox, Julius Vogel, and John Balance supported women's right to the vote. See 'Brief history', (Ministry for Culture and Heritage NZ) (online).

the Rights of Woman' had long roots in enlightened thought and cultural practices.[55]

However, although women's presence was difficult to ignore there was no overall political plan to place women on an equivalent status with men.

By the beginning of the 20th Century there was legislation which improved the legal ability of women to vote and participate in politics. However, the legislative changes were limited and somewhat piecemeal. In Canada it was not until 1929, when the decision in *Edwards v AG of Canada (Persons Case)*[56] was delivered by Lord Sankey,[57] that women became eligible to fully participate in parliament.

The background to the *Persons Case* may be seen from previous judicial decisions which emphatically upheld the common law rule that women were ineligible to take part in government. The resistance of the judiciary to legislative reforms to allow women access to public office and/or the legal profession is, clear from the many cases which came before the courts in the time prior to the *Persons Case*.[58]

In 1867 the *Representation of the People Act* extended the right to vote. It provided that every 'man' who met the requisite qualification could enrol to vote. More than 5000 women in the borough of Manchester enrolled but an official removed their names from the register. The women challenged his decision. The Court was unanimous in agreeing that the women were disqualified from voting which was restricted to men.[59]

In 1889 in *Beresford-Hope v Sandhurst,*[60] Lady Sandhurst was elected to the local county council. She defeated a male candidate who sought an order of the court declaring that the election was void because only men were eligible to stand for council. Women had

55 B Taylor and S Knott, *Women, Gender and Enlightenment* (Palgrave Macmillan UK, 2005) xix.

56 *[1930] AC 124.*

57 Jakob de Villiers, 'The Persons Case Revisited' (2003) 61 (3*) Advocate (Vancouver Bar Association)* 359.

58 Robert J Sharpe and Patricia I McMahon, *The Persons Case: The Origins and Legacy of the Fight for Legal Personhood* (Toronto; Buffalo: Published for the Osgoode Society for Canadian Legal History by University of Toronto Press, 2007); Jakob de Villiers (n 57).

59 *Chorlton v Lings* [1868-69] LR 4 PC 374.

60 (1889) 23 QBD 79.

been granted the right to vote at council elections in 1867 but the legislation did not specifically provide that they were eligible for election. The Order was granted.[61]

In 1918, women were granted a limited right to vote[62] and were given a right to be elected to the House of Commons.[63] In 1919, Parliament passed the *Sex Disqualification (Removal) Act* which was intended to allow women to participate fully in government.

In 1922, Viscountess Rhondda, a hereditary peer was determined to take her seat in the House of Lords. She petitioned the King asking that a writ of summons be issued. The petition was referred to the Committee for Privileges which found in favour of her petition. Shortly thereafter the committee was called upon by Lord Birkenhead, the Lord Chancellor to reconsider their report. At the second sitting it was decided that she was ineligible to take a seat in the House of Lords. The decision of the Lord Chancellor was an exercise in selective statutory interpretation and a review of the cases that had for nearly 60 years prevented women from full participation in government.[64] Like those earlier cases he considered that women were under a legal disability when it came to public office. His statement that a female 'is a female until she dies' appears to accurately depict his opinion on the role of women.[65] His reasoning reflected the views in the previous cases which they did by interpreting the legislation in a very restrictive manner or, as he did, ignore the legislation altogether.[66]

61 See also *Reg v Harrald* [1872] LR 7 QB 361; *De Souza v Cobden*, [1891] I QB 687; *Nairn v University of St Andrews*, [1909] AC 147; *Bradwell v Illinois* 83 US. (16 Wall) 130 (1873); cf *The King v Stubbs* (1788) 2 TR 394 395, 397, where a woman's appointment as an overseer of the poor was upheld because there was no eligible person available that is, a man; Robert J Sharpe, 'The Persons Case and the Living Tree Theory of Constitutional Interpretation' ('The Living Tree') (2013) *University of New Brunswick Law Journal* 1.

62 *Representation of the People Act 1918*.

63 *Parliament (Qualification of Women) Act 1918*.

64 *Viscountess Rhondda's Claim* [1922] 2 AC 339.

65 *Peerage Act 1963* - women who were hereditary life peers were finally able to sit in the House of Lords.

66 *Sex Disqualification (Removal) Act 1919*.

These were the decisions reflecting the staunchly held views about women in public office with which five Canadian women were faced when their case came before the Judicial Committee of the Privy Council in 1929.[67]

Emily Murphy was a women's rights activist who was the first woman appointed as a magistrate in the British Empire.[68] She had an ambition to be appointed to the Senate but the Canadian government although appearing supportive were of the strongly held opinion that constitutional amendment would be needed to allow women to appointed to the Senate. It did not appear that legislative action would take place in the short-term.[69]

Therefore, at that time the interpretation of the *British North America Act 1867* (*BNA Act*) was the legislative obstacle which Murphy had to overcome. The *BNA Act* provided that, unlike the House of Commons, members of the Senate were to be appointed and that to be eligible for appointment it was necessary to meet the criteria of 'qualified person'. The government was petitioned.[70]

In October 1928, in response to the petition the Governor in Council requested that the Supreme Court of Canada answer the question:

67 See Mary Jane Mossman, 'Feminism and Legal Method: The Difference it Makes' in *At the Boundaries of Law (RLE Feminist Theory) : Feminism and Legal Theory* (ed) Martha Albertson Fineman, and Nancy Sweet Thomadsen (Francis & Taylor, 2012) 283.

68 See *R v Cyr* (1917) XII ALR 320, 326, 328 where the Supreme Court of Alberta upheld a conviction for vagrancy. It was argued that the Alice Jamieson the female magistrate who had determined the matter had not been validly appointed because she was a woman and only males could hold the office. It was held that her appointment as a police magistrate was valid.

69 The Prime Minister at the time was giving the appearance if encouraging Murphy's lobbying but appointing her to the senate was not on his political agenda. In his diary he wrote that Mrs Arthur Murphy because she appeared too 'masculine', 'too aggressive' and a 'genuine person'. He wrote that he: 'promised her nothing.' See the Diary of, William Lyon Mackenzie King (26 October 1922) (online) Archives Canada Item 8288.

70 *In the Matter of a Reference as to the meaning of the Word Persons' in Section 24 of the British North America Act 1867* [1928] SCR 276; CanLii 55 (SCC).

> Does the word 'Persons' in section 24 of the British North America Act, 1867, include female persons?[71]

In April 1929 the Supreme Court answered this question in the negative.

Lord Chief Justice Anglin noted that the case was not

> concerned with the desirability or the undesirability of the presence of women in the Senate, nor with any political aspect of the question submitted. Our whole duty is to construe, to the best of our ability, the relevant provisions of the B.N.A. Act, 1867, and upon that construction to base our answer.[72]

The majority felt that binding precedent clearly showed that women remained under the same political and civil disability as they did in in 1867.

The decision was labelled as 'absurd'[73] and met with much criticism from women's groups, their supporters [74] and from some newspapers.[75] However, that did not stop Murphy and her colleagues from pursuing the goal of women's appointment to the Senate. They appealed to the final appellate body of the British Empire, the Privy Council.

On October 18th1929, the Judicial Committee unanimously decided that the word 'persons' in Section 24 of the Act 'included members both of the male and female sex'. Lord Sankey delivered the Opinion of the Board.[76]

71 *Reference re meaning of the word "Persons" in s.24 of British North America Act* [1928] SCR 276; [1928] CanLii 55 (SCC).

72 Ibid 282-283.

73 Sharpe, 'Living Tree' (n 61) (see his note 40).

74 Anon, 'Women Liberals Become Indignant at Ottawa Ruling', (25 April 1928; *Toronto Globe)*.

75 J de Villiers, (n 57) who refers to an anonymous comment on the judgment, 366; it has also been criticised by constitutional lawyers as being an incorrect application of the doctrine of 'orginalism' which they were purporting to apply; see S Reid, 'The twisted tree; how Canada's courts have misread a historic ruling, giving themselves the power to rewrite the constitution. (2012, Oct 22). 8

76 See observations for example observations of Sharpe, 'The Living Tree' (n 61) 14 on this and on the other four members which constituted the board (13-14).

He agreed with the court below that the case was not to be decided upon issues about the status of women. There were two things to consider. The first was, [t]he external evidence derived from extraneous circumstances such as previous legislation and decided cases'.[77] The second was '[t]he internal evidence derived from the Act itself'.[78]

Lord Sankey traced the exclusion of women from public life to ancient civilisation.

> The exclusion of women from all public offices is a relic of days more barbarous than ours, but it must be remembered that the necessity of the times often forced on man customs which in later years were not necessary.[79]

He took care to avoid the issue of the systemic subjugation of women and stated that this issue was not one of rights but of interpretation.

> Nor are their Lordships deciding any question as to the rights of women but only a question as to their eligibility for a particular position. No one either male or female has a right to be summoned to the Senate. The real point at issue is whether the Governor-General has a right to summon women to the Senate.[80]

He had previously noted that '[n]o doubt in any code where women were expressly excluded from public office the problem would present no difficulty'.[81] The irony of this assertion was highlighted on the seventieth anniversary of the case when Claire L'Heureux-Dubé of the Supreme Court of Canada pointed out that if the 'discrimination were express, there would be no need or means to strike it down'.[82] She added that this was '[n]ot exactly a landmark statement in favour of women's equality'.[83]

Having found that the history of the section was not decisive,[84] Lord Sankey looked to the interpretation of the *BNA Act.* In doing this he used the analogy of a tree which had

77 *Edwards v. Canada (Attorney General*), 1929 CanLII 438 (UK JCPC) [1930] AC 124, [1930] DLR 98, 99 (*Persons Case*).

78 Ibid 99.

79 *Persons Case* 99,100.

80 Ibid 107-108.

81 Ibid 104.

82 Claire L'Heureux-Dubé, 'The Legacy of the Persons Case: Cultivating the Living Tree's Equality Leaves' (2000) 63 (2) *Saskatchewan Law Review* 389.

83 Ibid 390.

84 *Persons Case* 105.

been planted and intended to grow.[85] This meant that the Privy Council should not impose 'rigid adherence to the customs and traditions of another' on Canada.[86] The development of Canada required that the Privy Council as its 'final Court of Appeal'[87] ought not interpret the provisions using 'a narrow and technical construction'.[88]

The Lord Chancellor considered that the appropriate meaning of 'person' included members of both sexes'.[89] He added, 'to those who ask why the word should include females, the obvious answer is why should it not'.[90] His further statement, that 'the burden is upon those who deny that the word includes women to make out their case', is curious in that he cites no authority for it.[91] The question was answered in the affirmative and the King accepted the advice of the Privy Council.

The reactions were as expected. Women and their supporters applauded it because women were now recognised as 'legal persons' and could fully participate in political life.[92]

The immediate reaction from the Canadian legal profession was respectful but highly critical.[93] George Henderson, a Senior Barrister, stated.

> Under ordinary circumstances, a criticism of a judgment of the Judicial Committee of the Privy Council is inadvisable, but a recent decision of that tribunal . . . has led to so much press criticism of the Supreme Court of Canada that proper respect for the administration of justice in Canada demands examination and comment.[94]

Pervasive throughout the article are thinly veiled insults about and contempt for the Privy Council. It also alleged that the decision was made in the knowledge that it

85 Ibid 106-107.
86 Ibid 106.
87 Ibid.
88 Ibid 107.
89 Ibid 108.
90 Ibid.
91 Ibid 108.
92 Sharpe, 'The Living Tree' (n 61); Anon, 'A Woman's Big Victory in Privy Council', *Evening Standard* (London) (18 October 1929).
93 George Henderson, 'Eligibility of Women for the Senate' (1929) 7 *Can Bar Rev* 617.
94 Ibid

accorded with the wishes of the Canadian government. Henderson concludes with the statement that

> one wonders if the average Canadian would care to think that judicial legislation has altered the constitution of the Senate of Canada.[95]

The reaction of the media indicated that the claims of women could no longer be dismissed. In newspaper reports women were congratulated, in a condescendingly courteous fashion, 'on the progress they were making'.[96] The press previously highly critical and uncomplimentary of the activities of women seeking a role in governance, now complimented the women. The overall tenor was that woman had become worthy and overcome the things that had previously rendered her ineligible for public office.[97]

The decision however was important as an indication of the possibilities of reform but did not result in immediate or sweeping change. The decision was extremely narrow. It allowed for women who were appropriately qualified to be appointed to the Senate. This did not legally compel any appointments.[98] Nor did it remove discrimination on the basis of racism or poverty. Indigenous people were excluded from voting altogether and there were many poor and immigrant persons who were ineligible to vote.

Although heralded as a model for other countries the decision was about the Canadian Constitution and appointments of women to its Senate.[99] In Britain the status quo remained because the case was only precedent for those for whom the Privy Council was the final appellate body. England had not yet granted women access to full

95 Ibid 628.

96 Robert J Sharpe *The Persons Case* (n 58*)* 39.

97 Ibid 39-40.

98 Emily Murphy was not appointed to the Senate.

99 It was reported that it 'will have an indirect bearing on the political activities of women throughout the Empire' cited by Sharpe (n 61)15 his note 67.

participation in government.[100] It was potentially relevant to 'white' women in New Zealand who had an appointed upper house.[101]

'White' women in Australia [102] had already been given the right to vote and to participate in public affairs. The decision did not apply to the indigenous people of Canada nor did it apply to those who could not meet the eligibility criteria under section 23 of the Act. Nevertheless, it did signify a potential for the future treatment of women as equivalent persons.

Emily Hunt and her colleagues, revered as the 'Famous Five', became symbols of what feminism could achieve. It is argued that they deserve this accolade. The obstacles they faced and the commitment with which they pursued their goal to have women identified as legal persons is difficult to appreciate for people of the 21st Century. To state the obvious women activists of the 19th and early 20th Centuries bear little resemblance to current feminists and did not consider themselves such.[103]

Sharpe has described the women activists around the time of the *Persons Case*.

100 Under the *Representation of the People Act 1918* women over 30 who met the property qualifications were given the right to vote in the House of Commons; the *Parliament (Qualification of Women) Act 1918* allowed women voters to stand for election to the House of Commons; the *Equal Franchise Act 1928* gave the vote to everyone over the age of 21; the *Life Peerages Act 1958* s1 (3) provided for the appointment of women to the House of Lords.

101 The *Statutes Amendment Act* 1941 (5 Geo VI no 26) (NZ) s40 allowed for women to be appointed to the Legislative Council which was abolished in 1950 by the *Legislative Council Abolition Act 1950 (No 3)* (NZ); William Keith Jackson *The New Zealand Legislative Council: a study of the establishment, failure and abolition of an upper house (Dunedin: University of Otago Press, 1972);* The *Electoral Act 1893 (57 Vic 1893 No 18)* allowed women to vote s 6; Indigenous persons received very limited voting rights, s7; *Women's Parliamentary Rights Act 1919* (10 Geo V 1919 No 16) allowed women to stand for the Legislative Assembly.

102 The *Australia Commonwealth Franchise Act* 1902 (Cth) the right to vote and stand for election.

103 See Elizabeth Crawford, The Women's Suffrage Movement in Britain and Ireland: A Regional Survey (Women's and Gender History), (London and New York, Routledge; 2006).

> They were overwhelmingly middle-class, white, heterosexual, Anglo-Saxon Christians with an elitist sense of their own virtue and moral superiority. They viewed women as "naturally the guardians of the race," and that race was decidedly white, British, and Protestant. Maternal feminists were progressive but they shared the racist and xenophobic attitudes that prevailed in the society in which they lived. Worse still to the modern eye, Murphy and her group promoted eugenics as a means to improve public health including laws that permitted the sterilization of "mental defectives".[104]

Nevertheless, the actions of people must be understood within the historical context in which they occurred. Accordingly, they can remain symbols of achievement.

Lord Sankey's image of the *BNA Act* planting 'in Canada a living tree capable of growth and expansion within its natural limits'[105] has also provided flexibility for the interpretation of Constitutional law[106]. and the *Canadian Charter of Rights and Freedoms of 1982*. [107] However, the application of the 'living tree' approach in judicial decisions did not occur until some decades after the *Persons Case*.[108]

> From a legal perspective, the Persons Case is significant not only because it allowed women to be named to the Senate, but because it gave women's struggle for equality a legitimacy in law. It inspired future generations of women to continue to fight for their rights in the legislatures, the courts, and in all areas of society.[109]

Canadian women were finally recognised as having legal and civil personhood. Lahey points out that

104 R Sharpe, *The Living Tree* (n 58) 9.

105 *Persons Case* per Lord Sankey 106-107.

106 G Huscroft, 'The Trouble with Living Tree Interpretation (2006) 25 (1) *University of Queensland Law Journal* 3.

107 Ibid.

108 See S Reid, 'The twisted tree; how Canada's courts have misread a historic ruling, giving themselves the power to rewrite the constitution. (2012, Oct 22) 8.

109 Michelle Falardeau-Ramsay, 'Gender Equality and the Law: From the Famous Five to the New Millennium' (1999) 19 (1) *Canadian Woman Studies* 52-56.

> Without civil status ("legal personhood" or "legal personality"), people cannot access the legal process, but merely exist in the shadows of the law, subject to the whims of anyone who has more personal power, or who can invoke the power of the state to back up them up.[110]

The *Persons Case* illustrates the problematic nature of decision making which is not undertaken within a theoretical framework which promotes equivalence between persons.[111] The case provides a background to Drucilla Cornell's theory of equality or individuation which is addressed in the next section.[112]

### B Drucilla Cornell's Argument in Favour of Autonomy

The preceding discussion gives an indication of some of the constituents of autonomy. However, the definitions do not provide a theory which may be applied to practical situations which arise during pregnancy and which may threaten women's autonomy. A woman's decision to terminate her pregnancy is one situation in which her autonomy may be threatened if her wishes are not respected.[113] Similarly, her autonomy may be threatened if she refuses her consent to medical treatment and her decision is not accepted.[114] An abstract theory which is capable of practical application is of importance in explaining why pregnancy ought not to have a detrimental impact upon a woman's autonomy. The purpose of this section is to outline a framework by which to examine the practical aspects of autonomy, as addressed in the following chapters of this thesis.

One theory which provides a way in which to consider autonomy during pregnancy is that of Drucilla Cornell. On an abstract level, Cornell puts decision making in the hands of all persons without reference to sex, status, race, religion or other historically subordinated group. All persons are regarded as being equivalent. Drawing from Kant and Rawls, she explains,

110 Kathleen A Lahey, 'Legal Persons and the Charter of Rights: Gender, Race, and Sexuality in Canada (1998)77 Can. B. Rev. 402, 405 (1998).

111 Obviously, there are numerous judicial decisions which would satisfy this purpose.

112 Drucilla Cornell, *The Imaginary Domain: Abortion, Pornography and Sexual Harassment*, (Routledge, 1995).

113 Ibid.

114 See Chapter 5 – Medical Treatment – Refusal and Consent.

> The rightfulness of a law is tested by the "as if" in the following way: a rightful law is one that all citizens, regarded as free and equal, could have agreed to if they were in a position to actually consent within the general will. This contract is an idea of reason with practical effect in that it can guide legislators with a test for rightfulness.[115]

The test of whether a law or decision is 'just' is whether people who are 'free and equal', and in a position to participate, could agree with it. Not only are they to be viewed 'as if' they were free and equal, but Cornell requires that they are to decide 'as if' they did not know their situation in life and therefore they would not know how the decision might affect them. Applied to law making which impacts upon pregnant women they would need to consider how the law could impact upon this group.

A starting point is to consider what she understands by personhood. Cornell uses personhood in two different contexts. The first is the political and legal. Cornell applies Rawls' analysis that a person is 'free and equal' and a participant in public life. The test of whether legislation or a legal decision is 'just' is whether free and equal persons would agree to the passing of the legislation or the judicial decision.[116] The second idea of personhood is the concept of the self or the persona who is continuing to work on individuation or the project of becoming a person. This might be seen as developing a self-identity which is based on the right to happiness, respect, 'prohibition from degradation' and freedom.[117]

Cornell's theory is a complex of several other philosophies which she has modified so that she may provide a feminist perspective of what is means to be a person. It is noted that there are other theories, both similar and divergent, which would provide appropriate insights into the thesis questions.[118] Indeed Cornell's work ought not to be

115 Cornell, The Imaginary Domain (n 112) 12.

116 John Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press; 1971) 136-137; Drucilla Cornell, *The Imaginary Domain* (n112) 12-1 3.

117 Drucilla Cornell, *The Imaginary Domain* (n 112) 4-5; see Janice Richardson, *The Classic Social Contractarianism* (Ashgate Publishing Limited, 2009) 113-114.

118 Patricia A Cain, 'Feminism and the Limits of Equality' (1990) 24 *Georgia Law Review* 803. For examples of feminist theories see, e g, Nedelsky (n 24); Oshana (n 24); Friedman (n 24).

seen in isolation but has been developed and critiqued by eminent scholars.[119] Cornell is used as a basis here because she provides a framework which acknowledges the need to remove sexism, misogynism, patriarchy and paternalism from the operation of the law. She also attacks other forms of subordination or 'degradation' – such as racism, heterosexism, sexual harassment – using the same conceptual framework. She provides a framework which identifies the continued existence of subjugation and the need to confront the sometimes-unacknowledged viewpoints which have no place in decision making in respect of pregnant women's autonomy.

Her theory requires closer analysis to see how it might apply to pregnant women's autonomy. A starting point is the philosophy of Immanuel Kant, which Cornell adeptly reformulates, to include feminism in clarifying what it means to be an autonomous person. She then draws from other relevant philosophies such as Rawls to provide an unusual but plausible theory of equality or as she describes it, the 'project of becoming a person' or 'individuation'.[120]

The philosophical works of Kant remain highly influential in shaping contemporary philosophy, particularly 'moral philosophy'.[121] A brief summary of Kant's principle of 'moral autonomy' provides a context in which to understand how Cornell has adopted the progressive aspects of his philosophies and reworked them. The result is that she provides a philosophy which, whilst furthering the requirements of women's autonomy, does so from within a philosophical framework that promotes the needs of all persons, as having equivalent rights to self-determination.[122] This approach avoids the image of

119 Jill Marshall, *Humanity, Freedom and Feminism (Ashgate Publishing, 2005)* 73, 120–5; Susan H Williams, 'Feminism's Search for the Feminine: Essentialism, Utopianism, and Community (1990) 75 *Cornell Law Review*, 700; Karin van Marle, 'The Doubly Prized World — On Transformation, Ethical Feminism, Deconstruction and Justice' (1969) 29 *Comparative and International Law Journal of South Africa* 329, 337.

120 Cornell, *The Imaginary Domain* (n 112).

121 Richardson, *The Classic Social Contractarians* (n 117) 109, 117; Drucilla Cornell, *The Imaginary Domain (n 112*); Christine Battersby, 'Stages on Kant's Way: Aesthetics, Morality, and the Gendered Sublime', in Peggy Zeglin Brand and Carolyn Korsmeyer (ed), *Feminism and Tradition in Aesthetics* (Pennsylvania State Press 1995) 88; *Stanford Encyclopedia of Philosophy*, *Immanuel Kant* (25 January 2016) Web.

women as a special case, requiring protection. Neither is it merely appended to a male-centric and misogynist view of philosophy and autonomy as a monopoly of men.[123]

To Kant there was a fundamental relationship between autonomy and morality.[124] Strength of moral character and rationality are central to the recognition and exercise of autonomy. The failure to meet the criteria of Kant's morality, which results in the misuse, abuse or denial of autonomy, becomes important when discussing autonomy in respect of abortion and medical treatment.

Freedom is a necessary attribute of what he sees as 'moral autonomy'.[125] Kant asserts that:

> Man's freedom as a human being … can be expressed in the following formula. No-one can compel me to be happy in accordance with his conception of the welfare of others, for each may seek happiness in whatever way he sees fit, so long as he does not *infringe* upon the freedom of others to pursue a similar end … i.e. he must accord to others the same rights as he enjoys himself.[126]

122 Richardson, *The Classic Social Contractarians* (n 117) 31–44, 109–130. Cw Inder S Marwah, 'What Nature Makes of Her: Kant's Gendered Metaphysics' (2013) 28 *Hypatia* 551.

123 Arguably Cornell does not adopt an 'add women and stir' approach to applying Kant's theory. For an example of a limited recognition of women's participation in philosophy see Bix, above n 4, 67–9, who restricts his biographies to male philosophers, referring only to Catharine MacKinnon and Carol Gilligan in a somewhat limited entry on 'feminist legal theory'.

124 Kant's meaning of morality is far more broadly based than 'sexual morality', which was the focus of the 'Hart/Devlin debate' in H L A Hart, *Law Liberty and Morality* (Oxford University Press, 1963); Patrick Devlin, *The Enforcement of Morality Morals* (Oxford University Press, 1965).

125 Immanuel Kant, *The Metaphysics of Morals* (Mary J Gregor ed, Cambridge University Press, 1996).

126 Immanuel Kant, *Kant's Principles of Politics, including his essay on Perpetual Peace. A Contribution to Political Science*, trans W Hastie (Edinburgh: Clark, 1891); see also John Stuart Mill, 'On Liberty' in Mary Warnock (ed), *Utilitarianism, On Liberty, Essay on Bentham* (Fontana Press, 1962) 135.

Cornell cites Kant's definition of freedom but modifies it.[127] She replaces the word 'infringe' with that of 'degrade' and argues that by doing so she is in keeping with the 'spirit' of Kant's definition.[128] To Cornell degradation 'is the challenge to the worthiness to be happy and to be regarded as equal in one's personhood'.[129]

To Cornell the principle of 'prohibition of degradation' is more able to ensure that all persons should be entitled to self-respect and should have the equivalent opportunity to seek happiness and freedom to undertake their imaginary journey. Of importance is the correlative principle that all persons must be treated with respect.[130]

Kant's view is deontological[131] in that the only thing that gives an action moral worth is that it is based on duty and is not result driven. It is reason, based upon duty and not desire, which must motivate the action. Kant's concept of autonomy is based upon a moral strength of character in exercising choice. The autonomous person is one who is a rational being, able to be self-directional, and eschew extraneous influences associated with desire and happiness. These are the very basic tenets of Kant's 'moral autonomy'.

Kant was committed to the philosophy of enlightenment and strongly believed that people should think for themselves. In 1784 he explained that

> [e]nlightenment is man's release from his self-incurred tutelage. Tutelage is man's inability to make use of his understanding without direction from another. Self-incurred if the tutelage when its cause lies not in lack of reason but in lack of resolution and courage to use it without direction from another. *Sapere aude*! [dare to know] "have courage to use your own reason!" – that is the motto of enlightenment.[132]

Here Kant is admonishing the laziness and complacency he identifies with the person who does not think for themself. He calls for all persons to throw off the 'yoke' of

127 Drucilla Cornell, *The Imaginary Domain* (n 112) 11.

128 Ibid 11.

129 Ibid.

130 Ibid 8-10.

131 The study of duty.

132 Immanuel Kant, 'An Answer to the Question: What is Enlightenment? 1784' in Mary J McGregor, (trans Ed) *Immanuel Kant. Practical Philosophy*, (Cambridge University Press, 1996) (online).

tutelage even though it may be safer and less onerous to remain as a subordinate. To him there is no excuse for a person who has the attribute of reason not to use it.

Returning to Cornell it can be seen that she cleverly modifies Kant's conceptual framework. In doing so she avoids the debate over whether Kant's philosophy was or was not sexist and provides a framework which may be used to apply principles of equivalence without entering into polemic and sometimes vitriolic debates based upon strongly held opinions which the parties concerned are unlikely to modify. Cornell recognised that previous philosophical thought and contemporary legal thought needed re-interpretation to remedy its mistakes and reflect what it means to be a person.[133]

It is central that women, as legal persons, may use the law to recognise, enforce and protect their autonomous rights. She argues that both men and women should, as persons, have the equivalent right to their 'project of becoming a person'.[134] This is important because it establishes a need for a philosophy which is sufficiently abstract and of general applicability and which does not set down criteria which are directed towards a particular result. Both women and men have the equivalent right to imagine their bodies and bodily integrity as areas over which they have control in a free society.[135] The role of the law is to ensure that there is no interference or undue influence in individuals undertaking the project of individuation and they are free to explore their imaginary domain. Cornell notes that women cannot guarantee that the law will not change and that it is possible to lose rights.[136] However, this is a part of their project, that is, the implementation of the plan to develop into who they want to be and what they want to do. It is up to the person to decide for himself or herself and at the same time accept the consequences of his or her decision. The pregnant woman who elects to have an abortion or refuses medical treatment and later regrets the decision must accept that this is part of exercising her autonomy.

For Cornell, drawing from Kant and Rawls, the important question in assessing the validity of a law is whether 'free and equal persons' could agree to this decision'[137] Here, Cornell integrates women into the law in their capacity as persons and not as 'women'.

133 Richardson, *The Classic Social Contractarian* (n 117), 120.

134 Cornell, *The Imaginary Domain,* (n 112) 4-5.

135 See Cornell, *The Imaginary Domain*, (n 112) 231-237.

136 Ibid 28.

The question is not whether a man or a woman would agree. Important here is that when considering what free and equal people would decide it is necessary not to interpret 'free and equal' from one's particular and 'own' perspective. It will be seen that this point is integral to the analysis of the practical application Cornell's philosophy to issues of abortion, access thereto and making choices about medical treatment during pregnancy.[138]

At this stage, it is useful to explain Cornell's use of John Rawls' *Theory of Justice*. He introduced the idea of a 'veil of ignorance' to the 'as if' when law-making or making judicial decisions. A person who is positioned under a 'veil of ignorance' does not know her/his situation in life when making a decision. S/he must consider that s/he may be of any class or any position in society.[139] However, unlike Kant, Rawls ignored gender, race and class. Susan Moller Okin considered that Rawls correctly included the family 'as one of those basic social institutions that most affect the life chances if individuals and should therefore be part of the primary subject of justice'.[140] However she considered that he failed to address the importance of the gendered structure of the family and its importance to his theory of justice.

She concluded that

> [i]f Rawls were to assume throughout the construction of his theory that all human adults are participants in what goes on behind the veil of ignorance, he would have no option but to require that the family, as a major social institution affecting the life chances of individuals, be constructed in accordance with the two principles of justice.[141]

Okin considered that Rawls theory of justice would answer feminist criticisms if it were read

> in such a way as to take seriously both the notion that those behind the veil of ignorance do not know what sex they are and the requirement that the family and

137 See Cornell, *The Imaginary Domain (n 112) 12;* see discussion in Richardson, *The Classic Social Contractarians, (n 117) 109–117.*

138 Considered in Chapters 3, 4 and 5 of this Thesis.

139 Cornell, *The Imaginary Domain* (n 112) 12-13.

140 Susan Moller Okin, *Justice Gender and the Family* (Perseus Books Group, 1989) 96.

141 Ibid 97.

> the gender system , as basic social institutions , are to be subject to scrutiny, to constructive feminism criticism of these contemporary institutions follows. So, also do hidden difficulties for the application of a Rawlsian theory of justice in a gendered society.[142]

Thus, Okin using Rawls' 'veil of ignorance' would call upon those making decisions to decide 'as if' they did not know their position in society. This included that their gender and their social situation was unknown but they might be members of a gendered institution. In doing this any decision making must take into account gender,which had frequently been ignored.[143] Rawls did not include racism and gender as important in the application of the 'as if' under the 'veil of ignorance'.

Whereas Rawls uses the 'thought experiment' of the veil of ignorance to support his theory of justice, Cornell argues that the idea of what free and equal persons would do under a 'veil of ignorance', should be repeated by both judges and the legislature whenever they make a legal decision. It prompts them to consider everyone as a person with equivalent chances of self-development. These are not to be constrained by the idea that they risk having others impose upon them, decisions that are central to their own bodily integrity.

For Rawls and Cornell, objective reasoning is required in assessing the legitimacy of law. However, there is another dimension to Cornell's theory and that is the interaction between the socio-economic-political and other intrinsic and/or seemingly extraneous factors and the law. Central to this is an understanding of how sexism, stereotyping, patriarchy and paternalism have impacted upon the development of law and its operation. Why Cornell's theory is integral to the arguments in this thesis is that it precludes these attitudes from being directly used in the law and decision making.

Cornell questions Rawls' assumption that all persons have the capacity for citizenship and the abilities necessary for living together in a just society from the start. Cornell's starting point is to identify what it is that allows the development of these qualities in the first place. She focuses on how we develop the qualities of citizenship and justice.

142 Ibid 101-102.

143 Ibid.

She contends that all persons need to be given an equivalent opportunity to undertake the 'project of being a person' or at self-development.[144]

First, she identifies that all persons require an equivalent chance of self-development. This is what she identifies as the 'project of becoming a person'. This project is ongoing. Logic would suggest that the project starts at birth, that is the first interaction with other persons, develops during childhood, minority, and continues during adulthood and through the ageing process. In effect the project of becoming a person is a lifetime pursuit which is everchanging and intrinsic to the individual person. Adopting Rawls' assumption that everybody is capable of developing the qualities necessary to live in a just society ignores the inequalities endemic in society. It undermines the opportunities for some persons of having an equivalent chance to develop as a person. In other words, there must be an opportunity to undertake the project of becoming a person. It is for the state to facilitate the 'project of becoming a person'. However, the state may not interfere by prescribing what makes a good citizen. The project is an individual one, it is for the person to make the decisions.[145]

Cornell considers that women and men should be treated as equivalent persons. Therefore the decision-making process does not differentiate between men and women. Integral to Cornell's philosophy was the recognition that the substantive equality and the formal equality doctrines have not achieved what had been hoped for and that there was a need for an alternative perspective. She notes as problematic the nature of seeking 'equality' where the 'equality' is measured against the male standard. She considers that the substantive theories of equality—treating different groups differently —'re-encode the unconscious structures of gender hierarchy',[146] and 're-invests us in limited conceptions of femininity'.[147] Further, 'it undermines the full power of the appeal to equality itself by forcing us to make an appeal based on an implicit comparison with men which seeks to bring women "up to" the position of men'.[148] This lacks respect and is degrading.

144 Cornell, *The Imaginary Domain* (n 112) 17-18.

145 Ibid Chapter1.

146 Cornell, *The Imaginary Domain* (n 112) 21.

147 Ibid.

148 Ibid.

The failure of the 'substantive equality' theory is particularly obvious where there is a claim for equality for pregnant women 'because women are not like men, therefore they cannot claim that they should legally be treated like men'.[149] Similarly 'formal equality', the claim that all person should be treated the same, is no better a solution since it fails to provide for the important unique differences of women where issues of reproduction are concerned.[150]

Cornell proposed a new approach to sexual difference and equality which she called 'ethical feminism'.[151] This is a perspective which does not focus upon measuring one's worth against the 'masculine norm'. Instead, she claims that there ought to be a focus upon freedom. She calls this a project of striving for individuation (akin to autonomy) ensuring basic freedoms protected by the law, by which all people are to be valued equally and given the 'equivalent' opportunity to strive to be their own 'sexuate beings'.

Her project of equality or 'ethical feminism' requires three essential elements of protection which are required for autonomy or individuation and states:

> [t]hey are as follows: 1) bodily integrity, 2) access to symbolic forms sufficient to achieve linguistic skills permitting the differentiation of oneself from others[152], and 3) the protection of the imaginary domain itself.[153]

She begins by indicating that the meaning of familiar terms is not given and that language is contextual and fluid. In effect, this is a theme which underlies the project of becoming a person. The 'project' relies upon all those taking part rethinking the present and past by looking forward and imagining what might be.

The term 'person' is used in more than one sense.[154] Cornell stresses the importance of thinking about what it means to be a 'person'. What it is to be a 'person' should be part of the individual's 'project of becoming a person' and not defined by the liberal state. She

149 Ibid.

150 Ibid 22.

151 Ibid 4.

152 'Symbolic forms' refers to cultural symbolism (eg film, theatre, TV) associated with the achievement of linguistic skills; see Drucilla Cornell, *The Imaginary Domain* (n 112).

153 Ibid.

154 Ibid 4-5.

adopts the allegory of the masks of ancient Greek theatre[155] which exaggerated the features of the character and covered the entire face. As there were several roles and few actors (all male) it was important not to penetrate the façade created by the mask. The ironical symbolism of the mask for women and the metaphorical view of women provides a means to rethink how feminists can move beyond the equality/difference debate by focusing on freedom as understood through the 'project of becoming a person.[156] If the mask gives an image to the outside world which does not accord with the person's self then the project of the woman is 'to imagine herself as whole even if she knows that she can never truly succeed'.[157] Cornell uses the word 'persona'[158] as meaning shining through the 'mask' of 'femininity' and transcending the image which has been imposed upon women.

Thus, women ought to have 'a chance' to have freedom to achieve 'individuation' or autonomy. Importantly, the liberal state cannot guarantee 'who you can become' because to do so would be to impose the state's image of what is good upon its citizens. The liberal state's role is to preserve 'minimum conditions of individuation' and ensure freedom from interference in the project of becoming a person. That is the extent of the role of the state.[159] The state cannot be actively involved in the process of individuation to do so would be to undermine the rights of the individual and is contrary to the essence of the liberal state. However, the law may be invoked to protect the ability to undertake the 'project of becoming a person', of having an equivalent right to self-development and to prevent attempts by others to coerce or interfere in the project.

Cornell argues that all 'persons' are sexuate beings. It is important to recognise that sex has been important in the development of who we are and in how we view ourselves and others view us. It is not a free and conscious choice.

155 The two masks in the tragedy of Greek theatre have been influential in the development of drama.

156 Drucilla Cornell, *The Imaginary Domain*, (n 112).

157 Ibid 4.

158 Derived from the Latin, (plural form personae); persona is used in psychology by Jung to mean the outward social being in contrast to the inner self): Cornell, *The Imaginary Domain*, (n 112), 4.

159 Cornell, *The Imaginary Domain*, (n 112), 5.

> [T]o deny a person their life as a sexuate being, as they have imagined it … is to deny them a fundamental part of their identity.[160]

This deprives them of their chance to achieve 'their equality as sexuate beings'. The free and equal woman may be trapped behind the mask of 'femininity'. This creates difficulty because the stereotypical views of 'femininity' hinders everyone's ability to recognise women as free and equal persons. Therefore, the woman is free to imagine a 'persona' which transcends the masquerade and allows her and others to see and treat her as free and equal.

Cornell's project requires that women are to be free from the coercion that requires them to adopt a particular image of themselves and thereby deprives them of the self-respect essential for achieving equivalence.[161] Self-respect requires that the woman must be able to believe in her own worth without depending upon others. Rawls' analysis is again employed and extended to encompass women's self-respect.[162] Women must be free from degradation and humiliation in any form and in all spheres of life and being.[163] Therefore, she ought not be labelled 'a stupid woman', 'weak', 'wanton' 'a whore', 'selfish slut', 'a hysteric' or the like.[164] Just as she may not impose her beliefs upon others they should not interfere with her through the language of degradation.[165]

160 Ibid 7.

161 Ibid.

162 Ibid; see A Biscoe and G Kidson-Gerber, '"Avoidable" Death of a Pregnant Jehovah's Witness with Acute Promyelocytic Leukaemia: Ethical Considerations and the Internal Conflicts and Challenges Encountered by Practitioners' (2015) *45 Internal Medical Journal* 461.

163 John Rawls, *A Theory of Justice* (Harvard University Press, 1971) 440, quoted in Cornell, *The Imaginary Domain* (n 112) 26.

164 Bridgeman, (n 58) ; see Michael Thomson, *Reproducing Narrative: Gender, Reproduction and Law* (Ashgate, 1998) 89–93.

165 Mathew Dearnaley, 'Auckland Bar Denies Pregnant Teacher a Drink', *NZ Herald* (Auckland), 18 March 2015; Bill de Blasio and Carmelyn P Malalis, 'Legal Enforcement Guidance on Discrimination on the Basis of Pregnancy: Local Law No 78 (2013); NYC Admin Code § 8-107(22)' (NYC Commission on Human Rights, 2016); Terri Peters, 'Drinking when Pregnant: New NYC Guidelines Tell Servers Not to Discriminate', *Today* (online), 11 May 2016 .

> The only restriction on the free play of our sexual imaginary is the respect for the equal worth of others in public space demanded by the degradation prohibition. The respect we owe one another.[166]

For equality to occur the lawmakers and the judiciary are called upon to exercise their imagination and apply the 'as if' test.[167] As discussed previously, the tests of the validity of a law or a legal decision is whether people who are 'free and equal', and in a position to participate, could agree with it. Integral to the 'as if' test are the requirements of reasonableness and public reason.[168] To Cornell 'reasonableness is the "demand" that the ['as if'] test is applied in determining the "rightfulness" of the law consistent with the evaluation of each one of us as a free and equal person.'[169]

Reasonableness has been subjected to criticism, particularly by feminists. It has been criticised as being neither a normal nor an objective concept.[170] It is criticised as a socio-political construct which disadvantages women who do not measure up to the standard of 'male reasonableness' implicit within it. Feminists have argued that the reasonable man standard, in its invocation of the reasonable man, is biased against women. The fault of the standard is found in its reliance on how men, rather than women, perceive their social world.

The feminist criticism of the use of the 'reasonable man' standard may be accepted but this does not itself preclude the use of reason and reasonableness in decisions by law-makers and the judiciary. Cornell argues that the feminist suggestion that there be a 'reasonable woman standard with varying degrees of specificity'[171] is not workable. Thus there may be a proliferation of different categorisations; such as, the reasonable doctor, lawyer, sportsperson, crane operator and so forth. The list is infinite.

166 Cornell, *The Imaginary Domain* (n 112) 232.

167 Cw the 'veil of ignorance' test of Rawls discussed in Cornell, *The Imaginary Domain* (n 112) 12.

168 Ibid 14. Both Kant and Rawls used the ideas of reason and reasonable but in different ways.

169 Cornell, *The Imaginary Domain* (n 112) 13.

170 Eg, Alyssa Agostino, 'The Reasonable Woman Standard's Creation of the Reasonable Man Standard: The Ethical and Practical Implications of the Two Standards and Why They Should Be Abandoned' (2017) 41 *Journal of the Legal Profession* 339

171 Drucilla Cornell, *The Imaginary Domain* (n 112) 16.

She notes

> If the problem is the conflation of the purported universal with the masculine, the proliferation of standards – even political standards – cannot be the solution.[172]

Substituting subjective for universal standards does not make the law more just; if anything, it turns the law away from the struggle for justice by embroiling the law in a myriad of formal and doctrinal disputes about the reasonable woman, the reasonable black woman, and the reasonable LGBT etc.[173]

Cornell argues that

> [w]e must struggle to maintain the legal ideal of reasonableness, explicitly tailored by an appeal to the Kantian "as if", as the test for the rightfulness of law with the explicit demand for the equivalent evaluation of all of us as worthy of personhood.[174]

Rawls presumes that human beings have two basic moral powers – a sense of justice and a capacity for good.'[175] Cornell considers that these moral powers cannot be assumed. There is a question which must be answered before applying Rawls' theory. Her question is:

> What must a person be like to engage in practical reason?[176]

Her response is:

> They must be individuated enough to have the equivalent chance to become persons in the first place.[177]

To have the ability for justice there must be self-development which is an ongoing process which starts at birth, progresses through childhood and continues to develop during adulthood. This is the project of becoming a person. Integral to this is that the law may not be used to dictate or interfere with this project. To pass laws which prohibit abortion interfere with the project of becoming a person because they impose a

172 Ibid 16.

173 Ibid 17; Lesbian Gay Bisexual and Transgender (LGBT).

174 Ibid.

175 Ibid 17.

176 Ibid.

177 Ibid 18.

knowledge that should a woman become pregnant she will lose control over her bodily integrity because she will be forced to remain pregnant. This interferes with her project of self-development and from becoming a citizen who is just and has a capacity for good. Further no free and equal person would agree to laws that undercut a woman's 'project of becoming a person'. So, no free and equal persons could agree to anti-abortion laws that undercut their self-image of bodily integrity.

Cornell employs a concept of 'practical reason' which may be seen as having two components. First, drawing from Rawls, there must be a willingness to propose fair terms of cooperation and to abide by these, provided that others do the same. Secondly there must be a willingness by law to recognise the burdens of judgment and to accept their consequences for the use of public reason in directing the legitimate exercise of political power in a constitutional regime.[178] Lawmakers must 'accept these burdens by asking what free and equal persons would agree to'. Cornell demands that law makers and judges exercise reason. By doing so she deftly achieves a reversal of roles. Most frequently it has been the woman who has been assumed as unreasonable or unable to reason. To request that the decision maker acts reasonably requires that they must be able to justify their decision and the process by which it was reached. To do so they need to be intrinsically just.

What if the judiciary in the *Persons Case* discussed above had applied the 'as if' under a veil of ignorance? It would be hoped that they would have and interpret the law 'as if' they as free and equal persons could be affected by it.

Cornell's is not the only theory which may be applicable to the thesis questions. Of relevance also are the public health perspectives which demonstrate that a socially progressive policy which allows women a safe and timely access to abortion promotes women's autonomy and well-being. At the same time there is abundant evidence to suggest that restrictive abortion regimes do not prevent abortions.[179] Rather women will be forced to seek an abortion outside the narrow parameters of the abortion laws in the jurisdictions where they reside. The result is that their health and well-being will be

178 See Rawls (n 116).

179 EM Jackson, *Regulating reproduction law, technology and autonomy*. (Hart. 2001) 72; Anibal Faúndes and Iqbal H Shah 'Evidence supporting broader access to safe legal abortion' (2015) 131 (1) *International Journal of Gynecology & Obstetr*ics 556.

unnecessarily compromised and their autonomy undermined. The arguments based in the promotion of women's health have an appeal as being utilitarian and practical. They are also consistent with the argument that abortion ought to be regulated as a matter of women's health and not under the criminal law.[180]

## III LEGAL PERSONHOOD

### A Introduction

Central to what it means to be a person is the right to autonomy. It is important for all adult persons including pregnant women. It follows that it is necessary to identify a way in which to determine who comes within the category of legal person and who does not.

A starting point is the observation that all living human beings are legal persons. Usually this does not cause a problem. However, it is the beginning of life and the end of life which have been the subject of controversy. The broader debate over reproductive rights centres on the status of the foetus and the pregnant women. This in itself is extremely controversial and underpins the argument of the thesis. If the foetus is regarded as a person then it has autonomous rights. The pregnant woman, whilst alive, is a legal person,[181] with the equivalent rights of all persons. Even if the foetus is given legal rights how can these justify the negation of the pregnant woman's rights?

A starting point is to consider legal personhood and where the foetus fits, if at all, within the concept. A simple explanation of legal personhood is suggested by Bryant Smith, who stated that:

> [t]o be a legal person is to be the subject of rights and duties. To confer legal rights or to impose legal duties, therefore, is to confer legal personality.[182]

180 Sarah Roberts, Liza Fuentes, Nancy F Berglas, Amanda Dennis, 'A 21st-Century Public Health Approach to Abortion' (2017) 107 (2) *American Journal of Public Health* 1878; RK Jones: L Lindberg and E Witwer, 'COVID-19 Abortion Bans and Their Implications for Public Health' (2020) 52 *Perspect Sex Repro Health* 65; Nathalie Kapp et al 'A review of evidence for safe abortion care ' (2013) 88 (3) *Contraception (Stoneham*) 3503.; WA Rogers (2006). 'Feminism and public health ethics' (2006) 32 (6) Journal of medical ethics 351

181 Personhood raises questions about when life begins and ends; Jeff McMahan, *The Ethics of Killing: Problems at the Margins of Life* (Oxford University Press, 2003) 330–2.

The legal person is someone 'who may sue and/or be sued'.[183]

> In a moral or ethical sense, a 'person' is a subject endowed with free will and reason, capable of establishing its own purposes freely as well as finding means to complete them.[184]

This describes what a legal person is but does not provide the criteria for deciding who or what is or is not a legal person. It gives no indication of how the status of a foetus is to be assessed.

Establishing how personhood is acquired is central in determining the status of the foetus. The law recognises two categories of persons. They are 'natural persons' and 'artificial' persons.[185] 'Natural persons' are those human beings who are living breathing individuals. They are those whom most people think of when the word person is used. 'Artificial persons', also called 'juridical persons', refers to entities created by the law. In contrast to 'natural person', the designation 'juridical person' is used to refer to an entity that is not a human being, but for which society chooses to afford some of the same legal rights and obligations as accorded natural persons. Corporations can exercise the right to sue and be sued for example and are a good example of this category, but juridical persons may also include other entities.[186]

182 Bryant Smith, 'Legal Personality' (1928) 37 *Yale Law Journal* 283; Environmental Defenders Office of Northern Queensland, 'Legal Personality for Great Barrier Reef' (2014) 120 *Chain Reaction* 40.

183 Commonwealth, Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Litigation Report* (2015) 496.

184 Elvia Arcelia Quintana Adriano, 'The Natural Person, Legal Entity or Juridical Person and Juridical Personality' (2015) 4 *Penn State Journal of Law & International Affairs* 363, 370.

185 Companies and deceased estates are obvious examples of artificial legal persons.

186 Jessica Berg, 'Elephants and Embryos: A Proposed Framework for Legal Personhood' (2007) 59 *Hastings Law Journal* 369, 373.

The state may bestow legal personhood on anyone or anything it so decides. It may deem that animals,[187] rivers,[188] coral reefs,[189] statues, objects and even trees are legal persons.[190] It may also provide that certain people do not have legal personhood but have the status of slave, for example.

The law may provide that some humans have limited personhood. As discussed previously, women were not accorded full legal personhood rights in western society until the 20th Century.[191] The state may also withdraw the recognition of full legal personhood and the autonomy which it accords. Until the 19th Century women, upon marriage, had only 'limited' legal personality. Their civil and economic rights were denied and they were reduced to the status of servant and property of the husband.[192]

Babies are regarded as legal persons from the moment of birth. and as such fit the definition of personhood. [193] However they have limited legal capacity. By their very nature they are unable to exercise their autonomy but are dependent upon others to do this for them.[194] Usually their parents are the persons who do this but sometimes the state will assume this responsibility. The parents of a child will usually make decisions about their medical treatment during their minority.[195] Children gradually gain rights

187 David Grimm, 'Lawsuits Seek "Personhood" for Chimpanzees' (2013) 342 *Science*, 1154; David Grimm, 'Is a Dolphin a Person?' (2010) 327 *Science* 1070; Corinne Ramey, 'Chimpanzees to Get Another Day in Court', *Wall Street Journal* (New York, 15 March 2017).

188 Abigail Hutchison, 'The Whanganui River as a Legal Person' (2014) 39 *Alternative Law Journal* 179, 182.

189 Environmental Defenders Office of Northern Queensland, above n 81.

190 See Berg (n 185) 373.

191 Robert J Sharpe and Patricia I McMahon, *The Persons Case* (n 58}.

192 Judith Allen, *Sex & Secrets: Crimes Involving Australian Women Since 1880* (Oxford University Press, 1990); Catherine Bishop (n 37).

193 Jon Garthoff, 'Decomposing Legal Personhood' (2019) 154 (4) *Journal of Business Ethics* 967.

194 Heather Montgomery and Marc Cornock, 'Children's Rights in and out of the Womb' (2011) 19 (1) *The International Journal of Children's Rights*

195 See *Children and the Law: Medical Treatment* (Report) LRC103-2011) IELRC 103 (July 2011) for a detailed examination of the approaches taken by England Wales, Northern Ireland, Scotland, Canada, Australia and New Zealand.

and obligations as they develop and mature. They are considered to have full legal personhood at 18 years of age in most of the jurisdictions considered here. Although it varies as between the jurisdictions the age at which they can exercise the right to consent to or refuse medical treatment may be 16 years.[196] This will depend upon the type of treatment they seek or refuse and the jurisdiction in which they reside.[197] The closer the child is to the age of majority the more likely s/he is deemed to have capacity to refuse or consent to medical treatment.[198]

As stated above some jurisdictions have legislation which provides that once a child reaches the age of 16 s/he may consent to or refuse medical treatment.[199] Under the common law children are not presumed to have decision making capacity but may be able to make decisions if they are considered to be 'Gillick competent', which refers to the decision of the House of Lords in the UK which held that the authority of parents to make decisions for their children reduced as the minor matured.[200]

The rights of a pregnant child who wants an abortion are problematic as too are their rights in respect of refusal of or consent to medical treatment.[201] In jurisdictions where the age of capacity to make medical decisions is 16 or she is considered to be 'Gillick competent' she may obtain an abortion provided she meets the legislative criteria applying to abortions in the jurisdiction in which she resides.[202] On the other hand the

196 *Family Law Reform Act 1969* (UK) s8; *Age of Majority Act (Northern Ireland) 1969* s4; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s6; *Minors (Property and Contracts) Act 1970* (NSW) s49; *Care of Children Act 2004* (NZ) s36 and s38 (Consent to abortion).

197 See eg *X v The Sydney Children's Hospitals Network* [2013] NSWCA 320 where a person aged 17 years and 8 months refused a blood transfusion but the court considered that the interest of the state in preserving the life of the young was paramount.[60]-[61].

198 *Children and the Law: Medical Treatment* (Report) LRC103-2011) IELRC 103 (July 2011) Part B

199 Eg, *Health (Miscellaneous Provisions) Act 1911 (WA)* Section 334;; *Family Law Reform Act 1969* (UK) s8; *Age of Majority Act (Northern Ireland) 1969* s4; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s6; *Minors (Property and Contracts) Act 1970* (NSW) s49; *Care of Children Act 2004* (NZ) s36.

200 *Gillick v West Norfolk and Wisbech Area Health. Authority* [1986} AC 112.

201 See Chapter 5 – Medical Treatment Consent and Refusal.

202 See Chapter 3 – The Legal Regulation of Abortion.

law is less clear where the child is under 16 years. Girls as young as 12 become pregnant. This was the situation in *Central Queensland Hospital and Health Services v Q.*[203] Here the hospital administration would not allow an abortion to be performed on a child aged 12 without a court order. This was so even though all parties thought this was the appropriate medical treatment. Justice Meekin held that Q did not have capacity to consent and noted that there would be 'very few 12 year olds who could have the maturity to comprehend the impact of a decision' to have an abortion.[204] The court considered that an abortion was 'one procedure where the parent's consent is arguably not sufficient'.[205] Therefore it was proper to invoke the jurisdiction of the Supreme Court.[206] He decided that the termination was in Q's 'best interests' and that the abortion could be performed.[207] The case remains of some concern because it indicates that children who are pregnant must have undergo the additionally stressful experience of having the matter brought before the court. This may apply also to women who have reached the age of majority but lack capacity to consent to medical treatment.[208]

Clearly, the foetus may have rights of personhood and /or protection granted by legislation. Although the state may bestow 'juridical personality' upon whoever and whatever it sees fit, those granted artificial personhood are not 'natural persons'. Only '[h]umans are called "natural" persons because they are persons by virtue of being born, and not by legal decree'.[209] In all jurisdictions considered here, the foetus is not a 'natural person'.[210] Nor has the foetus been deemed to be a 'non-natural person'. Some

203 *Central Queensland Hospital and Health Service v Q* [2017] 1 Qd R 87; [2016] QSC 89 (24 April 2016) (McMeekin J).

204 Ibid [32].

205 Ibid [20].

206 Ibid [33].

207 Ibid [48].

208 See *QBD* [2017} QCAT 280; *QRC* [2017 QCAT 268.

209 Alexis Dyschkant, 'Legal Personhood: How We Are Getting It Wrong' [2015] *University of Illinois Law Review* 2075.

210 In Ireland there was some ambiguity as to the status of the foetus until the amendment to Article 40. 3. 3 by the *Thirty-sixth Amendment of the Constitution Act 2018*; see Chapter 3 – The Legal Termination of Pregnancy.

jurisdictions have legislated and interpreted existing law to give some rights to the foetus but they have not granted full legal personhood to the foetus.[211]

Two factors are important for the discussion of foetal 'rights' here. First, 'artificial personhood' is a legal fiction which is employed to serve the, usually collective, interests of natural persons, usually men.[212] 'Juridical personhood' is analogous to 'natural personhood' in that it relies on the use of human reasoning and requires individual or collective 'natural persons' to act as 'agents' in the exercise of its functions and protection of its rights. For example, a company is constituted by individuals, who act, not as natural persons, but in their designated capacity as a president, secretary or other role.[213]

Secondly, natural persons have greater rights and greater protection than artificial persons. According to the definition there is no such thing as a non-human natural person.[214] Important for present purposes is that natural persons have a 'right to life' whereas artificial persons do not.[215] A company may be wound up by law but the individual 'natural person' may not be murdered. Arguably, the foetus if granted 'artificial personhood' would not be guaranteed 'a right to life' and the pregnant woman's autonomy would take precedence.

In some jurisdictions there is legislation which deems the foetus to have rights of personhood. These rights may be revoked or amended by further legislation which may be more difficult if they are contained in the Constitution of a state.[216]

Under common law the foetus was not a natural person but by legislation may be considered to be a juridical person for some purposes. This again raises questions not only about how personhood is determined but why this is important. Autonomy

211 La Rev Stat Ann §§ 9:121, 9:123 (1999).

212 Katherine Hall, 'Theory, Gender and Corporate Law' (1998) 9(1) *Legal Education Review* 31; David A Matsa, and Amalia R Miller, 'Chipping Away at the Glass Ceiling: Gender Spillovers in Corporate Leadership' (2011) 101 (3) *American Economic Review* 635.

213 Dyschkant (n 208) 2082.

214 Berg (n 185) 374.

215 See eg *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948, Article 3.

216 See eg, The *Constitution of Ireland* 40.3.3. repealed by the *36th Constitutional Referendum.*

includes the right to freedom under and protection of the law. Thus there are laws which punish offences against the person, including murder and manslaughter. Only persons can commit murder or be the victim of murder or an offence against the person.[217]

Historically, a foetus became a legal person by being born alive. This meant that it could not be a victim of murder, manslaughter or assault until it was born alive. It followed that no person male or female could be convicted of a crime against it. This is seen as important for pregnant women's autonomy. It also accords with Cornell's theory whereby the imaginary journey begins at birth.[218] The pregnant woman is the legal person and it ought to follow that decisions as to what is to happen to her body are for her alone to make. Any attempt to interfere or impose decisions upon her will undermine her equivalent rights in respect of her 'project of becoming a person'[219] or, deny her access to the minimum conditions of in individuation'.[220]

Cornell argues that bestowing legal personhood upon the foetus severely threatens and prevents women from being 'autonomous persons'. To Cornell, pregnancy is unique and the foetus is an integral part of pregnancy's distinctiveness 'precisely because it exists inside the body of the woman'.[221] It should be respected and valued as part of the

217 See Sarah Field et al. *When Business Kills: the Emerging Crime of Corporate Manslaughter*. (Business Expert Press: First ed, 2018) Chapter 1: The Common Law Framework; Chapter 2: Criminal Legislation: The *Corporate Manslaughter and Corporate Homicide A*ct 2007.

218 This does not mean that experiences in the womb do not shape who the person, once born, becomes. Rather any influence may be received as part of the foetal development and experiences whilst in the womb. See David K James 'Fetal learning: A Critical Review' (2010) 19 *Infant And Child Development* 45; Marcy Martens, 'Plenty of Womb to Learn' (2013) 28 *International Journal of Childbirth Education* 73; Ravindra Arya et al, 'Maternal Music Exposure during Pregnancy Influences Neonatal Behaviour: An Open-Label Randomized Controlled Trial' [2012] *International Journal of Pediatrics* 1; Barbara S Kisilevsky and Sylvia M J Hains, 'Onset and Maturation of Fetal Heart Rate Response to the Mother's Voice over Late Gestation' (2011) 14 *Developmental Science* 214; Eva Jablonka and Marion J Lamb, 'Précis of Evolution in Four Dimensions' (2007) 30 *Behavioral and Brain Sciences* 353, 359, 377; Chantal E H Dirix et al, 'Aspects of Fetal Learning and Memory' (2009) 80 *Child Development* 1251.

219 Cornell, *The Imaginary Domain* (n 112) 4 -5.

220 Ibid.

221 Ibid 67.

woman's ability to be 'a self who projects and continuously re-imagines herself and the meaning of her embodiment.'[222] She notes that all persons have 'a shared need' ... 'to project a self-image of bodily integrity'.[223] As a result there must be 'some control over the divide between what is inside the body and out, and over what is publicly exposed' and women would be 'marked' as less than equal if they were denied this protection. [224] Women would

> be reduced to a function which is then commanded for the use of others, for the use of the anonymous other of the state which imposes its own meaning on a woman's reproductive capacity. The imposition denies women their personhood, pure and simple'.[225]

In short, the pregnant woman would become analogous to a 'foetal container' and would lose her control over both her private and public persona. If the state interferes with autonomy by removing the ability of the woman to make decisions about her medical treatment during pregnancy (including abortion) it reduces her to the status of a 'non-legal' person and analogous to a lowly hand-maiden or slave.[226] Cornell argues that:

> Since a crucial aspect of the right to project one's self as a coherent whole is control over what is exposed to the public, the woman must be allowed to make the final decision of when and how the fetus is to be taken out of her body.[227]

222 Ibid 65.

223 Ibid.

224 Ibid 65–6.

225 Ibid 66; Drucilla Cornell, 'Dismembered Selves and Wandering Wombs' in Janet Halley and Wendy Brown (eds), *Left Legalism/Left Critique* (Duke University Press, 2002) 362.

226 George J Annas, 'At Law: Pregnant Women as Fetal Containers' (1986) 16 *The Hastings Center Report* 13; Margaret Attwood, *The Handmaid's Tale* (Houghton Miffin, 1986) 'We are two-legged wombs, that's all; sacred vessels, ambulatory...' Offred, 146; Madeleine Davies, 'Margaret Atwood's Female Bodies', in Coral Ann Howells (ed), *The Cambridge Companion to Margaret Atwood* (Cambridge University Press, 2006) 58; Linda C Fentiman, 'The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children' (2006) *84 Denver University Law Review* 537.

227 Cornell, *The Imaginary Domain (*n 116), 67.

Cornell notes, however, that once the foetus is no longer within the body of the woman and is born then both the woman and the state have a duty to protect it. The relationship has changed because the neonate has a separate legal personality.[228]

The *born alive rule* provides one method of determining when a foetus becomes a legal person Dissatisfaction with the born alive rule and calls to give the foetus rights and greater protection has led to alternative an approach which is referred to here as the *foetal protection* or *foetus personhood* approach. This approach recognises the foetus as acquiring legal rights at a time earlier than birth. These two ways of considering the status of the foetus will be discussed in the next two sections, that is Section A and Section B.

### *B The Born Alive Rule*

The *born alive rule*[229] has its origins in the common law and remains the method for determining personhood in Australia,[230] the UK,[231] Canada[232] and NZ.[233] It also applies in some states of the USA.[234]

228 Ibid.

229 See Achas K Burin, 'Beyond Pragmatism defending the "Bright Line" of Birth' (2014) 22 (4) *Medical Law Review* 494, 495-496; The born alive rule has been incorporated into legislation for some purposes and in some jurisdictions, eg *Criminal Code 1900* (ACT) s 20; *Crimes Act 1900* (NSW) s 20; *Criminal Code 1899* (Qld) s292; *Crimes Consolidation Act 1935* (SA); *Criminal Code* (Tas)s 153 (4); *Criminal Code 1913* (WA) s 262; *Infant Life Preservation Act 1929* (UK) s1(1); *Congenital Disabilities (Civil Liability) Act 1976 (UK) s4; Births and Deaths Registration Act 1953* (UK) s 41; *Coroners Act (Northern Ireland 1959* S18 (a).*Criminal Code of Canada* s223 a 'human being' does not exist unless and until it has proceeded fully in a living state from the body of its mother; *Child Protection Act 1999* (Qld) 21A; *Children Young Persons and Their Families Act 1997*(Tas) s 13.

230 *R v Iby (2005) 63 NSWLR; Barrett v Coroners Court* 2010) 108 SASR 568; *Attorney – General (Qld) (Ex re Kerr) v T* (1983) 46 ALR 275, 277.

231 *Re F (In Utero)*; C v S; *Paton v British Advisory Service Trustees* [1979] QB 276, 279; *Attorney-General's Reference (No 3 of 1994)* [1998] AC 245, 261; *Kelly v Kelly* [1997] ScotCS CSIH_2 (24 May 1997).

232 *Medhurst v Medhurst*; *Tremblay v Daigle*; Ian R Kerr, 'Pregnant Women and the "Born Alive" Rule in Canada' (2000) 8 *Tort Law Review* 713.

233 *Harrild v Director of Proceedings* [2003] 3 NZLR 289.

234 Eg, see *In re Peabody* 5 NY 2d 541 (1959) 547New York Court of Appeals.

The *born alive rule* has been articulated in various forms but put simply it states that a foetus becomes a person at 'birth' upon being 'born alive'.[235] What is meant by 'birth' and 'born alive' has varied throughout time and between jurisdictions. [236]

Coke's seminal definition of murder is important in any discussion of whether the killing of a foetus could be murder or manslaughter.

> Murder is when a man of sound memory and of the age of discretion, unlawfully killeth within any county of the realm any reasonable creature *in rerum natura* [in existence} under the king's peace, with malice aforethought, either expressed by the party or implied by law.[237]

What is important to the definition of murder is that the killing or the death must have been 'intentionally' caused by a 'person' and there must be a death of a 'person', that is 'a reasonable creature *in rerum natura'*.[238] For the present it is sufficient to note that the difference between the commission of the offence of murder, or an offence not being committed,[239] is that the foetus was born alive.

James Fitzjames Stephen observed in respect of Coke's requirement of being in *rerum natura* that:

> The line must obviously be drawn either at the point at which the foetus begins to live, or at the point at which it begins to have a life independent of its mother's life, or at the point when it has completely proceeded into the world from its mother's body. It is almost equally obvious that for the purposes of defining homicide the last of these three periods is the one which it most convenient to choose. The

235 What is meant by 'birth' and 'alive' is by no means fixed as will be appreciated through a discussion of the cases in this section.

236 From around *R v Sims* (1600) Gouldsborough 176; 75 ER 1075 to the present see eg *Barrett v Coroner's Court of South Australia* (2010) 108 SASR 568 (Barrett) .

237 Edward Coke, *The Third Part of the Institutes of the Laws of England* (Printed by M Flesher for W Lee & D Pakeman, 1644) 47, emphasis added.

238 The importance of this element becomes evident when assessing the current potential for liability of the pregnant woman and has provided for a great deal of analysis as to the relationship between the woman and her foetus. The different methods of establishing the woman/foetal relationship is discussed in Part III of this chapter.

239 Where all other elements of the definition had been established.

practical importance of the distinction is that it draws the line between the offence of procuring an abortion and the offences of murder or manslaughter.[240]

Stephen considered the test was appropriate in differentiating between the degrees of societal condemnation and therefore lesser culpability of procuring an abortion and the heinous offences of murder or manslaughter.[241] The *born alive rule* became recognised and applied as a matter of practicality, in the absence of precision in medical knowledge and the practice thereof. However, although the born alive rule became entrenched under the English common law,[242] it was necessary to be able to have a way to determine whether a foetus was 'stillborn' or 'born alive'. The judgments varied over what medical evidence would satisfy the court that the baby was 'born alive'.[243]

The rule provided a convenient 'bright line'[244] which could be used in differentiating between whether an offence against a person had or had not been committed. If there was a live birth and the baby died as a result of the actions of a third party the charge could be murder or manslaughter. This would depend upon the facts and whether the element of causation had been proved. Where a third party caused injury which resulted in a stillbirth s/he was not guilty of an offence because the foetus was not a person. An offence may have been committed against the woman.[245]

The rule remains relevant to delineating whether the action of killing the foetus may be classified as abortion, child destruction[246] or murder. Criminal liability can also attract to causing injuries sustained by the foetus in the womb and who is subsequently 'born alive'.[247] Similarly, the rule has been applied to make persons civilly liable for injuries they cause to a foetus whilst in the womb and s/he is subsequently born alive. It also

240 James Fitzjames Stephen, *A History of Criminal Law of England* (MacMillan, 1883) vol 3, 2.

241 Ibid.

242 Gerard Casey, *Born Alive: The Legal Status of the Unborn Child in England and the USA* (Barry Rose Law Publishers, 2005) Ch 2.

243 D Seaborne Davies, 'Child-Killing in English Law' (1937) 1 *Modern Law Review* 203, 206–8.

244 [1992] EWCA Civ 2 (18 March 1992) Burin (n228) 498.

245 *Attorney-General's Reference (No 3 of 1994*) [1998] AC 245.

246 Or child destruction in those jurisdictions which retain this offence; see eg, *Infant Life (Preservation) Act 1929,* 19 & 20 Geo 5, c 34.

247 *R v Sims* (1600) Gouldsborough 176; 75 ER 1075.

applies for the purposes of posthumous inheritance rules.[248] The common factor here is that liability for injuries to the foetus only arise upon the 'live' birth of the foetus

The determination of whether there is a live birth has been the subject much judicial consideration and different opinions. The reason for this is that the decision on whether the born alive rule is satisfied will depend upon the facts of the case as established by the evidence. A consideration of some of the cases provide an understanding of the born alive rule's development and is useful in providing a context in which to discuss abortion and consent to medical treatment in the following chapters.

The *born alive rule* finds early expression in the oft quoted statement of Coke that:

> if the child be born alive, and dieth of the potion, battery, or other cause, this is murder; for in law it is accounted a reasonable creature, in rerum natura, when it is born alive.[249]

In 1874, in *R v Handley*[250] Brett J had to consider whether a new-born baby who was dead when it was discovered, was born alive.

He instructed the jury that

> a child was considered to have been born alive, i.e. whether it existed as a live child, that is to say, breathing and living by reason of its breathing through its own lungs alone, without deriving any of its living or power of living by or through any connection with the mother.[251]

Indications that the baby had lived included: the umbilical cord was cut; the internal organs were healthy; and the bowel, bladder and stomach were functional. The lungs indicated that the baby was alive at birth.

248 Carl Wellman, *Medical Law and Moral Rights* (Springer, 2005) 71; see also *Watt v Rama* [1972] VR 353.

249 Coke (n 220) 50.

250 *(1874) 13 Cox CC 79.*

251 Ibid; see also *R v Poulton* (1832) 5 C & P 329, evidence of breathing but not fully extruded; *R v Enoch* (1833) 5 C & P 539, breathing not sufficient and 'independent circulation' of the baby's' respiratory system required; *R v Brain* (1874) 6 C & P 349, baby must be entirely extruded but no need to have breathed.

In 1953 in Victoria the *born alive rule* was explained by Justice Barry in his often referred to charge to the jury in *R v Hutty.*[252]

> Murder can only be committed on a person who is in being, and legally a person is not in being until he or she is fully born in a living state. A baby is fully and completely born when it is completely delivered from the body of its mother and it has a separate and independent existence in the sense that it does not derive its power of living from its mother.[253]

His Horour emphasised that whether the baby had been born alive was a matter of fact for the decision of the jury. Barry J directed the jury that that this was not a case of murder but that 19-year-old Hutty could be convicted of manslaughter or infanticide. Dorothy Hutty was acquitted on all charges.[254]

In the UK signs of breathing or breathing attached to a ventilator is sufficient to satisfy the test.[255]

In 2005 in R v *Iby (Iby)*, [256] 'the defendant ... was alleged to have been driving at high speeds and dangerously'. '[T]here was a head-on collision with a vehicle driven by a 38 weeks' pregnant woman'.[257] A caesarean was performed and the baby was put on artificial respiration. Evidence indicated that his heart was beating and blood circulating. It was not certain that there was any brain activity. Nor was it clear that he had breathed independently. The machine was turned off about two hours after his birth. On trial by a judge, without a jury, it was decided as a matter of fact that the *born alive rule* had been satisfied. Iby was convicted.

On appeal, it was argued that the *born alive rule* was not satisfied because the baby had not breathed independently. The NSW Court of Criminal Appeal rejected the argument

252 [1953] VLR 338.

253 Ibid 339.

254 *Hutty* [1953] VLR 338, 342.

255 *C v S* [1987] 1 All ER 1230, 1234 (QB); see Burin (n 228)

256 *R v Iby (2005) 63 NSWLR 278; cf R (on the application of T) v HM Senior Coroner for West Yorkshire [2018] 2 WLR 211 [2017] EWCA Civ 318 focus on whether* 'breathed post-expulsion', Burnett and Irwin LJJ [11]

257 *Iby* (2005) 63 NSWLR 278.

and dismissed the appeal. The Court noted that there was no precision as to the requirements for being born alive.

> As an issue of fact, live birth can be proven by many different overt acts including crying, breathing, heartbeat, etc. The case law does not support the Appellant's contention that unassisted breathing must exist before a baby can be said to have been born alive.[258]

It was sufficient that there was any sign of independent life.[259] Spigelman CJ considered that the *born alive rule* had two discrete parts. First, 'the foetus must have completely left its mother's body (although the umbilical cord does not have to be cut)'; and, secondly, 'the child must be alive at or after birth, in that sense, had occurred'.[260]

In 2010, the Full Court of the Supreme Court of South Australia was called upon to decide whether *Iby* correctly stated the law.[261] *Barrett* was an application for judicial review of the Deputy Coroner's decision that he had jurisdiction to enquire into the death of a neonate. The court had to decide whether the case involved a 'reportable death' under the *Coroners Act 2003* (SA). To have jurisdiction it had to be established that there was the 'death of a person'.[262] A precursor to that was establishing whether there was a live person in the first place. Thus the Court had to decide whether the neonate was born alive or whether she had been stillborn.

The applicant was a midwife who assisted in a planned home birth. The pregnancy was considered a normal pregnancy and the foetus healthy but above average weight. During the birthing process the baby's head 'became entrapped' behind the woman's pelvis and complications arose. By the time she was born she had been deprived of oxygen for some time and appeared lifeless. The first attempts at getting her to breathe failed. Medical assistance arrived soon after the birth and a heart monitor was used to register

258 *Iby* (2005) 63 NSWLR 278, 285 [46] (Spigelman CJ).

259 Ibid 287 [56].

260 Ibid 283 [27].

261 *Barrett* (2010) 108 SASR 568, 570 [1] (Anderson J), 585 [75] (Peak J).

262 *Coroners Act 2003* (SA) ss 3, 21(1)(b); see *Coroners Act (Northern Ireland) 1959* s28(1)(a); *Baby L Re* [2017] *NICoroner* 11.

'pulseless electrical activity' ('PEA'). The reading gained showed that the baby had a heart rate of 15 beats per minute. The PEA was the only indication of life.[263]

Coroner's inquest held that the baby had been born alive and then died. The midwife applied for judicial review of the Coroner's decision. The Supreme Court applied the *born alive rule* broadly. It agreed that the death of the baby had been caused by acute deprivation of oxygen.

> The infant did not display at any time after separation from the mother any of the recognised signs of life such as a heart beat or pulse, breathing, moving or crying. The only possible sign of life was the PEA registered on the heart monitor.[264]

The Court noted that there was a 'public interest served by the conduct of inquests by the Coroner' and this ought to be considered in the application of the 'born alive rule'.[265] Agreeing that 'any sign of life' was the correct interpretation of the law as explained by Spegilman in *Iby* their honours held that the PEA was to be regarded as a sign of life. Therefore, the baby was born alive. The application for judicial review of the Coroner's decision was refused. An application for leave to appeal to the High Court was refused.[266]

Of interest is that originally the baby was thought to be dead. It was the practitioner who performed the autopsy who thought that the baby had been born alive. It was after making enquiries that the result of the PEA was discovered and the matter referred to the Coroner. In this case there were only minimal signs of life but they were sufficient. This would no doubt help in finding whether the baby lived or was stillborn and therefore ought to make the test relatively easy to apply.[267]

### C The Foetal Personhood and Protection Approach

Historically, the *born alive rule* was applied in the USA. In 1984 the Massachusetts Supreme Court in *Commonwealth v Cass* ('*Cass*')[268] decided that the rule was not in

263 *Barrett* (2010) 108 SASR 568, 570, [3]– [6] (Anderson J); 576–80 (White J); 602 [148] (Peek J).

264 Ibid [17] White J.

265 Ibid [40] White J.

266 *Transcript of Proceedings, Barrett v Coroner's Court of South Australia* [2011] HCA Trans 165 (10 June 2011).

267 See the UK test discussed above.

268 *Commonwealth v Cass*, 467 NE 2d 1324, 1328 (Mass Sup Ct,1984).

keeping with modern day medicine and technological advances. The Court stated that 'medical science now may provide competent proof as to whether the fetus was alive at the time of the defendant's conduct and whether his/her conduct was the cause of death'.[269] Generally, the current approach in the USA is to eschew the *born alive rule* and to consider the foetus a person both morally and legally.

The compelling interest of the state in the protection of the foetus, in its own right and as a future member of society, is well documented.[270] Eryn Correa has noted that '[b]ecause the fetus could have survived, the state's interest in preserving its life is triggered and therefore justifies a conviction' for murder.[271] One point of controversy is over the stage at which the state interest arises. This is demonstrated by the campaigns of some anti-abortion groups who argue that the foetus is alive from the time of conception, but perhaps earlier or later.[272] This view maintains that any intentional killing of the foetus is prima facie murder. Those who support this viewpoint differ, however, as to the time at which the foetus ought to be recognised as a legal person.[273]

A second point of controversy arises when delineating the persons from whom the foetus ought to be protected. It is argued here that it is not only impracticable to endow the foetus with rights against the woman but it goes against the fundamental basis of her autonomy. The USA has accorded the foetus rights under specifically enacted legislation and by interpreting existing laws to include the foetus. This may be referred to as endowing the foetus with limited personhood or granting it protection. However described, the foetus is not a person in the same sense as a person who is alive and has legal personality. In some respects the description 'foetal personhood' is misleading and

269 Ibid.

270 See Eryn Correa, 'Fetal Homicide Laws: The Utmost Protection of Reproductive Autonomy' (2014) 74 *University of Pittsburgh Law Review* 572, 578

271 Ibid.

272 The now repealed *Protection of Life During Pregnancy Act 2013* (Ire) s 2(1) from implantation; Mark Rankin, 'The Roman Catholic Church and the Foetus: A Tale of Fragility' (2007) 10 *Flinders Journal of Law Reform* 271; Marge Berer, 'Termination of Pregnancy as Emergency Obstetric Care: The Interpretation of Catholic Health Policy and the Consequences for Pregnant Women: An Analysis of the Death of Savita Halappanavar in Ireland and Similar Cases' (2013) 21 *Reproductive Health Matters* 9.

273 Under Arkansas law a foetus must be of 12 weeks' gestation to be the subject of an unlawful killing: see Correa, (n 253).

it is more appropriate to speak of foetal protection, although neither nomenclature is entirely satisfactory.[274]

The majority of states make third parties criminally liable for injuries to the foetus once it has reached a requisite stage of development. Some states also make pregnant women criminally responsible to a lesser or greater extent.[275] In addition, existing offences may be used to criminalise and control the behaviour of pregnant woman. An example of one such law is that which allows for the prosecution for child abuse. A pregnant woman who drinks alcohol during pregnancy may be subject to prosecution for 'child abuse'. Another example would be an offence of supplying alcohol to a child. Here the pregnant woman is deemed to have supplied the alcohol through the umbilical cord. Where this occurs the term 'child' is interpreted to include the foetus in the womb.[276] This is in direct contradiction to Cornell who would say that women and men have the equivalent right to their project of becoming a person. This includes their images of their own bodily integrity.[277]

The enactment of laws which give the foetus rights and which may be used to outlaw abortion interfere with a woman's right to equivalent bodily integrity. This being so the denial of access to an abortion is 'a wrong that prevents the achievement of the minimum conditions of individuation necessary for any meaningful concept of selfhood'.[278] This could also be applied to laws which are used to force pregnant women to undergo medical treatment to which they do not consent.

In 2004, the *Unborn Victims of Violence Act of 2004* ('*UVVA*') was passed by Congress.[279] It provides that a third party who killed a foetus was to be subjected to the same punishment as s/he would have been for an offence under federal law against the

274 The term protection allows for laws to be enacted to prevent injury which comes from external influences. Unfortunately it has overtones and may perpetuate the myth of the foetus being in conflict with the woman. This is difficult to resolve because the approach targets pregnant women as well as the behaviour of third parties. Eg USA law targeting women directly.

275 Michele Goodwin, 'Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront' (2014) 102 *California Law Review* 781; Fentiman (n 225).

276 Goodwin (274); Fentiman (n 225).

277 See Cornell, *The Imaginary Domain* (n 112) 35–7.

278 Ibid 33.

279 *Unborn Victims of Violence Act of 2004*, 18 USC § 1841; 10 USC § 919a (2004).

pregnant woman. It excludes the pregnant woman from liability by expressly providing that the statute shall not be construed in a manner so at 'to permit the prosecution ... of any woman with respect to her unborn child'.[280]

Most states have legislation protecting the foetus. Many of these were enacted before the *UVVA*.[281] The wording of provisions, the elements which constitute the offence, the attribution of criminal responsibility and the designated punishments provided, vary as between the states. The legislation also varies in respect of whether it applies: to third parties only; pregnant women and third parties; pregnant women only; or does not specifically restrict its operation to third parties and is capable of being interpreted to apply to pregnant women. The first type of legislation does not apply to pregnant women.[282] The second type is legislation which is the same as the *UVVA* but does not specifically exempt pregnant women from criminal liability for injuries to the foetus. The third category of legislation contains provisions which give the foetus legal rights. The fourth genre is where a range of existing legal provisions have been interpreted as applying to the foetus.

There are some 38 jurisdictions with foetal protection laws. Several of these do not contain a pregnancy exemption from criminal liability for the death of the foetus.[283] These laws have or could be used to prosecute women for abortion or even killing the foetus where she refuses medical treatment.[284] In 2014, Tennessee became the first American state to have legislation in force that allowed criminal charges to be laid against women for drug abuse during pregnancy.[285] The relevant part of the offence provided that 'a woman may be prosecuted for the illegal use of a narcotic drug while pregnant, if her child is born addicted to or harmed by the narcotic drug'. It was a defence if the woman was enrolled in a drug rehabilitation program. Shortly after the legislation came into effect, Mallory Loyola was charged with the assault of her neonate.

280 Ibid § 1841(c)(3).

281 W Derek Malcolm, 'The Unborn Victims of Violence Act: Addressing Moral Intuition and the Right to Choose' (2005) 1 *Tennessee Journal of Law and Policy* 277, 279–83.

282 This is not relevant here and therefore will not be discussed.

283 See National Conference of State Legislators, Fetal State Homicide Laws (3 April2015).

284 See Chapter 5 – Medical Treatment – Consent and Refusal.

285 Guttmacher Institute, State Policies in Brief — Substance Abuse During Pregnancy (1 May 2015).

She had tested positive for methamphetamine which she had smoked several days before giving birth. It was argued that she had not committed a crime within the meaning of the section because methamphetamine is not considered to be a narcotic. There was no evidence that she had used a narcotic and, no evidence that she had harmed her new-born baby.[286] However after nearly a month in custody, Mallory pleaded guilty to the charge and was placed on probation which was conditional upon her participation in a drug rehabilitation program. The legislation was highly criticised and a governmental decision was made to allow its expiration to take effect, resulting in its abrogation from the 1 July 2016.[287]

In 1998, the Wisconsin legislature substantially revised its child protection legislation to specifically provide for the protection of the foetus.[288] It also enables pregnant women who use alcohol and/or drugs during pregnancy to be confined for the duration of the pregnancy.[289] The statute specifically applies to the foetus from the time of conception.[290] The use of language in the legislation is significant.The legislature repeatedly employs two central terms: 'unborn child' and 'expectant mother'. A statute's language, the legislators' choice of terms, can reflect the underlying ideology that inspired the law and have a practical impact on how the policy is implemented.[291]

The provisions have been further criticised because they maintain the focus on the 'child' rather than fully recognizing and considering any other rights at stake. It is

286 Tara Culp-Ressler, 'Tennessee Arrests First Mother Under Its New Pregnancy Criminalization Law' *ThinkProgress* 11 July 2014; Tara Culp-Ressler, 'Tennessee Will Now Criminally Charge Pregnant Women Who Use Drugs' *ThinkProgress* 29 April 2014 (online); WBIR Staff & Aaron Wright, 'Mom Charged under Drug-Addicted Baby Law Going to Rehab' (5 August 2014) (online)

287 *Fetal Assault Law 2014*, SB 1391 amended Tennessee's fetal homicide law Tenn Code Ann §§ 39-13-107, 39-13-214 (2014).

288 South Dakota also enacted similar legislation in 1998 and currently some 36 USA jurisdictions have FPLs of some type, see NCSL, above n119.

289 Wis Stat § 48.133 (2013), courts were invested with 'exclusive original jurisdiction' over a foetus where the pregnant woman is an 'habitual' substance abuser.

290 Ibid.

291 Kenneth De Ville and Loretta M Kopelman De Ville, 'Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal, Wrong Remedy' (1999) 27 *Journal of Law, Medicine and Ethics* 332

difficult to envisage a situation in which 'any involuntary maternal confinement policy can be justifiably enacted,' and it would, at minimum, have to take full account of the liberty interests of the individuals confined against their will.'[292] The child abuse provisions do not meet this requirement. The woman may be required under the law to comply or else have her foetus placed under guardianship. In practical terms this would require control of the woman which would fail to respect her right to bodily integrity.

Child welfare legislation has been interpreted in a manner which punishes and controls the actions of pregnant women. Legislation enacted to enable the state to protect children who are at risk from the current situation in which they live is intended to protect children and not to punish their parents. Some legislation provides for sanctions which may result in lengthy sentences of imprisonment. One example is found in *Whitner v South Carolina*[293] where the *Children's Code of South Carolina* was interpreted as including a viable foetus. The relevant part of that section provided that:

> Any person having the legal custody of a child ... shall, without lawful excuse, refuse or neglect to provide proper care and attention, so that the life, health or comfort ... is endangered or likely to be endangered.[294]

The welfare legislation, which did not specifically apply or refer to the foetus as a 'child', was interpreted in a manner which included the foetus. The Court considered that Whitner's drug taking amounted to neglect and she was sentenced to 8 years' imprisonment.[295] Other courts have deemed the foetus to be abused and/or neglected and pregnant women have been compelled to behave in a manner directed by the court.[296]

### D *Born Alive or Personhood?*

What then may be said of the *born alive rule* and the *foetal personhood approach*, when applied in delineating the legal status of the foetus? Both of these approaches are

292 Ibid 333.

293 492 SE 2d 777 (SC Sup Ct, 1997); *cert* denied, *Whitner v South Carolina*, 523 US 1145 (1998).

294 SC Code Ann § 20-7-50 (currently § 63-7-20).

295 Chanapa Tantibanchachai, 'Whitner v. South Carolina (1997)' *Embryo Project Encyclopedia* (30 November 2014) (online).

296 See Goodwin (n274).

flawed. The *born alive rule* is subject to the criticisms that given the state of medical knowledge[297] it is anachronistic, arbitrary and fails to take account of the need to recognise the value of the foetus.[298] On the other hand many laws are arbitrary, being based on convenience and a need for clarity and precision in delineating legal responsibility.[299] In common with these, the *born alive rule* is convenient.[300] Further it is unnecessary to endow the foetus with legal personhood to make third parties responsible for injuries to the foetus.[301] This overcomes one of the problems raised by applying the *foetal personhood approach*. It is possible to extend the operation of those laws which already punish third party assaults on pregnant women.[302]

The use of the *born alive rule* can be justified because although it is arbitrary it is effective in deciding personhood and relatively easy to apply and when stated in terms, such as 'any sign of life'. The medical expertise currently available can provide reliable evidence as to what is or is not in fact, a sign of life. This facilitates the task of the jury, the judge sitting without a jury or other judicial decision maker, such as a Coroner.

297 See Elizabeth Chloe Romanis, 'Challenging the "Born Alive" Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood' (2019) 28 (1) Medical Law Review which discusses the problem of foetal operations outside the womb and then replacement of foetus back in the womb and impact of ectogenesis upon personhood.

298 Clarke Forsythe, 'Homicide of the Unborn Child: The Born Alive Rule and Other Legal Anachronisms' (1987) 21 *Valporaiso University Law Review* 563, 626; Casey (n 241); *R v Iby* (2005) 63 NSWLR 278, 284, 288 (Spigelman CJ); see *Attorney Gen Ref (No 3 of 1994)* [1998] AC 245 (Mustill LJ); cf Burin, (n 228); see Kristin Savell, 'Is the "Born Alive" Rule Outdated and Indefensible?' (2006) 28 *Sydney Law Review* 28.

299 See discussion in Pam Stewart and Anita Stuhmcke 'Legal Pragmatism and the Pre-Birth Continuum: An Absence of Unifying Principle' (2007) 15 *Journal of Law and Medicine* 272, 294–95; other arbitrary criteria may be seen in laws which provide for the time at which a person may legally drink, smoke and or gamble are based upon date of birth.

300 *Harrild v Director of Proceedings* [2003] 3 NZLR 289, 313; Burin (n 228, 495, who argues that the *born alive rule* may be justified on grounds other than convenience or pragmatism.

301 See eg, *Unborn Victims of Violence Act of 2004*, 18 USC § 1841; 10 USC § 919a (2004); *Crimes Act 1958* (Vic) s 15; *Crimes Act 1900* (NSW) s 4; Savell (n 281) 664.

302 Except for the criminalisation of abortion which is discussed in the following chapter.

There is one further theoretical aspect which applies to the analysis of women's autonomy and which is related to the *born alive rule* and the *foetal personhood approach*. In addressing the autonomy of pregnant women there is a need to consider the nature of pregnancy. The next part considers the theories which may be applied to describe the nature of pregnancy and the relationship between the woman and her foetus. It also considers the utility of the theories in promoting or impeding pregnant women's autonomy.

## IV THE NATURE OF PREGNANCY

Various paradigms are used to explain the nature of pregnancy and the connection and association between the woman and foetus.[303] The way the relationship is constructed provides a method by which to allocate or not allocate rights of personhood to the foetus. Where the relationship is used as a means of bestowing rights of personhood upon the foetus the likelihood is that access to abortion will be restrictive and that there would be greater intervention into women's decisions about medical treatment. Consequently, women's autonomous rights may be substantially diminished.

Theoretical frameworks, which promote the belief that the woman and the foetus have conflicting interests and that the woman is a threat to the foetus who is unprotected, are problematic.[304] They are to undermine women's human rights and fertile women's self-image of bodily integrity. The myth of 'woman v foetus' is contrary to the project of becoming a person [305] and fails to appreciate the true feelings of the women for the

303 John Seymour, *Fetal Welfare and the Law* (Australian Medical Association,1995); Isabel Karpin, 'Legislating the Female Body: Reproductive Technology and the Reconstructed Woman' (1992) 3 *Columbia Journal of Gender and Law* 325; Robyn Rowland, *Living Laboratories: Women and Reproductive Technologies* (Sun Books, 1992); Dworkin (n 8); John Seymour, 'A Pregnant Woman's Decision to Decline Medical Treatment: How Should the Law Respond?' (1994) 2 *Journal of Law and Medicine* 27; Laura Shanner, 'Pregnancy Intervention and Models of Maternal-Fetal Relationship: Philosophical Reflections on The Winnipeg C.F.S. Dissent' (1998) 36 *Alberta Law Review* 751.

304 Sheena Meredith, *Policing Pregnancy: The Law and Ethics of Obstetric Conflict* (Taylor & Francis, 2016).212–14; and also, 132 – 134.

305 Cornell, *The Imaginary Domain* (n 112)

future child. What is overlooked is that there are very few women who undergo an abortion without due consideration of all the factors involved.[306]

When a woman makes decisions whilst pregnant she will consider a range of factors and potential outcomes. Her choice will no doubt be influenced by being pregnant.[307] It is unlikely to be the only factor. Conflict does not arise because of this.[308] It is when another person who disapproves and/or thinks they are in a better position than the woman to make a decision that a potential conflict may arise. It is at that stage that that other person may try to intervene but they need to justify any perceived right to do so. Sheena Meredith notes that

> claims may be adversarial not necessarily because of inherent conflict between the pregnant woman and her foetus but, again, because of *conflict with those who think they know best*, and who have scant regard, in comparison, for the woman's well-being, much less her autonomy.[309]

According to Cornell's theory people are entitled to think that the pregnant woman is making the wrong decision. They are entitled to an opinion that pregnant women should not have an abortion or should or should not have a particular medical treatment. However, the right to hold an opinion does not justify a person imposing his or her beliefs upon pregnant women. To do so is to interfere with and undermine the woman's autonomy. Likewise, the pregnant woman cannot impose her opinions on others because to do so would violate their rights

As a preliminary point, it is stated that the theory of individuation as proposed by Cornell above makes any analysis of the nature of a woman/foetal relationship contextually relevant. This is because, drawing from Cornell, a pregnant woman is still a legal person who should have the right to both bodily integrity and to have an equivalent right to self-development, in common with all other persons. The pregnancy and therefore the foetus are part of the woman's ongoing project of becoming a person.

306 Action Canada for sexual and Health Rights 'Common Myths About Abortion' 7 September 2019; April L Cherry, 'The Social Construction of Maternal Deviance, and Some Thoughts About Love and Justice' (1999) 8 (2) *Texas Journal of Women and the Law* 245.

307 Meredith (n 303).

308 Meredith (n 303) 132–4, 212–14.

309 Ibid 132 (emphasis added).

This 'project of becoming a person' is undermined if the state or others impose their image, of what she should be, upon her by denying her an abortion or overriding her consent/refusal of medical treatment.[310]

Four of these approaches are broadly representative of the different perspectives: 'the tripartite analysis'; 'the choice model', 'the 'property model' and the 'pregnancy in context' position.

## A *The Tripartite Analysis*

Much academic writing uses a tripartite analysis or model in considering the relationship between the woman and her foetus.[311] The first analysis considers the woman and her foetus as one entity. Under the second they are regarded as two separate entities. The third regards them as two entities which are inseparably connected or rather as being not-one but not two entities.[312]

### *1 The Single Entity Model*

Under the single entity model the foetus is regarded as a part of the woman's body. Before the advances in medical technology it was considered that the woman and foetus were one and indivisible. The foetus was present in her body. It emerged at birth and became separate with the cutting of the umbilical cord. On this analysis the single entity is the pregnant woman and the rights of the foetus are subsumed within the rights of the woman. It would follow that she does not owe any duty not to injure what is but part of herself. Here the foetus has no legal rights. Any protection under the law is accorded by legislation which is specific to the foetus.[313]

However, the description of the foetus as a part of the woman's body is problematic. It overlooks the reasons why, as well as the way in which the foetus comes into existence. The reason for a foetus being created may be sexual. It may be for social interaction or

310 Cornell, *The Imaginary Domain* (n 112).

311 Seymour, *Fetal Welfare and the Law* (n302), 443–57; Karpin (n 302); Rowland (n 302); Dworkin (n 8); Seymour, 'A Pregnant Woman's Decision to Decline Medical Treatment' (n 302); cf Shanner (n 302) who adopts a four-model classification.

312 A similar three-part classification uses the terms 'woman-centred, fetus-centred, and woman and fetus as distinct individuals'; Shanner (n 302).

313 For example, 'child destruction' *Infant Life (Preservation) Act 1929,* 19 & 20 Geo 5, c 34 (UK) s 1; see Chapter 3 - II D of this thesis.

deliberate procreation. There may be other reasons, such as the result of rape. However, its presence in the body of the woman although not an unusual occurrence is not analogous to the existence of internal or external components of the body. It does not have and make its presence apparent. It does not contribute to the functioning of the body. It is the purpose or utility of body parts such as the heart or the limbs. It will grow and move not an unnatural growth, such as, a cancer, a tumour or a disease which may be removed or treated. Frequently, its presence is welcome. Nor, is its purpose to cause ill health to the woman. On the other hand, the woman's body does undergo change because of the development of the foetus.[314] Upon birth the relationship changes and duties arise because of the new relationship of mother and child who are now two persons.

Catharine MacKinnon has likened the status of the foetus to a parasite saying that, '[p]hysically, no body part takes so much and contributes so little. The fetus does not exist to serve the woman as her body parts do.'[315] MacKinnon points out that unlike the woman's body parts the foetus within the woman's body is temporary and finite. She concludes that the analogy between the foetus and parts of the body lacks credibility since '[n]o other body part gets up and walks away on its own eventually'.[316]

As a theory it has been criticised as too superficial to account for the complexities which occur during pregnancy and thus of little utility.[317] Nevertheless the single entity theory has an advantage in that it is clear and simple. Applying the theory the entity is the woman. The law upholds her autonomy. The rights which may be upheld are those of the woman. The woman is not held legally responsible for injuries or harms, which under this theory, are only to her own person.

Where actions of third parties injure and/or kill the foetus they may be liable for harming the pregnant woman.[318] However, the charges for which they might be

314 Susan Tucker Blackburn, M*aternal, Fetal, & Neonatal Physiology : A Clinical Perspective* (4th ed. Amsterdam: Elsevier Saunders, 2013.)

315 Catharine MacKinnon, 'Reflections on Sex Equality Under Law' (1991) *Yale Law Journal* 1281, 1314.

316 Ibid 1314–15.

317 Seymour, *Fetal Welfare and the Law* (n 302) 48–50.

318 See, eg, *Crimes Act 1958* (Vic) s 15, where an injury to a pregnant woman leading to the destruction of the foetus is defined as a 'serious injury' and therefore carries a heavier

prosecuted might not reflect their culpability. The definition of murder requires that the killing be of another person. Assaults and like offences provide that they only to apply to persons and the foetus is not a person.[319] This has occurred when women have been injured in vehicle collisions and the foetus dies whilst in the womb. The woman's grief is understandable as is her wish to see the person responsible for the death of her foetus punished. However, she may not believe that the offences prosecuted and the punishment imposed reflect the sense and extent of the loss caused by death of the foetus.[320] The theory is criticised as reinforcing the immunity of third parties who injure the foetus and undermining the pregnant woman's interest in her foetus.[321]

John Seymour concluded that the single entity theory is too limiting.

> Insistence on the view that 'there is nothing to protect' ... compels the conclusion that the fetus is not sufficiently distinctive to have interests which can be harmed, for example, by a criminal assault or by environmental pollution. In short, the single entity model lacks the flexibility to accommodate [a] range of legal problems[322]

An important reason for rejecting this theory is that it perpetuates and promotes the idea that there is woman/foetal conflict in which the foetal interests are subordinate to the woman rights of personhood. Ergo the woman is a danger to the foetus.[323]

penalty than for a lesser injury; under the *Offences Against the Person Act 1861* (UK) s 23 the foetus cannot be the victim because it is not a 'person'.

319 See *CP (A Child) v Civil Injuries Compensation Authority* [2015] QB 459, where it was decided that the foetus could not be a victim of an assault for the purposes of the *Criminal Injuries Compensation Act 1995* (UK) c 53.

320 *R v King* (2003) 59 NSWLR 472, where King kicked heavily pregnant Flick in her stomach and caused a stillbirth, this was a crime against Flick not her foetus.

321 In respect of this criticism see Nick Priaulx, 'Giving a foetus 'personhood' will have serious consequences for women' *The Conversation*, 7 November 2014 http://theconversation.com/giving-a-foetus-personhood-will-have-serious-consequences-for-women-33910 ; J Dalmau, 'An alternative to Zoe's Law' (2015) 22(3) *Journal of Law and Medicine* 698; H Robert, 'The bereavement gap: grief, human dignity and legal personhood in the debate over Zoe's law' (2014) 22 (2), 319.

322 Seymour, *Fetal Welfare and the La*w, (n 302) 49.

323 April L Cherry, 'The Social Construction of Maternal Deviance, and Some Thoughts About Love and Justice' (1999) 8 (2) *Texas Journal of Women and the Law*; see Meredith (n 303)

Cornell's approach does not rely upon a perceived relationship between the woman and foetus and does not classify it as a conflict. Her approach places the foetus in the context of a woman's project of becoming a person which requires respect but non-interference from others.[324]

### *2 The Separate Entity Model*

Advancements in medical technology, such as sonograms, and advanced treatments have played an instrumental role in the development of the separate entity theory.[325] This model regards the foetus as an entity which is separate and distinct from the pregnant woman. The woman is a person and the foetus is a distinct entity. Under the separate and divisible entities paradigm there is the potential to recognise that the foetus may have interests that can be protected by law. The consequences of this recognition may have a substantial impact upon women's autonomy.

One criticism of the separate entities model is that it emphasises and legitimises a misperception that the relationship of the pregnant woman and the foetus is essentially one of conflict. This may be used to promote the health of the foetus at the expense of the pregnant woman's autonomy.[326] It ignores the reality that the conflict, if any, is between the woman and those who would undermine her autonomy.[327]

A model which proposes that there are two separate entities assumes that one must take priority over the other. As discussed in Chapter 5 this becomes relevant when doctors decide that the foetus may be regarded as an individual patient.[328] There are

324 See Chapter 5 — Medical Treatment: Consent and Refusal.

325 Elizabeth Chloe Romanis, 'Challenging the "Born Alive" Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood' (2020) 28 (1) *Medical Law Review* 93.

326 Kate Wevers 'Recent case developments in health law: *Burton v Florida*: maternal-fetal conflicts and medical decision-making during pregnancy' (2010) 38 (2) *Journal of Law, Medicine & Ethics* 436.

327 Cherry (n 322); see Meredith (n 303) .

328 Neha A Deshpande, and Corrina M Oxford, 'Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery' (2012) 5 (3-4) *Reviews in Obstetrics and Gynecology* e144, e 147;P Desaunayet al, 'High-Risk Behaviours for the Fœtus in Pregnant Women: The Medicolegal and Judicial Aspects' (2017) 46 (5) *Journal of Gynecology Obstetrics and Human Reproduction* 431.

flow-on effects. If the right of the foetus takes precedence over the woman's autonomy, she will have greater restrictions on her autonomy solely because she is pregnant. Pregnant women may lose their rights to autonomy and individuation.[329] Decisions may be made about them as a group.

To a certain extent this is already occurring.[330] There are campaigns aimed at preventing pregnant women from conducting themselves in a way which may risk foetal health. The objective is to exercise control over and compel pregnant women to abstain from doing such things as drinking alcohol or smoking; over eating and/or eating unhealthy foods; participating in professional sport and sporting or other activities which involve risk of injury; wearing high heels and using certain beauty products.[331] If these campaigns were to be enforced by law then the suggestion that pregnant women could become analogous to incubators becomes a reality and women's autonomy is revoked during pregnancy.[332]

Strong criticism of the separate entity theory is found in the writings of MacKinnon who stated that:

> Separate fetal status ... risks further entrenchment of women's inequality ... The fetus could be given the right to the use of the pregnant woman's body from conception to birth.[333]

She develops the idea that the elevation of the foetus to the status of personhood would have extensive and adverse impacts upon all aspects of the rights of pregnant women.[334] Undoubtedly, it could result in control of her actions in every aspect her life whilst pregnant and even extend to her total reproductive rights. In addition, a most powerful

329 Cornell, *The imaginary Domain* (n 112).

330 Meredith (n 303) 132–3.

331 Helen Watt, *The Ethics of Pregnancy, Abortion and Childbirth : Exploring Moral Choices in Childbearing* (Routledge Annals of Bioethics ; 2016) 74; 'High Heels a Threat for Pregnant Women', *Belfast Telegraph* (Belfast), 15 June 2010; Rachel Wells, 'Women Drinking, Smoking in Pregnancy' *The Sydney Morning Herald (Sydney) 15* November 2011.

332 See George J Annas, 'Some Choice: Law, Medicine, and the Market' (Oxford University Press, 1998) 277; G Annas, 'At Law: Pregnant Women as Fetal Containers' (n 209) 13–14.

333 Catharine MacKinnon, *Women's Lives, Men's Laws* (Harvard University Press, 2007) 269.

334 Ibid 138–140.

sanction of society, the criminal law, may be invoked should she deviate in a manner which harms her foetus.

Seymour concludes, in respect of the separate entity theory, that:

> The ascription of rights to the fetus simultaneously generates conflict, devalues the woman and subjects her to control ... and is an inadequate conceptual tool.[335]

The separate entity model may give recognition that the foetus is something and 'not nothing'.[336] The foetus has value.[337] In many pregnancies the foetus has a very high value to the woman.[338] The recognition that the women and foetus are two entities, joined by the umbilical tube does not, however, provide a formula for decision making. It is the woman's body which must be penetrated so that 'others' can gain information and treat the foetus which remains part of the woman. It is difficult to comprehend how a description of the physiological nature of pregnancy can in itself trump the right to bodily integrity of the woman. Additionally, the theory does not justify why others are in a better position to care for the woman's foetus. Nor does it identify how this may be achieved. Whilst the foetus remains within the body of the woman they may be theoretically 'two patients' but for all practical purposes they are indivisible. That medical professionals, either implicitly or explicitly, consider they are treating 'two patients' becomes important when issues of consent to or refusal medical treatment arise.[339]

### *3 The Not-One-But-Not-Two Entities*

The third model proposes that they are indivisibly linked entities or that they are not-one-but-not-two entities. This descriptor, attributed to Karpin,[340] is frequently used in

335 John Seymour, *Fetal Welfare and the Law* (n 302) 53.

336 *Attorney-General's Reference (No 3 of 1994*) [1998] AC 245.

337 See Helen Keane, 'Foetal Personhood and Representations of the Absent Child in Pregnancy Loss Memorialization' (2009) 10 *Feminist Theory* 153, who discusses the issue of the significance of the foetus who is killed by a third party.

338 Fentiman, (n 225), 599; Guttmacher Institute, 'Unintended Pregnancy in the United States' September 2016 (online) it is noted that there is a difference between unwanted, wanted and untended pregnancy and a woman's response to becoming pregnant.

339 See Chapter 5 — Medical Treatment – Consent and Refusal.

340 See Karpin, (n 302).

academic writings.[341] This theory emphasises the 'interconnectedness' between the woman and her foetus rather than one of conflict.[342] Dworkin has emphasised the complex nature of the relationship between the woman and her foetus.

> Her fetus is not merely 'in her' as an inanimate object might be, or something alive but alien that has been transplanted into her body. It is 'of her and is her more than anyone's' because it is, more than anyone else's, her creation and her responsibility: it is alive because she has made it come alive.[343]

Building upon MacKinnon's analysis, he identifies the reasons why the pregnant woman should make decisions for herself and her foetus. The foetus, whilst being a distinct or 'unique organism'[344], is the creation of the pregnant woman. Without her the foetus would not exist, it would not develop, and it would not become a person. The woman is in the best position to assess health requirements and to make her own judgments. Who else is in a better position to understand the needs of pregnancy?

MacKinnon rightly asked: 'Why should women not make life or death decisions?'[345] Cornell provides the reason why pregnant women must be allowed to make the decisions. Applying her theory requires that everybody has an equivalent right to participate in the project of becoming a person. Bodily integrity, respect and freedom to develop in their own way is part of the project of individuation of all persons.[346] It may be added that pregnant women as equivalent persons are entitled to make decisions about medical treatment in the same way as other women and men exercise that right. This means without interference. Others may offer advice and assistance on a variety of relevant matters. However, it is only the women who can locate the advice within the context of her pregnancy, which is an inseparable part of her and her project of

341 John Seymour, 'The Legal Status of the Fetus: An International Review' (2002) 10 *Journal of Law and Medicine* 28, 55–6.

342 Karpin, (n 302).

343 Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia and Individual Freedom* (Vintage Books, 1994) 55.

344 *Attorney Gen Ref (No 3 of 1994)* [1998] AC 245.

345 Catharine MacKinnon, *Feminism Unmodified (Harvard University Press, 1987) 994*; MacKinnon, *Women's Lives, Men's Laws,* (n 216).

346 Cornell *The Imaginary Domain*, (n 112) Chapter 1.

becoming a person.[347] She may do with her body what she considers appropriate provided that she does not harm or interfere with the rights of other legal persons.[348]

### B *The 'Choice' Model*

Another model may be seen from what has been called the 'choice' model. Where a woman continues with a pregnancy she is deemed to have made a commitment to her foetus. This is said to justify intrusions upon her autonomy.[349] The reason she continues with her pregnancy is irrelevant under this model. Once she continues with a pregnancy she is obliged to continue with it.

In 1983, John Robertson argued that there was a distinction to be drawn between the women's right to procreate and her rights during the course of procreation.[350] A woman may decide not to become pregnant or may terminate a pregnancy in the early stages. However, he argues, once she continues with a pregnancy by making that 'choice' she is committed to ensuring the welfare of the foetus throughout gestation.

> Once she decides to forgo abortion and the state chooses to protect the fetus, the woman loses the liberty to act in ways that would adversely affect the fetus.[351]

Robertson argues that the commitment to pregnancy means the woman must subsume her welfare and health to the welfare of the foetus. The state is entitled to compel her to do so. Thus, she may be punished for actions which are both illegal and legal, for example, drug abuse and drinking alcohol.[352] Further she may be confined if this is in the interests of the foetus.[353]

347 Ibid.

348 Mill, *On Liberty* (n 126).

349 John A Robertson, 'Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth (1983) 69 *Virginia Law Review* 405, 438.

350 John A Robertson, 'Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth' (1983) 69 *Virginia Law Review* 405, 437–9; see also Elaine Sutherland, 'Regulation of Pregnancy' in Elaine Sutherland, Alexander McCall and John Kenyon Mason (eds), *Family Rights: Family Law and Medical Advance* (Edinburgh University Press, 1990) 105; Eike-Henner W Kluge, 'When Caesarean Section Operations Imposed by a Court Are Justified' (1988) 14 *Journal of Medical Ethics* 206, 209–10.

351 Robertson, (n 349) 437.

352 Ibid 442–3.

353 Ibid 446.

Shanner, on the other hand, argues that not having an abortion does not reflect a 'choice' to commit to pregnancy and regulation of the gestational period until birth.[354] Many women continue with an unplanned pregnancy for a variety of reasons which are unrelated to the freedom of choice. The term 'choice' may be inaccurate because it invokes the ability to have options from which to choose and a freedom in decision making. For many women, particularly those who are socio-economically or otherwise disadvantaged, there is frequently no real choice. This freedom may be undermined by the fact that a woman may not be aware of being pregnant until it was too late, or be unable, to obtain an abortion and exercise a choice.

Cornell would consider that the project of becoming a person is a continual one and therefore one which changes and evolves.[355] This is diametrically opposite to any framework which suggests that a woman must abide by a decision and cannot modify or change it as her circumstances alter. To adopt the 'choice model' would severely undermine women's freedom and bodily autonomy.[356]

### C *The Property Model*

Mary Ford has suggested that a model based upon property law concepts would empower pregnant women.[357] She recognises that it '[I]ntuitively ... may seem like an absurd or even an offensive idea'[358] but argues that a greater analysis of property law concepts disclose their flexibility and their potential for objectivity. She notes that the nature of property is an open-ended category, it being impossible to provide any exhaustive definition of property. What is classified as property is understood in conceptual terms which allows for the foetus to be property. Common to property (however described) is that it includes the relations 'between persons in respect of

354 Shanner, (n 302); Meredith, (n 303) 26–7; Rebecca Brione, 'To What Extent Does or Should a Woman's Autonomy Overrule the Interests of Her Baby? A Study of Autonomy-Related Issues in the Context of Caesarean Section' (2015) 21 *The New Bioethics* 71, 79–80.

355 Cornell, *The Imaginary Domain* (n 112).

356 Ibid.

357 Mary Ford, 'A Property Model of Pregnancy' (2005) 1 *International Journal of Law in Context* 261, 267.

358 Ibid 266.

things'.[359] This she claims avoids the instinctive initial adverse 'reaction without committing ourselves to the "awkward" definition of property as things. Rather, property consists in relationships about things'.[360]

To support her argument, she adopts the description of property used by Ocepek,[361] when referring to frozen embryos. The view of property as relationships between people has perhaps its most familiar expression in the claim that property is a 'bundle of rights'.[362] Property as a bundle of rights is a relationship between people and the rights over property as opposed to the relationship between a human being and a thing. Ford claims a relationship between the woman and foetus which is based upon the foetus as 'property', and in which the woman has an interest, can avoid the use of models which create and perpetuate the myth of the maternal/foetal conflict. The focus is diverted from the debate over whether the foetus is an entity. The analysis instead returns attention to women's ownership of their property, a foetus. Ford claims that it facilitates the court's adjudicative role without the obfuscation caused by debating the moral value of any given viewpoint. She states:

> The property model of pregnancy is not intended as an alternative to, or an end to, moral debate. The advantage of the property model is simply that it would allow courts to do the work of adjudication in the absence of moral consensus.[363]

359 Ibid.

360 Ibid 266 (emphasis omitted).

361 Brian M Ocepek, 'Heating Up the Debate Over Frozen Embryos' (1995) 4 *Journal of Pharmacy and Law* 199, 217; for the use of 'bundle of rights' as a metaphor for property see Jane B Baron, 'Rescuing the Bundle-of-Rights Metaphor in Property Law' (2013) 82 *University of Cincinnati Law Review* 57, who refers to Gregory S Alexander, *Commodity and Propriety: Competing Visions of Property in American Legal Thought, 1776–1970* (University of Chicago Press, 1997) 319 ('No expression better captures the modern legal understanding of ownership than the metaphor of property as a "bundle of rights."'); J E Penner, 'The "Bundle of Rights" Picture of Property' (1966) 43 *UCLA Law Review* 711, 712; ('The currently prevailing understanding of property in what might be called mainstream Anglo-American legal philosophy is that property is best understood as a "bundle of rights."').

362 Ford (n 356) 272.

363 Ibid 266; Mary Ford, 'The Consent Model of Pregnancy: Deadlock Undiminished' (2005) 50 McGill Law Journal 619.

Ford asserts that by classifying the foetus as property the woman has exclusive and unfettered property rights. In support of this claim she refers to the decision in *Evans v Hadley*.[364] This case involved a claim over who had the right to deal with frozen embryos. The decision that the male donor could prevent the women from using the embryos meant that there is a distinction to be drawn between the embryo before implantation and the foetus *in utero*. The difference is based upon the location of the foetus. Once it is in the body of the woman it is her property.[365]

She reaches this conclusion by noting that property rights are insignificant unless there is an ability to exercise those rights.[366] Since the unborn entity can only be accessed through her body, exercise of property rights by others would necessitate a right of trespass to the body of the pregnant woman and would be likely to involve restrictions on her right to consent or refuse medical treatment. This would represent a dramatic limitation on women's autonomy and bodily integrity sufficiently severe to constitute a loss of legal personhood.[367]

In Cornell's analysis, the trespass would undermine the pregnant woman's image of herself as having bodily integrity. She would be unable to determine what happens to her body and so her project of becoming a person is undermined.[368]

Ford uses personhood as applying to the pregnant women and the foetus is her property. It follows that as her property she makes all decision about the foetus. She has the right as against other people to bodily integrity. Other persons cannot interfere with her property rights as they might do if the foetus was accorded legal rights or legal personhood.[369]

The idea of viewing the foetus as property allows for the woman to have rights over the foetus in the same manner as she has rights over other property. The nature of these

364 *Evans v Amicus Healthcare Ltd* [2005] Fam 1; *Davis v Davis*, 842 SW 2d 588 (Tenn, 1992); *Kass v Kass*, 235 AD 2d 150 (NY Sup Ct, 1998) 696 NE 2d 174 (NY Ct App, 1998) upheld.

365 Ford, 'A Property Model of Pregnancy' (n 340).

366 Ibid.

367 Ibid 273.

368 Ibid

369 Ford (n 356).

rights may be similar to those which she has in respect of her organs, blood and other bodily parts.[370]

Applying Cornell, the property model undermines the women's image over her bodily integrity and therefore over what happens to her body and the project of becoming a person'. Both Cornell's and Ford's arguments are framed in terms of personhood. However, the meanings they give to personhood differ. To Ford personhood denotes an entity with legally enforceable rights who can sue and be sued,[371] In this context Ford is talking about legal personhood whereas Cornell is talking about 'what it is to be a person'. As discussed above Cornell's use of the term describes an ongoing process of self-development. To have her the foetus classified for her and deemed property could undermine her project of becoming a person and limiting her freedom.[372]

The law has both historically and currently been less than precise and consistent in its classification as to what is property and what is a legal person. Formerly, slaves were both property and persons depending upon whether the law was looking at their role as belonging to their master or whether they had committed a crime. For criminal acts they were liable as persons to the full punishment of the law.[373] However, the law did not protect them from their owner.

The classification of entities, as either persons or property, remains problematic and unpredictable. As Lord McCluskey has stated:

> Legal personality is a construct of the law and merely relates to a basket of rights and responsibilities recognised by the law as effeiring[374] to certain specified creatures, effeiring including man-made creatures: there are many examples in history of adult, sentient human beings being denied human status and legal personality and of limited liability companies and even of non-human animals being accorded rights and responsibilities normally appropriate only to human beings.[375]

370 Ibid.

371 Ibid.

372 Cornell, *The Imaginary Domain* (n112).

373 Casey( n 241) 211–15.

374 Meaning suitable or appropriate.

375 *Hamilton v Fife Health Board* [1993] SC 369, 383.

Overall, there would be nothing to prevent the enactment of legislation which severely inhibits the ability of pregnant women to exercise autonomous rights over the foetus irrespective of whether it is classified as 'property' or as something else. This is where Cornell's theory may assist. Her idea of personhood focuses upon the woman and not the foetus.

### D *Pregnancy in Context*

Laura Shanner has argued that 'in order to resolve the ethical and legal problems in pregnancy intervention, we must first clarify our understandings of the physical and metaphysical relationship between pregnant women and foetuses'.[376]

Kate Parsons gives a clear description of her notion of the relational model of pregnancy. She acknowledges the connectedness of the woman and foetus in the physical sense but states that there is more to the paradigm. It is possible to separate the physical actuality from the way in which she perceives her foetus on a psychological level. Her feelings in relation to her foetus and her pregnancy may fluctuate or change. Parsons emphasises the individual woman's construction of the nature, value and importance of her foetus. The model does not question whether the women is right or wrong in her conclusions about the foetus. Only the woman's assessment is relevant, and she may attach 'as little or as much emotional significance to the relationship as each woman deems fit'[377]

The value of this model is that it

> appreciates the dependence of the embryo/fetus on the woman, and the ways in which the woman and embryo/fetus are growing and developing together. But it also allows for individual variation on how each woman herself thinks and feels about her embryo/fetus.[378]

In psychological and health studies the pregnancy experience has been deemed of great significance. From this perspective, the framework of the prenatal relationship may assist in understanding why some pregnant women act to improve their health practices

376 Shanner (n 302) 752.

377 Kate Parsons, 'Feminist reflections on miscarriage, in light of abortion' (2010)3 (1) *International Journal of Feminist Approaches to Bioethics* 1, 12.

378 Ibid.

while others are reluctant to do so, and in explaining the often-puzzling behaviour and worries of drug-addicted or hospitalised pregnant women.[379]

Recognising pregnancy as a process of development and change for both the woman and foetus allows for an understanding of the woman and the manner in which she makes the many different decisions in reaction to the challenges she may encounter. The nature of the link between foetus and the woman's emotional response to her foetus will be influenced by many factors. These may include: her wish to have children; her familial status; her existing children; her socio-economic status; her race, caste and/or religion; her physical and mental health; and her career aspirations and situation. Irrespective of individual circumstances the association between the woman and her foetus is one of complexity.[380]

Women view pregnancy in a variety of ways. Van den Bergh has observed that:

> [T]he relationship with the foetus is manifested in behaviours, attitudes, thoughts and feelings that demonstrate care and commitment to the foetus, including: nurturance (eating well, abstaining from smoking and alcohol), comforting (stroking the belly), talking to the baby, physical preparation (buying baby clothes and furniture), talking to the partner about the baby and the future, choosing a name, getting information about the developing baby. t.[381]

This portrayal of pregnancy is one which indicates the anticipation of an event that may change the status of the woman socially. Not specifically articulated in this comment, but nevertheless implicit, is the importance of the overall health and other potential risks to both the woman and foetus. When talking about pregnancy it is not uncommon for women, their doctors, family, friends and acquaintances to call the foetus 'baby'. The language of pregnancy paints a hopeful picture and is frequently optimistic. It recognises the future value of the foetus as a person by according it value, during the pregnancy. Most women, whether the pregnancy is planned or unplanned, care for their

379 Bea Van den Bergh and Annelies Simons 'A Review of Scales to Measure the Mother–Foetus Relationship' (2009) 27 *Journal of Reproductive and Infant Psychology* 114, 115.

380 Judi Walsh et al, 'Maternal–Fetal Relationships and Psychological Health: Emerging Research Directions' (2013) 31 *Journal of Reproductive and Infant Psychology* 490–99; Casey above n103, 114.

381 Van den Bergh and Simons (n 378).

foetus and place a high value upon both its health and her own.[382] However, the reality is that the foetus cannot be fully appreciated as an individual person to be touched, held and socially included (or grieved when it spontaneously or therapeutically aborts) until it has emerged from the womb. In short 'birth changes the relationship between baby, mother and society'.[383]

It ought to be added that the woman who may not plan to become pregnant, but for various reasons continues with pregnancy, ought not to be labelled as not being concerned with and not protective of the foetus.[384] She will no doubt have physical connections with the foetus and emotional feelings which may be subject to constant or some change. The woman who does not value her foetus is uncommon.[385] And the woman who injures her foetus may do so whether she values her foetus or not. However, either injuring or not 'valuing' her foetus does not provide a reason to limit women's autonomy.

As discussed extensively elsewhere, the pregnant woman's behaviour may have more to do with her low socio-economic status than any wrongdoing on her behalf. Pregnancy exacerbates the disadvantages of low socioeconomic status and has been found to impair the health of both woman and foetus.[386] Gray found that:

> low socioeconomic status (SES) mothers were more likely to present with histories of cigarette smoking and insufficient weight gain during pregnancy, as well as generally poorer prenatal care than higher SES mothers. Interestingly, these peri-natal factors have been implicated in developmental disabilities, cerebral palsy, seizure disorders, and learning disabilities. Thus, one reason for the importance of socioeconomic variables in predicting developmental outcomes may

382 Keane, (n 336) where the focus upon foetal loss gives an insight into how the foetus is regarded as a developing person.

383 Burin (n 228), [21].

384 See Rebecca Stone, 'Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care' (2015) 3 *Health and Justice* 1.

385 Rebecca Traister, 'Let's Just Say It: Women Matter More than Fetuses Do' 12 November 2014. *The New Republic* (Online).

386 Jeffrey W Gray, Raymond S Dean and Ruth A Lowrie, 'Relationship Between Socioeconomic Status and Perinatal Complications' (1988) 17 *Journal of Clinical Child Psychology* 352.

relate to a potential for greater numbers of peri-natal risk factors for lower SES individuals.[387]

Drug abuse, alcohol use, smoking, depression, obesity and poverty are some behaviours and conditions which will be deleterious to pregnancy. Nevertheless, it does not follow that laws should compel women to alter their behaviour and does not justify an intrusion upon their autonomy. Pregnant women ought not to bear the blame or punished for circumstances beyond their control and better recognised as social rather than purely legal problems.[388]

Cornell requires that all persons are entitled to equivalent respect and happiness irrespective of their situation.[389]

## V SUMMARY

Part II of this chapter considered Cornell's theory of what it means to be an equivalent person who is worthy of respect and who is autonomous. The application of this theory requires that those responsible for law-making make their decisions 'as if' they were free and equal and had assumed the *veil of ignorance*. They must enquire as to what free and equal persons could agree, if given the opportunity, would agree is a just law. situations that they could be disadvantaged by the law or decision.

Part III presented the *born alive rule* and the *foetal personhood or protection* approach. Both were found to be open to criticism. However, it was argued that at present the *born alive rule* is the more appropriate way of determining when legal personhood begins.

Part IV of the chapter considered the nature of pregnancy and how it is usually conceptualised and discussed as a 'relationship' between two things rather than a sharing of a womb. The reality of what occurs is obscured by adopting fixed models.[390] Some models, at least to some extent, presented the woman and the foetus relationship as one of conflict and the woman as being a threat to the foetus who is vulnerable. Once the model is presented as identifying the need for protection of the foetus it is assumed that the next step is to override the autonomy of the woman. There is little

387 Ibid 353.

388 Eliza Duggan, 'A Velvet Hammer: The Criminalization of Motherhood and the New Maternalism' (2016) 104 *California Law Review* 1299; Goodwin (n 274).

389 Cornell, *The Imaginary Domain* (n 212).

390 This arguably does not apply to the 'not one but not two' model.

consideration of the rights of the pregnant woman as a legal person. Any interference with her bodily integrity denies the equivalent right to her project of becoming a person, as enjoyed by men. The rights of the fertile but not pregnant women are also undermined because they are forced to see themselves in a future situation in which they could be denied decision making over their bodies. The following chapters consider the areas of abortion regulation, access thereto and the right to make decisions about medical treatment.

# CHAPTER 3 THE LEGAL REGULATION OF ABORTION

## I INTRODUCTION

Chapter 2 set out the theories and principles which are relevant to autonomy during pregnancy, in particular the analysis of autonomy in the context of Cornell's amendment of Kant's conceptual framework. A decision to continue or not continue with a pregnancy is a fundamental reproductive right. Any interference with this right may be regarded as impinging upon a woman's bodily integrity or 'project of becoming a person'.[1] This chapter considers whether the principles of autonomy are recognised and applied by the laws on abortion in Australia, Britain,[2] Ireland, Northern Ireland, Canada, NZ, and the USA.

An analysis of the laws applying to abortion in the legal systems considered here reveals several things. First, although their laws have common antecedents in the English common law, the current regulation of abortion not only differs markedly between countries but may also vary as between the jurisdictions in those countries.[3] Second, although the extent to which the pregnant woman may exercise her autonomy in respect of termination varies between jurisdictions, none of these legal systems allow women to 'demand' an abortion, or guarantees access to safe legal terminations. Women's autonomy to continue with or terminate a pregnancy is the focal point of this chapter. The extent to which a woman may be able to access the medical procedure required to terminate her pregnancy is considered separately in Chapter 4 which explores the idea that the existence of a law which allows for a legal termination does not automatically result in being able to access the required medical procedure in a timely and safe

1 See *Roe v Wade,* 410 US 113 (1973) abortion is a constitutional 'right to privacy'.

2 Note that the Britain is used when discussing abortion legislation after the passing of the *Abortion Act 1967* (UK) which does not apply to NI. Where relevant NI will be treated separately. The jurisdictions which have been selected have common antecedents but have developed differently and provide varying responses to the recognition of women's autonomy.

3 Eg, Caroline de Costa et al, 'Abortion law across Australia — A Review of Nine Jurisdictions' (2015) 55 *Australian and New Zealand Journal of Obstetrics and Gynaecology 105;* Kerry Petersen, 'Abortion Laws: Comparative and Feminist Perspectives in Australia, England and the United States' (1996) 2 *Med Law International* 77.

manner or at all. There are factors other than the law which may operate to prevent a timely safe abortion being performed.

This chapter identifies the legal frameworks which regulate the provision of abortion in each jurisdiction. The origins of abortion laws and their entrenchment in the criminal law is identified as significant in perpetuating the negative attitudes to women who decide not to continue with a pregnancy. The chapter then considers the circumstances in which a termination will be unlawful or lawful, and the potential impact of the legal regulation of abortion upon the autonomy of women during pregnancy.

## II THE UNITED KINGDOM

### *A Early History and the Common Law Inheritance*

As former colonies of the British Empire the jurisdictions considered here inherited the common law tradition.[4] The common law of abortion became firmly entrenched in the criminal law legislation of the UK from the early 19th Century onwards. An analysis of these laws provides an understanding of how abortion law became located and entrenched in the criminal statutes and how it has only recently begun to be regarded in some jurisdictions as better dealt with as a health issue than a crime. The transition from abortion as a crime to abortion as legal and a part of women's autonomy is far from complete, as will be seen from the following examination.[5]

Abortion has not always been a criminal offence and was seen in early times as an appropriate means of population control.[6] Both the early common law and ecclesiastic law dealt with abortion in Anglo-Saxon times. The difference between the approaches was that the common law provided for compensation by payment whilst the ecclesiastical courts focussed upon penance as a means of spiritual redemption.[7] There is evidence to suggest that from the twelfth century to the time of the Reformation, in

4 The English common law tradition has been influential on the laws of many other countries which are not considered in this thesis.

5 Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36 (2) *Oxford Journal of Legal Studies* 334.

6 See John M Riddle, *Contraception and Abortion from the Ancient World to the Renaissance* (Harvard University Press, 1992) for a detailed history methods of birth control and its place in the development of the western world; see also Tania McIntosh, *A Social History of Maternity and Childbirth* (Routledge, 2013) 17, 24–42.

the mid 1600s, abortion was an ecclesiastical offence under the jurisdiction of the Church. Dickens writes that the ecclesiastical nature of the offence is confirmed by C Seaborne Davies who cites a treatise on Norman penal law of the 13th Century showing lay texts ignored the matter, regarding it as purely ecclesiastical.[8]

During the Middle Ages the ecclesiastical law began to view the matter far more seriously and to regard it as a capital offence. In Rome it was a capital offence but in Britain the church lacked the jurisdiction to impose that punishment.[9]

In the 13th Century Bracton wrote that 'if one strikes a pregnant woman or gives her poison in order to procure an abortion, if the foetus is already formed or quickened, especially if it is, he commits homicide'.[10] Historically, the term 'quickening' was used to indicate the time when the foetus gained a soul. It was a concept related to the mystical nature of birth and the lack of knowledge about pregnancy. The quickening is now used to signify when a pregnant woman first feels the movement of the foetus in the womb.[11] The 'quickening' was not a medical pronouncement because it was within the knowledge of the woman.[12] In what was regarded by the late Sir John Barry as an update of Bracton's work it was stated that:

> whoever shall have overlain a pregnant woman, or shall have given her drugs or blows in such a sort to procure abortion, or non-conception, after the foetus shall have already formed, and endowed with … *animatus* has committed murder.[13]

7 Gerard Casey, *Born Alive: The Legal Status of the Unborn Child in England and the USA* (Barry Rose Law Publishers, 2005) 11;

8 Bernard Dickens, *Abortion and the Law* (MacGibbon & Kee, 1966) 11–28.

9 Casey, *Born Alive* (n 7) 11.

10 Henrici de Bracton, *On the Laws and Customs of England: Of the Crown* (Travers Twiss trans, Longman 1879) 279 [trans of: *De Legibus of Consuetudinibus Anglaie: De Corona* (first published 1210–1268)].

11 Sally Sheldon, *Beyond Control: Medical Power and Abortion Law* (Pluto Press, 1997) 176; Dickens, *Abortion and the Law* (n8).

12 Julia Epstein, 'The Pregnant Imagination, Fetal Rights, and Women's Bodies: A Historical Inquiry' (1995) 7 *Yale Journal of Law and the Humanities* 139, 140.

13 John V Barry, 'The Law of Therapeutic Abortion' (1938) 3 *Medico-Legal Society of Victoria* 211, 213–14 (emphasis added: 'animatus' meaning 'endowed with a soul').

Other evidence suggests that early law considered the abortion of a viable foetus to be a serious offence, but not murder. Abortion after the 'quickening'[14] appears to be the criterion for a criminal law offence before 1803. Coke and Blackstone considered a woman would be guilty of an offence when the abortion occurred once she was 'quicke with childe'.[15] The medical knowledge of women's physiology and pregnancy was very limited. It was difficult to establish whether or not the woman had in fact been pregnant. Abortions under the common law abortion was not homicide. Rather it was a 'great misprision'[16] or a 'heinous misdemeanour'.[17]

### *B The Acts of 1803, 1828 and 1837*

The first statute criminalising abortion was *Lord Ellenborough's Act 1803 ('1803 Act').* From that time on, abortion was a very serious offence but not murder. Any doubts about the crime of abortion applying only after the woman was 'quicke with childe' were clearly resolved. The offence was committed irrespective of the stage of pregnancy.[18] The impetus for the offence of abortion is suggested in the Act's title which states that it is '[a]n act for ... the malicious using of means to procure the miscarriage of women; ... to prevent the destroying and murdering of bastard children'.[19]

Judith Orr claims that throughout history

14 'Life… begins in contemplation of law as soon as an infant is able to stir in the mother's womb': William Blackstone*, Commentaries on the Laws of England* (Clarendon Press, 1765), vol 1, 25.

15 William Blackstone*, Commentaries on the Laws of England* (Clarendon Press, 1765).

16 Edward Coke*, The Third Part of the Institutes of the Laws of England* (Printed by M Flesher for W Lee & D Pakeman, 1644.

17 Ibid

18 Judith Orr, *Abortion war: The fight for reproductive rights* (Bristol University Press, Policy Press, 2017) 49.

19 *Also known as the Malicious Shooting Act of 1803* (UK), *Stabbing Act of 1803* (UK), and the *Miscarriage of Women Act of 1803* (UK); for a discussion of the early history of abortion law see Barry (n13), 212–217; Louis Waller, 'The Tracy Maund Memorial Lecture: Any Reasonable Creature in Being' (1987) 13 *Monash University Law Review* 37; Judith Orr, *Abortion wars : The fight for reproductive rights* (Bristol University Press, Policy Press, 2017) 49 – 51; *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8, 11; [1986] QDC 011 (Mc Guire J).

> [a]bortion was an everyday reality as women tried to avoid constant childbearing, and conditions even pushed to infanticide when all else failed.[20]

By modern standards the *1803 Act* was extremely severe. The death penalty was imposed for administering 'any deadly poison, or other noxious and destructive substance or thing' with intent to procure the miscarriage of 'any woman, then being quicke with childe'.[21] Where the women was not or not proved 'quicke with childe' the punishment was a fine, imprisonment for up to 14 years, being placed in the public pillory, public or private whipping and/or transportation. The methods of abortion are analogous to current modern abortions in that they included 'medical abortion' or ingestion of a poison or substance to induce an abortion[22] and 'surgical abortion' which used ordinary household implements such as 'tea kettles, spoons',[23] 'a syringe and lysol'[24] and 'crochet and knitting needles'[25]to induce an abortion.[26] The use of domestic items and remedies evidence the normality of abortion in women's lives and 'their desire to manage their reproductive lives and health'.[27]

On the other hand, the legislation indicates that abortions were carried out for the purposes of escaping detection of behaviour deemed immoral and threatening to society. It also recognises that women were prepared to undergo unsafe and illegal

20 Orr (n 18), 48

21 *1803 Act* s I; See Orr (n 18) 285.

22 Cara Delay, 'Kitchens and Kettles: Domestic Spaces, Ordinary Things, and Female Networks in Irish Abortion History, 1922-1949' (2018) 30 (4) *Journal of Women's History* 11, 22-24: The use of household items in and normality of abortion was common throughout history.

23 Ibid 16.

24 Ibid 22.

25 Ibid 23-24; Orr (n 18) 49 – 51.

26 The term '*medical abortion'* is used in different ways in the law and literature. It may be used to include surgical abortion or abortion through the ingestion of medicine or other abortifacients. RU-486 is used here as a shorthand for abortion pills such as *Mifepristone* and *Misoprostol*.

27 Delay (n 22) 16; See Orr (n18) especially 'Chapter 3: Abortion as old as Humanity' and John M Riddle, *Contraception and Abortion from the Ancient World to the Renaissance* (Harvard University Press, 1992) the practice of birth control, including abortion, since ancient times has continued irrespective of regulation by the state.

abortion to avoid pregnancy. The scathing condemnation of abortion in the *1803 Act* reflected the contemporary attitudes to women. Single women who sought abortions were regarded as whores. Married women were expected to conform to the role of wife and mother.[28] Women at that time lacked autonomy being subject to the control and authority of their husband or father.[29]

The *Offences against the Person Act 1828*, (*'1828 Act'*) also known as *Lord Lansdowne's Act* repealed the *1803 Act*. Abortion remained a capital felony if the woman was 'quicke with childe'. Where the woman was not proved to be 'quicke with childe' the punishment was transportation for a period of seven to fourteen years, with or without hard labour, or imprisonment for up to three years. If the offender was male, he was liable to public or private whipping in addition to imprisonment. Section 13 of the *1828 Act* extended the prohibition on post quickening abortion to include attempts involving 'any instrument or other means whatsoever'.

The *Offences Against the Person Act of 1837* was passed to consolidate and amend the existing criminal law relating to offences against the person.[30] There are two matters worthy of note here: first, unlike the 1803 and 1828 Acts, no mention is made of the

28 Michele Adams, 'Women's Rights and Wedding Bells: 19th-Century Pro-Family Rhetoric and (Re)Enforcement of the Gender Status Quo' (2007) 28 *Journal of Family Issues* 501, 504–5.

29 Other areas where the law saw the woman as subordinate included: a married woman could not own property in her own right; a married woman did not need to consent to sexual intercourse with her husband; and, her husband could discipline her 'with a birch no thicker than his thumb' but not with 'a pestle' … or 'iron bar', see Giles Jacob, *The Laws of Appeal and Murder* (GALE Lincoln Inn, 1719) 38; T Davidson, 'Wifebeating: A Recurring Phenomenon throughout History' in Maria Roy (ed), *Battered Women: A Psychosociological Study of Domestic Violence* (Van Nostrand Reinhold, 1977); John William Edwards and William Frederick Hamilton, *Law of Husband and Wife: With Separate Chapters upon Settlements and the Married Women's Property Act 1882* (Butterworths, 1883) 2; William H Cord, *Treatise on the Legal and Equitable Rights of Married Women; As Well in Respect to Their Property and Persons as to Their Children* (Kay and Brother, 1861) c 1;Orr (n 18), 49 states that this was the first time abortion before the quickening was illegal.

30 *Offences Against the Person Act of 1837, 7 Will 4 & 1 Vict, c 85,* s XIII.

quickening or the non-quickening distinction; and secondly, the death penalty was removed as a sentencing option for the offence of abortion.[31]

### *C The Offences Against the Person Act of 1861*

In 1861 legislation was enacted to bring the crimes against the person under a single piece of legislation. The *Offences Against the Person Act 1861 (OAP Act 1861)* was extremely influential in the development of the laws of abortion in all jurisdictions considered here, except for the USA. Section 58 of the *OAP Act 1861* provided:

> Every Woman, being with Child, who, with Intent to procure her own Miscarriage, shall unlawfully administer to herself any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, and whosever, with Intent to procure the Miscarriage of any Woman, whether she be or be not with Child, shall unlawfully administer to her or cause to be taken by her any Poison or other noxious Thing, or shall unlawfully use any Instrument or other Means whatsoever with the like Intent, shall be guilty of Felony, and being convicted thereof shall be liable, at the Discretion of the Court, to be kept in Penal Servitude for Life, or for any Term not less than Three years,—or to be imprisoned for any Term not exceeding Two Years, with or without Hard Labour, and with or without Solitary Confinement.

Section 59 provided:

> Whosever shall unlawfully supply or procure any Poison or other noxious Thing, or any Instrument or Thing whatsoever, knowing that the same is intended to be unlawfully used or employed with Intent to procure the Miscarriage of any Woman, whether she be or be not with Child, shall be guilty of a Misdemeanour, and being convicted thereof shall be liable, at the Discretion of the Court, to be kept in Penal Servitude for the Term of Three Years, or to be imprisoned for any Term not exceeding Two Years, with or without Hard Labour.

These sections could be interpreted as prohibiting all abortion. They made a woman or other person liable of an offence whether or not the woman was pregnant. There was no definition of the state of being 'with child'. A reading of the section could mean at conception or some later time. The word 'unlawful' was ambiguous. On one level it could

31 Ibid s VI.

be used to emphasise the wrongfulness of abortion.[32] Or it could be interpreted, as it was during the 20th century, to connote that some abortions would be lawful.[33] The sections have played an important role in the regulation of abortion and they continue to apply in England, Scotland and Wales.[34] where unlawful abortions remain criminal under the *OAP Act 1861*.[35]

### *D The Infant Life (Preservation) Act 1929*

In 1929, the *Infant Life (Preservation) Act 1929 (ILP Act 1929)* was enacted due to concern over the difficulty of establishing whether a child had been killed at birth or before. If a child was born alive and then killed the crime charged could be murder or manslaughter depending on the intent of the defendant. The problem as perceived was one of proof. The death of a neonate was usually discovered some time after the birth. A claim that the baby was stillborn, though easily stated was difficult to refute. The Act was passed to overcome the perceived problem.[36]

Section 1 (1) creates an offence of 'child destruction'. A person who intentionally kills a foetus 'capable of being born alive' is liable to a maximum penalty of life imprisonment.[37] Section 2 provides that where the charge is abortion but the evidence shows that the foetus was 'capable of being born alive', the jury may convict under section 1(1).[38] Where the person has been charged with the offence of child destruction the jury may bring in a verdict of guilty of 'abortion'.[39]

32 *OAP Act 1861* s58-s59.

33 See *R v Bourne* [1939] 1KB 687; *R v Davidson* [1969] VR 667; *R v Wald* [1971] 3 DCR (NSW) 25; *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8.

34 And elsewhere, see eg, rt III Australia where most jurisdictions have decriminalised abortion except when it performed by persons other than medical practitioners or the woman herself..

35 *Abortion Act 1967* (UK).

36 United Kingdom, *Parliamentary Debates*, House of Lords, 22 November 1928, vol 269, cols 70 (Lord Darling), 270–2 (Lord Atkin), 275–8 (Lord Hailsham LC).

37 '[A]ny person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life.'

38 *ILP Act 1929,* s 2(2), the penalty is life imprisonment.

39 *Ibid* s 2(3).

The need for the crime of child destruction was questioned at, and since, the time of its enactment.[40] The provision is problematic in that the words 'child capable of being born alive' are arguably redundant given the expressed reason for the passing of the legislation was to protect the foetus during the birthing process.[41] The inclusion of the phrase has led to the criticism that instead of restricting the section to criminal liability for acts which cause death during the birthing process there is the potential for the section to be used in respect of abortions at both the later and earlier stages of gestation. The enquiry thus centres upon what is meant by 'capable of being born alive'. The inclusion of the presumption that a child was viable at 28 weeks' gestation did not provide a complete answer.[42] This is because the presumption is rebuttable and thus did not preclude the section being applied to an earlier stage of pregnancy. The offence potentially made pregnancies terminated at any stage 'child destruction'. Rankin has asserted that:

> an otherwise lawful medical abortion performed on a foetus that, if fully born, would show any sign of life, even for an instant, may constitute the offence of child destruction. As to how many otherwise lawful medical abortions may be caught by the offence of child destruction so enunciated, one must first determine how early in a pregnancy a foetus might be described as a child capable of being born alive.

40 See United Kingdom, *Parliamentary Debates*, House of Lords, 22 November 1928, vol 269, cols 70 (Lord Darling), 270–2 (Lord Atkin), 275–8 (Lord Hailsham LC); see also Waller (n 19) 41; I J Keown, 'The Scope of the Offence of Child Destruction' (1988) 104 *Law Quarterly Review* 120, 120; Mark J Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion' (2013) 35 *Sydney Law Review* 1.

41 All Australian jurisdictions except NSW enacted similar offences, see *Crimes Act 1900* (ACT) s 42; *Criminal Code* (NT) s 170; *Criminal Code* (Qld) s 313; *Criminal Law Consolidation Act 1935* (SA) s 82A(7); *Criminal Code* (Tas) s 165; *Crimes Act 1958* (Vic) s 10(2); *Criminal Code* (WA) s 290. In 2008, Victoria abrogated the offence of chid destruction (*Abortion Law Reform Act 2008* (Vic) s 9), and in 2013 Tasmania did likewise (*Reproductive Health (Access to Terminations) Act 2013* (Tas) s 14(g)); see Mark Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion'(2013) 35 *Sydney Law Review* 1, 3.

42 *Infant Life (Preservation) Act 1929, 19 & 20 Geo 5, c 34,* s 1(2).

> In other words, at what stage of gestation is a foetus likely to show any sign of life if fully born?[43]

Prosecutions for child destruction were not forthcoming and the courts were not called upon to interpret the phrase 'capable of being born' until more than fifty years after the passing of the legislation. By this time attitudes to abortion had markedly changed, the *Abortion Act 1967* provided that some abortions were legal. Abortions were the readily available.

*In re C v S*[44] and *Rance v Mid Downs Health Authority)*[45] the courts were called upon to interpret the phrase in the context of an application to restrain a woman from having an abortion. In both cases the Courts rejected the argument that the phrase could be interpreted as applying at any time once the foetus is 'viable'[46] and defined it in a manner which was consistent with the reasons for enacting the legislation, that is, the killing of the foetus during birth.

The *ILP Act* although not enforced reaffirmed perceived public disapprobation of abortion. However, the result was not that women ceased to have termination procedures. On the contrary, 'backstreet abortions' flourished.[47] There was much concern for the safety of women and there were calls for a clarification of the abortion laws.[48] Sally Sheldon has pointed out that sections 58 and 59 of the *OAP Act 1861* were extremely broad in that they 'contained no time limit, made no distinction between abortions early and late in pregnancy and contained no explicit exception for therapeutic abortion'.[49]

43 Rankin, 'Child Destruction' (n 40),20.

44 *C v S [1988] QB 135, 147);* cf *Roe v Wade*, 410 US 113 (1973).

45 *Rance v Mid Downs Health Authority* [1991] 1QB 587; cf *Roe v Wade*, 410 US 113 (1973).

46 *C v S [1988] QB 135,* 151 (Donaldson MR); *Rance v Mid Downs Health Authority* [1991] 1QB 587.

47 Bernard Dickens, *Abortion and the Law,* (n 8) 73–89.

48 Sally Sheldon, *Beyond Control* (n 11).

49 Ibid 21–24.

### *E R v Bourne*

In 1938, *R v Bourne ('Bourne')*[50] brought the risk posed by 'backstreet abortions' to women's health and safety to public attention when MacNaghten J was called upon to interpret the abortion laws. His ruling resulted in the easing of abortion laws in the United Kingdom and subsequently in other jurisdictions.[51]

In *Bourne,*[52] a fourteen-year-old girl had been brutally raped and became pregnant. Mr Aleck Bourne, an eminent obstetrician performed an abortion on the girl and was charged with using an instrument with the intent to procure a miscarriage.[53] His defence argued that the abortion was not unlawful because the inclusion of 'unlawful' in the section indicated that some abortions could be lawfully performed. The Trial Judge, MacNaghten J analysed the law and its problems in some depth. Since that time, his summing-up and directions to the jury have been used to interpret similar provisions.

MacNaghten J considered that s 1 of the *ILP Act1929* was relevant to interpreting the offence charged. He acknowledged that the offence created by the section was one of 'child destruction' rather than the offence of 'abortion' under s 58 of the *OAP Act 1861*. However, he considered that the proviso, in the *ILP ACT,*[54] that the Crown must prove that the act was not done in good faith and not done to preserve the life of the mother, had always been the common law. He opined that the word 'unlawful' was 'not meaningless'.[55] Unlawfully, was included to show that the offence of procuring a miscarriage was qualified by a similar proviso as that contained in the *ILP Act*.[56]

His Honour considered definition of 'preserving the life of the mother' problematic. His approach was to take a 'reasonable view of the words'.[57] The words did not mean that the woman's death must be imminent. He considered that if the doctor forms an opinion

50 *[1939] 1 KB 687.*

51 See, eg, *R v Davidson* [1969] VR 667.

52 *[1939] 1 KB 687.*

53 *OAPA 1861,* s 58.

54 *Section 1(1): Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.'*

55 *Bourne* [1939] 1KB 687, 691.

56 Ibid.

57 Ibid 692.

based 'on reasonable grounds and with adequate knowledge that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck' the doctor may be regarded as having acted 'lawfully'.[58] Thus a defence was provided for the doctor but women's autonomy was not recognised. It was not until 1967 that there was legislative reform of abortion law.[59]

### *F The Abortion Act 1967 and Beyond*

The *Abortion Act* lessened the rigidity of the law.[60] Under the Act an abortion is lawful where two medical practitioners agreed that the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or existing children or her family, greater than if the pregnancy were terminated;[61] or, that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.[62] Originally the section was silent as to the time up until which lawful abortions could be performed.[63] The *Abortion Act 1967* currently provides that lawful abortions may be performed up until the 24th week of gestation. After that time an abortion will be only lawful where 'it is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman' or 'a substantial risk' that the child would be born with a severe foetal abnormality.[64]

58 Ibid.

59 *Abortion Act 1967* (UK) c 87; see Bernard Dickens, *Abortion and the Law* (n 8) 73–89, 107–71; Judith Orr, *Abortion wars: The fight for reproductive rights* Chapter 4 -An Act of Liberation 67-81 (Bristol University Press 2017) for a good analysis of the passing of the Act, its impact and on women's autonomy; Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79 (2) *Modern Law Review* 283, 285 –289

60 This Act applies to England, Wales and Scotland but not Northern Ireland.

61 *Abortion Act 1967* (UK) c 87, s 1(2).

62 *Ibid* s 1(3).

63 'Capable of being born alive' was 28 weeks or more: *Infant Life (Preservation) Act 1929, 19 & 20 Geo 5, c 34,* s 1; the *Human Fertilisation Act and Embryology Act 1990 (UK) c 37, s 37(1)(4)* lowered the time to 24 weeks; see *C v S [1988] QB 135*, 151–2 in which Heilbron J stated that at 18-22 weeks a foetus was not capable of being born alive.

64 Section 1 of the *Abortion Act 1967* (UK) c 87 now reads:

when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—

### *G Conclusion*

Overall, it may be concluded that the English law allows abortions in some but not all circumstances.[65] It does not represent an entitlement to an abortion on demand. This is despite the general perception that an abortion is relatively easy to obtain in England.[66] The current law provides a degree of certainty which allows for the medical profession to be confident that they are acting lawfully so long as they comply with the legislation.[67]

> a that the pregnancy has not exceeded its twenty-fourth week 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; or
> b that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
> c that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
> d that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
> 2 In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (*a*) or (b) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.
> 1.3 Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital …
> 1.4 Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

65 Ibid

66 Fiona Bloomer and Kellie O'Dowd, 'Restricted Access to Abortion in the Republic of Ireland and Northern Ireland: Exploring Abortion Tourism and Barriers to Legal Reform' (2014) 16 *Culture, Health and Sexuality* 366; Ann Furedi, 'The UK Abortion Anomaly That Can No Longer Be Ignored' (2014) 348 *British Medical Journal* 3610; Andrea Mulligan, 'The Right to Travel for Abortion Services: A Case Study in Irish 'Cross-Border

However, the law does not recognise the woman as a fully autonomous person. Sally Sheldon correctly observes.

> The law clearly aims to protect medical autonomy and discretion rather than grant substantive rights to the woman, ... the regime introduced by the Abortion Act offers the qualified doctor (and only derivatively his patient) a valid defence against the crime of unlawful procurement of miscarriage.[68]

Her criticism equally applies to *Bourne* [69] and to some of the laws of abortion in the other jurisdictions discussed later in this chapter.[70] There are several factors which indicate that women in England, Wales and Scotland do not have full autonomy in making the decision not to continue with a pregnancy.

First, the law delegated decision making to the medical profession. The woman is not empowered to make decisions. She must convince the medical professionals that she meets the statutory criteria of the *Abortion Act 1967*. Her medical record will provide those details of her health which satisfied the criteria of the Act. It may state that she is either physically or mentally unwell and is unable to cope with the pregnancy. Where the record is accurate then there is not a problem. However, if to meet the requirements she has provided misinformation to the diagnostic questions, her medical record will be inaccurate and untrue.[71]. If she does not lie and the doctor performs the abortion both the doctor and the woman will be denied the operation of section 1 of the Abortion Act 1967 and will have committed an criminal offence against the *OAP Act 1861*. Alternatively the doctor may refuse to perform the abortion.

Although abortions are considered to be readily available the practice of abortion is closely regulated and those involved in their provision are given guidelines and

Reproductive Care' (2015) 22 *European Journal of Health Law* 239, 240, 260; Abortion Statistics, England and Wales: 2013 (Department of Health, 2014).

67 Sally Sheldon, 'Subject Only to the Attitude of the Surgeon Concerned: The Judicial Protection of Medical Discretion' (1996) 5 *Social and Legal Studies* 95, 99.

68 Sheldon, *Beyond Control* (n 11).

69 *Above Part II– E.*

70 Below Part III, IV and VI.

71 Emily Jackson, 'Abortion, Autonomy and Prenatal Diagnosis'. (2000) 9 (4) *Social & Legal Studies*9, no. 467

instructions which warn of the consequences of them not following both the law and any directions.[72]

The procedures the woman must comply with under the *Abortion Act 1967* do not respect her nor do they respect her ability to make decisions about her medical treatment and her freedom to exercise her autonomy as equivalent to all legal persons.

The requirement that both medical and surgical abortions must take place in an approved facility proved an unnecessary burden in many situations.[73] A 'medical termination' requires the ingestion of two abortifacients at different times.[74] Originally a woman was required to take both pills at the 'approved facility'. The first taken is mifepristone and the second is misoprostol taken 24 to 48 hours later. [75] This was inconvenient for many because it required two visits. Some women had to travel some distance and/or some found it difficult to attend because of childcare, work or other regular commitments.[76]

There were other problems as well. The British Society of Abortion Care Providers (BSACP) explained that

> [t]he cramps and bleeding triggered by misoprostol usually start about 1–2 hours after administration, however they may start sooner. This means that some women begin to expel the pregnancy, or completely expel the pregnancy, whilst

72 Sexual Health Policy Team, 'Guidance in Relation to Requirements of the *Abortion Act 1967*: for all those responsible for commissioning, providing and managing service provision' Public Health Directorate, Department of Health, May 2014.

73 *Abortion Act 1967* s 1 (4).

74 The section was enacted, before RU-486 became available, to apply to surgical abortions which require that the woman attend an approved facility. Research and medical opinion maintain It is safe for most women to have a medical abortion at home, or elsewhere if she so wishes and there are nearby medical facilities if something should go wrong; see Sally Sheldon, 'Empowerment and Privacy? Home Use of Abortion Pills in the Republic of Ireland' (2018) 43 (4) *Signs: Journal of Women in Culture and Society* 823; Sally Sheldon, 'British Abortion Law: Speaking from the Past to Govern the Future' (2016) 79 (2) *Modern Law Review* 283, 283 – 285.

75 *Abortion Act 1967 (UK)* c 87, s 1(4); *Part II – E*.

76 *British Pregnancy Advisory Service v Secretary of State for Health* [2011] EWHC (Admin)

travelling home. This is undoubtedly a distressing experience, and one that does not need to occur given the proven safety of administering misoprostol at home.[77]

In 2001 *British Pregnancy Advisory Service v Secretary of State for Health*[78] had made an application to allow misoprostol to be self-administered at home for early medical abortions. It was unsuccessful but the Mr Justice Supperstone did note that the amendment in 1991[79] authorised

> the Secretary of State to react to further changes in medical science… [and] to approve a wider range of place, including potentially the home, and the conditions on which such approval may be given relating to the particular medicine and the manner of its administration or use.[80]

In 2018 it became lawful for women to take the second abortion pill in their home which became 'an approved place for the purposes of the *Abortion Act 1967*.[81]

It was argued that this amendment did not go far enough and it is questioned why the woman could not take both pills in her home. There were calls to remove the requirement that 'medical terminations' are carried out at a prescribed facility.[82]

In April 2020 it was announced that both abortion pills could be legally taken at home. The change is not permanent but is only to remain in effect until the expiry of the *Coronavirus Act 2020* which is two years after its enactment. Allowing women to self-

77 Adams, Amy, 'Abortion in the 21st Century: Home Administration of Misoprostol in Early Medical Abortion' *British Society of Abortion Care Providers*, 29 April 2018.

78 [2011] EWHC 235 (Admin).

79 See *Abortion Act 1967* s 1 (3A).

80 *British Pregnancy Advisory Service v Secretary of State for Health* [2011] EWHC (Admin) [32].

81 News story, 'Government confirms plans to approve the home-use of early abortion pills; Women in England will be allowed to take the second of 2 early medical abortion pills in their own home'; Department of Health and Social Care 25 August 2018; Unknown 'Abortion pill can be taken at home in England, under new plan' BBC News, 25 August 2018.

82 See Sheldon, *Beyond Control*, (n 11) Chapter 7, 124, for the background of RU-486 in the UK; see Michael Thomson, *Reproducing Narrative: Gender, Reproduction and Law* (Ashgate, 1998) for an analysis of the viewpoints of those supporting the *Abortion Act 1967* (UK) (c 87 ch 3, ss 63–85) and the manner in which they stereotyped women, Chapter 4, 87-114.9.

administer the abortion pills is a good step but it is only one step towards women being accorded equivalence. The next step would be to allow for the woman to obtain the pill over the counter or by a means which may ensure quality control. It would be a retrograde development to make women return to a situation where one pill is taken at a clinic and only the second may be taken at home.

It is more than 50 years since the passing of the *Abortion Act 1967.* There is a need for further reform which completely removes abortion from the criminal law[83] and regulates it as a routine health matter.[84] The location of abortion in *OAP Act 1861* is archaic especially when placed in a global context[85] and compared with reforms that have taken place elsewhere.

## III AUSTRALIA

### *A Introduction*[86]

Under the *Australian Constitution*[87] the law making power is divided between the Federal Government, which was given jurisdiction over specific matters relating to the

83 Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36 (2) *Oxford Journal of Legal Studies* 334.

84 Sally Sheldon, 'Abortion Law Reform in Victoria: Lessons for the UK' (2017) 43 (1) *The Journal of Family Planning and Reproductive Health Care* 25; 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; See also Sheldon, 'British Abortion Law'( n 59).

85 Women's autonomy over their body and their reproductive rights has become an important global issue as well as an intranational issue. See Fiona Bloomer, Claire Pierson, and Sylvia Estrada Claudio. 'Criminalisation' in Reimagining Global Abortion Politics: A Social Justice Perspective 11-30. (Bristol: Bristol University Press, 2019) 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.

86 For an overview of abortion laws in Australia, prior to the Qld reform in 2018 and the NSW reform in 2019, see Caroline de Costa et al, 'Abortion Law Across Australia — A Review of Nine Jurisdictions' (2015) 55 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 105; E Mulligan and Mary Heath, 'Abortion in the Shadow of the Criminal Law? The Case of South Australia' (2016) 37(1) *Adelaide Law Review* [41]-[68].

87 *Commonwealth of Australia Constitution Act 1900 (Imp) 63 & 64 Vict, c 12, s 9.*

governing of the country, and the states.[88] At Federation nearly all residual powers of legislation remained with the states.[89] Criminal law was not granted as an exclusive power to the Commonwealth and so remained with the states.[90] Since abortion was within the existing purview of the criminal law at Federation, it remained within the jurisdiction of the states.[91]

The Federal Government, has an indirect but effective influence upon the access to abortion.[92] This has been through exercising its powers over the provision of funding for termination procedures and the importation of drugs including RU-486.[93] The influence over abortion access at Federal level is discussed in the next chapter.[94]

The origins of the laws of abortion in Australia may be traced to the *OAP Act 1861*. As such the laws of the states were originally located in the criminal law and were particularly draconian. [95] However, at no stage were the laws identical as between the

88 The states or former colonies New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia retained their constitutions.

89 Colin Howard, *Australian Federal Constitutional Law* (Law Book, 3rd ed, 1985) 2–3.

90 The Commonwealth has a *Criminal Code* which covers crimes against federal law. Although there are some matters where there are both Federal and State/Territorial crimes the Commonwealth has not legislated on abortion. This does not mean that the Commonwealth has not had an influence abortion laws.

91 The six states are completely autonomous. The Commonwealth has authority to repeal legislation enacted by the Northern Territory and the Australian Capital Territory.

92 Australia's national health insurance fund which provides some benefits for all Australian residents and some visitors. Private health insurance is also available to supplement the public scheme; see Mariette Brennan, 'The Good, the Bad and the Unhealthy: An Assessment of Australia's Compliance with the International Right to Health' (2015) 39 (2) *University of Western Australia* 373, 375-389.

93 *Therapeutic Goods Administration Act 1989* (Cth); see Chapter 4 — Access to Medical Treatment, which looks at the role of the Federal Government in preventing the RU-486 pill from being generally available to Australian women who wished to terminate pregnancies until 2012; see Leslie Cannold, 'RU486: A Win For Women and Choice' *The Drum* 31 August 2012 (online).

94 The word 'states' here is used to includes the Northern Territory and the ACT unless otherwise specified.

95 The abortion laws under *Criminal Code* (Qld) ss 224–226 and *Crimes Act 1900 (*NSW) ss 82–84 remained in force, although they had not retained the very harsh penalties of the

states and legislative enactments occurred at different times. What is consistent in the history of abortion laws throughout Australia is that abortion although an offence did not prevent women from having abortions.[96] This meant that abortions were performed in secret usually by backyard abortionists[97] or by unethical and insufficiently skilled doctors who saw a way to make money by charging excessive amounts for their services.[98] There is disagreement about the qualifications of those labelled as 'backyard' abortionists. There were some skilful lay 'midwives' who were not trained nor registered nor recognised by the medical profession but who were often more skilled than many registered doctors. The doctors were becoming a cohesive group and becoming a profession and were working towards a medical monopoly over pregnancy. This made it advantageous to discredit the lay midwives by labelling them as 'quacks' and calling them by derogatory terms.[99]

Problematic for Australia has been the lack of uniformity in the law. Despite a trend to law reform undertaken or proposed in all jurisdiction there remains a likelihood that some inconsistencies will remain.[100] The consideration of the abortion laws in Australia considers the jurisdictions which have actively sought to reform abortion laws and to remove them from the criminal law. They are the Australian Capital Territory, Victoria,

original laws, until they were repealed in 2018 and 2019, respectively. See *Abortion Law Reform Act 2019* (NSW).

96 Victorian Law Reform Commission, *Law of Abortion: Final Report*, Report No 15 (2008) Appendix A: History of Abortion Law Policy.

97 E Millar, *Feminism, Foetocentrism, and the Politics of Abortion Choice in 1970s Australia* in S Stettner (ed) *Transcending Borders* (Palgrave Macmillan, 2017).

98 Judith Allen, *Sex and Secrets: Crimes Involving Australian Women Since 18*80 (Melbourne: Oxford UP, 1990): 96-107, 158-67, 200-17; Gideon Haigh, *The Racket: How Abortion Became Legal in Australia* (Melbourne University Publishing, 2008).

99 Barbara Baird, '"The incompetent, barbarous old lady round the corner": The image of the backyard abortionist in pro-abortion politics' (1996) 22 (1*) Hecate* St Lucia 7.

100 Unfortunately there has been little success in achieving uniform criminal law or codes for Australia; see Greg Taylor, 'The Victorian Criminal Code' (2004) 23 *U Queensland LJ* 170; Andrew Hemming, 'Why Bentham's Vision of a Comprehensive Criminal Code Remains Viable and Desirable as the Model Design for a Code' (2012) 14 *U Notre Dame Austl L Rev* 125; A Loughnan, '"The Very Foundations of any System of Criminal Justice": Criminal Responsibility in the Australian Model Criminal Code'(2017) 6 (3) *International Journal for Crime, Justice and Social Democracy* 8.

Tasmania, the Northern Territory, Queensland and New South Wales whose regimes are intended to be minimally intrusive in women's decisions to terminate pregnancy.[101] The laws attempt to implement a policy that the decision not to continue with a pregnancy is a health one and for the woman in consultation with her doctor. In these jurisdictions[102] it is no longer 'the function of the [criminal] law to intervene in the private lives of citizens, or to seek to enforce any pattern of behaviour'[103]

### *B The Australian Capital Territory*

In 2002, the Australian Capital Territory (ACT) decriminalised abortion.[104] Mr Berry MP in presenting the Bill made it clear that its purpose was to allow a woman to make a choice about whether to have an abortion 'free of sanctions'.[105] Abortion is currently regulated under the *Health Act 1993* (ACT) and is neither a crime at common law, nor under the *Crimes Act 1900* (ACT).[106] Abortion is regulated in the same manner as other medical procedures. The meaning of 'abortion' includes a 'medical abortion', that is the administration of a drug, as well as surgical abortion.[107] Section 81 provides that a 'doctor' must prescribe supply and/or administer the abortifacient. However, in practice the meaning of 'doctor' includes a registered and authorised nurse practitioner who has been accredited to perform this service. Since the introduction of national regulation and accreditation of the health professions the designation of the person authorised to carry out a particular health service must be assessed according to that person's

101 For recent law reform see the *Termination of Pregnancy Reform Act 2017* (NT), which came into force on 2 July 2017; *Abortion Law Reform Act 2019* (NSW).

102 SA & WA are not included here as, it is probable that they will enact legislation in the near future. For a good overview of the laws see Caroline de Costa et al, 'Abortion Law across Australia — A Review of Nine Jurisdictions' (2015) 55 *Australian and New Zealand Journal of Obstetrics and Gynaecology 105.*

103 This quote whilst made in the context of other crimes of morality is apt here; Committee on Homosexual Offences and Prostitution, *Report of the Committee on Homosexual Offences and Prostitution*, Reference HO 345/1 (1857) 19.

104 *Crimes (Abolition of the Offence of Abortion) Act 2002* (ACT); *Medical Practitioners (Maternal Health) Amendment Act 2002* (ACT); *Health Act 1993* (ACT).

105 Mr Berry, Legislative Assembly for the ACT: 2002 Week 1 Hansard (12 December) 105-108, 107.

106 *Crimes (Abolition of the Offence of Abortion) Act 2002* (ACT) s 3.

107 *Health Act 1993* (ACT) s 80.

qualifications as well their professional title. If a person is not registered and authorised an offence is committed which is punishable by imprisonment of up to 5 years.[108] A surgical abortion must be performed by a 'doctor'[109] and the procedure must take place at an approved facility. [110] If the person performing the abortion is not a registered medical practitioner within the meaning of *Health Act 1993* (ACT) a criminal offence is committed, punishable by imprisonment of up to 5 years.[111]

The decriminalising of abortion, in contrast with the *Abortion Act 1969* (UK), recognises the pregnant woman's right to be treated as equivalent. In not legislating gestational limits after which an abortion cannot be legally performed there is a greater opportunity for the pregnant women to exercise her right to equivalence with all other persons making decisions about medical treatment. The reasons for this were identified by Mr Berry in presenting the reforms to the ACT Parliament. First most abortions occur in the earlier stages of pregnancy and the number decreases significantly close to full gestation.[112]

There are some features of the reform which fall short of giving women unfettered autonomy. The provisions as presently framed reinforce the monopoly of the medical profession, including accredited nurses and midwives as the sole providers of abortion.[113] A woman may request a termination but the medical professional, (including a nurse practitioner, midwife or pharmacist when authorised in respect of a

108 Ibid s 81; *Legislation Act 2001* (ACT) s 2 (definition of 'doctor'); *Health Professionals National Regulation Act (Act) 2010* (ACT); *Health Professionals National Regulation(Act)* (ACT) s5; Medicines, Poisons and Therapeutic Act 2007 (ACT).

109 Ibid s 82, the maximum penalty for this offence is imprisonment 5 years.

110 *Ibid* s 83, the maximum penalty is 50 penalty units or 6 months imprisonment or both; *Legislation Act 2001* (ACT) s 133(1): penalty unit equal a monetary amount; *Legislation Act 2001* (ACT) s 133(2): $150 = 1 penalty unit (individuals); *Sentencing Act 1991* (Vic) ss 109–110: $100 = 1 penalty unit; *Penalty Units and Other Penalties Act 1987* (Tas) ss 4–4A: 1 penalty unit in 2015 = $154 and is indexed each year; see *Penalties and Sentences Act 1992* (Qld) ss 5–5A for the meaning and differing amounts of penalty units.

111 *Health Act 1993* (ACT) s 81;

112 Mr Berry, Legislative Assembly for the ACT: 2002 Week 1 Hansard (12 December) 105-108, 107.

113 L Mainey, C O'Mullan, K Reid-Searl, ATaylor and K Baird ' The role of nurses and midwives in the provision of abortion care: A scoping review. J Clin Nurs. 2020; 29: 1513– 152

medical abortion) decide whether to accede to the request. This is indicated by the inclusion of the right to refuse medical services where the professional has a conscientious objection [114]

The second reason for concluding that that the law in the ACT does not recognise the right of the woman to complete autonomy over her body is indicated by the retention of the crime of child destruction which adopts the phrase 'prevents the child from being born alive' in the *Crimes Act 1900* (ACT).[115] As in England and Wales the offence is criticised as being a potential way of criminalising late-term abortions.[116] This was not the professed intention of the legal reforms in the ACT. Nevertheless, the offence was deliberately retained as a criminal offence because they rarely occur.[117] This would seem to provide a reason for repeal rather than retention of the offence. The repeal of this law would be in keeping with the abrogation of the 'child destruction' in Victoria[118] and a call for consistency in the laws of Australia.[119]

114 Health Act 1993 (ACT) s84; Mark J Rankin, 'Recent Developments in Australian Abortion Law: Tasmania and the Australian Capital Territory' (2003) 29 *Monash University Law Review* 316, 333; Rebekah Yeaun Lee, Rebekah Moles and Betty Chaar, 'Mifepristone (RU486) in Australian Pharmacies: The Ethical and Practical Challenges' (2015) 91 *Contraception* 25.

115 *Crimes Act 1900* (ACT) s 42; Mark J Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion' (2013) 35(1) *Sydney Law Review* 1, 2, 4-6.

116 Mark J Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion' (2013) 35(1) *Sydney Law Review* 1, 4; Emma Cave, *The Mother of All Crimes: Human Rights, Criminalization, and the Child Born Alive* (Ashgate, 2004) 72-74.

117 See Berry 107. He also seemed to think that women and their doctors would be unlikely to decide that an abortion was appropriate at that stage.

118 *Abortion Law Reform Act 2008* (Vic) s 9; NSW has never had an offence of 'child destruction'.

119 Caroline M de Costa and Heather Douglas, 'Abortion Law in Australia: It's Time for National Consistency and Decriminalisation' (2015) 203 *Medical Journal of Australia* 349, 350.

### *C Victoria*

#### *1 Pre-Reform*

Prior to 2008 abortion was criminal, punishable by up to 10 years gaol, under the *Crimes Act 1958* (Vic)[120] which closely resembled the provisions in the *OAP Act 1861*. Child destruction was included as a criminal offence in 1949.[121] It was similar to the *Infant Life (Preservation) Act 1929.*[122] Of significant difference was the inclusion of the word 'unlawfully' and the omission of a statutory defence such as that contained the English legislation on child destruction. As noted above the English provision on child destruction did not include the word 'unlawfully'.

As in England, there had been little attention to the meaning of the term 'unlawful' in respect of abortion. Prosecutions of unqualified practitioners, although not numerous, were those which most usually came before the court.[123]

Sir John Barry noted in 1938 shortly after the trial of Dr Bourne that the direction given by the judge was not binding upon a Victorian court.[124] He conceded that the principles of *Bourne* probably applied to the practice of abortion in Victoria. Nevertheless, there was a high degree of uncertainty amongst medical professionals and many were reluctant to perform abortions. Therefore the practice of illegal abortions remained prevalent as did the dangers they posed to women's health.[125]

120 *Crimes Act 1958* (Vic) ss 65–66.

121 *Crimes Act 1949* (Vic) s 5.

122 *Infant Life (Preservation) Act 1929, 19 & 20 Geo 5, c 34,s1 (1).*

123 Judith A Allen, *Sex & Secrets: Crimes Involving Australian Women Since 1880* (Oxford University Press, 1990) 101–3; Caroline de Costa, Heather Douglas and Kirsten Black, 'Making it Legal: Abortion Providers' Knowledge and Use of Abortion Law in New South Wales and Queensland' (2013) 53 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 184; Mark Rankin, 'The Disappearing Crime of Abortion and the Recognition of a Woman's Right to Abortion: Discerning a Trend in Australian Abortion Law?' (2011) 13(2) *Flinders Law Journal* 1, 10; Mary Heath and Ea Mulligan, 'Abortion in the Shadow of the Criminal Law: The Case of South Australia' (2016) 37 Adelaide Law Review 41; Ronli Sifris, 'The Legal and Factual Status of Abortion in Australia' (2013) 38 *Alternative Law Journal* 108, 111; *R v Trim* [1943] VLR 109; *R v Brown* [1949] VLR 177; *R v Salika* VR 272.

124 Barry (n 13), 227.

The issue of 'unlawful' abortion, finally, came before the Victorian Supreme Court in 1969 in *R v Davidson ('Davidson')*.[126] Dr Davidson was charged with *unlawfully* using an instrument to procure a miscarriage and an offence of conspiracy under s 65 of the *Crimes Act 1958* (Vic). During the trial Menhennit J delivered his subsequently influential ruling on the element of 'unlawfulness'. He noted that the inclusion of the term 'unlawful' in the section implied that there were circumstances when an abortion would be lawful. His Honour referred to *Bourne* as the only relevant judicial interpretation of 'unlawfully' of which he had knowledge.[127] He stated however, that *Bourne* was decided upon a proviso and that the Victorian law did not contain such a proviso.[128] Thus he concluded that the meaning of 'unlawfulness' must be determined according to the principles of 'necessity' and 'proportionality'.[129]

He said, 'necessity is the appropriate principle to apply to determine whether a therapeutic abortion is lawful or unlawful'[130] and then outlined the principles of what constituted the defence of necessity. The defendant had to hold an honest belief, based upon reasonable grounds, that her/his act was necessary 'to preserve the woman from a serious danger'. The danger included serious risks to 'physical and mental health' which needed to be more than those normally experienced in 'pregnancy and childbirth'.[131] The actions needed to be proportionate to danger to the woman. [132] The doctor was acquitted.[133]

Before *Davidson* some doctors provided abortions but this was mostly done in association with a network of police officers to whom money was paid to avoid raids

125 For the history of abortion in Victoria see Gideon Haigh, *The Racket (98);* see also AJ McMichael and Abortion Law Reform Association, *Abortion, the Unenforcable Law : The Reality of Unwanted Pregnancy and Abortion in Australia* (Abortion Law Reform Association of Victoria, 1972)

126 [1969] VR 667.

127 Ibid 668.

128 *Crimes Act 1958* (Vic) s 10

129 [1969] VR 667, 670–2.

130 Ibid 670–1.

131 Ibid 671.

132 Ibid 672.

133 Ibid.

and prosecution.[134] *Davidson* resulted in measures to put an end to police corruption in respect of abortion.[135] From then on the medical profession controlled access to abortion in Victoria. They could perform abortions without undue fear of prosecution and consequently abortion was more freely available and safer. This did not mean that the law was not uncertain, however. Nor did it mean that women had autonomy to continue or not continue with a pregnancy. *Davidson* provided a defence for doctors who were willing to provide abortions, but it did not give women the choice. The medical professionals retained the right to decide whether to provide and which patients would undergo termination procedures.[136]

### *2 The Abortion Law Reform Act 2008 (Vic)*

In 2007, the Victorian Law Reform Commission was requested to provide options for the decriminalisation of the law governing the termination of pregnancy.[137] As a result of its recommendations the *Abortion Law Reform Act 2008* (Vic) was passed.

The Act decriminalised most abortions and transferred 'lawful' abortions to the control of the medical profession. Section 65 of the *Crimes Act* 1958 (Vic), as amended, now provides that abortions by *unqualified* persons will be liable to a maximum of 10 years' imprisonment. The need for this section retains an unnecessary stigmatising connection between abortion and the criminal law. It is argued that medical procedures performed by unqualified persons may be dealt with by the medical authorities as part of the existing regulatory framework as occurs in the ACT.[138]

It is no longer a crime for a woman to attempt to procure or procure her own abortion.[139] Section 66 abrogates the common law offences relating to procuring a

134 Bronwyn Naylor, 'Judge-made Law: The "Menhennit Ruling" and Abortion Law Reform in Victoria' (2017) 88 (1) *Victorian Historical Journal* 97, 104.

135 Gideon Haigh (n 98); Board of Inquiry into Allegations of Corruption in the Police Force in Connection with Illegal Abortion Practices in the State of Victoria, *Report of the Board of Inquiry into Allegations of Corruption in the Police Force in Connection with Illegal Abortion Practices in the State of Victoria* (Victorian Government Printer, 1971).

136 Naylor (n 134) 106; See Chapter 4 — Access to Legal Terminations.

137 Victorian Law Reform Commission, Law of Abortion: Final Report, Report No 15 (2008).

138 *Health Act 1993* (ACT) s 81; see also *Health Practitioner Regulation National Law Act*.

139 *Crimes Act 1958* s 65.

woman's miscarriage, This section was included to prevent the possible use of obsolete or unknown laws to circumvent the objects of the Act .[140]

Under the Act a woman's pregnancy may be terminated up to 24 weeks' gestation.[141] The drug may be supplied and/or administered by a registered and authorised nurse or pharmacist. (ABA s3 See also Abortion Law Reform Act 2019 (NSW)s 8 allows a health practitioner to assist in a medical abortion on the instruction of a medical practitioner; s7 Termination of Pregnancy Act 2018 section 7) which allows a registered health professional to assist on instruction of medical practitioner) which broadens the scope of who may legally provide medical abortions. The termination is a matter for discussion between the authorised professional and woman. It is s/he who will make the final decision as to whether it will be performed.[142] 'Medical abortion', the use of 'pills' commonly referred to as RU486, is readily available in the early stages of pregnancy (up to about eight weeks). 'RU–486' may be prescribed by a doctor including a nurse practitioner, obtained from a pharmacist and administered at home. In some circumstances the woman need not attend a clinic but may have a tele-communication consultation which will result in her obtaining the RU–486 drug. Otherwise a surgical abortion may be performed.

After 24 weeks, there are limitations upon obtaining either a medical or surgical abortion. A registered medical professional may perform an abortion only if s/he reasonably believes that the abortion is appropriate in all the circumstances[143] and s/he has consulted with at least one other registered medical practitioner who forms the same opinion.[144] In considering whether the abortion is appropriate, the medical practitioner must consider 'all the relevant medical circumstances'[145] and also the 'woman's current and future physical, psychological and social circumstances'.[146] This latter reflects the former common law requirements for a lawful abortion.[147] Only a

140 See Victorian Law Reform Commission, *Law of Abortion Final Report 15*, 2008, 7.

141 *Abortion Law Reform Act 2008* (Vic) ss 4, 6.

142 *Abortion Law Reform Act 2008* (Vic); see Chapter 4 — Access to Legal Terminations.

143 *Abortion Law Reform Act 2008* (Vic) s5(1)(a).

144 Ibid s 5(1)(b).

145 Ibid s 5(2)(a).

146 Ibid s 5(2)(b).

registered medical practitioner may perform the termination,[148] with the woman's informed consent.[149] A doctor who does not act in accordance with section 5 will be guilty of professional misconduct under the *Health Practitioner Regulation National Law.*[150]

### *3 Conclusion*

The reform of the law in Victoria was welcomed and gives the woman a degree of autonomy. It also authorises registered and authorised pharmacists and nurses to supply and administer a drug to cause an abortion. This ought to improve a woman's ability to access an abortion. s. ( Fn s 6 Abortion Law Reforma act) but the actual provision of the drug remains with the ohsyiscian of the pharmacist or nurse and within the medical monopoly. Nevertheless, there are aspects of the legislation which require further reform if autonomy is to be achieved.

The medical profession remains as the gatekeeper of access to the provision of the procedure. This is so, especially where a woman seeks a termination after 24 weeks' gestation. In that situation the legislation requires that two medical professionals, not the woman, should make the final decision. And yet, their credentials are presumed rather than justified. The decision is a health one which has medical aspects. It is not purely a medical decision. The women's health may be positively or negatively influenced by a wide variety of factors including social ones. This is recognised in the legislation and the doctors are to consider these in making the decision about a termination after 24 weeks' gestation. What is not explained is why the medical professionals are given the final decision in this situation. Why should an abortion be treated differently from other medical treatment? It is the role of the doctors to advise and discuss all aspects and consequences of the requested procedure. It ought to be for

147 The ruling in *R v Davidson* [1969] VR 667, as subsequently developed by the common law in Australia; see, eg, *R v Wald* [1971] 3 DCR (NSW) 25; see also Explanatory Memorandum, cl 5.

148 See *Abortion Law Reform Act 2008* (Vic) s 3 for the definitions of 'abortion' and 'registered medical practitioner'.

149 See *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 10(c); *Rogers v Whitaker* (1992) 175 CLR 479; *Medical Treatment Act 1988 (*Vic) s 1.

150 See *Abortion Law Reform Act 2008* (Vic) s3.

the woman to make the final decision. If the woman's decision has a negative impact upon her health then she is the one who must take responsibility. That is part of her autonomy.

### *D Tasmania*

#### *1 Pre-Reform*

Prior to the passing of the *Reproductive Health (Access to Terminations) Act 2013* (Tas), the laws on abortion were to be found in the *Criminal Code Act 1924* (Tas). The laws were similar to those applying in Victoria prior to the passing of the *Abortion Law Reform Act 2008* (Vic).

The term 'unlawful' was not defined in the 1924 legislation nor was it judicially considered. It was generally assumed that because of its common origins and similarity with the other Australian jurisdictions, the *Davidson* ruling applied in Tasmania. Of influence was that Queensland, which had almost identical provisions as Tasmania,[151] had adopted the *Davidson* ruling.[152] In addition, in Tasmania, there had not been any prosecutions for abortion by medical professionals for more than 76 years.[153]

However, the assumptions upon which medical practice had been based were thrown into doubt in 2001 when a complaint was made to the police that abortions were performed at the Royal Hobart Hospital. This led to the questioning of the legality of the medical practices. The immediate response of the Tasmanian medical profession was to refuse to perform abortions.[154] This resulted in women being required to travel to other jurisdictions, usually to Melbourne, to terminate their pregnancies. The situation subsequently led to calls for changes to the abortion laws. The government quickly responded by passing the *Criminal Code Amendment Act (No 2) 2001* (Tas) which sought 'to clarify the law' of abortion in Tasmania and to allow for the decision to be made by

151 Of interest is that Queensland has the defence of medical emergency under the *Criminal Code Act 1899 (Qld) s 282*. Tasmania did not include a reference to the 'unborn child' in the defence under the *Criminal Code Act 1924* (Tas) s 51.

152 *Davidson* [1969] VR 667.

153 Tasmania, *Parliamentary Debates*, House of Assembly, 19 December 2001, 28 (Judith Jackson, Minister for Health and Human Services).

154 'Abortion Law Clarified in Tasmania' 10 *Reproductive Health Matters* (2002) 199 (online).

the woman and her doctor.[155] The legislation did not achieve this objective. Instead it gave control of lawful abortion to the medical profession and a lawful safe abortion generally remained unavailable to many women.[156] The abortion rate did not alter.[157] Few Tasmanian doctors were trained and/or willing to perform abortions and hospitals or clinics which provided these services were scarce. Some abortions were provided by doctors who flew from interstate and many Tasmanian women flew to Melbourne to have the procedure.[158] Little had in fact changed.[159]

The women within the Tasmanian Parliament were aware that the 2001 Act was severely flawed.[160] Their campaign for change in Tasmania became part of the wider push for the recognition of women's right to health as a national issue. It considered reforms taking place elsewhere and carefully examined the *Abortion Reform Act 2008* (Vic) as an appropriate model for Tasmania.[161]

### *2 The Reforms of 2013*

Finally, in 2013 Michelle O'Byrne, the then Minister for Health, introduced the Reproductive Health (Access to Terminations) Bill 2013 into Parliament. In her second reading speech she strongly affirmed 'that access to pregnancy termination services is first and foremost a health matter and not a matter for regulation under criminal laws'.[162] She asserted that it is up to women to make an independent decision as to

155 Tasmania, *Parliamentary Debates*, House of Assembly, 19 December 2001, 29 (Judith Jackson, Minister for Health and Human Services).

156 Ibid.

157 Robert Johnston, *Historical Abortion Statistics, Tasmania (Australia)* (3 January 2015) Johnson's Archive (online).

158 Carolyn Nickson, Julia Shelly and Anthony Smith, 'Use of Interstate Services for the Termination of Pregnancy in Australia' *(2002) 26 Australian and New Zealand Journal of Public Health 421, 423.*

159 Mark J Rankin, 'Recent Developments in Australian Abortion Law: Tasmania and the Australian Capital Territory' (2003) 29 *Monash University Law Review* 316.

160 Ibid 321; see Tasmania, *Parliamentary Debates*, House of Assembly, 19 December 2001, 25 (Judith Jackson, Minister for Health and Human Services).

161 Tasmania, *Parliamentary Debates*, Legislative Council, 16 April 2013, 44 (Michelle O'Byrne, Minister for Health).

162 Ibid.

whether they require counselling and that therefore the Bill did not provide for mandatory counselling.

### (a) Health Regulation

Terminations of pregnancy are regarded as a health matter and are regulated under the *Reproductive Health (Access to Terminations) Act 2013* (Tas) (*RHAT Act 2013)* which provides for a lawful termination of a pregnancy by a medical professional with the informed consent of a woman who is no more than 16 weeks' gestation.[163] This is well before viability.[164]

After 16 weeks' gestation the pregnancy may be terminated if certain conditions are met.[165] Section 5 provides that the requires two medical opinions. One of these must be an obstetrician or a gynaecologist.[166] They must reasonably conclude that continuing of the pregnancy would be a greater risk to the health of the woman than a termination of it.[167] They are required to consider the 'woman's physical, psychological, economic and social circumstances'.[168] This undoubtedly would increase the time taken before the woman could have an abortion, and add additional expense for which there seems to be no justification. More importantly it restricts her autonomy. The criteria to be applied in deciding whether a termination should be performed reflect those of the repealed s 164 of the *Criminal Code Act 1924* (Tas), in that there must be a 'reasonable belief' by the medical professionals that there is a 'greater risk of injury' to the woman's health in continuing the pregnancy than in terminating it.[169]

The medical practitioners are mandated to take into consideration the circumstances in which the woman is placed. These are specified as including 'physical, psychological,

163 *RHAT Act* s 4; the Act does not specify where abortions are to be performed.

164 Defined as 'Capable of being born alive and living a separate existence. The legal age of viability of a foetus is 24 weeks, but some foetuses now survive birth at an even earlier age' by Jonathan Law, 'Viable (in Medical Law)' *A Dictionary of Law* (OUP, 2018).

165 Ibid s 5.

166 Ibid s 5(3).

167 Ibid s 5(1)(3).

168 Ibid s 5(2).

169 Ibid s 5(1)(a)–(b).

economic and social circumstances'.[170] Circumstances would include both 'current and future' factors. These may incorporate: her age; the current duration of the pregnancy; her physical and psychological health; foetal health; the likelihood of the pregnancy going to full term; the number of children in her family; prior pregnancies; her familial situation; her economic status; her work and other commitments; the existence and extent of support; and, in effect, anything else which the medical practitioners consider relevant. These are factors which autonomous persons take into consideration, so far as relevant, when making decisions about medical treatment in general. Their inclusion in legislation reflects an erroneous assumption that woman are unable and/or not to be trusted to make independent decisions. Arguably it is a potential contravention of the degradation prohibition of Cornell. The medical professionals may enquire into all facets of her life and into matters which are of a strictly personal nature.

Women should be presumed to be able to assess and decide based upon the advice. Further, as Cornell explains, the failure of law to guarantee that women have control over decisions about their bodies undermines their autonomous right to be equivalent with men. Viewing themselves as having bodily integrity is important to their project of becoming a person. Therefore free and equal persons could not agree to such laws.[171]

**(b) Criminal Regulation**

exeemptsSections 134 and 135 of the *Criminal Code Act 1924 (Tas)* were repealed thus decriminalising abortion. Importantly for the autonomy of women, section 8 of the *RHAT Act* provides that a woman is neither criminally nor otherwise liable to sanction in respect of the termination of her pregnancy.[172] The offence of child destruction was repealed which was in keeping with the Victorian reform.[173]

The criminal law remains applicable in some situations. Section 178E makes it a criminal offence for any person, including a medical practitioner, to perform a termination without the woman's consent. The mental requirement is either intention or being reckless as to consent. Whether the woman suffers any other injury is

170 Ibid s 5(2).

171 Drucilla Cornell, *The Imaginary Domain: Abortion, Pornography and Sexual Harassment* (Routledge, 1995) 33, 34.

172 *RHAT Act (Tas).*

173 *Abortion Law Reform Act 2008* (Vic).

irrelevant. The provision reflects the general principles of battery where consent will render lawful what would otherwise be unlawful. This has been central to the carrying out of routine and more complex medical procedures.[174] The section further provides that a medical professional will not be charged with an offence where the woman is unable to give consent,[175] the termination is 'performed in good faith', 'with reasonable care and skill',[176] for her 'benefit', and is reasonable in the circumstances.[177]

### 3 *Conclusion*

The situation in Tasmania indicates that the law regards termination of pregnancy as a health issue because the regulation of abortion has for the most part has been removed from the criminal law. A woman's request to terminate her pregnancy either before or after 16 weeks' gestation is controlled by the medical profession. A possible exception arises when a woman performs the abortion on herself, section 178D exempts her from criminal responsibility.

## *E Queensland*

### *1 Introduction*

Up until the passing of the *Termination of Pregnancy Act 2018* (Qld) abortion law, in Queensland remained unlawful and urgently in need of reform.[178] Abortion was a crime under the *Criminal Code Act 1899* (Qld).[179] The laws had remained substantially the

174 Chapter 5 — Medical Treatment — Consent and Refusal discusses the role of consent in medical treatment.

175 *Criminal Code Act 1924* (Tas) s 178E(2).

176 Ibid s 178E (2)(b).

177 Ibid s 178E (c).

178 Heather Douglas and Caroline M de Costa, 'Time to Repeal Outdated Abortion Laws in New South Wales and Queensland' (2016) 205 *Medical Journal of Australia* 353; see Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws - Consultation Paper* WP No76 Dec 2017 for a detailed examination of the Queensland laws on abortion.

179 *Criminal Code Act 1899* (Qld) ss 224–226; section 224 incorporates those sections and provided:

Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious

same as when enacted. A self-induced abortion was an offence even if the woman was not actually pregnant. The intent required was that of intending to procure the abortion.[180] Section 226 made it an offence to provide the means for an abortion.[181] Unlike the English *OAP Act 1861* there was, and remains, a limited statutory defence where a surgical operation or medical treatment was performed to save the life of the woman.[182]

There were few judicial considerations of abortion law under the Queensland *Criminal Code*.[183] Medical practice appeared to consider that the ruling of Justice Menhennit in the

> thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.

Section 225 provided that:

> Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment for 7 years.

180 Under the former English legislation, for self-induced abortion to attract criminal liability, the woman was required to be 'with child': *OAP Act 1861* s 58.

181 Maximum of 3 years' imprisonment. Originally the penalties under the *Criminal Code Act 1899* (Qld) were contained in ss 18 and 19 and ranged from good behaviour to life imprisonment. A female could not have the punishment of whipping inflicted upon her: s 18. Section 224, 14 years' hard labour; s 225, 7 years' hard labour; s 226, 3 years hard labour. These sections should be read in the light of ss 18 and 19.

182 Section 282 provided:

> A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation or medical treatment upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

The *Criminal Code Act 1899* (Qld) s 282 was amended in 2009 by the *Criminal Code (Medical Treatment) Amendment Act 2009* (Qld) to add 'medical procedure'.

183 For example, in *R v Ross* [1955] St R Qd 48, a police operation resulted in the prosecution of those involved in an illegal abortion facility at which a doctor was in attendance. The Court appeared to accept *R v Bourne,* but there was no discussion of the meaning of the term 'unlawful'. Rather, the justices were concerned with the onus of proof on the prosecution to establish that the defendants had not complied with s 282 of the *Criminal*

Supreme Court of Victoria in *Davidson* applied in Queensland. In *Re Bayliss,*[184] Justice McPherson observed that the unlawfulness of these terminations was unclear and that the dicta of Williams J in *K v T*[185] had accepted that *Davidson,* represented the law.[186] In 1986, the trial of Drs Bayliss and Cullen on charges of abortion came before Judge McGuire in the Queensland District Court.[187] McGuire J followed the ruling of Justice Menhennit in *Davidson*[188] but did not widen the grounds for abortion to include the woman's economic, social or medical or other reason'.[189] From then on the medical profession continued to be the 'gatekeepers of abortion' but the law lacked clarity.[190]

### *2 R v Brennan and Leach*

This changed in 2009 after police raided the home of Tegan Leach and Sergie[191] Brennan.[192] The precise circumstances surrounding the raid of the couple's home are unclear. The police had raided several premises looking into the disappearance of a Cairns drug dealer, who was later found murdered.[193] Subsequently it was announced that the charges against the couple were unrelated to the search. During the raid, on the

*Code Act 1899* (Qld). In *K v T* [1983] 1 Qd R 396, a man sought an order to restrain a woman by him from having a termination. Williams J found that the court did not have jurisdiction because the foetus was not a person.

184 *Re Bayliss* (Unreported, Supreme Court of Queensland Chambers, McPherson J, 24 May 1985) This was an application to vary bail conditions.

185 *[1983] 1 Qd R 396, 398.*

186 *Re Bayliss* (Unreported, Supreme Court of Queensland Chambers, McPherson J, 24 May 1985).

187 *R v Bayliss and Cullen* (1986) 9 Qld Lawyer Reps 8; [1986] QDC 011.

188 *Ibid.*

189 *R v Wald* [1971] 3 DCR (NSW) 25.

190 Heather Douglas, 'Abortion Reform: A State Crime or a Woman's Right to Choose?' [2011] *Crim Law* J 33,77-79.

191 Here, Brennan's first name is spelt 'Sergie', as is used in the trial transcript: *R v Brennan and Leach (Brennan & Leach)* Unreported, Queensland District Court, Everson DCJ, 12 October 2010) 2. Many of the writings about the case use the spelling 'Sergei'; see Caroline de Costa*, Never, Ever, Again: Why Australian Abortion Law Needs Reform* (Boolarong Press, 2010) 10; ABC Radio National, 'Abortion on Trial in Queensland', *Background Briefing*, 7 November 2010 (Wendy Carlisle).

192 de Costa, *Never Ever Again* (n 192) 13–26.

193 Jamie Walker and Viva Hyde, 'Murder Hunt Led to Abortion Pair', *The Australian (Sydney)*, 5 August 2009.

1st February, some abortion pills were discovered in the couple's bedroom.[194]. In March, they were formally interviewed and charged.[195] In April, they were committed to stand trial in the District Court, charged with offences under the *Criminal Code 1899* (Qld). The response to the decision to prosecute caused a great deal of indignation among many, especially those committed to the equal autonomy of all persons. [196]

The medical profession was concerned. This was because the defence in s 282 applied to '*surgical*' but not '*medical*' abortions performed to maintain the woman's life. [197]The case drew this to the notice of doctors who had been performing 'medical abortions' and they were worried that s 282 would no longer provide them with a defence.

The government was unable to reassure the medical professionals. Katharine Betts noted that 'the situation in Queensland was at an impasse. Hospitals were not performing medical abortions and the few private practitioners who were able to provide this service ceased to do so'. [198]

The section was amended to include 'medical' abortion and thereby protected the medical profession.[199] This was irrelevant to the defendants and women since the defence onlydid not apply to them. Its limited nature was much criticised and there was anger that the government was doing nothing to assist Brennan and Leach.[200]

194 *R v Brennan and Leach* (Unreported, Queensland District Court, Everson DCJ, 12 October 2010) 14–15 (Det-Seargant Adrian Worth). 32 (Constable Megan Johnston).

195 Ibid 22 (Det-Sergeant Adrian Worth).

196 Kerry Petersen, 'Abortion Laws and Medical Developments: A Medico-Legal Anomaly in Queensland' (2011) 18 *Journal of Law and Medicine* 594; de Costa, *Never, Ever, Again*, above (192); Anna Greer, 'You Can't Be Just a Little Bit Pro-Choice' *New Matilda* 2 July 2009 (online).

197 Petersen (n 196), Emphasis added.

198 Katharine Betts, 'Attitudes to Abortion: Australia and Queensland in the Twenty-First Century' (2009) 17 *People and Place* 25, 34; Anthony Goodwin, 'Bligh Government Amends Abortion Laws', *News Weekly* (Melbourne), 19 September 2009; J Walker, 'Bligh Widens Abortion Law as Doctors Revolt', *The Australian*, 22–23 August 2009.

199 Amended in 2009 by the *Criminal Code (Medical Treatment) Amendment Act 2009* (Qld).

200 Kerry Petersen, 'Abortion Laws and Medical Developments: A Medico-Legal Anomaly in Queensland' (2011) 18 *Journal of Law and Medicine* 594; de Costa, *Never, Ever, Again*, above (n 192); Greer, above n 181.

In 2010, Brennan and Leach were tried in the Cairns District Court before Everson DCJ. Brennan was charged with supplying drugs to procure an abortion and faced a term of imprisonment of up to three years. Leach was charged with attempting to procure her own abortion and faced a maximum term of imprisonment of seven years.[201] Whether or not she had been pregnant was irrelevant. They were the first to face abortion charges in Queensland since 1986.

The judge's instructions to the jury were pivotal to the acquittal of the young couple. What constituted an 'unlawful' abortion was not in issue. There was nothing in the evidence which could suggest that the abortifacients were taken to preserve the health of Leach.[202] The issue was whether they were 'noxious' within the meaning of the section. Everson DCJ told the jury that they must be satisfied beyond reasonable doubt that the defendant Leach administered to herself a 'noxious' thing. 'It is a question of fact for you to decide whether "a thing" is noxious.'[203]'

> [W]hether the thing administered was noxious must be determined in terms of whether or not it was *noxious to the defendant* Leach and *not to any foetus* which may or may not have been present at the time she took the drugs. [204]

The question was not whether the 'noxious thing' was harmful to any foetus, which may or may not have existed when Teagan administered the abortifacients. It was the harmfulness to Leach which was the legal criterion. The evidence of the expert witness indicated that the combination of the drugs Mifepristone and Misoprostol was unlikely to be the least bit harmful to a person. He attested that it had not been harmful to Leach.

Brennan had been charged under s 226 which made it an offence to assist another to procure an abortion, that is, giving Leach the abortion pills. Section 226 did not include the word 'noxious'. Everson DCJ instructed the jury that

201 A charge of attempting to procure an abortion under section 224 had been withdrawn at the committal proceedings.

202 *Criminal Code Act 1899* (Qld) s 225; She had previously volunteered that she had taken the pills to terminate her pregnancy.

203 *R v Brennan and Leach* (Unreported, Queensland District Court, Everson DCJ, 14 October 2010) 6.

204 Ibid 7 (emphasis added).

> the Crown has conducted its case against the defendant Brennan on the basis that the substance, that is the combination of the drugs Mifepristone and Misoprostol was noxious, so if you are also not satisfied beyond reasonable doubt that the substance was noxious you must acquit the defendant Brennan.[205].

The direction adroitly avoided the need to read the word 'noxious' as applying to supplying of 'anything whatever' in s 262.[206.] Brennan and Leach were acquitted.

There were problems which resulted from the case. T he first concern was the reasons why the case was brought in the first place. If anything, a charge under the Commonwealth legislation for importing a proscribed substance, was appropriate in respect of Brennan.[207]. Secondly, why was Leach charged? The immense publicity surrounding this case supported a call for law reform in this area. Thirdly, the case had the potential to be used as a precedent. Normally, the directions of a Trial Judge are of little authority. Here the decision is one of a District Court Judge as was the case in *R v Bayliss and Cullen*. In *Davidson* the ruling was that of Justice Menhennit of the Supreme Court of Victoria which may have been regarded as persuasive. However, history has shown that prosecutions for abortion offences are rare and so those which are available may be referred to as is appropriate. Those cases on point, such as *Davidson,* have been regarded as stating the law on the meaning of 'unlawfully'.[208] Hereafter, where the charge is one of 'medical' abortion, must the prosecution prove that the abortifacients were harmful to the woman rather than the foetus? [209]The answer was not clear and the Premier was called upon to enact legislation decriminalising abortion.[210]. This did not occur.

205 Ibid 8.

206 *But see R v Lindner [1938] SASR 412, 415; cited as 'R v Linda'* in *R v Brennan and Leach* (Unreported, Queensland District Court, Everson DCJ, 13 October 2010) 43.

207 Perhaps, under the *Therapeutic Goods Act 1989* (Cth) s14; *Criminal Code Act 1995* (Cth) or an offence for possession under *Drugs Misuse Act 1986* (Qld).

208 See Naylor (n134).

209 See de Costa, *Never, Ever, Again* (n 192) 10; Carlisle, ( n 175).

210 Jamie Walker, 'Premier Faces Call to Act on Abortion', *The Australian* (Sydney), 12 March 2009; Jamie Walker, 'Draft Abortion Laws Ready for Anna Bligh', *The Australian (Sydney)*, 17 August 2009, 1. Bligh, the then Premier, although having promised reform during her election campaign, was reported as stating that there was 'insufficient' support for reform

### *3 Central Queensland Hospital and Health Service v Q*

In 2016, in *Central Queensland Hospital and Health Service v Q*[211] Her parents request that an abortion be performed was rejected by the hospital administration who followed legal advice that Q lacked capacity to consent and that the hospital could not perform an abortion without a declaration by the court that it would be acting lawfully. Her medical practitioners and psychiatrist were highly supportive of Q, a 12-year-old pregnant child was required to get a court order before an abortion would be performed. She was pregnant by a boy of the same age. There was evidence the girl was suicidal. Her parents request that an abortion be performed was rejected by the hospital administration who followed legal advice that Q lacked capacity to consent and that the hospital could not perform an abortion without a declaration by the court that it would be acting lawfully. Her medical practitioners and psychiatrist were highly supportive of Q. Justice Meekin thought that it was 'clearly in Q's best interests for termination of her pregnancy to proceed'.[212] Applying the test in *Davidson* he decided that the abortion was required in 'to avoid danger to her mental and physical health'

Her obstetrician was highly critical of 'the court's ruling that its intervention was appropriate' The decision meant that teenage girls in Q's situation and who required a termination would have to go to court and 'endure the delays, the embarrassment, the humiliation and the interference of the courts in decisions that until now have been theirs to make in conjunction with their local health care providers. This situation was a "disaster for [girls] like Q"'.[213]

of abortion laws.

See the stance taken by Victoria in repealing the *Crimes Act 1958* (Vic) s 10, and making 24 weeks gestation as the time up until a woman may elect to terminate her pregnancy in the *Abortion Law Reform Act 2008* (Vic) ss 4, 6. For more details see Part II C Victoria below.

211 *Central Queensland Hospital and Health Service v Q* [2016] QSC 89 (24 April 2016) (McMeekin J); *Queensland v B* [2008] QSC 231 (26 September 2008) was a similar case where Wilson J authorised an abortion for a 12 year old child who was 18 weeks pregnant.

212 Ibid [44].

213 Ibid. Lucy Clark, 'Forcing a 12-year-old to Court for an Abortion — That's an Offence against Morality', *The Guardian* (online), 27 April 2016

A newspaper report by Lucy Clark concluded with what many might agree and regard as common sense:

> All this might have happened without the courts – it seems clear that the risk to her mental and physical health was sufficiently worrying to warrant the exceptional circumstances required under the law. But Queensland laws on abortion can make a provider jumpy.[214]

The girl finally underwent an abortion. It amplified the concerns that pregnant teenagers were considered 'women' if they were pregnant but children lacking autonomy in respect of a decision to terminate their pregnancy (see discussion in Chapter 2).

Once again, the need to reform Qld's anachronistic law came under scrutiny. After this case independent Cairns MP, Rob Pyne, on two occasions introduced bills without success.[215] He acknowledged that it was 'clear that a majority of MPs were not prepared to support my bills despite the weight of public opinion'.[216]

## *4 Reform*

In June 2017 the issue of 'modernising the laws on abortion was referred to the Law Reform Commission. It tabled its report to Parliament in the 16th July 2018'[217] noting that significantly different policies and legal principles to those which existed when 19th Century law was enacted, were required.[218] The guiding principles included a need to

214 Joshua Robertson, 'Queensland doctor in abortion case says more teenagers face 'appalling' choice' The Guardian (Australia)16 Jun 2016 (online).

215 Abortion Law Reform (Woman's Right to Choose) Amendment Bill 2016; Health (Abortion Law Reform) Amendment Bill 2016.

216 First Session of the Fifty Fifth sitting of Parliament Record of Parliament , 282, 296; see Anonymous, 'Most want abortion to be decriminalised, survey says' *Courieri Mail* 21 February 2017; Caroline de Costa and Heather Douglas, 'Drag Queensland's abortion laws out of the 19th century' Courier-Mail (Brisbane) 21 February 2017, 20 (Tabled by Pyne MP 28 February).

217 Queensland Law Reform Commission *Review of Termination of Pregnancy laws*" (No. 76) . (QLRC Report); Queensland Law Reform Commission, *Review of Termination of Pregnancy Laws - Consultation Paper*, 'Terms of Reference', WP No 76, December 2017, 2 and Appendix A).

218 QLRC Report 1.28.

respect and promote women's autonomy and that abortion was a health issue and should be decriminalised.[219]

The *Termination of Pregnancy Act 2018* (Qld) (*TPA 2018*) now regulates pregnancy termination in Qld. The reasons for the new laws are identified as being 'to allow women reasonable and safe access' to terminations and to 'regulate the conduct of the medical profession' in the provision of terminations.[220] The stated purposes, especially read in conjunction with the relevant provisions of the *TPA 2018* make it clear that women have limited autonomy

An abortion is legal where the woman is no more than 22 weeks' pregnant and it is performed by a medical professional.[221] This has been referred to as abortion 'on request'.[222] Where the woman is more than 22 weeks' gestation, the abortion may be performed only where certain criteria are satisfied. The medical practitioner must consult with another medical practitioner and if they agree that 'in all the circumstances the termination should be performed'[223] In appraising the appropriateness of termination after 22 weeks, the medical professional consider 'all the relevant circumstances'. Under section 6 (1) these include all the relevant medical circumstances[224] and the 'physical', 'psychological' and 'social' situation of the woman.[225] The appropriate professional practices must be taken into account.[226] These requirements may be dispensed with in a situation where the life of the woman or another unborn child is in danger.[227]

Terminations have not been completely removed from the criminal law. Those which are performed in accordance with the Act will lawful but other abortions remain within the

219 QLRC 1.29.

220 *TPA 2018* s 3.

221 Ibid s 5.

222 Termination of Pregnancy Bill 2018 (Qld) Explanatory memorandum 6.

223 *TPA 2018* s 6 (1).

224 Ibid s 6 (2) (a).

225 Ibid s 6 (2) (b).

226 Ibid s 6 (2) (c).

227 Ibid s6 (3); see also s282 *Criminal Code 1899;* see also *TPA 2018*, s7 regulates who may perform or assist in terminations and s9 which specifically refers to medical professional conduct.

criminal law. The pregnant woman is not criminally liable, however, for consenting to, assisting in, or performing a termination on herself.[228] A medical practitioner who contravenes the provisions of the will be subject to discipline under the *Health Practitioner Regulation National Law(*[229] but is unlikely to be charged under the *Criminal Code 1899* (Qld).[230]

Section 319A of the *Criminal Code 1899* (Qld) creates a new offence of performing or assisting in the performance of a termination of pregnancy where the person is not a qualified medical professional. Assisting includes such things supplying or obtaining a termination drug. The penalty for an offence under the section is 7 years imprisonment.

It is suggested that the provision requires reconsideration and amendment. If the facts of *R v Brennan and Leach*[231] arose under the new law, Tegan Leach would not commit a crime because of the provisions of the *TPA 2018.* However, Brennan could be convicted of an offence under section 319A and liable to imprisonment of up to 7 years. He obtained the pills and supplied them to Tegan. It ought to be asked whether the crime reflects his culpability, if any. It would appear that his wrongdoing, if any, is associated with illegally importing the RU-486 pills and not the unlawful practice of abortion.

The justification for the creation of this offence was the need to to protect the health and safety of women by deterring the practice of unregulated or 'backyard' terminations. Further this is claimed to 'align with modern views about women's health'.[232] There is a distinction drawn between acts done by the medical professional and those done without medical registration. First, it is questionable whether all abortions need to be within the monopoly of the medical profession. Secondly, it is questionable whether it is a necessary disincentive to the unlawful practice of medicine which is already subject to control Australian Health Practitioner Regulation Agency (AHPRA).[233]

228 *TPA 2018* s 10.

229 Ibid s 9.

230 Sections s313 (1) Killing an unborn (1) (b).

231 See above part E 2.

232 Termination of Pregnancy Bill 2018 (Qld) Explanatory Memorandum 5.

233 AHPRA - Regulating Australia's health practitioners in partnership with the National Boards; Health Practitioner Regulation National Law and Other Legislation Amendment Act 2019 (Qld) applies to all jurisdictions except WA. https://www.ahpra.gov.au/Notifications/Raise-a-concern/Reporting-a-criminal-

Thirdly, it would appear at variance with the objective of treating terminations of pregnancy in the same manner as other health issues. Instead the provisions appear to single out these procedures in a manner which may unnecessarily contribute to rather than decrease the stigma and cost attached to abortion.[234]

### *5 Conclusion*

Since the reformed law has only been in operation for less than two years it is difficult to assess its impact upon the autonomy of women. The reform is laudable in that it brought the law closer to parity with most of the jurisdictions within Australia. It also gives women the right to request an abortion. Importantly the woman is no longer liable for acts done by her in seeking an abortion.[235] Unfortunately, abortion was only partially decriminalised. Nevertheless, there is recognition that women ought to be accorded autonomy.[236]

## *F New South Wales*

In NSW, until 2019 the laws relating to abortion remained similar to the *OAP Act of* 1861 from which they were derived.[237] Under section 83 of the *Crimes Act 1900* (NSW) it was a criminal offence, punishable by up to 10 years imprisonment, to unlawfully procure an abortion. Section 84 made it unlawful to provide the means for procuring an abortion.[238]. The pregnant woman could be guilty of an offence and sentenced to up to 10 years in gaol or 2 years if the offence was determined summarily.[239]

Similar to elsewhere in Australia the existence of a defence to a charge of abortion depended upon the interpretation of the word 'unlawfully' as found in the sections. The

offence.aspx.

234 See Chapter 4 – Access to Lawful Terminations, Part E Stigma and Access.

235 *TPA 2018* s 10.

236 Kamala Emanuel, , and Alex Bainbridge, 'Big Win as Abortion Decriminalised in Qld' (2018) 1200 *Green Left Weekly* 11.

237 The provisions were effectively the same as those which applied in Victoria before the reforms of 2008; that is except that the offence of child destruction (*Crimes* Act 1958 (Vic) s10) was never part of NSW's criminal law.

238 5 years' imprisonment.

239 *Crimes Act 1900* (NSW) s82, *Criminal Procedure Act* 1986 (NSW) s6, Schedule 1, Table 1A, 2.

ruling by Menhennit J in *Davidson* was applied and expanded in *R v Wald* [240] *(Wald)* to add that 'any economic, social or medical ground or reason …could constitute reasonable grounds'.[241]

After *Wald,* the New South Wales Attorney-General, Kenneth McGaw, issued a statement to clarify the law. Abortions performed by an unqualified person were illegal irrespective of the circumstances in which they were performed. A qualified medical practitioner who terminated a pregnancy in the honest belief that the pregnancy posed a severe threat or injury to the health of the woman, did not commit an offence. If the medical practitioner does not form the bona fide belief, then an offence was committed.[242]

Given the small number of cases which defined 'unlawful' and set down principles applicable to the defence of necessity Parliament did not make any statutory clarification.[243] Nevertheless prosecutions which raised questions as to the need for reform did occur.

In 1986, a medical practitioner was convicted of performing an unlawful abortion. In *R v Sood,*[244] Justice Simpson accepted that *Wald* represented the law of New South Wales. Dr Sood was guilty of unlawful abortion because the jury accepted that she could not have formed the requisite beliefs, about necessity and proportionality, for the abortion to be lawful. There had been no conversation, or other form of communication, between the doctor and her patient which would have allowed Sood to form these beliefs.[245] Dr Sood,

240 (1971)3 DCR (NSW) 25; *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311; (1982) 8 FamLR 756.

241 *Wald* 25.

242 Ministry of Health, 'Questions Women Ask About Abortion', NSW Health Department July 2001 (Reviewed September 2004); Ministry of Health, 'Policy Directive Pregnancy—Framework for Terminations in NSW Public Health Organisations' (NSW Government, Re-issued 2014); Talina Drabsch, 'NSW Parliamentary Library Research Service Abortion and the law in New South Wales' (Briefing, Paper No 9/05)1, 20.(This did not apply to Private Hospitals)

243 Talina Drabsch, 'NSW Parliamentary Library Research Service Abortion and the law in New South Wales' (Briefing, Paper No 9/05)1, 19 – 21.

244 [2006] NSWSC 1141.

who was subsequently deregistered as a medical practitioner, received a non-custodial sentence.[246]

In 2017, in *DPP (NSW) v Lasuladu*[247] a 28 year pregnant woman who had five children, aged 4 to 9, took drugs to abort her 28 week old foetus.[248] She had wanted to give birth but her partner, after initially agreeing, became insistent that she have an abortion.[249] Registered medical facilities refused her request due to the advanced stage of her pregnancy.[250] She obtained several abortion pills from a person 'Patrick' who assumedly was not authorised to supplyRU-486. After ingesting the pills she felt unwell and sought medical treatment. Her baby was delivered by caesarean section and lived. She was charged with the offence of self-administering a drug for the purposes of obtaining an abortion.[251] Although the offence was a serious one for which she could have faced up to ten years imprisonment it was determined summarily and she was convicted by the Local Court.[252] Reportedly she received a sentence of probation for 3 years.[253]

There were concerns with this case.[254] Prosecutions of women, in Australia, for procuring or attempting to procure their own abortion are regarded as rare and this would not have been an offence in many parts of Australia including the geographically proximate ACT. Only two prosecutions appear to have been initiated in the past twenty years.[255]. The case indicated that archaic and draconian laws could still be used to

245 For a discussion of the case see Kate Gleeson, 'The Other Abortion Myth – the Failure of the Common Law' (2009) 6 *Bioethical Inquiry* 69.

246 [2006] NSWSC 762 (Ruling No 3).

247 [2017] NSWLC 11 (5 July 2017).

248 Ibid [9].

249 Ibid [11], [16].

250 Ibid [11].

251 *Crimes Act 1900* (NSW) s 82.

252 *R v Lasuladu* [2017] NSWLC 11 (5 July 2017).

253 Damien Carrick, 'Calls for decriminalisation of pregnancy terminations in NSW and Queensland' *Law Report*, *Radio National* 22 August 2017.

254 See Kamala Emanuel, 'NSW Abortion Conviction, Late Abortion and the Right to Choose.' (2017) 1151 *Green Left Weekly* 10.

255 See *Brennan & Leach*; Michaela Whitbourn, 'Sydney woman prosecuted for taking abortion drug' Sydney Morning Herald 14 August 2107; there have been a few in NI, see eg, Anon, 'Abortion pills prosecution challenge by NI mother adjourned' ABC New 20 September

undermine women's autonomy. It also put Ms Lasuladu through an unnecessarily distressful experience. It is thought that neither the partner nor Patrick were charged in respect of the attempted abortion.[256]

Julie Hamblin expressed concern that the defence of necessity as it applied in NSW was not used 'to argue that the abortion was lawful by analogy'. She explained.

> [I]t's important to understand that the wording of the offence in the New South Wales Crimes Act for both the offence covering the doctor and the offence covering the woman says that it's an offence if you unlawfully perform or undergo an abortion. And what the case law in New South Wales has said in the very few cases that have looked at doctors is that it is lawful for a doctor in New South Wales to perform an abortion if the doctor can reasonably believe that the abortion is necessary to prevent a serious risk to the life or health of the woman.[257]

Rankin is highly critical of 'necessity' as applied to the criminal law in NSW and elsewhere. He advocated the repeal of the offence on the basis that the necessity defence is not theoretically coherent as it applies to the offence of abortion[258]

He correctly observed 'that while abortion remains a crime it can never be a woman's right'.[259]

Irrespective of the criticisms of the case it came at a time of widespread recognition that NSW abortion law was overdue for reform. Public opinion in NSW, as elsewhere in Australia, was in favour of allowing the decriminalisation of abortion.[260]. However, there

2018; Gabriella Swerling, 'Northern Ireland woman acquitted of buying abortion pills for daughter following a landmark law change' *The Telegraph* 23 October 2019.

256 *DPP (NSW) v Lasulada* [2017] NSWLC 11 (5 July 2017) .

257 Carrick, 'Calls for decriminalisation of pregnancy terminations in NSW and Queensland' Law Report, Radio National Tuesday 22 August 2017 5:30pm https://www.abc.net.au/radionational/programs/lawreport/2017-08-22/8764004.

258 Mark J Rankin, 'Abortion Law In New South Wales: The Problem With Necessity' (2018) 44 (1) *Monash University Law Review* 32,33.

259 Ibid.

260 Dr Mehreen Faruqi, 'First ever polling of abortion issues in NSW shows overwhelming support for abortion law reform and exclusion zones across political party affiliation' Sydney (AUST): The Greens NSW MP; 2015 Sep 27 (online); see Alexandra Barratt et al, 'Knowledge of Current Abortion Law and Views on Abortion Law Reform: A Community

was also a great deal of opposition. The issue of decriminalising abortion had not suddenly become controversial but had been so for some time. Problematic was that there was great division within parliament.[261]

Anti-abortion proponents have a lengthy history of trying to prevent or restrict the availability of abortions. Several Bills ought not to be ignored. They are a potential threat to women's autonomy. The Rev Fred Nile has been prolific in the introduction of legislation which may restrict women's autonomy. These include the Pregnancy Termination (Information About Pain to Child in Utero) Bill[262]; the Pregnancy Termination (Mandatory Counselling Bill 2015; Pregnancy Termination (Mandatory Reporting) Bill 2015; Pregnancy Termination (Reporting and Reasons for Termination) Bill 2015; Crimes Amendment (Pre-natal Termination) Bill; [263] and Crimes Amendment (Zoe's Law) Bill 2015.[264] It may be more accurate to say that some of the bills have been 're'-introduced because the Rev Nile, an active 'anti-abortionist', since his election to the Legislative Council in 1981, persists in proposing anti-abortion legislation. The significance of his actions should not be underestimated. Whilst his legislation is unlikely to pass, at least in the near future, it is indicative of unspecified support for measures which limit and/or remove pregnant women's rights to terminate pregnancy.[265]

Survey of NSW Residents.' (2019) 43 (1) *Australian and New Zealand Journal of Public Health* 88.

261 See Drabsch (n 646).

262 Legislative Council, Notice of Motion, 05/05/2015.

263 Long Title, *An Act to amend the Crimes Act 1900 to prohibit the destruction of any child in utero with a detectable heartbeat.*

264 Pip Hinman, 'Fred Nile resurrects foetal personhood bill [online]. Green Left Weekly, No. 1076, 10 Nov 2015: 5. Availability:<http://search.informit.com.au.ezproxy.lib.monash.edu.au/documentSummary;dn=633674216964597;res=IELHSS> ISSN: 1036-126X. [cited 27 Mar 16]: Michael Safi, 'Fred Niles outlines agenda including abortion law changes for NSW', The Guardian, 6 May 2015

265 Clementine Ford, 'The bill that could criminalise abortion in Australia', Daily Life, 5/09/2013, last accessed 27th March 2015,

At the same time terminations of pregnancy were easier to obtain than a reading of the relevant legislation would indicate. Abortion law in NSW lacked clarity and it was clearly out of step with the other jurisdictions.[266]

As elsewhere in Australia there were many who were supporting abortion law reform. In 2104, Mehreen Faruqi of the Legislative Council introduced the Crimes Amendment (Decriminalisation of Abortion) Bill which subsequently lapsed. She then introduced the Abortion Law Reform (Miscellaneous Acts Amendment) Bill 2015 which was defeated in 2016.[267] Although defeated there was confidence that reform would eventually occur. Finally, in August 2019, the Reproductive Health Care Reform Bill (RHCR Bill) was introduced into the Legislative Assembly by independent MP Alex Greenwich.[268]

The RHCR Bill was unique as Alex Greenwich MP pointed out in the Second Reading Speech.[269] It had 'more co-sponsors than any other bill in the Parliament's history and it is the first co-sponsored bill to be introduced in the Legislative Assembly.'[270]

The anachronistic and unworkable state of the existing law was emphatically stated in introducing the RHCR Bill. [271] It

> recognises that the best outcomes in women's reproductive health care are achieved when abortion is treated as a health matter, not a criminal matter, and a woman's right to privacy and autonomy in decisions about their care is protected.

266 See discussion of Ireland below … and Northern Ireland particularly in the case of *Family Planning Association of Northern Ireland (FPANI) v The Minister for Health, Social Services and Public Services and Public Safety Minister*

267 In 2014 she introduced the Crimes Amendment (Decriminalisation of Abortion) Bill 2014 which lapsed in Sep of that year. She resigned on 14th August 2018.

268 Heather McNab, 'New Bill May Decriminalise Abortion in NSW' AAP *General News Wire (*Sydney), 2019.

269 2nd Reading Speech LA, 8 Aug 2019, Hansard; Also had the support and input from many groups including the NSW Pro-choice alliance and the Australian Medical Association).

270 Ibid, Hon Shelley Hancock MP, Trish Doyle MP, the Hon Brad Hazzard MP, Ryan Park MP, Jenny Leong MP, the Hon Leslie Williams MP, the Hon Penny Sharpe MLC, Alex Greenwich MP, the Hon Trevor Khan MLC, the Hon Abigail Boyd MLC, Jo Haylen MP, Jenny Aitchison MP, Felicity Wilson MP, Greg Piper MP and the Hon Emma Hurst MLC) which included the Health Minister.

271 Ibid.

> In New South Wales it has been a criminal offence to procure an unlawful abortion since 1900, when the Crimes Act was first written. The law has not changed since then. This was a time when women could not vote and, because they could not stand, there were no women in this Parliament. Now not only can women vote and stand for office, but also our State has a female Premier, a female Leader of the Opposition and a female Governor.[272]

It was recognised that times had changed. Of course, the question remained '. . . Why has it taken so long?' [273]

The Bill as introduced was based upon the legislation of Victoria and Queensland with the intention of 'bringing the law in line with clinical practice, community attitudes and the rest of the country'.[274]

Predictably and unfortunately the passage of the Bill in both Houses of Parliament invoked contentious debate and compromises. As one commentator remarked.

> It took eight weeks of protests, public blood-letting from the Liberal Party, threats to plunge the Government into minority and even an abandoned move on Gladys Berejiklian's leadership.[275]

Although the name of the RHCR Bill 2019 was changed to the *Abortion Law Reform Act 2019* (NSW) the main features remained unaltered.

As under the Queensland law a woman may request her medical practitioner to perform an abortion where she is not more than 22 weeks pregnant.[276] Termination of pregnancies of more than 22 weeks requirements include: assessment by two specialist practitioners; performance by a specialist; an optional request for advice from a multi-disciplinary team and that it be performed at a hospital or approved facility under the *Health Services Act 1997* (NSW).[277] The regulation of a termination after 22 weeks is

272 Alex Greenwich, MP, 2nd Reading Speech LA, 8 Aug 2019, Hansard.

273 Pringle, Helen, 'After 119 years, NSW is set to decriminalise abortion. Why has reform taken so long?' *The Conversation* 31 July 2019.

274 See Greenwich, MP 2nd Reading Speech (n 676).

275 Ashleigh Raper (State Political Reporter Australian Associated Press) 'Abortion decriminalised in NSW after marathon debate' *The Guardian* 26 Sep 2019.

276 *Abortion Law Reform Act 2019* (NSW) s 5.

277 Ibid s 6.

more complex than originally proposed due to the need to meet with the many objections to the legislation. The RHCR Bill was also amended to include the requirement of informed consent.[278] This is arguably redundant as all medical treatment requires informed consent. A further compromise was to include counselling.[279] Under section 7 the need for counselling must be assessed and information about the provision of counselling must be given to the person in the specified circumstances.

Overall, abortion was decriminalised so long it was performed in accordance with the legislation[280] and its regulation was transferred to the medical profession. Section 12 provides that the pregnant woman does not commit an offence. Section 82 of the *Crimes Act 1900* (NSW) provides that an unqualified person who performs an abortion will be guilty of an offence may be imprisoned for up to seven years.[281]

Once passed the proponents of reform understandably considered the passing of the Act to be a major victory for women and especially when contrasted with the provisions of the former *Crimes Act 1900* (NSW). Although the Act is a little more complicated than the original Bill it is a remarkable achievement. Many of the opponents of the reform were far from happy and not prepared to accept the result. Fred Niles MLC almost immediately notified parliament that he would introduce a Bill, the name of which shows its intention. It is simply called Abortion Law Reform Act Repeal Bill 2019.[282]

### G *Summary*

In summary, Caroline de Costa and Heather Douglas remain correct in arguing that

> there is an urgent need for legislative uniformity across Australia so that the law is in step with modern medical practice, and so that women, regardless of where they live, have equal access to abortion services.[283]

278 Ibid s5 (2) and 6 (1) (c).

279 Neither the *Abortion Law Reform Act 2008* (Vic) nor the *Termination of Pregnancy Act 2018* (Qld) contain requirement for counselling.

280 *Abortion Law Reform Act 2019* (NSW), Schedule 2 Amendment of Acts s 2.1[2].

281 See also s 545B which makes it offence to intimidate in respect of terminations.

282 Notice of motion 22 October 2019; See also Chapter 4 – Access to Abortion.

283 Caroline M de Costa and Heather Douglas, 'Abortion Law in Australia: It's Time for National Consistency and Decriminalisation' (2015) 203 *Medical Journal of Australia* 349, 350.

After much reform an Australian framework for the legal regulation of abortion has not come to fruition.[284] The reforms of the ACT, Tasmania, Victoria, the NT, Qld and NSW recognise a degree of autonomy for women. WA and SA are likely to undertake further reforms in the near future. Nevertheless, the Australian regimes still differentiate between Australian women based upon the jurisdiction in which they live and the gestational stage of their pregnancy. This in turn results in inequality of treatment and of autonomy. The medical professionals have retained their role as 'gatekeepers' of abortion and their monopoly over its provision. Further reform is necessary.[285]

## IV NEW ZEALAND

### *A Introduction*

On the 24th March 2020, the *Abortion Legislation Act 2020* (NZ) came into operation. Its primary objectives were to amend the *Contraception Sterilisation and Abortion Act 1977*(NZ*) (CSA 1977)* and the *Crimes Act 1961* (NZ). Its purposes were to reform the law so as to decriminalise abortion and to recognise the autonomy of women to makes decisions about pregnancy. The legislation is of importance for New Zealand but also provides direction for the other jurisdictions considered here.

The new legislation and the legislation it replaced are not unique to NZ. Although differing in detail to the other jurisdictions, the evaluation of the previous laws indicated, among other things, a distrust of women and the continuance of paternalistic attitudes which have been prevalent since early times.[286]

284 Ibid.

285 It is certainly a great pity that the ground breaking policies , on abortion and other related matters, proposed by the Prime Minister Gough Whitlam and the quite revolutionary work of the Royal Commission on Human Relations which reported in 1977 after Whitlam's dismissal on 11 November 1975, were not enacted in legislation; see Elizabeth Evatt, Felix Arnott, Anne Deveson, *Royal Commission on Human Relationships* (Australian Government Publishing Service, 1977); Michelle Arrow, *The Seventies: The personal, the political and the making of modern Australia* (NSW Publishing, 2019); Talina Drabsch, 'NSW Parliamentary Library Research Service Abortion and the law in NewSouth Wales' (Briefing, Paper No 9/05)

286 See under the heading for each jurisdiction in this chapter.

## *B Previous Regulation*

Prior to the new legislation the *(CSA 1977)* and the *Crimes Act 1961* had regulated abortion for more than 40 years.[287] The long title of the *CSA 1977* stated that it was enacted 'to provide for the circumstances and procedures under which abortions may be authorised after having full regard to the *rights of the unborn child'*.[288] From this it is clear that the interests in women's reproductive autonomy, if any, were of secondary importance to the protection of the foetus.

An abortion was criminal from the time of conception and even before the woman may have realised she was pregnant.[289] 'Miscarriage' included the destruction or premature expulsion of the embryo or foetus after implantation'.[290] It was an offence to perform a medical abortion[291] or a surgical abortion[292] or an abortion by any means.[293] The woman did not need to be pregnant.[294] There was a harsh penalty of a

287 On the history of abortion in NZ, see Megan Cook, 'Story: Abortion' *Te Ara — The Encyclopaedia of New Zealand 5 May 2011*; Dame Margaret Sparrow, *Rough on Women: Abortion in 19th-Century New Zealand* (Victoria University Press, 2014); New Zealand, Royal Commission on Contraception Sterilisation and Abortion in New Zealand, *Report of the Royal Commission of Inquiry (1977)*; Dame Margaret Sparrow, *Abortion Then & Now: New Zealand Abortion Stories from 1940 to 1980* (Victoria University Press, 2010) 149; Abortion Services in New Zealand, *A Brief History of Abortion Laws in New Zealand* (21 November 2014); Eliza Berman, 'How a German Measles Epidemic Stoked the Abortion Debate in 1965', *Time* (online), 2 February 2015; Marita Leask, 'From Bad Women to Mad Women: A Genealogical Analysis of Abortion Discourses in Aotearoa New Zealand' (2013) 28 *New Zealand Sociology* 104.

288 Emphasis added.

289 *Crimes Act 1961* (NZ) ss 182–187.

290 s 182A; This is the view taken by Catholicism.

291 *Crimes Act 1961* (NZ) s 183(1)(a).

292 Ibid s 183(1)(b).

293 Ibid s 183(1)(c).

294 Ibid s 183(2).

maximum of 14 years' imprisonment.[295] But it was, however, no longer an offence for women to attempt to or procure their own miscarriages.[296]

The word 'unlawfully' was defined under s 187A and provided an extensive and definitive list as to when abortions would be 'lawful' or 'unlawful'. [297] The section, in general terms, provided that a termination, up to 20 weeks' gestation, would be lawful, where it was believed that: there was a serious risk to the woman or of foetal abnormality; the pregnancy was the result of sexual intercourse with a 'lineal relationship', dependent family member; or, the pregnancy was the result of 'sexually

295 Ibid s 183(1):

Everyone is liable to imprisonment for a term not exceeding 14 years who, with intent to procure the miscarriage of any woman or girl, whether she is pregnant or not,—

a unlawfully administers to or causes to be taken by her any poison or any drug or any noxious thing; or

b unlawfully uses on her any instrument; or

c unlawfully uses on her any means other than any means referred to in paragraph (a) or paragraph (b).

296 *Crimes Amendment Act 1977* (NZ), repealing s 185 *Crimes Act 1961* (NZ); inserting s 183(2).

297 *Crimes Act 1961* (NZ) s 187A(1):

For the purposes of sections 183 and 186, any act specified in either of those sections is done *unlawfully* unless, in the case of a pregnancy of not more than 20 weeks' gestation, the person doing the act believes—

(a) that the continuance of the pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life, or to the physical or mental health, of the woman or girl; or

(b) that there is a substantial risk that the child, if born, would be so physically or mentally abnormal as to be seriously handicapped; or

(c) that the pregnancy is the result of sexual intercourse between—

i a parent and child; or

ii a brother and sister, whether of the whole blood or of the half blood; or

iii a grandparent and grandchild; or

c that the pregnancy is the result of sexual intercourse that constitutes an offence against section 131(1); or

d that the woman or girl is severely subnormal within the meaning of section 138(2).

exploitative intercourse with a severely impaired female'.[298] The age of the woman or girl concerned was considered.[299] Further that the woman has been raped or sexually violated was relevant.[300]

Once the pregnancy was more than 20 weeks the grounds which justified a termination were limited to where the abortion was necessary to save the life of the pregnant woman or to prevent 'serious permanent injury to her physical or mental health'.[301]

What can be noted from the regulation of abortion under the *Crimes Act* as amended in 1977, was the recognition of the foetus as having rights of personhood. This was assumed to justify removing the decision about not continuing with a pregnancy from the woman. Hugo Farmer said that the reasoning behind the restrictions on the grounds rendering a termination lawful was 'that the closer an unborn child is to birth ... the closer it is to attaining legal personhood,' and 'the more worthy of legal protection it becomes'.[302]

The *CSA 1977* set up a complex process to determine who met the criteria for a 'lawful' abortion. It established a Supervisory Committee which had the role of overseeing and

298 *Crimes Act 1961* (NZ) s 187(1).

299 Ibid s 187A (2):

The following matters, while not in themselves grounds for any act specified in section 183 or section 186, may be taken into account in determining for the purposes of subsection (1)(a), whether the continuance of the pregnancy would result in serious danger to her life or to her physical or mental health:

(a) the age of the woman or girl concerned is near the beginning or the end of the usual child-bearing years:

(b) the fact (where such is the case) that there are reasonable grounds for believing that the pregnancy is the result of sexual violation.

300 Ibid s 187A (2).

301 Ibid s 187A (3):

For the purposes of sections 183 and 186, any act specified in either of those sections is done unlawfully unless, in the case of a pregnancy of more than 20 weeks' gestation, the person doing the act believes that the miscarriage is necessary to save the life of the woman or girl or to prevent serious permanent injury to her physical or mental health.

302 Hugo Farmer, 'An Analysis of New Zealand's Abortion Law System and a Guide to Reform' [2013] *Public Interest Law Journal of New Zealand* 9, 12–13.

reviewing all aspects of the provision of lawful abortions,[303] of controlling the performance of legal abortions,[304] and, of reporting on all aspects of abortion.[305] It made the process of obtaining an abortion prolonged and thereby impacted adversely on the health of the women.

Paradoxically, terminations of pregnancy were considered relatively easy to obtain, unless a woman lived in a region which was poorly serviced.[306] Some argued that abortion was almost available on request[307] and that consultants were routinely 'certifying' women under the mental health exception in the *Crimes Act 1961* (NZ). [308] It was reported that 98% of the abortions performed were certified upon the danger to 'mental health exception'.[309] Overall the anti-abortion proponents were critical of the existing law and argued that the committee was not fulfilling its role in protecting foetal rights.[310]

303 *CSA Act* s 14(e).

304 Ibid s 14(b).

305 Ibid s 14(g).

306 Martha Silva, Toni Ashton and Rob McNeill, 'Improving Termination of Pregnancy Services in New Zealand' (2011) 124 *The New Zealand Medical Journal* 83; Martha Silva and Rob McNeill, 'Geographical Access to Termination of Pregnancy Services in New Zealand' (2008) 32 *Australian and New Zealand Journal of Public Health* 519.

307 *Right to Life New Zealand v Abortion Supervisory Committee* [2008] 2 NZLR 825, [56] (Miller J); Amy Dixon, 'Authorisation of Abortion for a "Serious Danger to Mental Health": Would the Practice Stand Up to the Judicial Test?' (2012) 43 *Victoria University of Wellington Law Review* 289,

308 . Dixon, 'Authorisation of Abortion for a "Serious Danger to Mental Health": Would the Practice Stand Up to the Judicial Test?' (2012) 43 *Victoria University of Wellington Law Review* 289, 290.

309 Abortion Supervisory Committee, *Report of the Abortion Supervisory Committee for 2011* (2012).

310 See Farmer, (n 7); *Abortion Supervisory Committee v Right to Life New Zealand Inc* [2012] 1 NZLR 176; Emma Jane Smith, 'The Functions and Failings of the Abortion Supervisory Committee – A critique of the New Zealand Supreme Court Decision in *Right to Life New Zealand Inc v The Abortion Supervisory Committee*'

Supporters of women's autonomy continued to be highly critical of the law, for several reasons.[311] The procedure led to delayed access to a lawful abortion[312] The laws disempowered women who had to 'present themselves as psychologically disturbed',[313] even if this were a lie. It is clear how this could interfere with women's self-image and development, which is central to Cornell's arguments as discussed in Chapter 2.

### *C Abortion Legislation Act 2020 (NZ)*

Pursuant to the 2020 amendments, abortion is no longer an offence under the *Crimes Act 1961* (NZ) but is regulated in the same manner as other medical procedures. However, abortions which are not performed by a qualified medical practitioner will be criminal and punishable by imprisonment.[314] The woman will not be criminally liable.[315]

Killing an 'unborn child' remains an offence[316] but the physician is not liable providing s/he is acting in accordance with sections 10 and 11 of the *CSA Act 1977* as amended by the *Abortion Legislation Act 2020* (NZ) *(AL Act 2020)*. The use of '[e]very one' in ascribing liability for child destruction is ambiguous when considering the potential liability of the pregnant woman. As discussed elsewhere in the thesis the offence of child destruction and its potential overlap with abortion is regarded as problematic.[317]

311 Abortion Law Reform Association of New Zealand (ALRANZ), '16 Reasons to Change NZ's Abortion Law', *Factsheet*, May 2014 (Online).

312 See Chapter 4 — Access to Medical Treatment.

313 Maureen Molloy, 'Rights, Facts, Humans and Women: An Archaeology of the Royal Commission on Contraception, Sterilisation and Abortion in New Zealand' (1996) 12 *Women's Studies Journal* 63, 78; Marita Leask, 'From Bad Women to Mad Women: A Genealogical Analysis of Abortion Discourses in Aotearoa New Zealand' (2013) 28 *New Zealand Sociology*; Hamilton, {n 21), 104–19.

314 *Crimes Act 1961* as amended by *Abortion Law Act 2020* s183(1) A person commits an offence and is liable on conviction to a term of imprisonment not exceeding 5 years if the person is not a health practitioner and—

(a) procures, or attempts to procure, an abortion for a woman; or

(b) performs, or attempts to perform, an abortion on a woman.

315 *Crimes Act 1961* as amended by *Abortion Law Act 2020* s183 (2).

316 *Crimes Act 1961* (NZ) S182 (1).

Persons who act in good faith to save the life of the 'child's mother' will not be held criminally responsible.[318]

The much-criticised Supervisory Committee has been abolished.[319] The decision to terminate a pregnancy, not more than 20 weeks' gestation, is now a matter for the woman in consultation with her doctor.[320] After that time

> [a] qualified health practitioner may only provide abortion services to a woman who is more than 20 weeks pregnant if the health practitioner reasonably believes that the abortion is clinically appropriate in the circumstances.[321]

Circumstances include consulting with another health practitioner and having regard to his/her obligations as a health professional.[322] S/he must also consider the health and well-being of the woman.[323] The 'gestational age of the fetus' is specified as a relevant consideration.[324] How 'late-gestational' abortions are not specifically proscribed.[325]

It is argued that the *Abortion Legislation Act 2020* has an importance which is greater than its contribution to New Zealand's substantive law. An analysis of the processes by which the Bill was introduced and finally became law provides directions for those working towards the recognition of full reproductive autonomy for women.

The NZ Parliament made this clear from its reasons for enacting the legislation. Andrew Little, in introducing the Abortion Legislation Bill 2019, highlighted the importance of autonomy stressing that the reform was 'not only about confirming the right of a woman to choose whether she proceeds with a pregnancy but also about *respecting her* ability to do so'.[326]

Amy Adams, MP said.

317 See eg Part II, D above Mark J Rankin, 'The Offence of Child Destruction: Issues for Medical Abortion' (2013) 35(1) *Sydney Law Review* 1.

318 *Crimes Act 1961* (NZ) S182 (2).

319 See *CSA Act 1977* as amended *Abortion Legislation Act 2020* (NZ) Schedule 1, Part 1, s 2.

320 *CSA Act 1977* s10.

321 Ibid s11 (1) .

322 Ibid s11 (2).

323 Ibid s11(2) (b)(ii).

324 *CSA Act 1977* s 11 (2) (b)(iii).

325 *Crimes Act 1961* (NZ).

> I'm very happy to stand up for the rights of women and to respect the autonomy of women, and I will continue to do that. I trust women—I trust women. I trust them not to make the sorts of irresponsible decisions we've heard thrown around this House as examples of what might happen. Women do not wake up late in their pregnancy and have just changed their minds for no reason. Women do not callously throw away a much-wanted pregnancy because of a difficult diagnosis.[327]

The need to affirm women's bodily autonomy as a right was emphasised throughout the passage and debate over the Bill.

> We need a law where a pregnant woman can and should be trusted to make the decision for themselves about an abortion in consultation with their health practitioner.

Jan Logie MP made the following poignant statement which forcefully encapsulates the unenviable position women have been put in when they sought to exercise reproductive autonomy.

> Women will not need to lie anymore. Women will not have to have miscarriages in their cars. They will not need to visit up to seven different health practitioners. They will not need to wait weeks to be able to get an abortion. They will not need to lie. They will hear that this House and that this country trusts them, believes them, and supports their right to sexual and reproductive health.[328]

Members of the New Zealand Parliament are finally speaking out against the patriarchal assumptions and myths which have informed debates about women's reproductive rights. This statement is important on a global level and reflects the requirements of Cornell that women must have an equivalent chance at the project of becoming a person. Women being treated as equivalent citizen's, entitled to participate equally in law making, is to be encouraged

326 Hansard 8th August 2019 First Reading, Hon Andrew Little; See *ABL Bill Explanatory Note* which reaffirms the commitment to place abortion within the health framework and give women far greater autonomy and far fewer obstacles than exist under the present regime.

327 Hansard 2nd Reading 3 March 2020.

328 Hansard 3rd Reading Abortion Legislation Bill 2019 18 March 2020, Logie MP

## V IRELAND AND NORTHERN IRELAND

### *A Introduction*

The Irish Republic and Northern Ireland have a commonality which stems from their historical antecedents.[329] They have a shared culture and geographical location. Religion and politics have had a profound influence in shaping their societies and particularly their laws on abortion. Despite the damage done to the reputation of the Catholic Church, by the enquiries into sexual abuse and misconduct of their clerics,[330] religion remained highly influential at a governmental level and is reflected in the regulation of and access to abortion in both jurisdictions.[331]

There are of course, substantial differences between the two jurisdictions. Most importantly the Republic of Ireland historically has been predominantly and staunchly Catholic whilst Protestantism is the predominant religion in Northern Ireland (with a minority of Roman Catholics). The conflict between Roman Catholic and Protestant religions, in Ireland, have a long history of violence which dates back to

> when James VI of Scotland ascended to the English throne in 1603 as James I [of England] and ratified Elizabeth I's policy of consolidating English Protestant rule in Ireland by 'planting' those who were loyal to the crown (from 1607 forward), while supplanting Catholics who were regarded as disloyal.[332]

329 See L Earner-Byrne and D Urquhart, *The Irish Abortion Journey* 1920-2018 (Palgrave Pivot, London, 2019).

330 There have been other 'scandals' that have tarnished and continue to tarnish the reputation of the church. Eg, the callous treatment of vulnerable young girls and women in the care of the Magdalene Laundries in Ireland: see A V Simpson et al, 'Doing Compassion or Doing Discipline? Power Relations and the Magdalene Laundries' (2014) 7 *Journal of Political Power* 253; Maeve O'Rourke, 'Ireland's Magdalene Laundries and the State's Duty to Protect' (2011) 10 *Hibernian Law Journal* 200, 237; Cathy Hayes, 'Researchers Correct Irish Gov: 1,663 Irish Women Died in Magdalene Laundries', *Irish Central (New York), 13 January 2015*; cf Ireland, Department of Justice and Equality, *Report of the Inter-Departmental Committee to Establish the Facts of State Involvement with the Magdalene Laundries* (2013) Chapter 3.

331 Bloomer and O'Dowd, (n 350).

332 L Philip Barnes, 'Was the Northern Ireland Conflict Religious?' (2005) 20 (1) *Journal of Contemporary Religion* 55, 57.

Dissent, disruption and intermittent outbreaks of violence occurred in British Ireland over the following two centuries. The factions were aligned according to whether they were Catholic or Protestant. In the early 20th Century, Britain divided Ireland into two parts. It granted independence to southern Ireland which was named the Irish Freestate. Northern Ireland remained as part of the United Kingdom. This was not popular with those who wanted independence and not partition. Barnes has written.

> Most nationalists naturally opposed the establishment of Northern Ireland. The constitutional issue divided opinion into two predictable camps that aligned along religious lines: Protestants who feared 'Roman' domination in a united Ireland and Catholics who aspired to belong to the Republic of Ireland, where the Catholic Church enjoyed privilege and position reinforced by legislation.[333]

The situation within the Northern Ireland Assembly at Stormont has at times resulted in the government failing to govern. This occurred on the 9th January 2017 and was only resolved on 10th January 2020,[334] when an agreement was reached with Westminster and the government returned to Stormont.[335]

Historically, the abortion laws in both jurisdictions were extremely restrictive and provided a stark contrast to the reforms and the moves to decriminalise abortion elsewhere.[336]

> Whilst the restrictive nature of abortion law on the island of Ireland has made it anomalous in Western Europe, it is in fact in keeping with the conservative nature of both jurisdictions, in particular, in relation to the status of women, reproductive right and sexual morality.[337]

333 Ibid.

334 Andrew Sparrow, 'Labour leadership: Thornberry in, Lewis out, leaving five candidates as deadline passes - as it happened' *The Guardian* 13 January 2020:

335 Arthur Beesley, 'Northern Ireland: draft deal on table to resume government' *Financial Times* 11 January 2020; Jill Lawless, 'After 3 years of acrimony, N Ireland has a government' *Star News* Online Jan 11 2020; Andrew Sparrow, 'Labour leadership: Thornberry in, Lewis out, leaving five candidates as deadline passes - as it happened' *The Guardian* 13 January 2020.

336 L Earner-Byrne and D Urquhart, *The Irish Abortion Journey* 1920-2018 (Palgrave Pivot, London, 2019) 2.

337 Earner-Byrne above (n 336), 1-2.

The value which religion has placed upon the 'foetus' resulted in political parties, who frequently were strongly discordant on various issues, finding a commonality which resulted in legislation which ignored the autonomy of pregnant woman. Under the guise of respect for women and promotion of the health of women the laws had in effect achieved the opposite. Earner-Byrne and Urquhart concluded that

> women's welfare and rights were consciously and repeatedly subordinated to moral and religious concerns in both states for much of the twentieth century. Well organised, well-connected and vocal, conservative groups yielded inordinate power, often brokering crucial issues relating to women's rights and autonomy behind closed doors. A common argument of these groups was that reproductive freedom, birth control and later abortion, harmed and demeaned women.[338]

Another factor operated to delay reform. Laws which prohibit abortion do not prevent women from seeking a termination. Irish women having to travel elsewhere for an abortion, usually to England, was well known to the Irish legislatures.[339] The irony of this is evident in the attitude to this practice. Politicians were reluctant to openly debate the issue but they 'chose to ignore the women leaving their shores to seek abortion elsewhere'.[340]

Currently, both Ireland and Northern Ireland have laws which can no longer be described as draconian and anomalous. The situation has changed. In Ireland from the 1st February 2019 the laws of abortion are regulated under the *Health (Regulation of Termination of Pregnancy) Act 2018* (Ire) which makes abortions up to 12 weeks lawful. In Northern Ireland effective from the 22nd October 2019 until May 2020 abortion was decriminalised by virtue of the operation of the *Northern Ireland (Executive Formation etc) Act 2019* (UK).[341] The reforms which have been welcomed by many came about in very different ways and for Northern Ireland it occurred somewhat unusually.

338 Earner-Byrne (n 336) 138;

339 Fiona Bloomer and Kellie O'Dowd, 'Restricted Access to Abortion in the Republic of Ireland and Northern Ireland: Exploring Abortion Tourism and Barriers to Legal Reform' (2014) 16 *Culture, Health and Sexuality* 366

340 Ibid 139.

341 Ss 8-12.

Ireland has had a history, at least since 1983 of being active in seeking reform. Northern Ireland on the other hand has not maintained a high profile, until recently, in calls for reform. [342] The next two sections will examine the manner in which the reforms came about, the influence of the passing of Ireland legislation in decriminalisation of abortion in NI, and, the resulting impact upon women's autonomy.

### *B The Irish Republic*

Analysing the pathway of Ireland's abortion laws, from being extremely repressive and virtually illegal to being legal in specific circumstances, demonstrates the practical importance of abortion law reforms for Irish women at a local level. It also indicates potential for change which recognises women's autonomy on a global level.

To understand the laws on abortion which currently apply in Ireland the thesis considers their development under the headings *Early Abortion and the Eighth Amendment*; *The Protection of Life During Pregnancy Act 2013* (Ire); and *The 36th Constitutional Referendum and its outcome.*

#### *1 Early Abortion and The Eighth Amendment*

Initially,[343] abortion was illegal under ss 58–59 *OAP Act 1861* which had remained in force after Independence in 1922.[344] The *Infant Life (Protection) Act 1929* (UK) did not apply in in the Irish Free State and therefore the defence that an abortion was not illegal

342 This is notwithstanding the continued operation of laws derived from the *OAP Act 1861*; see Pauline Daniels, Patricia Campbell and Alison Clinton, 'The Current State of Abortion Law and Practice in Northern Ireland' (2013) 22 *British Journal of Nursing* 326; Markus Baumann, Marc Debus and Jochen Müller, 'Convictions and Signals in Parliamentary Speeches: Dáil Éireann Debates on Abortion in 2001 and 2013' (2015) 30 *Irish Political Studies 199,* 200.

343 Fiona de Londras 'Constitutionalizing Fetal Rights: A Salutary Tale from Ireland' (2015) 22 *Michigan Journal of Gender and Law* 243, 290; Fiona De Londras, '"A Hope Raised and Then Defeated"? the Continuing Harms of Irish Abortion Law' (2020) 124 (1) *Feminist Review* 33

344 *Irish Free State (Agreement) Act 1922*, 12 & 13 Geo 5, c 4; see *Ireland Act 1949*, 12, 13 & 14 Geo 6. The Irish Free State left the British Commonwealth of Nations in 1949 and became the Republic of Ireland (Ire).

when necessary to save the life of the mother was not available.[345] Abortion was considered a very serious offence and akin to murder. What differentiated the Irish from their former British coloniser was that morality and legality were somewhat inseparable concepts in reproduction.[346] What was viewed as immoral by the Church was also illegal in many senses and all sections of society strived to 'shape independent Ireland's society in accordance with Catholic moral teaching'.[347]

Ireland practised reproductive control.[348] Contraception and abortion was both sinful and illegal. Pregnancy outside marriage was strongly condemned. .

> The Irish unmarried mothers from both jurisdictions believed that a ship was preferable to facing social stigma at home.[349]

Irish society was not only complicit in exporting shamed pregnant women but utilised methods of punishment such as incarceration. To Irish society

> [t]he unmarried mother was representative of declining moral standards and the response was to consign her to 'homes' or Britain. In both jurisdiction these homes were often old workhouse, in which the majority of unmarried mothers resided, or Magdalene asylums that predated partition.[350]

345 See *ILP Act 1929*, *S 1(1): '...no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.' See R v Bourne direction to the jury.*

346 Earner-Byrne above n 669, 11.

347 Earner-Byrne above n 669,11-17.

348 John M Riddle (n 6); Cara Delay, 'Kitchens and Kettles: Domestic Spaces, Ordinary Things, and Female Networks in Irish Abortion History, 1922-1949' (2018) 30 (4) *Journal of Women's History* 11;

349 Ibid 11, The Magdalene asylums remained in existence in Ireland until 1996; M O'Rourke, 'Concluding Observations of the UN Committee against Torture, Recommendation to Ireland Regarding the Magdalene Laundries, 2011' in E Rackley and R Auchmuty (Eds.) *Women's Legal Landmarks: Celebrating the History of Women and Law in the UK and Ireland* (pp. 575–582). (Oxford: Hart Publishing, 2019); see for a comparison of incarceration in these institutions of 'miscreants' and the socially unacceptable and the more recent incarceration of asylum seekers or refugees, Ronit Lentin, 'Asylum Seekers, Ireland, and the Return of the Repressed' (2016) 24 (1) *Irish Studies Review* 21 Web.

350 Ibid 121.

There was a large number of pregnant women leaving the country rather face the stigma of conceiving outside marriage. Alternatively they sought the help of local women or midwives who provided assistance. Ordinary items were used in the abortion process. Women,

> by using common household items—basins, soap, bottles, and rubber sheets—attempted to manage their own reproductive health care within the domestic sphere and with whatever they were able to access.[351]

Women attempted to exercise their right to bodily integrity through their neighbourhood network. Undoubtedly the Irish states preferred to ignore or deny the many pregnancies which were unwanted in a state where women's health was rhetorically important but was subordinate to interests of the state in foetus.[352]

Catholic society ostracised pregnancy in the unmarried.[353] It actively encouraged procreation within marriage.[354]

> The Criminal Law Amendment Act, 1935 introduced a complete ban on contraception with no exceptions. Clearly, an informed decision had been made to safeguard morality over maternal health.[355]

The impetus for the eighth amendment was attributed to the potential impact of the Irish Supreme Court decision of *McGee v Attorney General*[356] and a reaction to the liberalising of abortion elsewhere, particularly in the USA.[357] Mary McGee was a married

351 Cara Delay, 'Kitchens and Kettles: Domestic Spaces, Ordinary Things, and Female Networks in Irish Abortion History, 1922-1949' (2018) 30 (4) *Journal of Women's History* 11; see also Karen Brennan, 'Murderous mothers & gentle judges: Paternalism, patriarchy, and infanticide' (2018) 30 (1) *Yale Journal of Law and Feminism* 139

352 Earner-Byrne above n 669; ARA Aiken, DM Johnson, K Broussard et al, 'Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: a qualitative study' (2018) 44 *BMJ Sexual & Reproductive Health* 181.

353 See Moira J Mcguire, 'The Changing Face of Catholic Ireland: Conservatism and Liberalism in the Ann Lovett and Kerry Babies Scandals' (2001) 27 (2) Feminist Studies 335;

354 Earner-Byrne (n 336).

355 Earner-Byrne (n 336); see Chapter 2- 'Maternity and Moral Migration'.

356 *[1974] IR 284.*

357 See Rónán Duffy, 'From 1983 to 2018: A history of the Eighth Amendment' *The Journal IE* 1 April 2018; Maeve Taylor et al, 'The Irish Journey: Removing the shackles of abortion

woman with four children. Further pregnancies posed a threat to her life. Tried to import contraceptives which were seized by customs.[358] McGee claimed that her constitutional rights had been violated, in particular her right to marital privacy.[359] The Supreme Court, by a majority, granted her appeal.[360]

The extremely conservative government considered that this may lead to the liberalising of abortion. The Irish Supreme Court was persuaded by USA case law which had recently recognised abortion as a Constitutional right to privacy.[361] The majority verdict relied upon two US Supreme Court cases. The first, *Griswold v Connecticut*[362] held that married couples had a constitutional right to marital privacy and the use of contraceptives was part of this right. In the second, *Eisenstadt v Baird,*[363] this applied to unmarried couples also.

Not only the contraceptive rights which were of central concern to the anti-abortion contingent in Ireland. The apprehension stemmed from the much-publicised decision of *Roe v Wade*[364] in 1973, making abortion legal in the USA. The United States Supreme Court had held that the word 'person' in the Fourteenth Amendment did not include an 'unborn child'. The Irish concern was not without foundation. First, there were similarities between the equal protection clauses contained in the US Constitution and the Irish Constitution.[365] Second, the Irish Supreme Court had a great deal of respect for the US Supreme Court. Third, the section on citizenship in the Irish Constitution was difficult to extend to the unborn. Fourth, there were concerns about the implications of Ireland's obligations as a signatory to the *Convention on European Rights and*

restrictions in Ireland' (2019) 62 *Best Practice & Research Clinical Obstetrics and Gynaecology* 32.

358 Pursuant to the *Criminal Law Amendment Act 1935* (Ire) s 17(3).

359 *Constitution of Ireland* arts 40.3.1, 41.1.

360 See Angela Thompson, 'International Protection of Women's Rights: An Analysis of *Open Door Counselling Ltd and Dublin Well Woman Centre v Ireland*' (1994) *Boston University International Law Journal* 371, 374–5

361 *Roe v Wade* 410 US 113 (1973).

362 *381 US 479 (1965).*

363 *405 US 438 (1972).*

364 *410 US 113 (1973).*

365 See Quinlan, above n 214, 380.

*Fundamental Freedoms.*[366] The trend towards reform in other countries of the western law tradition added to the overall disquiet. Finally, the number of women travelling to England to have an abortion had risen 'from 64 in 1968 to more than 3600 in 1981'[367]. Together these matters posed a threat to the prohibition on abortion in Ireland.[368]

The preferred solution for the pro-life supporters was a constitutional amendment. This would preclude the Irish judiciary from holding that abortion prohibitions were unconstitutional.[369]

There was little or no opposition to amending the Constitution. The campaign was run close to an election and all political parties took an anti-abortion stance. As Quinlan has pointed out 'opposition ... by a political party might have been interpreted as a pro-abortion stance — a position no party could afford in a country that is ninety-five per cent Catholic'.[370]

The eighth amendment was passed in 1983 to constitutionally guarantee 'the right to life of the foetus' and thus further emphasise the importance of the foetus and the prohibition on abortion.[371] Article 40.3.3 provided:

> The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and as far as practicable, by its laws to defend and vindicate that right.[372]

The wording of the article may be interpreted as prohibiting all abortions. The mother is referred to as having an 'equal' right to life. The language and meaning of the provision are constructed in a manner that focuses upon the foetus. The inclusion of the mother's right might be read in such a manner that she may have an abortion to save her life but the wording was ambiguous.[373] Shortly before the referendum the Attorney-General

366 See Quinlan, (n 214) 399–401.

367 Figures quoted in Quinlan (n 214).

368 See Quinlan, (n 214).

369 See William Binchy, 'The need for a Constitutional Amendment', *Abortion and the Law* 116, 121,n16 (A Flannery, 1983).

370 Quinlan, above (n 214), 386.

371 See the *Eighth Amendment to the Constitution of Ireland Act 1983 (Ire)*.

372 *Constitution of Ireland Act 1983* (Ire).

Peter Sutherland criticised the wording saying it was 'ambiguous and unsatisfactory'.[374] With foresight he wrote in a memo.

> Further having regard to the equal rights of the unborn and the mother, a doctor faced with the dilemma of saving the life of the mother, knowing that to do so will terminate the life of "the unborn" will be compelled by the wording to conclude that he can do nothing. Whatever his intention he will have to show equal regard for both lives and his predominant intent will not be a factor. In these circumstances, I cannot approve of the wording proposed.[375]

### *2 Background to the 2013 Act*

In 1992, in *Attorney-General v X ('A-G v X'),*[376] it was held that an abortion may be permitted where 'there is a real and substantial risk to the life, as distinct from the health, of the mother'.[377] There was a real risk that the fourteen-year-old girl, X, who had been raped in brutal circumstances, would commit suicide. Her parents took her to England for an abortion. The Attorney-General obtained an interim injunction restraining X and her parents from leaving Ireland. They returned as soon as they found out about the injunction and before she had undergone the abortion. The High Court then made the injunction permanent and X's parents appealed to the Supreme Court

373 See John A Quinlan, 'The Right to Life of the Unborn — An Assessment of the Eighth Amendment to the Irish Constitution' [1984] *Brigham Young University Law Review* 371, 396; see

374 Sinead O'Carroll, 'The Attorney General's advice NOT to introduce 'pro-life' constitutional amendment – 1 7 extracts from Peter Sutherland's advice which predicted many of the issues Ireland has seen over the past 30 years' *The Journal IE* Dec 27th 2013,

375 Sinead O'Carroll, 'The Attorney General's advice NOT to introduce 'pro-life' constitutional amendment – 1 7 extracts from Peter Sutherland's advice which predicted many of the issues Ireland has seen over the past 30 years' *The Journal IE* Dec 27th 2013; see Marge Berer, 'Termination of Pregnancy as Emergency Obstetric Care: The Interpretation of Catholic Health Policy and the Consequences for Pregnant Women: An Analysis of the Death of Savita Halappanavar in Ireland and Similar Cases' (2013) 21 *Reproductive Health Matters* 9 where medical profession would not perform a termination to save the pregnant woman's life because there was a foetal heartbeat.

376 *[1992] 1 IR 1.*

377 Ibid.

which held that X could not be prevented from travelling outside Ireland to obtain an abortion. X miscarried shortly after the Supreme Court's decision.[378]

The problem for the right to autonomy of pregnant women was that the case only established that the court could not issue an injunction preventing a pregnant woman from travelling out of Ireland to have an abortion. Women were not accorded the right to have a legal abortion in Ireland in these circumstances.[379] Although Finlay CJ and McCarthy J expressed opinions that an abortion would be lawful in circumstances where the young girl was suicidal, these were strictly speaking obiter.

Justice McCarthy in *A-G v X,* referring to the 1982 constitutional amendment, insisted that:

> the failure by the legislature to enact the appropriate legislation is no longer unfortunate, it is inexcusable. What are pregnant women to do? What are the parents of a pregnant girl under age to do? What [is] the medical profession to do?[380]

In response, later in 1992, the conservatives put forward the 12th referendum to amend the Constitution to specifically provide for an abortion to preserve the life of the mother, except in the case of a threat of suicide. It was defeated. Of the defeat of the 'suicide exclusion' Ivana Bacik stated that:

> Unfortunately, although the defeat of the referendum was very important symbolically, demonstrating that even the combined power of the Catholic Church, the anti-abortion movement and the Fianna Fa´il party could not win over changing public opinion on this issue, defeat did not mark any step forward for pro-choice campaigners. It simply stopped the clock turning backwards.[381]

378 Ruadhan Mac Cormaic, X Case Judge says ruling is 'moot in current abortion debate' The Irish Times 6 July 2013.

379 Ibid.

380 Ibid [147]; Dearbhail McDonald, 'For All Our Sakes, the Government Must Define Legal Rights of the Unborn', *Independent* (online), 24 April 2008.

381 Ivana Bacik, 'The Irish Constitution and Gender Politics: Developments in the Law on Abortion' (2013) 28 *Irish Political Studies* 380, 391–2.

At the same time, Amendment 13, protecting freedom to travel abroad, was passed.[382] Amendment 14, was also passed. It allowed for access to information on reproductive rights and their availability in other jurisdictions.[383]

A third referendum was undertaken in 2002 to resolve the legal uncertainty created by *A-G v X*. The proposal was once again to exclude the risk of suicide as providing grounds for a lawful abortion. Abortions were to be lawful only when the woman's life was actually in danger because of the continuance of the pregnancy. It was defeated.[384] Thus *A-G v X* continued to state the law that an abortion would be lawful where the woman was suicidal.

Despite public opinion indicating support for *A-G v X* there was resistance to reform which lasted for more than 25 years.[385]

### *3 International Human Rights*

The severe restrictions on abortion in Ireland was demonstrated in a series of cases which came before the European Court of Human Rights (ECtHR) and concluded that Ireland had breached women's human rights in several cases.[386]

#### (a) *DG v Ireland*

In *D G v Ireland*[387] D was pregnant with twins. At eight weeks pregnant she found out that one of them would not live. At 17 weeks it was discovered that the second foetus had an abnormality. She decided that she could not cope with a pregnancy where one

382 *Constitution of Ireland* art 40.3.3; Bacik, (n 381); Mary Gilmartin and Allen White, 'Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights (2011) 36 *Signs* 275; *Regulation of Information (Services Outside the State For Termination of Pregnancies) Act 1995* (Ire).

383 *Constitution of Ireland art* 40.3.3.

384 John Downing, 'A Fourth Abortion Referendum Looms — But is Unlikely before a General Election', *Independent* (online), 19 August 2014 <http://www.independent.ie/opinion/columnists/john-downing/a-fourth-abortion-referendum-looms-but-is-unlikely-before-a-general-election-30517473.html>.

385 Linda Kelly, 'X case and the letter of the law' *Irish Examiner* 23 February 2012.

386 In 1985 Ireland became a signatory and ratified CEDAW. In 2005 CEDAW published a report on Ireland but did not report again until 2017.

387 *[2006] ECHR 210.*

foetus was dead and the other dying. Aware of the unlikelihood of obtaining an abortion in Ireland she travelled to the UK and had a termination.[388] She then filed a complaint in the ECtHR which detailed the difficulties which she had endured due to the restrictive nature of the abortion law in Ireland. The Court whilst seemingly aware of her problems declined to consider her case because she had not exhausted her domestic remedies.[389]

### (b) *A, B & C v Ireland*

In *A, B and C v Ireland* [390] there were three complainants with different factual situations. A and B made complaints under Article 8 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms ('ECHR')* claiming that Ireland had failed to implement 'the right to private life and family' by prohibiting abortion. This failed to recognise their autonomy. C alleged that Ireland had violated the same article by failing to implement a woman's constitutional right to termination where pregnancy poses a risk to her life.[391]

The majority declined to find in favour of A and B. However, in respect of C, they decided that her complaint was sustained. They 'found that the failure by the State to implement Article 40.3.3 constituted a failure to respect the third applicant's right to respect for her private life in violation of Article 8 of the Convention'.[392]

The Court was critical of the Irish Government, especially because of its clear recommendations.

> The Court considers that the uncertainty generated by the lack of legislative implementation of Article 40.3.3, and more particularly by the lack of effective and accessible procedures to establish a right to an abortion under that provision, has resulted in a striking discordance between the theoretical right to a lawful

388 Ibid [2]–[8].

389 Ibid [102]–[103]; *Convention for the Protection of Human Rights and Fundamental Freedoms* art 35 § 1 ('*ECHR*').

390 *A, B and C v Ireland* [2010] ECHR2032; see Brenda Daly, 'Access to Abortion Services: The Impact of the European Convention on Human Rights in Ireland' (2011) 30 *Medicine and Law* 267.

391 *A, B and C v Ireland* [2010] ECHR2032 [254], [264]–[265];

392 Ibid [277], 71(5).

abortion in Ireland on grounds of a relevant risk to a woman's life and the reality of its practical implementation.[393]

There are other ECtHR decisions which highlight the lacunae of concern for the right to autonomy of pregnant women in Ireland.[394] However, the preceding description is sufficient to illustrate that, by 2012, the criticisms of Ireland's stance on abortion laws should have caused the Irish Government a high degree of concern.

### (c) The Death of Savita Halappanavar

The failure of the government to heed warnings from various sources, most prominently the Irish Judiciary, the ECHR and the medical profession, that legislative clarification in respect of terminations of pregnancy was long overdue brought Ireland world-wide attention in 2012. The circumstances in which this occurred were avoidable.[395]

In 2012, Savita Halappanavar visited Ireland with her husband. She was seventeen weeks' pregnant and looking forward to the birth of her first child. She was admitted to hospital where it was found that her foetus was no longer viable. Savita's life could have been saved. She was refused urgent treatment because it would have required an illegal abortion. Allegedly, a medical professional explained the refusal on the basis that the hospital was Catholic and a foetal heartbeat was present.[396] By the time the hospital agreed to treat her, Savita had developed sepsis and died.

There was a public outcry and calls for government responsibility in protecting pregnant women's health. An inquest into Savita's death found medical misadventure because the hospital did not realise that Savita's life was definitely at risk. Therefore,

393 Ibid 262.

394 See Human Rights Committee, *Views: Communication No 2324/2013*, 116th sess, UN Doc CCPR/C/116/D/2324/2013 (31 March 2016) ('Mellett v Ireland); Max Bearak, 'UN Judgment Says Ireland's Anti-Abortion Laws Are a Violation of Human Rights' *Washington Post (Washington DC)*, 9 June 2016.

395 Editorial, 'Women's Choice is Key to Reduce Maternal Deaths' (2012) 380 *The Lancet* 1791.

396 Lori R Freedman, Uta Landy and Jody Steinauer, 'When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals' (2008) 98 *American Journal of Public Health* 1774.

medical staff could not have formed an opinion in good faith as required by law and therefore an abortion would have been illegal.[397]

The Catholic Bishops in Ireland reacted by seeking to clarify their position.[398] They asserted that it had never been one of their teachings that the foetus should have priority over the life of a pregnant woman.

> Where a seriously ill pregnant woman needs medical treatment which may put the life of her baby at risk, such treatments are ethically permissible provided every effort has been made to save the life of both the mother and her baby.[399]

However, their stance becomes equivocal when the above statement is read in context of their assertion that abortion is 'gravely immoral in all circumstances'.[400] Catholic teaching contends that abortion is distinguishable from medical treatment because the latter does not seek to kill the foetus.

> 'Current law and medical guidelines in Ireland allow nurses and doctors in Irish hospitals to apply this vital distinction in practice while upholding the equal right to life of *both* a mother and her unborn baby'.[401]

397 Paul Cullen, 'Savita Halappanavar Jury Returns Unanimous Medical Misadventure Verdict' *The Irish Times* (online), 19 April 2013 <https://www.irishtimes.com/news/health/savita-halappanavar-jury-returns-unanimous-medical-misadventure-verdict-1.1365716>.

398 Irish Catholic Bishops' Conference, *Statement by the Standing Committee of the Irish Catholic Bishops' Conference on the Equal and Inalienable Right to Life of a Mother and Her Unborn Child* (19 November 2012) <https://www.catholicbishops.ie/2012/11/19/statement-standing-committee-irish-catholic-bishops-conference-equal-inalienable-life-mother-unborn-child>; see United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (5th ed, 2009) 26.

399 Irish Catholic Bishops' Conference, *Statement by the Standing Committee of the Irish Catholic Bishops' Conference on the Equal and Inalienable Right to Life of a Mother and Her Unborn Child* (19 November 2012).

400 Irish Catholic Bishops' Conference 'Two Lives, One Love – pastoral message for 2018 on the right to life' news Archive 9 March 2018

401 Irish Catholic Bishops' Conference, statement 2012(n597) emphasis added.

This would appear to be exactly what the medical staff did in Savita's case. The foetus had a heartbeat and therefore was 'equal'. Once the heartbeat ceased it was permissible to save Savita's life but by then it was too late.

The hospital was considered to have followed the guidelines of the church .[402] However, as Marge Berer points out Savita and her 17 week foetus did not 'have an equal chance of survival'.[403] Following the religious directive remains in breach of the ethics of the medical profession and ' . . .violates the Hippocratic oath to do no harm violates the Hippocratic oath to do no harm'.[404]

### *4 The Protection of Life During Pregnancy Act 2013*

In answer to criticisms and to clarify the government stance on the termination of pregnancy the *Protection of Life During Pregnancy Act 2013* (Ire) ('*PLDP Act 2013'*) was passed. The Act reinforced the stance taken in *Roche v Roche*[405] that Article 4.3.3 'can be fairly interpreted as meaning the right of life not yet born to live, or to its life'.[406]

The Act did not answer the controversial and important question of when 'human life begins'.[407] However, Catholic dogma states that life begins at 'conception' and so a definition may have been considered unnecessary.

An analysis of the provisions of the Act indicated its extremely restrictive application.

402 Ibid; see Marge Berer, 'Termination of Pregnancy as Emergency Obstetric Care: The Interpretation of Catholic Health Policy and the Consequences for Pregnant Women: An Analysis of the Death of Savita Halappanavar in Ireland and Similar Cases' (2013) 21 *Reproductive Health Matters* 9.

403 Berer (n 402) 12.

404 Ibid 15.

405 *Roche v Roche* [2009] IESC 82 (15 December 2009); this case involved the question of whether and if so what protection an embryo has before implantation in the womb. The court had expressed the view 'that the frozen embryo is entitled to respect. This is the least that can be said. Arguably there may be a constitutional obligation on the State to give concrete form to that respect. In default of any action by the executive and legislative organs of the State, it may be open to the courts in a future case to consider whether an embryo enjoys constitutional protection under other provisions of the Constitution'.

406 Ibid Murray CJ.

407 *Roche v Roche* [2009] IESC 82 (15 December 2009).

The long title made it clear that the rights of the unborn are of paramount importance. The stated intentions, 'to protect human life during pregnancy' and 'to provide for an offence of intentional destruction of unborn life', expose the tenor of the legislation as being effectively to prohibit abortion in Ireland. [408] Clarity could have been achieved by a statement, to the effect, that the purpose of the legislation was to regulate legal terminations of pregnancy.[409]

Secondly, the provisions of the Act accorded with its intentions. Despite ss 58–59 of the *OAP Act 1861* being repealed, termination of pregnancy was not decriminalised[410] and the pregnant woman was unable to request an abortion. An abortion was legal where there was a 'risk of loss of life'. The grounds, which met this criterion, were stated in s 7 (physical injury); s 8 (emergency), and s 9 (suicide). These were the only circumstances under which an abortion was lawful. In respect of each situation there was a distinct and arguably deliberate manner in which the medical procedure is delineated. Neither the word abortion nor the phrase termination of pregnancy was used. Rather, in each of the sections it was provided that '[i]t shall be lawful to carry out a medical procedure in respect of a pregnant woman ... in the course of which, or as a result of which, an

408 See *PLDP Act 2013* long title:

An Act to protect human life during pregnancy; to make provision for reviews at the instigation of a pregnant woman of certain medical opinions given in respect of pregnancy; to provide for an offence of intentional destruction of unborn human life; to amend the Health Act 2007; to repeal sections 58 and 59 of the Offences Against the Person Act 1861; and to provide for matters connected therewith.

409 See e g, *Abortion Law Reform Act 2008* (Vic) s 1, which states that main purposes of this Act are—

(a) to reform the law relating to abortion; and

(b) to regulate health practitioners performing abortions; and

(c) to amend the Crimes Act 1958 —

(i) to repeal the provisions relating to abortion; and

(ii) to abolish the common law offences relating to abortion; and

(iii) to make it an offence for an unqualified person to perform an abortion; and

(iv) to amend the definition of serious injury to include the destruction of a foetus other than in the course of a medical procedure.

410 *PLDP Act 2013* s 5.

unborn human life is ended'.[411] The definition of 'unborn' made it clear that the law considered a foetus to have the rights of personhood. It stated

> 'unborn', in relation to a human life, is a reference to such a life during the period of time commencing after implantation in the womb of a woman and ending on the complete emergence of the life from the body of the woman.[412]

The procedural requirements were different in respect of each ground. Where there was 'a real and substantial risk of loss of the woman's life from a physical illness', the woman was examined by two doctors.[413] Both were required to form a reasonable opinion that the medical procedure was required. In doing this they were to have regard to the need to preserve unborn human life as far as practicable, and that abortion was the only means of averting the risk to the woman's life. One of the doctors was to be an obstetrician and the other to have relevant expertise.[414] Both, acting in good faith, were required to sign a certificate authorising an abortion to be performed.[415] Subject to the agreement of the woman, they were to consult with the woman's regular doctor.[416] The purpose of this was to assist in deciding whether to issue a certificate.

The procedure for authorising a termination, where the pregnant woman's life was at risk from physical injury and in an emergency situation, was provided for in section 8. In an emergency, one doctor was to examine the woman and if s/he believed 'in good faith that there [was] an immediate risk of loss of the woman's life from a physical illness' the operation could be performed.[417] Once again s/he was to have 'regard to the need to preserve unborn human life as far as practicable'.[418]

411 See Nick Hopkins, Suzanne Zeedyk and Fiona Raitt, 'Visualising Abortion: Emotion Discourse and Fetal Imagery in a Contemporary Abortion Debate' (2005) 61 *Social Science and Medicine* 393 for an account of how both visual and linguistic material can be used to deliberately form opinions based in emotion rather reason.

412 *PLDP Act 2013* s 2(1).

413 *Ibid* s 7(1)(a).

414 *Ibid* s 7(2).

415 *Ibid* s 19.

416 *Ibid* s 7(3).

417 *Ibid* s 8(1)(a).

418 *Ibid* s 8(1)(b).

Section 9 covered the situation which arose in *AG v X* discussed above.[419] If the pregnant woman was suicidal she was to be examined by three medical practitioners.[420] One of these was an obstetrician and the other two were psychiatrists. They were required to act in good faith and to all agree that there was 'a real and substantial risk that the woman [would] suicide'.

They were required to have 'regard to the need to preserve unborn human life as far *as practicable'* and believe that 'the risk can *only* be averted by carrying out the medical procedure'.[421] Hederman J in *A-G v X* had expressed the opinion that doctors might consider that it is practicable to closely supervise a 'suicidal' pregnant woman during her pregnancy and that any risk could be averted by doing so. Hederman J was quite adamant that threatened suicide under the previous legislation did not provide grounds for an abortion. He said:

> Suicide threats can be contained. The duration of the pregnancy is a matter of months and it should not be impossible to guard the girl against self-destruction and preserve the life of the unborn child at the same time. The choice is between the certain death of the unborn life and a feared substantial danger of death but no degree of certainty of the mother by way of self-destruction.'[422]

Hederman J had concluded that there had been insufficient evidence to show that the girl in *A-G v X* was in fact suicidal.[423]

To satisfy the requirements in respect of contraventions of *ECHR* and the criticism in A, B *& C v Ireland*[424] a domestic appeal system was incorporated into the *PLDP Act 2013*.[425] A woman who was refused a certificate authorising a termination could have her case re-determined by a review committee.[426] The system was complex and cumbersome.[427]

419 *[1992] 1 IR 1 (*Finlay CJ).

420 *PLDP Act 2013* s 9(1)(a).

421 Ibid 9(a)(ii) (emphases added).

422 *AG v X [1992] 1 IR 1,* [130].

423 *Ibid* [131].

424 *[2010] ECHR 2032, discussed above n.*

425 *PLDP Act 2013,* Part 2.

426 *PLDP Act 2013* s 10.

427 Ibid s 12, s 13.

The circumstances in which an abortion was able to be performed were therefore extremely restrictive. The government of Ireland did not acknowledge the right to autonomy of pregnant women nor indicate a concern for their health. The foetus was given superior rights to those of the pregnant woman. If the foetus was close to full term and viable, it was extremely unlikely that a termination would be performed.[428]

The operation of the Act caused concern. Few women met the restrictive requirements for lawful terminations of pregnancy. Only 26 abortions were carried out in the first year of the Act's operation.[429] The Minister for Health stated that the number was as expected and confirmed that abortion would remain illegal in Ireland.[430]

In keeping with government policy of restricting abortion, the procedures for review of decisions not to allow an abortion were time consuming. Above all it was extremely stressful for the women involved. This would be particularly so in the case where a woman was suicidal. [431] Joanna Erdman points out:

> [t]hat a woman may upon denial seek a second or any number of subsequent opinions, looping through the process again and again, is presented as an entitlement, rather than the likely predicament of socially vulnerable and disadvantaged women.[432]

428 See *Ms Y v Health Services Executive & Ors* [2016] IEHC 136; see Ruth Fletcher, 'Contesting the cruel treatment of abortion-seeking women' (2014) 22(44) *Reproductive Health Matters* 10,

429 Department of Health, 'Notifications in Accordance with Section 20 of the Protection of Life During Pregnancy Act 2013' (Annual Report 2014, June 2015) 3; the number or Irish women who travelled to the UK to have an abortion was about 3679 according to Andrea Mulligan, 'The Right to Travel for Abortion Services: A Case Study in Irish 'Cross-border Reproductive Care' (2015) 22 (3) *European Journal of Health Law* 239, 260.

430 Department of Health, 'Notifications in Accordance with Section 20 of the Protection of Life During Pregnancy Act 2013' (Annual Report 2014, June 2015) 3; Sinead O'Carroll, '26 Terminations Carried Out in Ireland under New Abortion Laws — Minister Leo Varadkar Revealed the Figures Today' The Journal. ie , 29 June 2015, http://www.thejournal.ie/abortions-ireland-26-2188298-Jun2015/.

431 Joanna N Erdman, 'Procedural Abortion Rights: Ireland and the European Court of Human Rights' (2014) 22 *Reproductive Health Matters* 22, 26.

This appeared true of women who attempted to utilise the procedures set down by the law. It was too unwieldy and intrusive. Thus women resorted to alternative means of accessing an abortion. They usually travelled to the UK if they had the means to do so.[433] Therefore in those cases the *PLDP Act 2013* did not improve women's autonomy.

There was only one application for review during its first year of operation. The case reviewed, *Ms Y,*[434] demonstrated a disregard for women's basic human rights and did nothing to promote women's autonomy. The phrase the 'risk can only be averted by carrying out the medical procedure' was interpreted literally.[435]

Ms Y had been raped in her home country. She was in Ireland as an asylum seeker when she discovered she was eight weeks pregnant. She was particularly confused by her situation and found it highly stressful. She wanted a termination and tried to travel to the UK. She was turned back because of her refugee status and referred to the Health Services Executive under the *PLDP Act 2013*.

The committee subsequently empanelled under the Act refused her application for an abortion. She was about 20 weeks pregnant. The health system had been aware of her pregnancy and circumstances for some twelve weeks. The Committee agreed that her life was indeed at risk but they considered that the rights of the foetus were paramount. Ms Y then went on a hunger strike. An application was made to the High Court for an Order that a caesarean section be performed upon her at 25 weeks and that they be allowed to forcefully hydrate her.[436] It is alleged that Ms Y eventually consented to the caesarean. However, it was pointed out by Ruth Fletcher that given the circumstances,

432 Ibid 26; see Chapter5 – Medical Treatment-Refusal and Consent for a further discussion of this case.

433 The right to information and travel for the purposes of obtaining an abortion, lawful or unlawful, was placed in statutory form under s 18 of the *PLDP Act 2013*; see Andrea Mulligan, 'The Right to Travel' above n 239, 250 – 266.

434 Kitty Holland, 'Timeline of Ms Y case' *The Irish Times* 4 October 2015*; Ms Y v Health Services Executive & Ors* [2016] IEHC 136; *Ruth Fletcher, 'Contesting the Cruel Treatment of Abortion-Seeking* Women' (2014) 22 *Reproductive Health Matters* 10.

435 *PLDP Act 2013* ss 7–9.

436 *Ms Y v Health Services Executive & Ors* [2016] IEHC 136.

whether there was a valid consent, is questionable.[437] The foetus was delivered by caesarean at 25 weeks and lived.

Fletcher argues that *Ms Y* demonstrates, among other things,

> just how unethical and rights-violating the substance of Irish abortion law is. Irish abortion law imposes cruel, inhuman and degrading treatment, violates integrity and autonomy, discriminates against women in general, and against women with mental health issues, women with few economic resources and women with limited mobility options, in particular.[438]

Ms Y's right to not continue with her pregnancy and to refuse medical treatment are both important to her autonomy. They were violated. As a women and a refugee she was not treated as an equivalent person or a chance at individuation.[439] This treatment makes women aware that their bodily integrity could be threatened in the future and that they will not be recognised as having human rights in the future.[440]

A final case which concerns the status of the foetus and its right life is *P P v Health Service Executive*[441] which raised serious concerns about the application of Article 40.3.3. to the status of the foetus. Here a brain-dead woman was placed upon life-support for the purposes of ma

intaining life of her 15-week-old foetus. The doctors did not believe that the foetus had even minimal chance of survival. Although not in pain its condition would deteriorate with time. The hospital considered that removing somatic support would kill the foetus and they would be in breach of the law. Some weeks after the woman was confirmed dead her father petitioned the High Court. The decision of the court involved an examination of Article 40.3.3. The Court noted.

437 Ibid 15.

438 Ibid 14.

439 See Cornell, *The Imaginary Domain,* (n 171).

440 See Lesley Murray and Nichola Khan (2020) The im/mobilities of 'sometimes-migrating' for abortion: Ireland to Great Britain' (2020) 15 (2) *Mobilities* 161 where migrants and refugees continue to be unable to have an abortion in Ireland and because of their status are prevented from travelling elsewhere.

441 [2014] IEHC 622.

> Given that the unborn in this jurisdiction enjoys and has the constitutional guarantee of a right to life, the Court is satisfied that a necessary part of vindicating that right is to enquire as to the practicality and utility of continuing life support measures.[442]

The description of the woman's physical appearance as described in the case is distressing. What her body had suffered could be labelled abhorrent.

> The tenets of Catholicism were pervasive in *PP*: had the doctors not feared breaching a law overtly based on these tenets, the case would probably never have reached a court, and the Irish High Court went out of its way to treat the non-viable foetus as having a right to the life that it could never attain.[443]

The Court did not regard it as a situation where in reality the withdrawing of the somatic support would result in the termination of the foetus. In effect the Court appeared to consider that the continuance on life-support of a pregnant woman denied her dignity in death and subjected her family to unnecessary and incomprehensible suffering.. Prolonging the life of the foetus was likely to be a 'futile' exercise which commenced only because of fears of prosecution.[444] Of concern, is the influence of the Catholic Church upon medical matters, particularly when the situation is one where it is virtually impossible for a foetus to be born or to be born in a healthy condition.[445]

### *5 Repealing the Eighth Amendment*

The cases just discussed indicated that it was not only time for a Referendum to repeal the Eighth Amendment, but such an action was long overdue. In 2016 a Citizen's Assembly was established. After extensive briefing, discussion and deliberation they concluded that the Eighth Amendment be repealed and abortion law reformed.[446]

442 *PP v Health Service Executive* [2014] IEHC 622, [Bailii 11 – 12].

443 S Pywell, 'The Influence of Catholic Doctrine on Medical Law When X's Life Poses a Threat to Y's Life' (2015) 4 (3)*Oxford Journal of Law and Religion* 520, 525.

444 *PP v Health Service Executive* [2104] IEHC 622, [ Bailii 8,11].

445 Pywell above n ,523.

446 Maeve O'Connell, 'Repealing the Eighth' (2018) 12 (8) British Journal of Healthcare Assistants 405,407.

The sequence of events prior to the referendum revealed the commitment to the respective stances taken on abortion and the potential divisiveness of the hotly contested debates.[447] Of note was the role of the medical profession which had not been highly represented in previous campaigns. They argued that they were unable to provide for the health and welfare of their women patients.

On the 26th May 2018 the people of Ireland by a two-thirds majority voted to repeal the Eighth Amendment. The 36th Amendment provided that Article 40 of the Constitution would be amended to allow the Oireachtas to enact laws to regulate abortion.[448]

Since the 1st February 2019 the laws of abortion have been regulated under the *Health (Regulation of Termination of Pregnancy) Act 2018* (Ire) *(Health (RTP) Act 2018 )* which repealed the *Protection of Life During Pregnancy Act 2013* (Ire).[449] Part 2 *Health* (*RTP) Act 2018* provides for the termination of pregnancy. Under section 12 a medical practitioner may terminate a pregnancy of not more than 12 weeks' gestation. S/he must provide a certificate to that effect.[450] The woman must wait 3 days, from the certification date, before the termination may be performed and it must be carried out before the pregnancy has exceeded 12 weeks.[451] The provision whilst it allows for early terminations on request has been the subject of criticism on the grounds that the 3 day waiting period is unnecessary and may prove detrimental to the woman's health. Further, the waiting period and the manner of calculating the weeks of gestation may mean that some women are outside the time limit in section 5 before they have had time to consider their options. They may not even be aware that they are pregnant. Nevertheless they will be outside the time-limit and their only option is to proceed under section 9.

Section 9 provides that a termination may be performed, after 12 weeks' durations, where two medical practitioners, one of which must be an obstetrician, have formed an opinion, in good faith, and certified, that there is a risk to the life or of serious harm to

447 Michael Kelly 'Irish government to hold referendum on right to life of mother, child' *National Catholic Reporter* 30 January 2018.

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450 S 12 (2).

451 S 12 (4).

the health of the pregnant woman and the foetus. It must be 'appropriate' to perform the abortion to avert the said risk and it must be performed before the foetus is viable.[452] Under section 10 a termination may be performed if it is an emergency situation. Section 11 provides for terminations in the situations where there is a condition from which the foetus is likely to die either before or within 28 days of birth.[453] An obstetrician and a medical practitioner of a relevant speciality will be required to sign the requisite certificate. There is a committee procedure established under the legislation to allow for a review of the decisions of the doctors.

Perhaps problematic is that there is no definitions of 'risk to life' and 'serious harm to health'. Given that the threat of suicide and other matters such economic and family situation have been the subject of discussion in respect of women's health it may have been appropriate to provide some guidance.

The *Health (RTP) Act 2018* also makes it an offence to intentionally end the life of a foetus unless in accordance with that Act.[454] It is an offence to 'aid, abet ,counsel or procure' a woman terminate a pregnancy.[455] It is also an offence to provide things to be used in an abortion except in accordance with the Act.[456] These offences do not apply to the pregnant woman but could apply to a friend or partner of someone else who for example; provides her with abortion pills or assists her in some other way. These offences carry a maximum penalty of 14 years imprisonment which is extremely severe. They also contribute to the stigma attaching to abortion even though abortion was intended to become a health issue.

It is suggested that the Act is far from perfect but it may be regarded as a very important initiative in reforming Ireland's abortion law to promote women's autonomy.

452 See s 9.

453 See discussion below C - Northern Ireland.

454 *Health (RTP) Act 2018* S 23 (1).

455 Ibid

456 S 23 (2).

## *C Northern Ireland*

### *1 Introduction*

In Northern Ireland, historically, the killing of a foetus from conception was regarded as murder. This reasoning, based in and perpetuated by religious dogma, confounded 'moral' and 'legal' rights to the detriment of women's autonomy. Northern Ireland's law did not allow abortion in cases of rape, incest or where the foetus had been diagnosed with defects which would mean they would not survive being born.[457] Legal abortions were almost impossible to obtain. Seemingly unquestioned was the equation of abortion with murder which subordinated the rights of the woman in favour of the foetus and indicated that being pregnant severely undermined women's autonomy.[458]

Until the 22nd October 2019 sections 58-59 of the *OAP Act 1861* plus the *Bourne* exemption represented the law on abortion in Northern Ireland. The maximum penalty was life imprisonment.[459] In 2019, the *Northern Ireland (Executive Formation etc) Act 2019* (UK) (*NI(EFA)A 2019*) repealed sections 58 and 59 of the *OAP Act 1861*[460] but only in respect of Northern Ireland. [461] This had the effect of decriminalising abortion in Northern Ireland. The impact of the repeal of the legislation meant that it was not a criminal offence to seek, perform, assist in or supply the means for an abortion. Initially it meant that a woman had, by law, an unfettered autonomy when it came to making a decision to have an abortion.

457 *In the Matter of an Application by the Family Planning Association of Northern Ireland for Judicial Review [2003] NIQB 48 (7 July 2003) [1] (Kerr J).*

458 This is discussed in Chapter 4 – Access to Legal Terminations; Amnesty International, *Northern Ireland – Barriers to Accessing Abortion Services,*15; Amelia Gentleman, 'Abortion figures prompt fresh calls for reform of Northern Irish laws' *The Guardian* 30 June 2017; Mary Gilmartin, 'Interrogating Medical Tourism: Ireland, Abortion, and Mobility Rights' (2011) 36 (2) *Signs* 275.

459 S 58 life imprisonment; s59 imprisonment.

460 *NI(EF)A 2019* ss8 to 12. There remains the offence of killing an unborn child under the *Criminal Justice Act (Northern Ireland) 1945* (UK) c 15, s 25(1)-(2) which mirrors the *Infant Life Preservation Act 1929* (UK) ss1-2.

461 *NI(EF)A 2019* s13(2).

The dramatic and total reversal of the strict and draconian laws was not the result of the usual law reform processes and occurred somewhat more quickly than usual. Certainly, whilst there may have been calls for and public protest in favour of relaxing the law,[462] the Northern Ireland Parliamentary input was limited.[463] Indeed the resulting legal 'hiatus' in respect of abortion may be surprising to some given that abortion has been highly controversial and remains a volatile issue within Northern Ireland.[464]

An understanding of how this 'unexpected' reversal of abortion regulation came about may be gleaned by considering abortion law up until the passing of the *NI(EF)A 2019.*

### *2 Repressive and Anachronistic Laws*

As previously stated, sections 58-59 of the *OAPA 1861* applied to Northern Ireland because it did not adopt the Abortion *Law Reform Act 1967*[465] Guilt or innocence of an offence relied partly upon the interpretation of the word 'unlawfully'. It might have been thought that Northern Ireland would apply *Bourne* when interpreting the element of 'unlawful' in ss 58–59 and this would allow greater access to abortion.[466] At first, the status of *Bourne,* [467] in interpreting 'unlawful', in Northern Ireland was equivocal.[468] It

462 Amnesty International, *Northern Ireland – Barriers to Accessing Abortion Services,* Report EUR 1057/2015, 6; Amelia Gentleman, 'Abortion figures prompt fresh calls for reform of Northern Irish laws' *The Guardian* 30 June 2017; see also above, sections III and IV of this chapter.

463 In December 2016, Mr Ford, a Private Member had introduced the Abortion (Fatal Abnormality) Bill but this had lapsed when the NI Parliament cased to govern in January 2017.

464 J Thomson, 'The National Institution: Westminster' in *Abortion Law and Political Institutions' Gender and Politics* (Palgrave Macmillan, Cham, 2019).

465 For a discussion on why they did not adopt the legislation, see J Thomson 'Introduction', in *Abortion Law and Political Institution Gender and Politics* (Palgrave Macmillan, Cham, 2019).

466 See *Northern Ireland Act 1998* (UK) c 47, sch 3 s 9(a) which provides that 'crime' is a reserved matter for legislation by the Northern Ireland.

467 See *R v Bourne* [1939] 1 KB 687.

468 *Northern Health and Social Services v A* [1994] NIJB 1, [2H] (MacDermott LJ); *Family Planning Association of Northern Ireland v The Minister for Health, Social Services and Public Safety* [2004] NICA 37–9 (8 October 2004) [6] (Sheil LJ, Campbell LJ and Nicholson

was considered, at least since devolution, that *Bourne* might not be successfully relied upon for establishing when an abortion may be 'lawful'.[469] *Bourne* did not result in any change to the attitudes to or the availability of abortion in Northern Ireland. This is not surprising when it is considered that:

> The role of religious and political discourse in framing sexual citizenship in Northern Ireland has resulted in religion being mapped onto the social and political backdrop, with traditional conservative roles mapped out for men and women.[470]

The decision in *Bourne* protected doctors who were already performing abortions. But it did not grant women the right to elect to have an abortion. There is no evidence to suggest that, in Northern Ireland, the medical profession was performing abortions or that there was social pressure to reform abortion laws at that time. Being a woman in Northern Ireland, meant conformity to repressive laws and sexuality. The existence of severe criminal sanctions for both pregnant women and doctors, who did not conform, was no doubt of deterrence.[471]

The courts of Northern Ireland finally considered *Bourne* in the 1990s. In 1993, *Northern Health and Social Services Board v F and G*[472] came before Shiel J at first

LJ) ('*Family Planning Association*').

469 *Northern Ireland Act 1998* (UK) c 47, s4 sch 3 s 9(a) which provides that 'crime' was a reserved matter for legislation by the Northern Ireland. It became a transferred matter under the *Northern Ireland Act 1998 (Amendment of Schedule 3) Order 2010*. Nevertheless there is controversy over whether 'abortion' is included in 'crime'. If it is then the NI Assembly has discretion to make laws applying to abortion. If is reserved it needs Westminster's approval. Robert Brett Taylor, 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, 91.

470 Bloomer and O'Dowd, above n 350, 367.

471 Sarah Harrison, 'Northern Ireland Urged to Clarify Abortion Rules: Abortion Laws in the Province Mirror Those in the Republic and Put Nurses at Risk' (2004) 18 *Nursing Standard* 8.

472 [1993] NI 268; Shiel LJ refers to this judgment in *Family Planning Association of Northern Ireland v Minister For Health Social Services and Public Safety* [2004] NICA 37 (8 October 2004) (Sheil LJ).

instance. K was a 14 year old teenager who was thirteen weeks pregnant, institutionalised, had a history of drug abuse, was suicidal, had attempted to 'self-abort' and was a ward of the court. In deciding that this was a situation where an abortion would be lawful, Shiel J quoted, with approval, the instructions to the jury in the English case of *R v Newton and Stungo*.[473] The direction included a requirement that lawfulness depended upon whether the termination was 'made in good faith' and for the 'purposes of preserving the mental as well as physical health of the woman'.[474] However, the abortion was not performed in Northern Ireland. K was required to travel to Liverpool in England to have the abortion.[475]

In *A,B and R (on the application of) v Secretary of State for Health*[476] an appeal, which would have extended NHS coverage to women from Northern Ireland who had an abortion performed in the UK, was rejected by the UK Supreme Court. The decision was based upon the need to 'afford respect to the democratic decision of the people of Northern Ireland'.[477] Two weeks later women from Northern Ireland who travelled to England for an abortion became eligible for NHS coverage.[478]

Subsequent cases sought to further clarify when an abortion would be lawful. In 1994, *Northern Health and Social Services Board v A and Ors*[479] came before McDermott LJ who decided that it was lawful for a severely mentally handicapped woman in her tenth week of pregnancy to have a termination. He stated that

> for the purpose only of preserving the life of the mother' does not relate only to some life-threatening situation. Life in this context means the physical and mental health or well-being of the mother and the doctor's act is lawful where the continuance of the pregnancy would adversely affect the mental or physical health

473 [1958] Crim LR 469.

474 [1993] NI 268.

475 Ibid 277F; *Family Planning Association of Northern Ireland v Minister For Health Social Services and Public Safety* [2004] NICA 37 (08 October 2004) [6].

476 *A and B, R (on the application of) v Secretary of State for Health* (Rev 1) [2017] UKSC 41 (14 June 2017).

477 Ibid [20].

478 Letter dated 29 Justine Greening June 2017 Minister for Women and Equalities, Letter to members of the House of Commons, 29 June 2017.

479 [1994] NIJB 1.

> of the mother. The adverse effect must however be a real and serious one and it will always be a question of fact and degree whether the perceived effect of non-termination is sufficiently grave to warrant terminating the unborn child.[480]

In 1995, in *Western Health and Social Services Board v CMB and the Official Solicitor*,[481] Justice Pringle of the High Court decided that it was lawful for a seventeen-year-old ward of court, who was twelve weeks pregnant and severely handicapped, to have an abortion. It is reported that the termination was performed in Northern Ireland.[482]

In the same year, another case involving the lawfulness of abortion came before Shiel J in the High Court. Here, a sixteen-year-old pregnant ward of court, was suicidal. The judge held that the abortion would be lawful.[483]

In 2004, the *Family Planning Association of Northern Ireland (FPANI) v The Minister for Health, Social Services and Public Services and Public Safety Minister*[484] came before the Court of Appeal. It was an appeal against an Order to Review made by Justice Kerr in 2003.[485] In allowing the appeal it was held that, among other things, the Minister had unlawfully failed 'to issue advice and or guidance to women of child-bearing age and to clinicians ... on the availability and provision of termination of pregnancy services'.[486] In the court below, Kerr J had considered that previous judicial decisions had adequately explained abortion law.[487] He stated that:

480 Ibid [5].

481 *[1995] NI (unreported) (Pringle J); see Family Planning Association of Northern Ireland v Minister For Health Social Services and Public Safety* [2004] NICA 37–9 (8 October 2004) (Sheil LJ, Campbell LJ and Nicholson LJ).

482 *Western Health and Social Services Board v CMB and the Official Solicitor [1995] (unreported) (Pringle J).*

483 *Re CH (A Minor)* [1995] NI (unreported) (Sheil J); discussed in *Family Planning Association of Northern Ireland v Minister For Health Social Services and Public Safety* [2004] NICA 37–9 (8 October 2004) (Sheil LJ, Campbell LJ and Nicholson LJ).

484 [2004] NICA 37–9 (8 October 2004) (Sheil LJ, Campbell LJ and Nicholson LJ).

485 *In the Matter of an Application by the Family Planning Association of Northern Ireland for Judicial Review [2003] NIQB 48 (7 July 2003) (Kerr J).*

486 *FPANI* [2004] NICA 38–9 (8 October 2004) [1], [3] (Campbell LJ and Nicholson LJ).

487 *In the Matter of an Application by the Family Planning Association of Northern Ireland for Judicial Review [2003] NIQB 48 (7 July 2003) (Kerr J),* referring to *Northern Health and*

> No evidence has been produced that the medical profession is incapable of recognising circumstances where abortion would be justified under the law in Northern Ireland or that women have been denied abortion because a lack of knowledge on the part of medical practitioners.[488]

In dismissing the application, he considered that any difficulties which the medical profession experienced in applying the law would not be solved by the Minister issuing guidelines. He opined that this was a matter for legislation.[489]

On appeal, Lord Justices Sheil, Campbell and Nicolson delivered separate concurring judgments which held that the law lacked clarity and the medical profession needed direction.[490] All Justices considered that the appeal was about providing guidance to medical professionals in respect of when abortions would be lawful in Northern Ireland. The decision was not concerned with altering the law in any way.

Nicholson LJ considered that the laws regulating abortion were properly located within the criminal law. As such, if all the elements of the offence were proved beyond reasonable doubt the offender would be liable to a maximum sentence of life imprisonment. A termination would be lawful where the 'jury considers that the continuance of the pregnancy would have created a risk to the life of the mother or would have caused serious and long-term harm to her physical or mental health'.[491] All other abortions would be unlawful.

Nicholson LJ suggested that foetal abnormality was relevant only where the pregnant woman would probably suffer serious long-term harm to her physical or mental health if she gave birth to an abnormal child.[492] Sheil LJ considered that foetal abnormality was

*Social Services Board v F and G* [1993] NI 268 [33]; *Northern Health and Social Services Board v A* [1994] NIJB [34]; *Western Health and Social Services Board v CMB and the Official Solicitor [1995] (unreported) [36] (Pringle J)* — a termination on a mentally handicapped 17 year old was lawful.

488 *In the Matter of an Application by the Family Planning Association of Northern Ireland for Judicial Review [2003] NIQB 48 (7 July 2003) [48] (Kerr J)*.

489 *Ibid* [1].

490 *FPANI* [2004] NICA 37 (8 October 2004) [10] (Sheil LJ).

491 *FPANI* [2004] NICA 39 (8 October 2004)[74] (Nicholson LJ).

492 Ibid [75](3).

not a sufficient reason to render an unlawful abortion lawful.[493] Their Lordships disagreed with Kerr J's opinion that the law on abortion was clear. In their opinion the opposite was true and 'it is not clear that clinicians or midwifes, let alone general medical practitioners or pregnant women, know what the law is'.[494] The Court granted the appeal.[495]

However, what was clear from the judgments was that the law of abortion in Northern Ireland was well established and indicated that the woman's right to choose whether or not to continue with a pregnancy was subordinate to the rights of the foetus, whose 'right to life' would only be overborne where the woman's life or long term well-being was at risk from the continuance of the pregnancy.[496] Governmental guidelines were then published which outlined the limited situations where abortion would be lawful.[497]

The development of human rights based analyses and critiques led to discussions of whether the laws in Northern Ireland and Ireland were consistent with women's human rights. In 2014, *Northern Ireland's Human Rights Commission's Application (NIHRC)*[498] came before Mr Justice Mark Horner of the High Court (Judicial Review). *NIHRC* sought a declaration that the failure to provide exceptions to the provision of abortion for pregnancies where there was a 'Serious Malformation of the Foetus' (SMF), a 'Fatal Foetal Abnormality' (FFA); or, the pregnancy was a result of rape or incest (sexual assault) violated the *European Convention on Human Rights (ECHR).*

Horner J held that the NIHRC had standing to bring the proceedings in its own name rather than those of the victims. His Honour made a declaration that the rights of women in Northern Ireland, who are pregnant with fatal foetal abnormalities or who are pregnant as a result of a sexual crime, were breached by the challenged provisions. He

493 *FPANI* [2004] NICA 37 (8 October 2004) [10] (Sheil LJ).Ibid [9].

494 *FPANI* [2004] NICA 39 (8 October 2004) [76] (Nicholson LJ).

495 Ibid [15] (Sheil LJ), [54] (Nicholson LJ), [116] (Campbell LJ).

496 Ibid.

497 Department of Health, Social Services and Public Safety, *Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland* (2009); withdrawn after objection as a result of *In the Matter of an Application by the Society for the Protection of Unborn Children for Judicial Review* [2009] NIQB 92 (30 November 2009) (Girvan LJ); reissued in 2016 after amendment.

498 [2015] NIQB 96.

made a declaration that the provisions were incompatible with Article 8 (the right to privacy and the right to family life) of the *ECHR* but that they were not in conflict with Article 3 (prohibition against torture and 'inhuman or degrading treatment or punishment') of the Convention.[499]

Mr Justice Horner's view reflected a degree of public sentiment but not that of the Parliament. On 14 February 2016, and in response to his Honour's decision, the Northern Ireland Parliament voted that the law should remain as stated in the *OAP Act 1861*. An appeal was lodged against Horner J's decision.[500] In June 2017 the Court of Appeal allowed the appeal and concluded that the laws were not incompatible. Although the decisions were reasoned differently their Lordships considered that any changes to the law were for the legislature and not the judiciary.[501]

Had the Court of Appeal upheld Horner J's advisory opinion, the result would not have liberalised abortion to any great extent. It would give a little more protection to the medical profession but would not have given women any greater autonomy over their bodily integrity and health. The decision as to whether or not to continue with a pregnancy would remain largely a matter for the criminal law unless the woman's case came within the meaning of 'unlawful' under the *OAPA 1861*.

The NIHRC then appealed to the Supreme Court of the United Kingdom[502] where Lady Hale adverted to the complexity of the case and said.

499 Henry McDonald, 'Northern Ireland Law on Abortion Ruled 'Incompatible with Human Rights', *The Guardian* (online), 1 December 2015.

500 Northern Ireland Human Rights Commission, *Challenge to Pregnancy Termination Laws at the Court of Appeal* (17 June 2016) <http://www.nihrc.org/news/detail/challenge-to-termination-of-pregnancy-laws-at-court-of-appeal>.

501 *The Attorney General for Northern Ireland & Anor v The Northern Ireland Human Rights Commission* [2017] NICA 42 (29 June 2017); Morgan LCJ[46][86], Gilland [LJ 105] and Weatherup LJ [138]-[139].

502 *In the matter of an application by the Northern Ireland Human Rights Commission for Judicial Review (Northern Ireland) and Reference by the Court of Appeal in Northern Ireland pursuant to Paragraph 33 of Schedule 10 to the Northern Ireland Act 1998 (Abortion) (Northern Ireland)* [2018] UKSC 27; *Human Rights Commission for Judicial Review (Northern Ireland: Abortion) (Rev 1)* [2018] UKSC 27 (7 June 2018).

> Not only are the substantive issues, relating to the compatibility of abortion law in Northern Ireland with articles 3 and 8 of the European Convention on Human Rights (the ECHR or the Convention), of considerable depth and sensitivity; but there is also the procedural issue raised by the Attorney General for Northern Ireland, who challenges the standing of the Northern Ireland Human Rights Commission (NIHRC) to bring these proceedings.[503]

A majority, Lord Mance, Lord Reed, Lady Black and Lord Lloyd-Jones, held that the NIHRC did not have standing to bring the proceedings and therefore the court lacked jurisdiction to decide the matter of incompatibility.[504] A minority, Lord Kerr, Lord Wilson and Lady Hale, held that the NIHRC did have standing.[505] They were prepared to make a declaration that the challenged provisions were incompatible with the *ECHR.* The case was rendered even more complex in that Lord Mance, agreed with Lord Kerr, Lord Wilson and Lady Hale that

> the current law is incompatible with the right to respect for private and family life, guaranteed by article 8 of the Convention, insofar as it prohibits abortion in cases of rape, incest and fatal foetal abnormality.[506]

Lady Black considered that it was only in the case of a 'fatal foetal abnormality' that the law contravened Article 8.[507] Lords Kerr and Wilson considered that the abortion law was not compatible with Article 3 which guarantees 'the right not to be subjected to inhuman or degrading treatment'.[508]

Lords Reed and Jones decided that the laws were not incompatible with either Articles 8 or 3.[509]

Of significance for abortion reform in Northern Ireland was that the members of the Court were prepared to address the substantive law claim of incompatibility of the

503 Ibid 1[1].

504 Ibid [3] Lord Mance [60], Lord Reed [333] Lady Black [365] and Lord Lloyd-Jones [333].

505 Ibid Lord Kerr [201], Lord Wilson [201] and Lady Hale [3] [18].

506 Ibid [2].

507 Ibid [371].

508 Ibid [201.

509 ] Ibid [2].

abortion laws with the ECHR despite the finding of the majority that the Court lacked the jurisdiction to make any declaration. Lord Mance stated that the

> challenge has been fully argued, and evidence has been put before the Court about a number of specific cases. It would, in the circumstances, be unrealistic and unhelpful to refuse to express the conclusions at which I would have arrived, had I concluded that the Commission had competence to pursue the challenge.[510]

The willingness of the Court to express an opinion as to the incompatibility of the abortion legislation may be regarded as unusual[511] but it may be understood in the broader political and legal context in which it was heard. Its decision that the NIHRC lacked jurisdiction due to the lack of specific victims as required under the *Northern Ireland Act (2018*)[512] but that Article 3 and Article 8 of the Convention were open to an interpretation of incompatibility will give some guidance to Northern Ireland specifically and to those subjected to restrictive abortion laws and seeking to enforce Human Rights, generally.

The Court of Appeal intended to make a ruling upon the issue of compatibility of the abortion laws of Northern Ireland with Article 8 which could be adopted in subsequent decisions, even though strictly speaking the ruling was *obiter dicta.* Some commentators considered it should have taken the opportunity to consider other matters such as Article 3.[513]

That the appeal was dismissed on procedural grounds only, denotes that the Court considered there were two separate issues for the court. The first was whether the NIHRC had standing to sue in its own right. The second was whether the current abortion law of Northern Ireland was incompatible with the ECHR. Had it been

510 Ibid [42].

511 Ibid Lord Reed [334]; Robert Brett Taylor 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, 100.

512 S 71 (2B)(c).

513 Brid Ni Ghrainne, 'Abortion in Northern Ireland and the European Convention on Human Rights: Reflections from the UK Supreme Court' (2019) 68 (2) *The International and Comparative Law Quarterly* 477, 487-489).

otherwise the Court would not have proceeded to address the question of incompatibility.

Tom Frost has argued that the case was important and may be instrumental to the reform of abortion law. He noted its significance.

> Despite the decision on the technicality of whether the *NIHRC* had standing, a four-to-three majority of the Court voiced their opinion that the abortion laws in Northern Ireland are in breach of Article 8 ECHR in cases of rape and incest, and a five-to-two majority held the laws were in breach of Article 8 ECHR in cases of fatal foetal abnormality. Commentators on the judgment made clear that it is important not to underestimate the significance of this ruling, as it is the first case considering Northern Irish abortion law in substantive terms, and the first identifying a human rights incompatibility.[514]

The Court indicated that there was a probability of several cases which did meet the standing requirements and this issue would return to the courts. [515] Subsequently an application for leave to seek Judicial Review to the High Court in Belfast was granted to Sarah Ewart,[516] who had been an Intervener in the *NIHRC* case.[517]

Justice Keegan, *In Re Ewart, Application for Judicial Review (Re Ewart)*[518] considered that the Court of Appeal stated the law to be applied on both issues and provided a summary of the different viewpoints taken by the Justices on both of the questions.[519] Ms Ewart, then aged 23 was nearly 20 weeks into her first pregnancy when an ultrasound scan indicated anencephaly. After a second ultrasound she was advised 'that the brain of the foetus had not developed and there was no skull'[520] It is usual for a foetus with this condition to die before being born, at birth or soon thereafter. Anencephaly is regarded

514 Tom Frost, 'Abortion in Northern Ireland: Has the Rubicon Been Crossed?' (2018) 39 (1)-(2) *The Liverpool Law Review* 175, 193.

515 *Re NIHRC Application for Judicial Review* [2018] UKSC 27 [135].

516 *In Re Ewart, Judicial Review [*2018] NIQB 85 (24 October 2018)McCloskey J.

517 *Re NIHRC Application for Judicial Review* [2018] UKSC 27.

518 [2019] NIQB 88 (03 October 2019).

519 Ibid.

520 Ibid [11].

as a 'fatal foetal abnormality [FFA]. Ms Ewart gave evidence that continuing with an abnormal pregnancy, which would result in the death of the foetus at some stage, filled her 'with horror and fear'.[521] She was compelled to go to England to have an abortion but was refused permission to bring the foetal remains back to Northern Ireland for the purposes of an autopsy which could confirm the risk of FFA in future pregnancies. She subsequently had two successful pregnancies but is 'at increased risk of pregnancies with neural tube defects'.[522]

She applied for declarations that:

a Article 8 is breached by sections 58 and 59 OAPA and section 25 of the Justice Act 1945 (heightened risk of a FFP) and a declaration of incompatibility

b A declaration of failure to ensure legislation complies with Article 8 ( see section 6(1) HRA.[523]

Justice Keegan noted that the issue of abortion had come before many courts and it had now been decided in the Supreme Court that a number of categories were incompatible with Article 8. She observed that the application before her was restricted to the issue of FFA. She noted that five out of the seven justices had found that FFA was a category which was incompatible with Article 8. Lady Black had stated that FFA was the only category of abortion which was incompatible. Justice Keegan reasoned that where the foetus is unable to live on its own 'there's no life outside the womb to protect'[524]

> [E]ven if allowance is made for the intrinsic value of the life of a foetus, the moral and ethical views of society cannot, it seems to me, be sufficient to outweigh the intrusion upon the autonomy of the pregnant woman, and her suffering. [525]

After noting that the Supreme Court had clearly determined 'that the current law is incompatible with the right to respect for private and family life of women guaranteed by Article 8 of the Convention in cases of fatal foetal abnormality'[526] and noting that although the Attorney-General had considered the 'Supreme Court decision is incorrect

521 Ibid [12].

522 Ibid [15].

523 Ibid [17].

524 Ibid [35].

525 Ibid, quoting *Re NIHRC Application for Judicial Review* [2018] UKSC 27, Lady Black [371].

526 In *Re Ewart, Application for Judicial Review* [36].

in a number of respects' other legal counsel made no objection to following it. Justice Keegan concluded that if she did not follow the Supreme Court it would mean that she would be 'effectively reopening the arguments already made and decided in relation to Article 8 compatibility by our highest court'.[527] She concluded that the 'decision on the substantive compatibility issue is not given "in passing" in the true sense of an obiter ruling but rather intended to have persuasive force'.[528]

Having decided that Ms Ewart had standing [529] and incompatibility had been established the next matter to consider was whether Justice Keegan should exercise her discretion and grant a declaration. She concluded that she could grant relief but, because sections 58 and 59 of the *OAP Act1861* were the subject of repeal, she adjourned to give the parties an opportunity to address the Court.[530]

### *3 CEDAW, Court Decisions, Politics and Reform Elsewhere*

Abortion law in Northern Ireland, including the impact of the cases of *Re NIHRC Application for Judicial Review*[531] and *Re Ewart,* ought, also, to be considered in the context of the reports of Convention on the Elimination of Discrimination Against Women Committee (CEDAW), governmental and political concerns, and domestic and global reform of the law elsewhere. This is particularly the case, with the successful referendum in Ireland and the resulting enactment of the *Health (RTP) Act 2018* (Ire). To enhance understanding of the intersection between these developments, it is useful to return to the status of Northern Ireland and its standing within the UK.[532]

In 1998 the governments of the Great Britain, Northern Ireland and Ireland entered an agreement which was intended to end the violence of more than 30 years.[533] The

527 Ibid [38].

528 Ibid.

529 Ibid [61].

530 Ibid [74]; see *Ewart, Re Judicial Review* [2020] NIQB 33 (7 April 2020) where she noted that the declarations were no longer required because of the repeal of ss58,59 of the *OAPA 1861*.

531 [2018] UKSC 27.

532 See Robert Brett; Taylor 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, 100.

533 *The Belfast Treaty* [2007] UKTS TS 0001

agreement made Northern Ireland self-governing with an elected Assembly which has devolved powers including equality, health and crime.[534] The government of NI was extensively criticised by CEDAW for breaching ICCPR in respect of abortion.[535] In particular CEDAW noted that criminalisation of abortion is counterproductive.

> Criminal regulation of abortion serves no known deterrent value. When faced with restricted access, women often engage in clandestine abortions, including self-administering abortifacients, at risk to their life and health. In addition, criminalization has a stigmatizing impact on women and deprives them of their privacy, self-determination and autonomy of decision, offending women's equal status, constituting discrimination.[536]

CEDAW, among other things, criticised the fact that the abortion law of Northern Ireland compelled women to travel to obtain a legal abortion.[537] Their recommendations were extensive and require that there was a complete revision of the abortion laws of NI.[538]

The political situation in Northern Ireland has been far from stable and relies on co-operation and agreement between the two major political parties, the DUP (Union) and Sinn Fein (Nationalist) and the minor parties. Bitter dispute between the parties led to the collapse of the government and resulted in a situation where Northern Ireland was without a government from early January 2017 until early January 2020.[539] The lack of a functioning parliament had a profound impact on the law on abortion in NI.[540] This was

534 Opening statement to the CEDAW committee, (2019, Feb 27). M2 Presswire – Web.

535 See CEDAW, *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*, Report of the Committee 6 March 2018 CEDAW/C/OP.8/GBR/1.

536 Ibid [59], 15/22.

537 Ibid [64], 16-17/22.

538 Ibid 21-22/22.

539 For details, see Ben Kelly, 'Why is there no government in Northern Ireland and how did power-sharing collapse? The region has passed the world record for the longest period without a government' Independent 30 April 2019).

540 See above 1 Introduction.

recognised in the decisions in *Re NIHRC Application for Judicial Review*[541] and *Re Ewart*.[542]

The recent reports by CEDAW and the obligations of Northern Ireland form an important part of the difficulties created by the lack of government in Northern Ireland. They were also referred to in both cases. Additionally the successful passing of the 36th Amendment to the Constitution of Ireland and subsequent changes to abortion law in Ireland provided increased impetus for change in Northern Ireland. There was also evidence which suggested that the people of Northern Ireland were in favour of reforming the abortion laws.[543] The obiter of the Court in the appeal by *NIHRC* indicated that there were other woman who would no doubt seek the judicial redress.[544] Several other applications were expected to be made in the near future.[545] The Court also indicated that there was a need for legislative reform.[546]

In the past, in contrast to Ireland and other jurisdictions, Northern Ireland had not had a high profile in pressing for decriminalisation of abortion. Perhaps a turning point was the lead up to and the success of the Referendum of 2018 in Ireland. Earner-Byrne has argued that

> The 2018 referendum in the Republic of Ireland has thrown abortion provision in Northern Ireland into sharp relief. On the same day as the referendum result, calls, accompanied by public protests, were made for abortion law reform in Northern Ireland.[547]

541 *Re NIHRC Application for Judicial Review* [2018] UKSC 27, [112], [121], 135 [also reported as Human Rights Commission for Judicial Review (Northern Ireland : Abortion) (Rev 1) [2018] UKSC 27 (7 June 2018)]

542 Ibid.[20].

543 *Re NIHRC Application for Judicial Review* [2018] UKSC 27,[110]-[112].

544 Ibid.

545 Taylor 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, 100,; see *Re Ewart*.

546 *Re NIHRC Application for Judicial Review* [2018] UKSC 27, [336] Lord Reed, RB Taylor (n545), 828,101.

547 Earner-Byrne (n 336) 133.

The number of protests had been steadily increasing even before the Referendum.[548] People in Northern Ireland were keenly aware of tragedies such as the death of Savita Halappanavar.[549] They were well aware of the intolerable situation which women faced in trying to obtain a legal abortion.

As discussed previously there were cases where women had been successfully prosecuted for illegally using RU-486.[550] In 2013, a case which was to draw worldwide attention, criticism and provide further impetus for calls for reform of abortion law occurred. Here a 15 year old girl was in an abusive relationship and was pregnant. She confided in her mother and decided that an abortion was necessary. Her mother obtained abortion pills via the internet and gave them to her daughter.[551]. The abortion was successful and shortly thereafter the woman and her daughter visited their GP for a reference to counselling services for the issues surrounding the abuse of the daughter. They told the GP, about the pills, who referred them to a counsellor. Later the GP reported the matter to the police and the woman was investigated. The Public Prosecutor was given the file and decided that the matter was of public importance and therefore the woman should be prosecuted. She was charged with the offences of unlawfully procuring and supplying drugs with intent to cause a miscarriage contrary to the *OAP Act 1861*.[552] Her trial was adjourned when a Belfast judge granted her application to the High Court for judicial review of the decision to prosecute. The basis

548 'Belfast protest against prosecution of Northern Ireland woman who used abortion drugs held outside Public Prosecution Service' *Belfast Telegraph Digital* 2016

549 Berer (n 402;) Tara Mills, 'Abortion rules: Could tragic case like Savita Halappanavar's happen in NI? BBC *News NI*, 14 November 2012

550 Anon, 'Abortion pills prosecution challenge by NI mother adjourned' *ABC News* 20 September 2018;

551 Gabriella Swerling, 'Northern Ireland woman acquitted of buying abortion pills for daughter following a landmark law change' *The Telegraph* 23 October 2019; Rory Carroll, Woman in Northern Ireland abortion pills case formally acquitted : Judge instructs jury to find woman not guilty after legal changes come into force' *The Guardian* 23rd October 2019.

552 Amnesty International, 'Northern Ireland: "Concern" as mother who bought abortion pills for daughter to face criminal trial'; Cassandra Vinograd and Lisa McNally, 'Abortion in Europe: Northern Ireland Conviction Inflames Debate' *NBC News* 25th April 2016

of the claim was that the prosecution breached the human rights of the mother and daughter.[553]

In December 2019, the High Court held that the decision to prosecute did not violate human rights. Lord Chief Justice Sir Declan Morgan of the High Court was reported as saying that

> [t]he decision to prosecute needs to be seen . . .in the context of child protection and exposure to harm through unregulated treatment.[554]

In dismissing the application for judicial review the High Court regarded it as appropriate that there should be laws which were there to protect the health of women who were taking abortion pills.[555]

Subsequently the trial was set down for hearing on the 18th November 2019. However, with the decriminalisation of abortion in October 2019 the trial was brought forward.

On the 23rd October the trial judge directed the jury to bring in a verdict of 'not guilty' on the basis that sections 58 and 59 had been repealed and abortion was no longer a criminal offence in Northern Ireland.[556]

In 2018 the strong words of Lord Mance could not have been a clearer call for extensive reform. His Lordship was emphatically of the opinion that

> the present legislative position in Northern Ireland is untenable and intrinsically disproportionate in excluding from any possibility of abortion pregnancies involving fatal foetal abnormality or due to rape or incest. . . . [T] he present law clearly needs radical reconsideration. Those responsible for ensuring the compatibility of Northern Ireland law with the Convention rights will no doubt recognise and take account of these conclusions, at as early a time as possible, by considering whether and how to amend the law, in the light of the ongoing

553 Alan Erwin, Prosecution of Northern Ireland mum for buying daughter abortion pills "did not breach human rights.," court rules' Belfast Telegraph 16 December 2019.

554 Ibid.

555 Ibid.

556 Woman in Northern Ireland abortion pills case formally acquitted : Judge instructs jury to find woman not guilty after legal changes come into force' *The Guardian* 23rd October 2019; Gabriella Swerling, 'Northern Ireland woman acquitted of buying abortion pills for daughter following a landmark law change' *The Telegraph* 23 October 2019

suffering being caused by it as well as the likelihood that a victim of the existing law would have standing to pursue similar proceedings to reach similar conclusions and to obtain a declaration of incompatibility in relation to the 1861 Act.[557]

In the absence of a functioning government in Northern Ireland, attention became focussed upon Westminster for resolution. The UK Parliament enacted the *Northern Ireland (Executive Formation and Exercise of Functions) Act 2018* (*NI(EF)A 2018)*[558] to provide for the formation of an Executive and allow for the Northern Ireland to function until government was restored at Stormont.

The Act also, provided for the implementation of the CEDAW recommendations[559] which included decriminalising abortion[560] and the enacting of legislation to regulate the provision of abortion[561] in accordance with the need to protect women's human rights.[562] Section 13(4) provides that the repeal of abortion laws were to come into force on the 22nd October 2019 unless an Executive was formed on or before the 21st October, in which case they would not come into force and NI could enact its own legislation under its devolved power over crime. A government was not formed and so abortion was decriminalised.

On November 4th 2019, Westminster issued a governmental consultation paper re-asserting its preference that Northern Ireland is best placed to reform the laws on abortion. In the absence of a functioning Executive and Assembly it was Westminster's responsibility to fulfil its legal obligations and to provide a regulatory framework for abortion in NI. To this end it set out proposals for discussion and the enactment of legislation to be in place by the 31stMarch 2020. On the 11th January 2020, it was announced that NI would form an Executive and the government at Stormont restored.[563]

557 *Re NIHRC Application for Judicial Review* [2018] UKSC 70.(Emphasis added).

558 Anon, 'Stormont: Why does Northern Ireland not have a government?' *Newsround*. 11 Jan 2020 (online)

559 *NI(EF)A 2019* S 9 (1).

560 *NI(EF)A 2019* S 9 (2), (3).

561 *NI(EF)A 2019* S 9 (4), (5).

562 *NI(EF)A 2019* S 9 (7).

On the 15th May 2020 the *Abortion (Northern Ireland) Regulations 2020 (A (NI) Regs 2020)*, made pursuant to *section 12(3) of the Northern Ireland (Executive Formation etc) Act 2019*, came into force. Currently these regulate abortion in Northern Ireland.

An abortion will be lawful where 'a medical professional is satisfied 'that the pregnancy has not exceeded its 12th week'.[564] Where the pregnancy exceeds 12 weeks but does not exceed its 24 week a termination may take place. Two medical practitioners must agree as to the stage of the pregnancy and that continuing with the pregnancy would involve greater risk to the physical or mental health of the woman. They may take into account her present and future circumstances.[565]

There is no gestational limit where the termination is one of necessity or an emergency to save the life or prevent severe permanent injury to the woman's health.[566] Two medical professionals must agree that a termination is necessary where there is a risk to the life or permanent injury of the woman.[567]

It is noted that the offence of 'Child Destruction' has not been repealed and so remains a criminal offence under section 25(1) of the *Criminal Justice Act 1945.* The maximum penalty is life imprisonment. The only defence is where the termination was done in 'good faith' and 'for the preservation of the life of the mother' under section 25 (2).[568]

### *D Conclusion*

The situations in Ireland and NI have changed substantially over the past few years. The autonomy of the pregnant Irish woman is at last being recognised, albeit not fully. The laws on abortion are now regulatory and no longer criminal. This gives Irish women greater access to abortion than in the past but there is need for further reform so that

563 Anon, 'Irish Times view on the Stormont deal: Now to make the institutions work' *The Irish Times* 11th January 2020; Denis Staunton, 'Boris Johnson says restoration of Stormont 'a great step forwards'; 'Labour party confirms it will back Westminster legislation in support of the deal' *London Editor* 11 January 2020.

564 *(A (NI) Regs 2020)* r3.

565 Ibid s4.

566 Ibid r5.

567 Ibid r6.

568 For the problematic nature of the offence of child destruction see the discussion in II D – The Infant Life Preservation Act.

abortion services are readily available and accessible.[569] Women have moved closer to having an equivalent chance in her project of becoming a person. Nevertheless, there remain restrictions in Ireland and NI such as requiring the medical profession to decide whether she may have her pregnancy terminated after 12 weeks and the lack of qualified abortion providers.

The position for women in Northern Ireland is less clear. The new regulations have met with polarised reactions and may be challenged. However, it might be predicted that the Northern Ireland will not be in a position, at least politically, to 'recriminalise' abortion. For the women of Ireland and Northern Ireland greater autonomy may be realised in the future.

## VI CANADA

### *A Introduction*

Since 1988 abortion has not been a criminal offence in Canada.[570] However, this did not result in unrestricted access to abortion for Canadian women. The dynamics that affect the availability of terminations are discussed in Chapter 4. This section focuses upon the landmark case of *Morgentaler v The Queen ('Morgentaler'*),[571] which recognised the importance of women's autonomy by deciding that the Canadian law on abortion should be struck down as unconstitutional and as infringing *Canadian Charter of Rights and Freedoms ('Charter').*[572] Amendments were made to the *Criminal Code 1985* in 2018[573] and in 2019[574] to repeal the laws relating to abortion.

#### *Background*

In 1867, the Dominion of Canada was established under the *British North America Act* (UK) (now the *Constitution Act* 1867). This Act established a federation whereby law-

569 See Sally Sheldon, 'Empowerment and Privacy? Home Use of Abortion Pills in the Republic of Ireland' (2018) 43 (4) *Signs: Journal of Women in Culture and Society* 823.

570 *Morgentaler v The Queen* [1988] 1 SCR 30.

571 Ibid.

572 The *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c 11 (Part I *Canadian Charter of Rights and Freedoms* ) s34.

573 Criminal Code RSC 1985 c46, s288 supplying noxious things repealed by SC 2018 c28 s28.

574 *Criminal Code* RSC 1985 c46, s287 procuring a miscarriage repealed by SC 2019 c25 s111.

making authority was divided between the federal and the ten provincial governments.[575] The Canadian Parliament was given exclusive power to deal with the criminal law.[576] The power to legislate on health care was vested in the provincial governments.[577] The first criminal laws on abortion were highly restrictive being based on the *OAP Act 1861*. Abortion was a criminal offence punishable by life imprisonment.[578] In 1969, the *Criminal Code* was amended to provide that abortions would be lawful if they conformed to s 251 which required certification by a duly constituted therapeutic committee that, 'the continuation of the pregnancy ... would or would be likely to endanger her life or health'.[579] In providing for abortion to be administered by committees which were to be established by hospitals, if they so wished, was in effect legalising the system which the medical profession had been using for some time. Therefore, the 1969 legislation could be seen as protecting the medical profession from prosecution and giving them a monopoly over abortion. There was no definition of 'likely to endanger her life'. Unlawful abortion remained an offence punishable by life imprisonment. [580] The woman could be guilty of an offence and liable to two years' imprisonment.[581] The procedure set down in the section was extremely complicated and made it difficult to establish that an abortion would be lawful.[582]

575 *British North America Act 1867*, 30 & 31 Vict, c 3.

576 *Constitution Act 1867 (Imp)*, 30 & 31 Vict, c 3, s 91(27) ('*Constitution Act 1867*').

577 *Ibid* s 92(7); this power is important when addressing issues of access to abortion; see Chapter 4 — Access to Legal Terminations.

578 *An Act Respecting Offences against the Person*, 1869, c 20, ss 59–60. The Act was also based on *Lord Ellenborough's Act*. Abortion was incorporated into the *Criminal Code*, SC 55 & 56 Vict, c 29, ss 272–274; and with slight changes were included in the *Criminal Code*, RSC 1906, c 146, ss 303–306; *Criminal Code*, RSC 1927, c 36, ss 303–306; *Criminal Code*, SC 1953–1954, c 51, ss 237–238; see *Morgentaler v The Queen* [1988] 1 SCR 30, 144–5 (McIntyre J) for a brief background to abortion law.

579 *Criminal Code, RSC 1970, C-34,* ss 251(4)(b) (c).

580 *Ibid* s 251(1).

581 *Ibid* s 251(2).

582 For a history of the development of the Canadian abortion law see; Rachael Johnstone Bader and Emmett Macfarlane, 'Public Policy, Rights, and Abortion Access in Canada' 51, (2015) *International Journal of Canadian Studies* 51; J P Maksymiuk, 'The Abortion Law: A Study of *R v Morgentaler*' (1975) 39 *Saskatchewan Law Review* 265.

> In Canada, as elsewhere, the issue of abortion was both controversial and polarising. Dr Henry Morgentaler played a central role and integral part in the decriminalisation of abortion and the provision of termination services for women. He continued to play an important role in providing access to abortion until his death in 2013.[583]

In 1970, Dr Morgentaler, a GP, set up clinics to provide this service. He knew that this was in contravention of the law.[584] He was charged with using an instrument to procure an abortion.[585] At his trial, in 1973, he relied on defences which were based on necessity and medical emergency.[586] After a number of appeals and court appearances, he was sentenced to imprisonment for 18 months, of which he served 10 months, being released after a heart attack.[587]

In 1975, the Badgley Committee was set up to determine 'whether the procedure provided in the *Criminal Code* for obtaining therapeutic abortion [was] operating equitably across Canada'.[588] The committee's response was unequivocally critical. The criticisms included the lack of hospitals with committees; many hospitals with committees did not perform terminations; lengthy delays which endangered women's health; and, the absence of any abortion facilities in some provinces. The Report found that 'obtaining therapeutic abortion is practically illusory for many Canadian women.'[589]

The addition of the *Charter* to the *Constitution* in 1982 may be regarded as opening the way for a fundamental change to the way in which the courts interpreted the law on abortion. The Canadian Supreme Court was able strike down any laws which conflicted

583 Robert D McFadden, 'Henry Morgentaler, 90, Dies; Abortion Defender in Canada', *The New York Times* (New York), 29 May 2013.

584 Madeline Weld, 'A Tribute to Henry Morgentaler: March 19, 1923 — May 29, 2013' (2013) 186 *Humanist Perspectives* 6.

585 *Criminal Code, RSC 1970, C-34,* s 251(1).

586 *Ibid s 7(3), 45.*

587 Celia Milne, 'Catching Up with ... Dr Henry Morgentaler: A Tale of Nine Lives' (2007) 43 *Medical Post* 58.

588 Committee on the Operation of the Abortion Law, Canada, *Report of the Committee on the Operation of the Abortion Law* (1977).

589 Ibid 141.

with the *Charter*.[590] The provinces which regulated health could enact legislation which regulated medical procedures but could not make abortion a criminal offence.

### *Morgentaler v The Queen (1988)*

In 1988, in *Morgentaler v The Queen (Morgentaler),*[591] the Supreme Court considered the validity of the Canadian abortion laws.[592] The defendants had been charged with conspiring to procure miscarriages contrary to the *Criminal Code*. Their counsel submitted that the indictment should be quashed because section 251 was unconstitutional. The legislation was held to be valid.[593] The defendants were tried and acquitted by a jury. The Crown's appeal to the Court of Appeal for Ontario was allowed.[594] The defendants then appealed to the Supreme Court of Canada.[595] The majority allowing the appeal, struck down s 251 of the *Criminal Code* and restored the acquittals.[596]

590 See generally Kent Roach, *Criminal Law* (Irwin Law, 4th ed, 2009) 23 et seq.

591 *[1988] 1 SCR 30.*

592 For analysis of the case when it occurred, see David MacAlister, '*R v Morgentaler: Access to Abortion and Section 7 of the Charter'* (1988) 7 *Canadian Journal of Family Law* 166.

593 *Regina v Morgentaler (No. 1*), 1973 CanLII 1280 (QC CS); see *Morgentaler v The Queen* [1976] 1 SCR. 616.

594 *R v Morgentaler, Smoling and Scott* (1985) 22 DLR (4th) 641.

595 *Morgentaler* [1988] 1 SCR 30, 46–47:

1 Does section 251 of the *Criminal Code* of Canada infringe or deny the rights and freedoms guaranteed by ss 2(a), 7, 12, 15, 27 and 28 of the *Canadian Charter of Rights and Freedoms*?

2 If so, is s 251 justified by s1of the *Charter* and therefore not inconsistent with the *Constitution Act, 1982*?

3 Is section 251 ultra vires the Parliament of Canada?

4 Does section 251 violate s 96 of the *Constitution Act,1867*?

5 Does section 251 unlawfully delegate federal criminal power to provincial Ministers of Health or Therapeutic Abortion Committees, and in doing so, has the Federal Government abdicated its authority in this area?

6 Do sections 605 and 610(3) of the *Criminal Code* infringe or deny the rights and freedoms guaranteed by ss 7,11(d), 11(f),11(h) and 24(1) of the *Charter*?

7 If so, are they justified by s 1 of the *Charter* and therefore not inconsistent with the *Constitution Act, 1982*?

596 Ibid 184 (Dickson CJ, Beetz, Estey, McIntyre, Lamer, Wilson and La Forest JJ).

Although the court considered seven constitutional questions it is the first two which are of importance here. They read, in part:

> 1 Does s 251 deny the rights and freedoms guaranteed by s 7 of the *Charter*?
> 2 If s 251 of the *Criminal Code* infringes or denies the rights and freedoms guaranteed is s 251 justified by s 1 of the *Charter*?[597]

The majority judges answered the first question in the affirmative and the second in the negative.[598]

The case is important for women's autonomy because it decriminalised abortion. The court delivered three majority judgments and two dissenting judgments which provide somewhat differing approaches and reasons.[599] The majority decision was that section 251 be struck down as breaching the *Charter*.

The Supreme Court was emphatic that it was not its role to 'decide or even to enter, the loud and continuous public debate' over abortion.[600] The court's mandate was to evaluate the law not to debate the morality of abortion. Central to the majority decision was the effect of section 7 of the *Charter* on section 251 of the *Criminal Code*. It provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The majority answered the first question in the affirmative and thus had to consider section 1, which 'guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'.[601]

Dickson CJ, for the majority, focussed upon the security of the person interest protected by 7 of the Charter. He was of the opinion that

> (f)orcing a woman, by threat of criminal sanctions, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a

597 Ibid 46–7.

598 Ibid 32, 138–9 (McIntyre J).

599 McIntyre and La Forest dissenting.

600 [1988] 1 SCR 30, 45 (Dickson CJ), 162 (Wilson J), 136–8, 157 (McIntyre J).

601 Ibid Dickson CJ 59-50.

> profound interference with a woman's body and thus a violation of security of the person.[602]

However, it was more than the negation of her decision-making rights which were in violation of section 7. The impact upon the woman physically and psychologically were unreasonably prejudicial to her right to security as a person. Her rights are framed in a negative manner. She has a right *not* to have her security violated. This did not mean that women have a right to abortion as matter of entitlement or 'on demand'.[603]

Dickson CJ decided that the procedural requirements of section 251 of the *Criminal Code* were not consistent with the principles of fundamental justice.[604] However, this was not conclusive of the matter. Satisfying the requirements of section 7 was a threshold requirement. Section 1 could operate to prevent invalidation. The legislature may overbear rights 'only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'.[605] The Chief Justice noted[606] that the principles to be applied had been enunciated previously by the Supreme Court[607] and that two main criteria needed to be satisfied. The first was whether the importance of the law required that it should prevail over a Charter right. If so, then the criterion of proportionality is applied. In considering proportionality Dickson CJ identified three considerations.

> First, the means chosen to achieve an important objective should be rational, fair and not arbitrary. Second, the legislative means should impair as little as possible the right or freedom under consideration. Third, the effects upon the relevant right or freedom should not be out of proportion to the objective sought to be achieved.[608]

602 [1988] 1 SCR 30, 56–7.

603 Ibid McIntyre LJ (dissenting) 132,134,152,158 who interprets the majority reasoning as legitimising 'abortion on demand'.

604 [1988] 1 SCR 30, 73.

605 *Charter* Article 1.

606 [1988] 1 SCR 30, 73.

607 Citing *R v Big M Drug Mart Ltd* [1985] 1 SCR 295 and *R v Oakes* [1986] 1 SCR 103.

608 [1988] 1 SCR 30, 74.

In considering the case before him, Dickson CJ, evaluated whether section 251 had struck the appropriate balance between the foremost concerns and goals of the pregnant woman, and the state interest in protecting the foetus.[609] He considered that the protection of the woman was a legitimate legislative objective when the imposition of 'criminal sanctions' posed a risk to her health and well-being.[610] In this case the three criteria of 'proportionality' were not satisfied. His reasons included that the procedures and administrative structures were 'often arbitrary and unfair'.[611] The systems in place meant delays to and even absence of access to abortion to women whose life and health were endangered.[612] If a woman was unable to obtain a legal abortion she may seek an unregistered abortion provider. Finally, Dickson CJ opined that, the provision did not meet the section 1 requirements of the *Charter* in that the constraints placed upon pregnant women were not only disproportionate to the 'objective sought to be achieved' but were counterproductive.[613] Therefore he concluded that section 251 breached section 7 of the *Charter*.[614]

Justice Wilson agreed with the majority judges that section 251 denied the right of security of the person. Her decision strongly supports women's autonomy. She stated that section 7 protects the pregnant woman's right to liberty. She agreed that the procedures for obtaining 'an abortion clearly subjects pregnant women to considerable emotional stress as well as unnecessary physical risk'.[615] But there was a great deal more to the resulting injustices to pregnant women. Accordingly, she thought that to focus on procedural unfairness was a peripheral issue only, saying that such a consideration became 'purely academic if such requirements cannot as a constitutional matter be imposed at all'.[616]

To Wilson J the fundamental question was 'whether a pregnant woman can, as a constitutional matter, be compelled by law to carry a foetus to term'[617] and whether the

609 Ibid.

610 Ibid 75.

611 Ibid 34, 76.

612 *Criminal Code, RSC 1970, c C-34*, s 251(4).

613 [1988] 1 SCR 30, 75–6.

614 Ibid 39.

615 Ibid 173.

616 Ibid 162–3.

617 Ibid 161.

abortion law was flawed.[618] Reflecting Kantian philosophy she identified what was wrong with the law.

> [W]hat it does is assert that the woman's capacity to reproduce is not to subject to her own control. It is to be subject to the control of the state. She may not choose whether to exercise her existing capacity or not to exercise it. This is not , in my view, just a matter of interfering with her right to liberty. . .[619] [or] personal autonomy in decision making, it is a direct interference with her physical "person" as well. She is truly treated as a means—a means to an end which she doesn't desire but over which she has no control. She is the passive recipient of a decision made by others as to whether her body is to be used to nurture a new life. Can there be anything less that comports with human dignity and respect? How can a woman in this position have any sense of security with respect to her person? . . .s251 of the *Criminal Code* deprives the pregnant woman of her right to security of the person as well as her right to liberty.[620]

Section 1 allows reasonable limitations upon autonomy. Justice Wilson considered what might be constitutionally acceptable. In assessing the time at which the state may have a valid interest in protecting the foetus she asked:

> At what point in the pregnancy does the protection of the foetus become such a pressing and substantial concern as to outweigh the fundamental right of the woman to decide whether or not to carry the foetus to full term? At what point does the state's interest become "compelling" and justify state intervention in what is otherwise a matter of purely personal and private concern?[621]

Referring to the approach in the United States in *Roe v Wade*[622] she decided 'that the value to be placed on the foetus as a potential life is directly related to the stage of development during gestation'.[623] This does not deny 'that the foetus is a potential life

618 Ibid 173.

619 Ibid 166.

620 Ibid 173–4.

621 Ibid 182.

622 *Roe v Wade, 410 US 113 (1973).*

623 [1988] 1 SCR 30, 182.

from the moment of conception'[624] and 'greater weight should be given to the state's interests in the later stages of pregnancy than in the earlier'.[625] To Wilson J, the pregnant woman's autonomy is regarded as absolute at conception and the state's interests in the foetus will permit greater intrusion on her autonomy as is appropriate to the developmental stage of the foetus.[626]

Wilson J looked at the unique problems with regulating pregnancy. She noted that when a pregnant woman decides upon abortion it is a process fraught with complex and frequently conflicting issues. To the woman, it involves a consideration of all aspects of her life. Her decision is not only medical. '[I]t is a profound social and ethical one'.[627] She identifies the difficulties of others in appreciating that pregnant woman are equivalent persons and therefore their decisions are entitled respect. She said:

> It is probably impossible for a man to respond even imaginatively to such a dilemma not just because it is outside the realm of his personal experience (although this is, of course, the case) but because he can relate to it only by objectifying it, thereby eliminating the subjective elements of the female psyche which are at the heart of the dilemma.[628]

Wilson J recognised that the 'project' faced by women is to protect their 'dignity and worth as a human being'.[629] This can be done by converting women's 'needs and aspirations' into constitutionally protected rights. One of these is the 'right to reproduce or not to reproduce'. The very process of having a committee make a decision which ought to be the pregnant woman's 'is just as great a violation of the woman's right to personal autonomy in decisions of an intimate and private nature as it would be if a committee were established to decide whether a woman should be allowed to continue her pregnancy'.[630] It would appear from Justice Wilson's reasoning that a woman's right to liberty is breached not by the nature of the decision made but the fact that her right to make the decision is usurped.

624 Ibid.

625 Ibid.

626 Ibid 183.

627 Ibid 171.

628 Ibid 171–2.

629 Ibid.

630 Ibid 172.

Wilson J came to the overall conclusion that section 251 must be struck down in its entirety as all parts were unconstitutional and did not come within the exception contained in section 1. She did however acknowledge that legislation, which complied with sections 7 and 1, could be enacted in the future. Nevertheless, it is clear that future legislation contravening pregnant women's autonomy would be unconstitutional and struck down as invalid.

### *B Conclusion*

The effect of *Morgentaler* was that section 251 was struck down as invalid and thus abortion was decriminalised. However, although attempts were made the Federal Government did not pass abortion legislation which would be consistent with Charter[631] It has since repealed the law on abortion.[632] Thus, there is a degree of consistency in that abortion is not a crime in Canada. The decision has been applauded because '[t]he court fully recognized that the law was unfair, that it presented unreasonable obstacles to women seeking abortions'.[633]

Striking down a provision criminalising termination of pregnancy was consistent with promoting women's rights as entrenched in and protected by the Charter which, not only authorised but ordered that courts protect those rights.

The controversy and polarisation evident in Canada, before and after *Morgentaler*, continues. Abortion may no longer be a criminal offence but this has not meant that it is available on demand and freely accessible. The issue of access will be considered in the following chapter.

631 See Thomas Flanagan, 'The Staying Power of the Legislative Status Quo: Collective Choice in Canada's Parliament after Morgentaler' (1997) 30 *Canadian Journal of Political Science* 31.

632 Criminal Code RSC 1985 c46, s288 supplying noxious things repealed by SC 2018 c28 s28: Criminal Code RSC 1985 c46, s287 procuring a miscarriage repealed by SC 2019 c25 s111.:

633 *Joyce Arthur, 'The Morgentaler Decision: Happy 10th Anniversary [1997–98]' Pro-Choice Press.*

## VII THE UNITED STATES OF AMERICA

### *A Introduction*

In 1973, *Roe v Wade*[634] the US Supreme Court upheld the constitutional right of women to decide whether to carry a pregnancy to full term. It was symbolic for the women of other countries who supported the right of pregnant women to decide not to continue with a pregnancy. The case gives the impression that pregnant American women have a constitutionally protected right to terminate their pregnancies. The court held that the right protected was that of privacy or freedom from unjustified state interference. It did not mean that there was a right to demand an abortion or that the state was obliged to provide an abortion.

It is not possible, or necessary here, to give a detailed analysis of the somewhat different laws applying throughout the USA.[635] The purpose of the following section is to provide an overview of the autonomy of pregnant women in the USA.

### *B Early History*

America was independent of the Britain prior to the English legislative proscription of abortion in 1803.[636] Sloan's opinion was that 'abortion was not a widespread social problem', in early America.[637] He alleges that the number of abortions was small, the practice discreet and hidden from view.[638] The lack of prosecutions indicated that there was no public and well-orchestrated opposition to abortion. There was little accurate knowledge about early pregnancy and doctors lacked the organisational structure

634 *Roe v Wade*, 410 US 113, (1973); Mary Ziegler 'A Provider's Right to Choose: A Legal History' in S Stettner et al (ed) *Transcending Borders* (Palgrave Macmillan, Cham, 2017) 155.

635 See Chapter 4 — Access to Legal Terminations for a discussion as to whether the right is rendered hollow in many states.

636 *Lord Ellenborough's Act 1803, 43 Geo 3, c 58*; for a summary of the history of abortion in the USA see *Roe v Wade*, 410 US 113, 715–26 (1973) (Blackmum J).

637 Irving J Sloan, *The Law Governing Abortion, Contraception & Sterilization* (Oceana Publications, 1988) 3–4. (He provides no evidence as to the information upon which he has based his analysis and therefore other reasons and explanations are possible.)

638 Ibid; for a history from a pro-life perspective see Marvin Olasky, *Abortion Rites: A Social History of Abortion in America* (Crossway Books, 1992).

needed to successfully influence legislative reform. [639] If a prosecution was initiated, the courts usually relied on the English common law and adopted the dictum of Coke, that abortion when a woman was 'quicke with childe' was 'a great misprision and no murder'.[640] An abortion before that time was not usually considered a crime in the USA.[641]

### *C The 19th and 20th Centuries*

In 1821, Connecticut passed the first American legislation making abortion a criminal offence. By 1840 there were eight jurisdictions with statutes on abortion.[642] Gradually from 1840 onwards attitudes began to change and this was reflected in the increased legislative prohibition on abortion. It has been suggested that more married women were seeking terminations of pregnancy where previously it had been 'unwed mothers' who had abortions performed. Married women managing reproduction through

639 Sloan (n 637); prior to 1789 there were some jurisdictions which had laws which proscribed abortion and 'killing unwanted, illegitimate children'; Olasky, (n 638), 26.

640 Edward Coke, *The Third Part of the Institutes of the Laws of England* (Printed by M Flesher for W Lee & D Pakeman, 1644) 50; cf *Roe v Wade*, 410 US 113, (1973) (Blackmun J), citing Cyril H Means, 'The Law of New York Concerning Abortion and the Status of the Fetus, 1664–1968' (1968) 14 *New York Law Forum* 411, 418–28 (1968; Cyril H Means, 'The Phoenix of Abortional Freedom: Is a Penumbral or Ninth-Amendment Right About to Arise from the Nineteenth-Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?' (1971) 17 *New York Law Forum* 335. Doubt about the accuracy of Blackmun's history of abortion law has been expressed by several authors: see David Fuqua, 'Justice Harry A Blackmun: The Abortion Decisions' (1980) 34 *Arkansas Law Review* 276, 296; John Keown, 'Back to the Future of Abortion Law: Roe's Rejection of America's History and Traditions' (2006) 22 *Issues in Law and Medicine* 3; Michael E Telzrow, 'Before *Roe v Wade*' (2008) 24 *The New American* 34.

641 Leslie J Reagan, 'When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867–1973' in Nancy Ehrenreich (ed) *The Reproductive Rights Reader: Law Medicine, and the Construction of Motherhood* (New York University Press, 2008) 78, 80; but see Olasky (n 638).

642 Irving J Sloan, *The Law Governing Abortion, Contraception & Sterilization* (Oceana Publications, 1988) 1.

termination of pregnancy was seen by some as threatening the family unit and therefore the social order.[643]

In the middle and late 19th century changes were occurring. These impacted upon the regulation of reproduction by law. Medical knowledge improved and became more scientific. The American Medical Association ('AMA') was established as the professional representative body. The medical profession became an organised and powerful group gaining hegemony over all surgical and medical treatment. This included women's reproduction. The medical profession became extremely influential in politics, law and society, as well. A result of the elevation of the status of the medical profession was the concurrent deference to its expertise. Doctors had a monopoly over medical expertise, including expertise about pregnancy.[644]

The greater medical understanding of pregnancy meant that the already maligned, 'quickening distinction' disappeared from the legislation of most states. Its abolition dispensed with the need to rely upon the pregnant woman becoming aware of the foetus in her womb. Pregnant women's knowledge was replaced by 'unimpeachable' medical opinion.[645] Medicine and religion combined to become the champions of foetal welfare and the arbiters of morality; particularly female morality.[646] States passed laws to restrict and penalise abortions. The change was attributed to the 'pressure from a medical profession eager to distance itself from unregistered quacks'[647] and midwives. 'One by one the states made abortion illegal, except to save the life of the woman'.[648]

643 See Horatio Robinson Storer, *A Proper Bostonian on Sex and Birth Control* (Arno Press, 1868); for advertising of abortion see Marvin Olasky, 'Advertising Abortion During the 1830s and 1840s; Madame Restell Builds a Business' (1986) 13 *Journalism History* 49; Ted J Smith III, 'The Press and Abortion, 1838–1988' (1989) 66 *Journalism Quarterly* 747–8.

644 Storer (n 643) 36–61; see also Michael Thomson, above n 350, for an analysis of the rise of the medical profession and the history of abortion in the USA and the UK in the 19th Century.

645 Reagan, (n 641) 78; Storer (n 643) 15–27.

646 Reagan, (n 641) 79, 82–3.

647 Discussion, 'Abortion USA' (1989) 333 *The Lancet* 879, 880; James C Mohr, *Abortion in America* (Oxford University Press, 1978).

648 Ibid.

Further, the medical profession was cognisant of the commercialisation of abortion and the opportunity to expand their power base.[649] Whatever the motive there was a growing awareness of abortion as a means by which women exercised reproductive control. Several groups saw this development as threatening and the anti-abortion lobbyists, led by the AMA, began to influence legislation from the mid-nineteenth century.[650]

In the ensuing years laws criminalizing abortion were passed by all states except Kentucky. The laws varied markedly between states. Although many states no longer used 'quickening' as the time to determine criminal responsibility, it was used to determine punishment.[651] The abortion laws became extremely restrictive and lawful safe abortions were not readily available.

By the late 1950s a high proportion of states prohibited all terminations of pregnancy unless to save the woman's life.[652] Women resorted to unsafe and unlawful abortions which resulted in a high maternal mortality rate. This caused concern among some medical professionals and a change of attitude within their ranks was discernible. The concern was heightened by an outbreak of German Measles and its link to foetal defects. At that time, the debate was not in respect of the risks of vaccination, but rather about 'whether a pregnant woman infected with the virus should be able to decide whether to *have* the baby in the first place'.[653]

The first half of the twentieth century heralded great social change. Many factors contributed to this. One was the changing role of women. Women of 'means' now entered the workforce during and remained after WWII. Women's organisations

649 Kristin Luker, 'Medicine and Morality in the Nineteenth Century' in Nancy Ehrenreich (ed) *The Reproductive Rights Reader: Law Medicine, and the Construction of Motherhood* (New York University Press, 2008) 69, 71.

650 In 1857 the American Medical Association Committee on Criminal Association was appointed, and its Report indicates its anti-abortion ideology: 'Report on the Committee on Criminal Abortion' in *Transactions of the American Medical Association* (1859) vol 12, 73–78.

651 *Roe v Wade*, 410 US 113 (1973) (Blackmun J).

652 *Ibid.*

653 Eliza Berman, 'How a German Measles Epidemic Stoked the Abortion Debate in 1965', *Time* 2 February 2015 (online).

demanding equal social, political and economic rights were beginning to engender social change.[654]

### *D Roe v Wade*

The background to *Roe v Wade* was part of the impetus for social change. Abortion was illegal under all but very restrictive situations. The 1960s, known as the 'hippie era' with the slogan 'peace not war', was a time which questioned authority.[655] It was a time of changing attitudes and challenges to all aspects of politics and society both in the USA and elsewhere. Groups emerged to promote civil liberties, gender equality, racial equality, world peace, and, to protest against the deployment of troops in foreign countries, particularly in Vietnam. It saw changing social attitudes and a more 'permissive society'.[656] Central to this time of questioning the status quo was 'women's liberation', as it was then known. Its ideology challenged the established role of women and particularly women's sexuality. Women wanted the right to control their bodies.

Jack Balkin has identified three main interest groups contributing to the initiation of *Roe v Wade*. The first group, he says, was the medical profession whose primary interest was 'freedom to practice medicine without interference from what they regarded as religiously motivated legislatures'.[657] The second was the public health system which was concerned about what they saw as a crisis in women's health brought about by a lack of access to safe legal abortion.[658] The third group was made up of feminist supporters of women's autonomy. He argues that 'this group had by 1970 begun to understand abortion as a basic right of women and began to press for repeal of existing abortion laws'.[659]

654 Victoria Hesford, *Feeling Women's Liberation* (Duke University Press, 2013).

655 Not all groups nor demonstrations were peaceful. See Chapter 4 – Access to Legal Terminations, Part F.

656 Hesford (n 654).

657 Jack M Balkin, '*Roe v Wade*: An Engine of Controversy' in Jack M Balkin (ed), *What* Roe v Wade *Should Have Said* (New York University Press, 2007) 6.

658 Ibid, Balkin notes that 'affluent' women did have this access.

659 Ibid.

In the 1960's, two cases, involving the right to use birth control, opened the way for the right to privacy being extended to abortion.[660]

In 1973, *Roe v Wade* sparked a controversy which continues to escalate rather than abate. The facts of the case provide the background to both the decision and its aftermath. Jane Roe (an alias) instituted proceedings against Wade, the District Attorney of Dallas County, Texas. She was single, pregnant and wanted a safe and legal termination carried out. She argued that she was precluded from doing so because under Texas law it was necessary to show that her life would be threatened. This she could not do. She lacked the financial resources to travel to a state where terminations were legally available. Her claim stated in part that the statutes breached her constitutional right to personal 'privacy'; and that she was suing 'on behalf of herself and "all other women" similarly situated'.[661]

Seven of the nine Justices struck down the Texas statute as unconstitutional. They held that the law breached the constitutional 'right to privacy' which 'is broad enough to encompass a woman's decision whether or not to terminate her pregnancy'.[662] Blackmun J gave the main opinion of the Court. He referred to the controversial and polarising nature of the debate about the morality of abortion and stated that it was not the judicial function to decide between the views.[663] He stated that 'the restrictive criminal laws in effect in a majority of states today are of recent vintage', enacted only in the second half of the nineteenth century.[664] Noting the difficulties of an unwanted pregnancy and the resultant harm to women's health and well-being, he concluded that 'these are factors the woman and her responsible physician necessarily will consider in consultation'.[665]

660 Referred to in respect of the laws on Northern Ireland in Part V above: *Griswold v Connecticut*, 381 US 479 (1965) held that married couples had a constitutional right to marital privacy and the use of contraceptives was part of this right; *Eisenstadt v Baird*, 405 US 438 (1972) held that the constitutionally protected right applied to unmarried couples also.

661 *Roe v Wade*, 410 US 113, 120 (1973).

662 Ibid.

663 Ibid.

664 Ibid.

665 *Ibid*.

However, the right to privacy was not limitless. There were circumstances where it was considered that the State had a legitimate interest in regulation.[666] The first interest was the pregnant woman's health and arose 'at approximately the end of the first trimester'.[667] Before that time the risks to the woman presented by a termination were less than the risk of maternal mortality in childbirth.[668] The state's second interest, medical integrity, was protected by deciding that only qualified medical professionals could perform abortions.[669] The third, the 'compelling' interest in the foetus, arose once the foetus was 'viable'. Once foetal survival outside the womb was possible the state would be able to proscribe abortion.[670]

### *E After Roe v Wade*

The immediate impact of *Roe v Wade* was to make many state laws which regulated abortion invalid. On a political and public level *Roe v Wade* was and remains controversial.[671] The issues include the accuracy of the law as decided;[672] that it was unnecessary because the states were already liberalising abortion; and, whether it had a positive or negative impact upon autonomy rights. George Annas has stated that since *Roe v Wade* 'the law has taken the lead in defining the contour of the continuing public debate over reproductive liberty'.[673]

It has been suggested that the reform would have occurred without the decision. Siegel has commented that sometimes depicted today as an historical aberration, *Roe v Wade*

666 Ibid.

667 Ibid 164.

668 Ibid 165.

669 Ibid.

670 Ibid 164–5.

671 Mary Ziegler, *After Roe: The Lost History of the Abortion Debate* (Harvard University Press, 2015).

672 Whether or not *Roe v Wade* is a correct interpretation of the Constitution is not considered here, being not within the scope of this work.

673 George J Annas 'The Supreme Court and Abortion Rights' (2007) 356 *New England Journal of Medicine* 2201; Lolita Buckner Inniss, 'Bridging the Great Divide — A Response to Linda Greenhouse and Reva B Siegel's Before (and After) *Roe v Wade*: New Questions About Backlash', (2012) 89 *Washington University Law Review* 963, 967.

was in fact one ripple in a nationwide tide.[674] Greenhouse and Siegel argue that *Roe* was not the stimulus for the polarisation and backlash against abortion. Rather it was but one factor of a much broader debate, which could be traced back to the advertising of reproductive techniques in newspapers of the early 19th century and which drew the problems of abortion to public attention and debate.[675] *Roe v Wade* did not start the controversy over abortion even though the 'public discussion of *Roe v Wade* implies not infrequently that it did'.[676] Mary Ziegler's criticism goes further stating that the impact of *Roe* was damaging, unnecessary and the impact counterproductive.[677]

It has been argued that, before *Roe v Wade*, there was legislation which allowed for abortion.[678] But there were few indications that abortion law reform was already occurring prior to *Roe v Wade.*[679] Further it is unlikely that all states would have enacted laws which made abortion legal.[680] Total uniformity in laws made by 51 jurisdictions would be difficult to achieve given the highly controversial nature of abortion and in particular, the very strong anti-abortion views held by both politicians and their constituents in several states.[681] Without the decision in *Roe* it would be improbable that

674 Linda Greenhouse and Reva Siegel, 'Before *Roe v Wade*: Voices That Shaped the Abortion Debate Before the Supreme Court's Ruling' (Public Law Working Paper No 257, Yale Law School, 19 August 2012) vii.

675 Greenhouse and Siegel, 'Before *Roe v Wade*' (n 674) viii; see Marvin Olasky, 'Advertising Abortion During the 1830s and 1840s; Madame Restell Builds a Business' (1986) 13 *Journalism History* 49.

676 Greenhouse and Siegel, 'Before *Roe v Wade*' (n 674) vii.

677 Mary Ziegler, 'Beyond Backlash: Legal History, Polarization, and *Roe v. Wade'* (2014) 71 (2) *Washington and Lee Law Review* 1021; Mary Ziegler, *After Roe: The Lost History of the Abortion Debate* (Harvard University Press, 2015).

678 Six jurisdictions had made reforms to their abortion regulation. They were Colorado (1967), California (1967), North Carolina (1968), Georgia (1968), South Carolina (1970), New York (1970), and Hawaii (1970); see discussion in Greenhouse and Siegel, 'Before *Roe v Wade*' (n 674) vii.

679 *Russell Hittinger, 'Abortion before Roe'* (2010) 201 *First Things* 59.

680 Amelia Thomson-DeVeaux, 'When Abortion Was Only Legal In 6 States' *FiveThirtyEig*ht28 August 2014

681 Eg, Texas: Guttmacher Institute, *22 States are Extremely Hostile to Abortion* (2017) (online);Guttmacher Institute, 93% of Women in the South Live in a State Hostile or Extremely Hostile to Abortion (3 January 2017)..

it could ever be said that in the USA abortion is a constitutional right to privacy which vests in all women.

At least in theory, *Roe v Wade* could be regarded as recognising women's rights to make autonomous decisions, albeit limited, and not to have decisions imposed upon them. Ronli Sifris considers that rendering women powerless was a deliberate consequence of exercising control over abortion.[682] She illustrates Mary Boyle's assertion, that law is just one method by which women's bodies are controlled by men. Sifris contrasts the situation before and after *Roe*, noting that the termination of pregnancy was previously a matter for the states, many of which had extremely restrictive laws which effectively 'disempowered' women.[683] The *Roe v Wade* decision 'rendered many existing State bans on abortion unconstitutional'.[684] It also placed important limitations on the ability of states to make valid laws regulating abortion.

> The effect of this one case was to transfer women from a position of 'powerlessness' to a position of relative empowerment — women could take some comfort in the knowledge that they had a constitutionally protected right to abortion.[685]

The use of the term 'relative empowerment', by Sifris is important here. The judgment did not accord full rights, to decide whether to terminate a pregnancy, to women. Rather the medical profession was given the central place in the decision-making process.[686] Further the right to privacy does not extend to a right to abortion on demand. *Roe v Wade* held that up to viability the woman's decision to have an abortion although made in joint consultation 'must be left to the medical judgment of attending physician'.[687]

Once the foetus is viable, the state has a 'compelling' interest to protect the health of the woman and the foetus and may thereby enact legislation for this purpose. *Roe v Wade* did not define 'viability' which put simply means that potentially the foetus can survive

682 Ronli Sifris, *Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinisation of Torture* (Taylor and Francis, 2013).

683 Ibid.

684 Ibid 187.

685 Ibid.

686 *Roe v Wade,*410 US 113 (1973).

687 *Roe v Wade*, 410 US 113, 164–5 (1973).

outside the womb.[688] However, as previously discussed the task of establishing whether or not a particular foetus is viable is quite complex. It is determined by a number of factors of which gestation is one. Viability is decided by the medical profession.[689] The final decision to perform the abortion is one for the medical professional.[690]

Irrespective of *Roe v Wade's* significance, the events during the decades since the decision, demonstrate that abortion remains extremely controversial. The anti-abortion groups have been extremely proactive in endeavours to have the decision overturned and to prohibit abortion. Their activities pose a threat to the limited autonomy of women not to continue with a pregnancy and require consideration.

It is possible to identify three important interacting influences, which have been central to the status of pregnant women's autonomy since *Roe v Wade*. The first, is the Supreme Court's decisions since *Roe v Wade*. Secondly, the changing composition of that Court may overrule *Roe v Wade*. The third, is the enactment state legislation which claims it is promoting women's health when its real purpose is preventing access to abortion.[691]

### *E After Roe v Wade*

There are several cases which indicate the continued controversial nature of abortion and the continued authority of *Roe v Wade*. Four of these will be used to show how the court has modified but not overruled the decision in *Roe v Wade*.

#### *1 Planned Parenthood v Casey*

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v Casey ('Casey'),*[692] the Supreme Court reconsidered *Roe v Wade* because of decisions which had raised doubts about its continuing applicability.[693] The Justices, recommitting to the importance of

688 See Hutton Brown et al, 'Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth' (1986) *Vanderbilt Law Review* 597, 850.

689 *Planned Parenthood of Central Missouri v Danforth*, 428 US 52 (1976).

690 There is a right to refuse to perform an abortion. This is discussed in Chapter 4 – Access to Legal Terminations, Part D.

691 Rachel Benson Gold, 'Lessons from Before Roe: Will Past be Prologue?' (2003) 6(1) *Guttmacher Policy Review 8*.

692 *Planned Parenthood of Southeastern Pennsylvania v Casey,* 505 US 833, 846 (1992).

693 Ibid O'Connor, Kennedy and Justice Souter, JJ 833-834, Blackmun, J 923.

precedent, stated that 'the central holding in *Roe v Wade* should be retained and reaffirmed'.[694] In reality, *Casey* substantially modified the law.[695]

A woman's right to an abortion up until the foetus was viable was affirmed. [696] However, the trimester approach was rejected and the validity of state law was to be tested against an 'undue burden' criterion.[697] The court considered that the state may make laws which are for the health of women *at any time* during the pregnancy but that these laws may not be unduly onerous. If they imposed an 'undue burden' they would be invalid.[698] 'Some' burden would appear to be insufficient to invalidate the law. Once a foetus is viable the state has the power to proscribe abortion except where there is a risk to the health of the women. The intention to restrict women's autonomy, based upon the belief that women require guidance and assistance, is thinly disguised in the following statement.

> What is at stake is the women's right to make the ultimate decision. Not to be insulated from all others in doing so. Regulations which do no more than create a structural mechanism by which the State or the parent or guardian of a minor, may express profound respect for the life of an unborn are permitted.[699]

694 *Ibid 834,846*

695 Ibid 846; The restatement of the *Roe* principles: 'First it is a recognition of a woman's right to choose to have an abortion before fetal viability and to obtain it without undue interference from the State, … a confirmation of the State's power to restrict abortions after viability, if the law contains exceptions for pregnancies endangering a woman's life or health; and the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.

696 *Casey,* 505 US 833, 846 (1992).

697 Ibid 837; Linda Greenhouse, 'Becoming Justice Blackmun: Harry Blackmun's Supreme Court Journey' (2005) 222; *Planned Parenthood of Southeastern Pennsylvania v Casey* 505*,* 505 US 833, 852 (1992).

698 The State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the foetus that may become a child.

699 *Casey,* 505 US 833, 846 (1992).

### *2 Stenberg v Carhart*

In 1999, *Stenberg v Carhart* came before the Supreme Court.[700] Nebraskan legislation criminalised the method used to perform 'partial birth' abortions but it did not criminalise all abortions.[701] The impugned law provided:

> No partial birth abortion shall be performed in this state, unless such a procedure is necessary to save the life of the mother ...[702]

'Partial birth' referred to a procedure which 'partially delivers vaginally a living unborn child before killing it'.[703] The section did not distinguish between the 'viable' and 'non-viable' foetus. The punishment for the offence was a maximum of twenty years' imprisonment.[704]

Adopting the principles in *Casey* the majority decided the law was unconstitutional and it was struck down.[705] The court held that the law did not differentiate between the methods of termination of pregnancy (the dilation and evacuation ('D&E') procedure or to the dilation and extraction ('D&X') procedure). The D&E procedure is usually used from 13 weeks' gestation and before viability.[706] Outlawing both procedures constituted an 'undue burden' on the woman by not allowing her access to the D&E before viability. Therefore the statute, designed to protect foetal life pre-viability, was unconstitutional

700 *Stenberg v Carhart,* 530 US 914 (2000).

701 For a detailed analysis of the argument, proceedings and cases see Roy M Mersky and Tobe Liebert (compilers), *A Documentary History of the Legal Aspects of Abortion in the United States: Stenberg v Carhart* (WS Hein, 2003); see also George J Annas, '"Partial-birth Abortion': And the Supreme Court (Legal Issues in Medicine)' (2001)344 (2) *The New England Journal of Medicine* 152; Frank A Chervenak and Laurence B McCullough, 'An ethically justified practical approach to offering, recommending, performing, and referring for induced abortion and feticide' (2009) 201 *American Journal of Obstetrics and Gynecology* 560, they criticise the use of the term 'partial birth' 560 e5.

702 Neb Rev Stat § 28-328(1) (Supp 1999).

703 Neb Rev Stat § 28-328(1) (Supp 1999).

704 Neb Rev Stat § 28-328(9)(2) (Supp 1999).

705 *Stenberg v Carhart,* 530 US 914 (2000) Breyer, Stevens, O'Connor, Souter, and Ginsburg JJ (majority); Rehnquist, CJ, Kennedy, Thomas and Scalia JJ (Dissenting) .

706 *Stenberg v Carhart,* 530 US 914, 924 (2000).

because it imposed an undue burden on the woman.[707] Once a foetus was viable the state may regulate and proscribe abortion except where it is necessary to preserve the life or health of the pregnant woman.[708]

A second aspect of the decision was that it effectively changed the burden of proof. *Stenberg v Carhart* requires that the proof of 'undue burden' will rest upon those alleging it, that is those challenging the law. Under *Roe v Wade* it was up to the state to prove that its law did not infringe the constitutional rights to privacy.[709]

### *3 Gonzales v Carhart*

In 2006, in *Gonzales v Carhart*[710] the Supreme Court decided, by 5 to 4, that the *Partial-Birth Abortion Act of 2003* (US) ('*Act*')[711] was valid.[712] The *Act* was passed by Congress to regulate abortion procedures and did not provide for an exception based upon saving the woman's life. The provisions had been framed with knowledge of the principles of *Stenberg v Carhart*. The language of the statute, unlike that in *Stenberg v Carhart*, went into explicit detail and described the procedure which was prohibited.[713] Intact D&E which is prohibited and applies to both pre- viability and viability only applies to vaginal partial births abortions. Justice Kennedy delivering the opinion of the Court stated that the *Act* addressed the problems in *Stenberg v Carhart*[714] by determining as a matter of fact that a 'moral, medical and ethical consensus exists that the practice of performing a partial-birth abortion is a gruesome procedure that is never medically necessary and should be prohibited'.[715] The assertion that a there was 'medical uncertainty' over whether it would ever be necessary to perform an intact

707 *Ibid* 916 (2000).

708 Ibid 930-931.

709 See Sarah Weddington, '*Stenberg v Carhart*: Another Piece of the Abortion Puzzle' in Roy M Mersky and Tobe Liebert (compilers), *A Documentary History of the Legal Aspects of Abortion in the United States: Stenberg v Carhart* (WS Hein, 2003) xi.

710 *Gonzales v Carhart, 550 US 124, 170–1 (2007).*

711 18 USC § 1531.

712 For a detailed analysis of the case (including the lower courts), arguments and proceedings see Kumar Percy Jayasuriya (compiler and editor), *A Documentary History of the Legal Aspects of Abortion in the United States: Gonzales v Carhart and Gonzales v Planned Parenthood* (WS Hein, 2014).

713 18 USC §1531.

714 *Stenberg v Carhart,* 530 US 914, 921 (2000).

715 *Gonzales v Carhart, 550 US 124, 170–1 (2007).*

D&E is open to question given the substantial medical literature regarding the methods of abortion.[716]

A statement by the court that '[w]hile we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained',[717] is arguably irrelevant since the decision was about constitutionality of the methods of abortion available to women. It has been argued that the judgment is flawed.

> ]T]he Court's decision is internally inconsistent. It professes to show respect for the sanctity of human life. Yet, the Act does not save a single fetus because physicians could instead use a standard D&E method. The Act criminalizes intact D&E, while allowing non-intact D&E in the exact same circumstances. This distinction lacks rationality since both methods of abortion have the same result.[718]

This criticism would seem unassailable because the *Act* does not prohibit abortion but only the choice of abortion method. The termination may be legally performed under an alternate method.

The Supreme Court concluded that the statute was valid, appropriately promotes respect for the foetus as a 'living organism' and did not impose a substantial obstacle to the pregnant woman. The tenor of the judgment may be understood as promoting restrictions upon abortion and focussing upon foetal health at the expense of women's health.

Justice Ginsberg in dissent was forthright and highly critical.[719]

> Today's decision is alarming. It refuses to take *Casey* and *Stenberg* seriously. It tolerates, indeed applauds, federal intervention to ban nationwide a procedure

716 See Lawrence O Gostin and Kumar Jayasuriya, 'Abortion Politics:Clinical Freedom, Trust in the Judiciary, and the Autonomy of Women', in Kumar Percy Jayasuriya, Compiler and Editor. *Documentary History of the Legal Aspects of Abortion in the United States*

717 *Gonzales v Carhart, 550 US 124, 170–1 (2007).*

718 Lawrence O Gostin & Kumar Jayasuriya, 'Abortion Politics Clinical Freedom, Trust in the Judiciary, and the Autonomy of Women', in Kumar Percy Jayasuriya (compiler and editor), *A Documentary History of the Legal Aspects of Abortion in the United States: Gonzales v Carhart and Gonzales v Planned Parenthood* (WS Hein, 2014) xv.

719 *Gonzales v Carhart 550 US 124, 170–1 (2007) (*Stevens, Souter and Breyer JJ joined in Ginsberg J's dissent).

found necessary and proper in certain cases by the American College of Obstetricians and Gynecologists (ACOG).[720]

The decision, perhaps, indicated a willingness by the Court to limit, refine and reconsider the constitutional right of women to terminate their pregnancies.[721] The Justices were seen to be forthcoming in promoting foetal rights to the detriment of the autonomy of women. The unsubstantiated assertion that women who have a termination will regret it, ought to be of concern.[722] The belief that women need to have decisions made for them is not even thinly disguised in the majority judgment.

Jessica Pieklo's observation that the decision in *Gonzales v Carhart* 'continues to be the single greatest jurisprudential threat to *Roe* and abortion rights'[723] is reinforced by the current legislative activity of several states limiting women's access to abortion.[724] Irrespective of the professed purpose of the legislation, the intention of many of the states is to control, restrict, curtail and prevent American women's right to terminate their pregnancy.

### *4 Whole Women's Health v Hellerstedt*

In June 2016, the USA Supreme Court, in *Whole Women's Health v Hellerstedt* ('*Hellerstedt*')[725] involved a challenge to the validity of a 2013 Texas statute known as HB2.[726] It was an 'Act relating to the regulation of abortion procedure, providers, and facilities, providing penalties'. It placed extremely strict requirements on those medical practitioners who, and clinics which, provided abortions. One requirement was that the providers have admitting privileges at a hospital which was no further than thirty miles

720 Ibid.

721 Richard HW Maloy, 'Will New Appointees to the Supreme Court Be Able to Effect and Overruling of *Roe v Wade*?', (2005) 28 *Western New England Law Review* 29.

722 *Gonzales v Carhart, 550 US 124, 129 (2007).*

723 Jessica Mason Pieklo, 'False Choices and the Legacy of "Gonzales v Carhart"' *Rewire* 18 April 2016.

724 See Chapter 4 — Access to Legal Terminations.

725 *Whole Woman's Health v Hellerstedt*, 579 US ___ (2016); *Whole Woman's Health v Cole*, 790 F 3d 563 (5th Cir, 2015); See Jon O Shimabukuro, 'Abortion and *Whole Woman's Health v. Hellerstedt*' CRS Report for Congress; R44205. 2016.

726 Ibid.

from their premises. Another requirement made it necessary for the facilities to be equal to that of an outpatient surgical centre.[727]

The legislation is an example of what are commonly referred to as TRAP laws. The acronym stands for *Targeted Regulation of Abortion Providers* laws.[728] The laws are directed at medical providers and hospitals. They restrict or prevent access to safe abortions by placing unnecessary and unachievable requirements on the providers. The aim is to diminish availability of abortion services and force the closure of premises where the services are performed. TRAP laws do not directly violate the constitutional right to terminate pregnancy and criminalise abortion. Their real purpose is thinly disguised under the claim that the measures are for the promotion of women's health because they ensure that providers meet the highest medical safety standards.[729]

In *Hellerstedt*, medical professionals challenged the validity of admitting privileges and minimum surgical requirements imposed by Texas legislation.[730] It was argued that the laws were '[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion'.[731] It was argued that the legislation if upheld by the Supreme Court would force the closure of around 75% of

727 Reva Siegel and Linda Greenhouse 'Casey and the Clinic Closings: When "Protecting Health" Obstructs Law' (2016) 125 *Yale Law Journal* 1428; Reva Siegel and Linda Greenhouse, 'When "Protecting Health" Obstructs Choice' (2016) 125 *Yale Law Journal* 1454; Amy Howe, *Justices Enter the Fray with Grant in Texas Abortion Case: In Plain English* (13 November 2015) Supreme Court of the United States Blog, The legislation also outlawed abortions once the women had reached 20 weeks' gestation, except to save the woman's life.

728 Rachel Benson Gold and Elizabeth Nash, 'TRAP Laws Gain Political Traction While Abortion Clinics — And the Women They Serve — Pay the Price' (2013) 16 *Guttmacher Policy Review* 7.

729 Elizabeth Nash et al, 'Trends in the States: First Quarter 2016' (Policy Analysis, Guttmacher Institute, 13 April 2016) reported that in the first quarter of 2016 states had proposed 411 abortion restrictions; *An Overview of Abortion Laws* (1 January 2018) <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>.

730 *Whole Woman's Health v Hellerstedt*, 579 US ___ (2016).

731 See, writ of certiorari: Supreme Court of the United States Blog <http://www.scotusblog.com/wp-content/uploads/2015/09/2015-09-02-Cert-Petition.pdf>.

the Texas clinics. [732] This would severely reduce women's access to safe and legal abortion services and would almost achieve the same result as a prohibition on abortion.

Applying *Casey*, the majority held that 'neither of these provisions confers medical benefits sufficient to justify the burdens upon access that each imposes'.[733]

Justice Ginsberg, adding to the majority opinion with whom she concurred, said:

> it is beyond rational belief that H.B. 2 could genuinely protect the health of women, and certain that the law 'would simply make it more difficult for them to obtain abortions'. ... When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux,* at great risk to their health and safety.[734]

The majority decision built upon the 'undue burden' test in *Casey*. The majority adopted the *Casey* 'balancing test' which requires the court to 'consider the burdens a law imposes on abortion access together with the benefit those laws confer'.[735] In *Hellerstedt* the Court provided a framework within which a cost-benefit decision making process would be applied. This required that courts carefully assess and weigh all evidence and decide on the basis of whether the burdens outweighed the benefits. As a result the case is regarded as having clarified *Casey* and as having 'left little room for future parties and courts to maneuver around this analytical framework without rejecting it outright'.[736]

732 Lyle Dennison, *Court to Rule on Abortion Clinic Restrictions* (13 November 2015) Supreme Court of the United States Blog <http://www.scotusblog.com/2015/11/court-to-rule-on-abortion-clinic-restrictions>.

733 *Whole Woman's Health v Hellerstedt*, 579 US ___ (2016)*Planned Parenthood of Southeastern Pennsylvania v Casey,* 505 US 833, 846 (1992).

734 Citing *Planned Parenthood of Wisconsin v Schimel,* 806 F 3d 910 (7th Cir, 2015); *Whole Woman's Health v Hellerstedt*, 579 US ___ (2016).

735 *Whole Woman's Health v Hellerstedt*, 579 US ___ (2016).

736 'Due Process Clause: Undue Burden: *Whole Woman's Health v Hellerstedt*' (2016) 130 *Harvard Law Review* 397.

The decision is regarded as significant.[737] For women it is a recognition that their right to health is paramount.[738] It also impacts upon several states, which have enacted or intend to enact TRAP laws and which mirror the Texas law.[739] The decision does not automatically invalidate the TRAP laws outside of Texas but it does pave the way for challenges to those laws.[740]

### *F The Future of Roe v Wade*

The decisions in *Roe v Wade* and subsequent cases recognise pregnant women's autonomy at least in the earlier stages of pregnancy. It is important that this autonomy is not undermined but that women be recognised as equivalent beings.[741] Opinion is divided as to whether the Supreme Court would overrule *Roe v Wade* in the future.[742] Whether the Justices would be prepared take a pro-active stance in changing the law and forego their adherence to the doctrine of *stare decisis* and to judicial method is a factor.[743] On the other hand, judicial appointments to the Supreme Court are political.

737 Michael Scott Leonard, 'Supreme Court Sides with Abortion Clinics in Landmark Ruling Striking Down Parts of Texas Law' (2016) 32 *Westlaw Journal Pharmaceutical* 1.

738 Carole Joffe, Carole, 'Reflections on *Whole Woman's Health v Hellerstedt*: Savoring Victory' 94 (5) (2016) Anticipating Further Challenges' *Contraception* 436; Steven R Morrison, 'Personhood Amendments after *Whole Woman's Health v Hellerstedt*' (2016) 67 Case W Res L Rev 447.

739 See, eg, Mississippi (*Currier v Jackson Women's Health Organization* (Docket No 14-997, 28 June 2016)); for Wisconsin, Alabama and Louisiana see Guttmacher Institute, *An Overview of Abortion Laws* (1 January 2018).

740 See Dennis Pathroff,'Abortion and Birth Control — United States Supreme Court Declares Texas' Restrictions on Abortion Facilities Unconstitutional: Impact on States with Similar Abortion Restrictions: *Whole Woman's Health v Hellerstedt*, 136 S Ct 2292 (2016)' 92 *North Dakota Law Review* 213, 225–31; Elizabeth Nash et al, 'Trends in the States: First Quarter 2016' (Policy Analysis, Guttmacher Institute, 13 April 2016) reported that in the first quarter of 2016 states had proposed 411 abortion restrictions; Guttmacher Institute, *An Overview of Abortion Laws* (1 January 2018).

741 See Chapter 2 — Theoretical Underpinnings.

742 Maloy (n 721); Robert A Sedler, 'The Supreme Court Will Not Overrule *Roe v Wade*' (2006) 34 *Hoffstra Law Review* 1207.

743 See Sarah Weddington, '*Stenberg v Carhart*: Another Piece of the Abortion Puzzle' in Roy M Mersky and Tobe Liebert (compilers), *A Documentary History of the Legal Aspects of*

President Trump elected on an anti-abortion platform among other policies, has the potential to influence decisions by making appointments of those of the same ilk.[744] The new appointments he has made and ones in the future may change the composition and political alignment of the Court.[745] Changes to the composition of the bench are inevitable, as President Trump is well aware.[746] The issue is a complex one [747] which is compounded by Trump's determination to both recriminalise abortion and prevent public funding of abortion services.[748]

## VIII CONCLUSION

The overview and the analyses of the laws regulating abortion showed that there were commonalities and differences within the jurisdictions.

> The early 21st Century has seen some positive changes in removing abortion regulation from the criminal law and regulating it as a health matter. In Canada and the USA abortion is a Constitutional right. Nevertheless, its continuance as such in the USA is under threat from those who are against access to abortion. Australia (except for WA and SA) and NZ may be regarded having progressive legislation. The changes which have taken place there have been remarkable. However, it may be the recent changes in the Irish Republic and Northern Ireland which stand out as having made the most dramatic changes to both the law and its operation. Up until January 2019 in Ireland and October 2019 in NI abortion was a criminal offence which was prosecuted. The reform of the abortion laws in both of those jurisdictions were long overdue. The new laws remain restrictive. Nevertheless, the legal reform has been of great significance for Irish women's

*Abortion in the United States: Stenberg v Carhart* (WS Hein, 2003) xi.

744 Eg, the nominations by President Trump of Judge Neil Gorsuch on 31 January 2017 and Judge Brett Kavanaugh on 9 July2018; see Conor Duffy, 'Donald Trump: Why the President's Supreme Court pick matters' *ABC News*, 01 February 2017 (online); Christine Rousselle, 'DC Judge Brett Kavanaugh Nominated to the US Supreme Court' *National Catholic Register,* 10 July 2018; cw Mark Joseph Stern, 'How Neil Gorsuch Became the Supreme Court's Most Unpredictable Justice' SLATE Jurisprudence 15 July 2020 (online).

745 Maloy (n 721).

746 Ian Millhiser, 'No president in recent memory has done more to change the judiciary than Donald Trump' *Vox* 19 December 2019 (online).

747 Maloy (n 721); Sedler (n 742).

748 This is addressed in Chapter 4 -Access to Legal Terminations.

autonomy. The complete reversal from criminal prosecution to legality in a country which has been strongly influenced by religion indicates that it is possible to change the laws in other jurisdictions where abortion laws are repressive. (Anonymous, 'FACTBOX - Abortion rights across Europe' *Thomas Reuters Foundation News* 22 October 2020).

# CHAPTER 4 ACCESS TO LAWFUL TERMINATIONS

## I INTRODUCTION

Chapter 3 considered the laws which regulate whether and in what circumstances a termination of pregnancy will be lawful. It argued that the method of legal regulation adopted by a jurisdiction impacted upon women's autonomy during pregnancy. Further it identified that the legal frameworks adopted conferred responsibility upon the medical profession for the implementation, administration and decision making in access to terminations of pregnancy.[1]

The theory of autonomy as outlined in Chapter 2 provides that all persons, irrespective of gender and whether or not they are pregnant, should be granted equivalent rights of self-development. In respect of deciding whether to continue with a pregnancy, the principle may be stated as the right to decide whether or not to reproduce. One aspect of the right is that it requires that abortion be legal, safe and accessible. Lawful abortion is recognised within the countries considered, albeit in different ways and to a different extent.[2] There are influences which, in addition to and sometimes in conjunction with the law as written, militate against being able to exercise autonomy. These indicate that there are differences between the theory of the law as enacted and the ability to invoke the law, that is the law in practice.

This chapter identifies and analyses some of the factors which operate in a manner which hinders or prevents pregnant women from implementing a decision not to continue with a pregnancy.[3] Part A considers the legal framework in which the laws of abortion operate and argues that there is not necessarily a correlation between the letter of the law and access to abortion. Part B considers the interrelationship between governmental policy, law making and funding and their impact upon access to abortion. Part C examines the important role of the medical profession as the law's proxy in the regulation of abortion and considers the right of medical professionals to refuse to

1 See Chapter 3 — The Legal Regulation of Abortion.

2 Eg, the now repealed *Protection of the Unborn During Pregnancy Act 2013* (Ire) provided that abortion was lawful in very restricted circumstances such as to save the life of the pregnant woman; see Chapter 3 — The Legal Regulation of Abortion.

3 They are of relevance also to medical treatment during pregnancy.

participate in the provision of termination procedures. Part D considers the broader issue of the impact of stigma upon accessing an abortion. Part E considers the manner in which those groups which designate themselves as 'anti-abortion'' attempt to prevent abortion by impeding physical access to institutions which provide reproductive services. The final section of the chapter provides a summary of and preliminary conclusions about the problems associated with accessing abortion.

### *A The Legal Framework*

In Chapter 3 it was observed that the legal frameworks regulating abortion varied extensively across the jurisdictions analysed here.[4] It is possible to visualise the different legal frameworks as belonging on a continuum. At each end the laws are polarised. At one end, there is a full recognition of women's autonomy. Here the legal framework provides for legal abortion as an aspect of the overall autonomy of women, including their health and wellbeing.[5] At the other end of the continuum the laws strictly limit or prohibit abortion and often reflect the legal system's moral and/or religious beliefs.[6] Between the polarised legal frameworks other laws sit at different points along the spectrum.[7] These allow the inference to be drawn that only the women at the first end of the continuum have full autonomy. This gradually diminishes until the other end is reached where woman have no autonomy.[8] Although not discussed here, the paradigm is applicable in the global context, at least, on a general level.[9]

4 See Chapter 3 – The Legal Regulation of Abortion.

5 Eg, Canada and ACT.

6 Human Rights Committee, *Views: Communication No 2324/2013*, 116th sess, UN Doc CCPR/C/116/D/2324/2013 (31 March 2016) (*'Mellett v Ireland'*); Max Bearak, 'UN Judgment Says Ireland's Anti-Abortion Laws Are a Violation of Human Rights', *Washington Post (Washington DC)*, 9 June 2016.

7 Hugo Farmer, 'An Analysis of New Zealand's Abortion Law System and a Guide to Reform' [2013] *New Zealand Journal of Public and International Law* 9, who identifies three approaches.

8 Ireland and Northern Ireland have recently reformed laws which were repressive and severely limited women's autonomy. This was the situation in theory in Qld and NSW until they reformed their legislation. (outlined in Chapter 3 – The Legal Regulation of Abortion).

9 BR Johnson Jr et al, 'A global database of abortion laws, policies, health standards, and guidelines'(2017) 95 *Bull World Health Organ* 542–544;World Health Organization. *Global Abortion Policies: A joint UN–WHO project*.; see also, for the need for improved information

The analysis of the laws of abortion indicated that:

1 None of the legal systems provide for abortion as a legally enforceable right;[10]

2 The laws vary from providing that terminations will be legal (where a decision is made in consultation a medical professional), or will be legal providing certain criteria are present (such as a threat to the health of the women, rape, incest) to being legal in extremely limited circumstances (only to save the life of the mother);

3 The laws varied as to the procedures which had to be followed in the provision or refusal of the termination procedure (some were detailed, and prescriptive others were less so);

4 Some jurisdictions continue to locate abortions within the criminal law and subject to a penalty of a fine or imprisonment; and

5 The laws regulating abortion have undergone much change during the first two decades of the 21st Century and particularly in past few years.[11]

The following discussion concentrates upon those features of the legal systems which regulate abortion and facilitate or militate against the exercise of autonomy by women who have decided not to continue with their pregnancy. It is argued that laws legalising abortion do not necessarily guarantee access to abortion in practice.

> Issues of stigma, cost, location of clinics, restrictions on who can provide abortion services and gestational limits continue to affect women's access to safe abortion even in cases where the law appears liberal.[12]

databases on abortion, Joanna N Erdman and Brooke Ronald Johnson, 'Access to Knowledge and the Global Abortion Policies Database' (2018) 142 (1) *International Journal of Gynecology & Obstetrics* 142, 120-24.

10 But see the *Abortion Law Reform Act 2008* (Vic); in Canada access to abortion is largely controlled through health legislation at the provincial and territorial level.

11 Eg, in the Britain ss 58 & 59 of the *OAP Act 1861* apply unless the abortion complies with the *Abortion Act 1967* (UK).

12 Fiona Bloomer, Claire Pierson, and Sylvia Estrada Claudio, 'Criminalisation' in *Reimagining Global Abortion Politics: A Social Justice Perspective*, 11 (Bristol University Press, 2019).

Access may be limited by government policy and funding, and medical administration and practices, which combine to control whether a woman will ultimately access a timely, safe and legal abortion.

Where abortions laws are restrictive then access to abortion usually becomes more difficult. Problems

> include accessing abortion away from regulated settings, and in doing so, risking unsafe abortion. Added complications include the need to pay for the abortion, which is often at a significant cost, having to travel to other jurisdictions, and most obviously the risk of prosecution if found to have procured an illegal abortion.[13]

The absence of safe and timely access to abortion services threatens women's autonomy. It threatens her health and well-being either because the alternatives are continuing with an unacceptable pregnancy or recourse to an unsafe abortion. As shown in the following discussion it is not only the legal regulation of abortion which inhibits access.

### *1 Overview*

This part has considered the legal framework in which the laws of abortion operate and argues that there is not necessarily a correlation between the letter of the law and access to abortion. Part B considers the interrelationship between governmental policy, law making and funding and their impact upon access to abortion. Part C examines the important role of the medical profession as the law's proxy in the regulation of abortion. It argues that the medical profession is the 'gate keeper' of and has a monopoly over the provision of termination services. It also addresses the issue of allowing medical professionals to refuse to participate in the provision of termination procedures. Part D considers the broader issue of the impact of stigma upon accessing an abortion. Part E considers the manner in which those groups which are anti-abortion attempt to prevent abortion by impeding physical access to institutions which provide reproductive services.

## *B Government Policy and Funding*

Governmental provision of control over and the administration of funding may also effectively restrict access to a termination of pregnancy. It is argued here that there is an identifiable connection between governmental policies in respect of abortion, funding of

13 Ibid.

health services, the subsequent allocation of funds, the administration of health services by the medical profession, and being able to access a timely and safe abortion. It is these dynamics which impact upon women's capacity to exercise autonomy.

The right to health, including the right to receive medical treatment, is regarded as a fundamental human right. States have an obligation to provide for their citizen's health and medical care.[14] The extent to which the jurisdictions considered here recognise and fulfil this obligation varies markedly.[15] For example, in the USA there is no universal health coverage but in the UK, Canada, New Zealand and Australia there are national health schemes.[16] The government and/or private sector may also provide for health

14 *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) art 25 states: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, and medical care ... [and that] every individual and every organ of society ... shall strive ... by progressive measures, national and international, to secure [its] universal and effective recognition'; Anonymous, 'Health — An Explicit Human Right' (2016) 387 *The Lancet* 917; Timothy C Okeke, 'Moral Obligation and Social Rationality of Government: The Affordable Care Act' [2011] *Forum on Public Policy: A Journal of the Oxford Round Table* 1; Alicia Ely Yamin, 'Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage' (2017) 39 *Human Rights Quarterly* 341.

15 Jack M Beermann, '*NFIB v Sebelius and the Right to Health Care: Government's Obligation to Provide for the Health, Safety, and Welfare of Its Citizens*' (2015) 18 *NYU Journal of Legislation & Public Policy* 277, 304; Michael J Selgelid, 'Improving Global Health: Counting Reasons Why' (2008) 8 *Developing World Bioethics* 115–25; Jean McHale, 'NHS Resource Allocation: A Question of Funding?' (2011) 20 *British Journal of Nursing* 888; Anonymous, 'NHS England: Preparing for PrEP' (2016) 388 *The Lancet* 634; Joanna Manning, 'Litigating a Right to Health Care in New Zealand' in Colleen M Flood and Aeyal Gross (ed), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014); Colleen M Flood and Aeyal Gross, 'Introduction: Marrying Human Rights and Health Care Systems' in Colleen M Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014); Christopher Newdick, 'Promoting Access and Equity in Health' in Colleen M Flood and Aeyal Gross (ed), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014).

insurance schemes which cover a percentage of the costs of medical treatment.[17] What is common to all the systems is that the role of the governments in providing funding and the medical profession in the administration of the health services have a major impact upon the affordability and adequate access to abortion.[18] What follows is a summary of some of the key features of the health regimes and their impact upon access to abortion.

The examination commences with the USA because it illustrates that a constitutionally protected right to abortion does not guarantee unhindered access to the required medical procedures. This will be followed by an analysis of Canada where abortion is legal and access problematic until relatively recently. The UK and NZ will follow as being other examples of jurisdictions which have national health schemes. Australia will provide the final exemplar of how funding of abortion may impact upon autonomy.[19]

### *1 The USA*

It is argued that the USA, federal governmental policy and the restrictions placed upon the funding of reproductive services is used as a deliberate measure to prevent abortion and has negatively impacted upon a woman's ability to access necessary medical services.[20] At the outset, it is noted that, in the USA, the provision of health care is one of

16 See eg, the NHS in the UK, *National Health Service Act 2006* (UK) c 41; *Health and Social Care Act 2012* (UK) c 7; Ministry of Health New Zealand, *Publicly Funded Health and Disability Services* (15 April 2011) *Canada Health Act, RSC 1985, c C-6*; *Accident Compensation Act 2001* (NZ); *Human Services (Medicare) Act 1973* (Cth); S Duckett, 'Expanding the breadth of Medicare: Learning from Australia' (2018) 13 (3-4) *Health Economics, Policy and Law* 344; Christopher Newdick, 'Promoting Access and Equity in Health' in Colleen M Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014).

17 Eg, Australia; for the origins of the systems in Australia see Kerry A Petersen, 'The Public Funding of Abortion Services: Comparative Developments in the United States and Australia' (1984) 33 *The International and Comparative Law Quarterly* 158, 171–80; Kerry Smith, 'Royal Women's Hospital cuts abortion service' (2018) Green Left Australia 12.

18 This applies also in respect of health for pre-natal, natal and post-natal care.

19 NI is now funded by the NHS; In Ireland abortion has been funded by the government since its decriminalisation in 2019, see Sydney Calkin, 'One year on, it's clear that the new Irish abortion services have serious limitations' *The Conversation* 15 January 2020.

'extreme complexity'[21] and it is not within the scope of this thesis, nor is it necessary, to undertake an analysis of the system in any detail. Two matters of significance will be addressed. First, governmental policy, exacerbates the socio-economic inequity in health care and access to abortion.[22] Second, the situation is compounded by the lack of a constitutionally protected right to health.[23]

First, access to health and medical services is disproportionately skewed in favour of the socio-economically advantaged and to the detriment of the poor.[24] Generally, Americans rely upon employment based private health insurance cover.[25] This obviously excludes those who are unemployed. According to Alicia Yamin and Jean Carmalt

> [b]ecause the system is designed around employment-based health insurance, this lack of coverage translates into a nearly insurmountable barrier to accessing

20 Anonymous, 'Trump Declares "war on Women's Health"' (2017) 2 (43) *Irish Medical Times* 89; Ann M Starrs, 'The Trump Global Gag Rule: An Attack on US Family Planning and Global Health Aid' (2017) 389 (10068) *The Lancet* 389, no 10068 (2017) 485; Kinsey Hasstedt, 'What the Trump Administration's Final Regulatory Changes Mean for Title X' 4 March 2019 *Health Affairs Blog* Guttmacher Institute, Web.

21 For an explanation and critique of the system in the USA see Alicia Ely Yamin and Jean Connolly Carmalt, 'The United States: Right to Health Obligations in the Context of Disparity and Reform' in José M Zuniga, Stephen P Marks and Lawrence O Gostin (eds), *Advancing the Human Right to Health* (Oxford Scholarship Online, 2013) 232; Petersen (n 17).

22 Bernie Sanders, 'An Agenda to Fight Inequality' (2017) 389 (10077) *The Lancet* 389.

23 Prah Ruger et al, 'The Elusive Right to Health Care under US Law' (2015) 372 (26) *The New England Journal of Medicine* 2558.

24 Alvin Powell, 'The Costs of Inequality: Money = Quality Health Care = Longer Life', *Harvard Gazette* (Cambridge) 22 February 2016 (online); Alicia Ely Yamin, 'Taking the Right to Health Seriously: Implications for Health Systems, Courts, and Achieving Universal Health Coverage' (2017) 39 *Human Rights Quarterly* 341; Benjamin Cowan and Benjamin Schwab, 'Employer-Sponsored Health Insurance and the Gender Wage Gap' (2016) 45 *Journal of Health Economics* 103.

25 Michelle Long et al, 'Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014' (2016) March *The Henry J Kaiser Family Foundation* 1; Ezra Klein, 'The Elusive Politics of Reform' (2008) 19 *The American Prospect* 4; Ezra Klein, 'The Three Best Ideas of Obama's Budget', *The Washington Post* (Washington DC) 11 April 2013.

adequate health services and those without insurance reflect the racial-, ethnic-, and income-based inequalities that permeate US society[26]

There is no universal health coverage in the USA. The federal government funded health programme is the Medicaid/Medicare scheme which is a federal and state venture funding medical treatment for those living below the poverty line.[27] It could be assumed that funding would be available for health services generally including abortion. However, federal policy prohibits funding for abortions.[28] Therefore, access to abortion for those without health insurance[29] but eligible for funding under the Medicaid or other schemes[30] must rely upon state funding policy which varies as between the states. Some states will provide finance for abortion whilst others will not or will only provide extremely limited funding.[31]

Secondly, the USA, whilst spending a great deal upon health[32] has not recognised it as a legal obligation. Lacking constitutional or other legislative protection it cannot be enforced like other rights, such as, freedom of speech, bodily integrity or privacy.[33] This has enabled health funding to be adjusted, at both federal and state levels, to implement anti-abortion policies and restrict access to abortion.

26 Yamin and Carmalt, 'Right to Health' (n 21), 231-232; see Cowan and Schwab (n 24); see Yamin (Taking the Right'(n 14) 344.

27 *Patient Protection and Affordable Care Act, Pub L No 111-148, 124 Stat 119 through 124 Stat 1025* ('*Affordable Care Act*').

28 Kinsey Hasstedt, 'Recent Funding Restrictions on the US Family Planning Safety Net May Foreshadow What Is to Come' (2016) 19 *Guttmacher Policy Review* 67.

29 Insurance providers are not obliged to provide coverage for abortion: *Affordable Care Act* (US) s 1303 — Special Rules; Michelle Andrews, 'Figuring Out Whether Health Insurance Covers Abortion Can Be Confusing', *Washington Post* (Washington DC) 25 January 2016.

30 For an overview of the funding schemes and their operation, see Richard Nadeau et al, *Health Care Policy and Opinion in the United States and Canada* (Routledge, 2015) 19 et seq; Megan K Donovan, 'In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact' (2017) 20 *Guttmacher Institute Policy Review* 1.

31 Heather D Boonstra, 'Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters' (2016) 19 *Guttmacher Policy Review* 46.

32 Ezra Klein, 'The Elusive Politics of Reform' (2008) 19 *The American Prospect* 4.

33 Prah Ruger (n 24) 2559.

The decision in *Roe v Wade* provides insight into why health is not regarded as a constitutionally protected right and in identifying how funding policy is used to restrict access to abortion. *Roe v Wade* was not based upon a 'right to health' but upon the constitutional 'right to privacy'.[34] The right to abortion was a 'negative right' and not a right to have an abortion at the expense of the state.[35]

In the USA, the concentration upon the protection of civil and political rights has meant that socio-economic rights, including the 'right to health', have been somewhat disregarded. The protection of a 'right to health' has been subsumed under laws which are not directly concerned with the recognition of such a right. Yamin and Carmalt have argued that 'to the extent that certain aspects of the right to health are legally protected, it is most often under laws that are framed in terms other than health'.[36] For example abortion and other reproductive rights are protected by privacy laws rather than laws which guarantee a right to health. By using 'funding' to regulate reproduction, including abortion, the government has implemented policies which are couched in terms of health and not privacy. Thus, abortion is legal but there is not a right to a publicly funded abortion.[37] Yamin and Carmalt have explained this:

> In the case of reproductive rights in particular, that legal framing has politicized aspects of reproductive decisions that might not otherwise be as open to politicization, such as the permissibility of terminating a pregnancy, and, as it has precluded governmental funding of certain services, has meant that in practice poor women do not have the same rights to abortion that wealthier women do.[38]

Ruger et al have pointed out that '[t]he Constitution does not contain the words "health", "health care", "medical care", or "medicine"'.[39] Writing in a broader context they argue that '[j]udicially crafted constitutional doctrine never aspired to and never could guarantee positive rights to health care, education and other primary care that all Americans need to flourish'.[40] They arrive at the salutary conclusion.

34 *Roe v Wade*, 410 US 113, 164–5 (1973).

35 *Maher v Roe,* 432 US 464, (1977); *Harris v McRae,* 448 US 297, 316 (1980).

36 See Yamin and Carmalt, (n 21) 327-328.

37 Prah Ruger et al (n 23).

38 Yamin and Carmalt (n21).

39 Prah Ruger (n 23) 2558.

40 Ibid 2562.

> Our Supreme Court is not the solution to what ails our health care system, nor should it be. But if it gets in the way of the ongoing and gradual democratic process of arriving at solutions, it is a major part of the problem.[41]

Since *Roe v Wade*, anti-abortion policies have used health funding in a deliberately political manner in the campaign against abortion, by targeting and restricting access to safe, lawful and timely abortions. It is worth exploring how this has occurred.

The decision in *Roe v Wade* was unpopular with many of those who oppose abortion. They have the primary objectives of having *Roe v Wade* overturned and prohibiting all or almost all abortions, on the basis that to them the destruction of the foetus is murder. *Roe v Wade* did not alter their anti-abortion goal but rather broadened the way in which the goal was to be pursued. Less direct but highly effective methods were employed to prevent legal abortions being performed. Controlling funding provided a significant means which could be used in a manner which did not conflict with the decision in *Roe v Wade*.[42]

In 1976, an amendment promoted by the late Republican Henry Hyde was passed by Congress. It prohibited the use of federal funds for the provision of termination procedures. The only exceptions were for the protection of the life of the woman or for the implementation of health plans by the Department of Health and Human Services. [43] This effectively prevented women being covered under Medicaid.[44]

Hyde was avowedly anti-abortion and acknowledged that the amendment discriminated against poor women.[45] His objective was to stop abortion *per se* and his first step was the denial of insurance coverage to the poor. He reportedly stated that:

41 Ibid.

42 Joanna N Erdman, 'In the Back Alleys of Heath Care: Abortion, Equality, and Community in Canada' (2007) 56 *Emory Law Journal* 1093, 1104.

43 Heather D Boonstra, 'Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape and Incest' (2013) 16 *Guttmacher Institute Policy Review* 2.

44 Ibid; see Heather D Boonstra, 'On *Roe* Anniversary, Let's Remember the US Women for Whom Abortion Is a Right on Paper Only' *Guttmacher Institute*, 19 January 2016 (online).

45 Heather D Boonstra, 'Insurance Coverage of Abortion …, above n 43; Susan Schewel, 'The Hyde Amendment's Prohibition of Federal Funding for Abortion — 30 Years is Enough!' (2006) September–October *Women's Health Activist* 1.

> I would certainly like to prevent, if I could legally, anybody having an abortion: a rich woman, a middle class woman, or a poor woman.[46]

In 1980, the law was challenged in the Supreme Court in *Harris v McCrae.*[47] In upholding the constitutionality of the *Hyde Amendment* the court opined that it was not in violation of a woman's freedom of choice to have an abortion because

> it does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. Although the government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation, and indigency falls within the latter category.[48]

Thus, the woman, by implication, was responsible for her poverty. The states could if they wished could provide funding; but they were not obliged to do so. In the same year, in *Williams v Zbaraz*, [49] the Federal Supreme Court held that state enactments of the Hyde Amendment were constitutional. A further change to the *Hyde Amendment*, effective from 1997, relaxed the provisions slightly by allowing funding for terminations because of rape or incest; or, where the continuance of the pregnancy posed a threat to the woman's life.[50]

Since that time the policy of restricting access to abortion by strict controls over funding for lower income groups has been consistently implemented; but not without attempts to alter the imbalance. In 2010, Obama Administration enacted the controversial *Patient Protection and Affordable Care Bill,* which came to be known as 'Obamacare'.[51] One of the

46 Carol A Emmens, *The Abortion Controversy* (Julian Messner, I987) 68.

47 448 US 297 (1980).

48 *Harris v McRae,* 448 US 297, 316–17 (1980) [emphasis added].

49 448 US 358 (1980).

50 Heather D Boonstra, 'Insurance Coverage of Abortion: Beyond the Exceptions for Life Endangerment, Rape and Incest' (2013) 16 *Guttmacher Institute Policy Review* 2.

51 See Louis Jacobson, *Does Barack Obama's Health Care Bill Include $1 Abortions? Politifact* 21 March 2012 (online); Unknown, 'Encumbered Exchange: The Affordable Care Act' *The Economist*, 10 September 2016, 23.

purposes of the Bill was to promote health services for planning pregnancy and parenthood.[52]

Obamacare needs to be seen in the context of the push to block any change which would allow freer access to abortion. Kinsey Hasstedt has asserted.

> Social conservatives have also long sought to undermine the network of publicly supported family planning providers that offer low-cost or no-cost care to women in need. Congressional leaders have their sights set on crucial family planning programmes. . . In particular, conservative policy makers are determined to deny federal funding to health centres affiliated with Planned Parenthood because, in addition to providing contraceptive and closely related care, such as testing and treatment of sexually transmitted infections, Planned Parenthood centres might also offer abortion care with non-federal funds.[53]

To secure the passing of the Bill, President Obama had agreed to retain a commitment to both the *Hyde Amendment* and the ban on federal funding of abortion. In 2016 only 15 states were providing funding for abortions to those registered for Medicaid.[54] This meant that the remaining states apply the *Hyde Amendment*. Heather Boonstra notes that women of colour are disproportionately reliant upon Medicaid.[55] It has been estimated that one in four women is unable to obtain an abortion.[56]

52 Heather D Boonstra, 'Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest' (2013) 16 *Guttmacher Institute Policy Review* 2 (online).

53 Kinsey Hasstedt, 'Recent Funding Restrictions on the US Family Planning Safety Net May Foreshadow What Is to Come' (2016) 19 *Guttmacher Policy Review* 67.

54 Heather D Boonstra, 'Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters' (2016) 19 *Guttmacher Policy Review* 46, 48; In 2018, 17 states had a policy on funding 5 of these states voluntarily direct Medicaid to pay 'medically necessary abortions' and 12 states provide funding when there is a Court Order, Guttmacher Institute, 'State Funding of Abortions under Medicaid' *State Laws and Policies*, 1 June 2018 (online); see also Heather D Boonstra 'Insurance Coverage of Abortion: Beyond the Exceptions For Life Endangerment, Rape and Incest' (2013) 16 *Guttmacher Policy Review* 2.

55 Heather D Boonstra, 'Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters' (2016) 19 *Guttmacher Policy Review* 46, 49–51: only 14% of all women 15-44 enrolled in Medicaid are white.

The availability of funding for abortion has been even more severely restricted under the Trump administration.[57] Upon Donald Trump becoming President in 2017, the *American Health Care Bill* was introduced to dismantle Obamacare and to put budgetary initiatives in place to prevent funding of abortions.[58] Obama's *Affordable Care Act* had not achieved what had been the objective, but it had had some positive results in that:

> over 20 million previously uninsured Americans gained health coverage, and the proportion of reproductive-age women who were uninsured dropped by more than a third. The law also substantially boosted access to birth control.[59]

Towards the end of his term President Obama also brought in measures intended to prevent the withholding of funding for family planning and related services. Thus, Planned Parenthood and like entities were to be funded for services including such things as contraception, HIV, breast and cervical cancer, pregnancy and abortion.[60]

56 Ibid 50; Dina Fine Maron, 'Under Obamacare, A Rollback of Abortion Coverage' (2014) 310 *Scientific American* 18.

57 Heather D Boonstra, 'Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters' (2016) 19 *Guttmacher Policy Review* 46, 49–50. Currently 16 states fund abortion 9 of these are by a court order the remainder are voluntary; see Anon, 'State Funding of Abortion Under Medicaid' *Guttmacher Institute* 1 January 2020 (online).

58 Arthur Tacchino, 'One Year of Trump: Health Care Changes and What They Mean for HR' (2018) March HR Legal and Compliance Excellence Essentials (*HR Comp*, 28 February 2018); President Trump makes his anti-abortion stance well publicised; see Sarah McCammon and Amita Kelly, '"You Love Every Child" ': President Trump Addresses March For Life' *NPR* 19 January 2018 (online); Anna North, 'How Trump helped inspire a wave of strict new abortion laws : An Iowa "heartbeat" bill is just one of several recent efforts to challenge *Roe v. Wade*' *Vox* 4 May 2018,.

59 Anon, 'US Reproductive Health and Rights: Beyond the Global Gag Rule', *States News Service (Washington) 7 March 2017;* Kinsey Hasstedt, 'Recent Funding Restrictions on the US Family Planning Safety Net May Foreshadow What Is to Come' (2016) 19 *Guttmacher Policy Review* 67; Linda J Beckman, 'Abortion in the United States: The Continuing Controversy' (2017) 27 *Feminism & Psychology* 101.

60 Alicia Gallegos, 'President Trump overturns Obama-era Title X family planning rule' (2017) 47 (8) *Family Practice News* 6.

In May 2018, President Trump announced that he would not allocate any funds to Planned Parenthood and like entities unless they completely separated the abortion services from their other services.[61] This affected a wide range of services including but not limited to reproductive services, once again adversely impacting upon the most disadvantaged groups.[62]

In 2019, *Title X*, known as the 'domestic gag rule' was updated and imposed further restrictions to funding. This included a veto on funding to services which shared premises and facilities with abortion providers. Advising or referring in respect of abortion also precludes being granted funds. Planned Parenthood provides abortions as part of their reproductive services and therefore no longer receives funding. This has a negative impact on their ability to provide services and increased the demand upon the resources of other service providers. The end result was a decrease in the availability of and access to abortions.

Benson states that:

> Each component of the new regulations is harmful. Taken together, the domestic gag rule is blatantly coercive and a violation of medical ethics and patients' rights. As a cornerstone of the Trump administration's ideological agenda against reproductive rights, the gag rule is designed to reduce access to family planning care for people with low incomes and force providers to make harmful compromises.[63]

On an International level, President Trump signed an Executive order by which the 'global gag rule' was brought back into effect.[64] Already controversial because of its use by conservative presidents as an anti-abortion measure to by using funding to restrict

61 Joshua Denton, 'President Trump, 'Upholds his Campaign Promise – Proposes Cuts to Planned Parenthood over Abortion' *Abortion, Life News*, California Council 19 May 2018; Jessie Hellman, 'Trump admin moves to ban federally funded clinics from giving abortion referrals' *The Hill* 22 May 2018; The Whitehouse, 'Support for the Trump Administration's Proposed Title X Rule' *Law and Justice, New Clips*, 22 May 2018; Nicole Einbinder, 'Trump Administration Aims to Cut Funding for Abortion Providers' *Frontline* May 25 2018,

62 Kinsey Hasstedt, 'How Dismantling the ACA's Marketplace Coverage Would Impact Sexual and Reproductive Health' (2017) 20 *Guttmacher Institute Policy Review* 48; Kinsey Hasstedt, 'Recent Funding Restrictions on the US Family Planning Safety Net May Foreshadow What Is to Come' (2016) 19 *Guttmacher Policy Review* 67.

access to funding of non-governmental family planning agencies, Trump broadened its effect.[65] Prohibitions were extended to all 'global health assistance furnished by all departments or agencies' which provide abortion services. These include those who work with a wide variety of health concerns such as (mal) nutrition, infant health, HIV and the Zika virus in countries which have limited resources.[66] For them the choice is between not providing any abortion services or foregoing funding from the USA. It is not surprising that the policy is causing extreme concern. Whichever choice the agency makes seriously undermines the autonomy of women by restricting their access to reproductive services.[67]

An inevitable conclusion is that the Trump Administration not only does not recognise pregnant women's autonomy nationally or internationally but is deliberately and openly working to undermine it.[68]

63 Rachel Benson Gold and Lauren Cross, 'The Title X Gag Rule Is Wreaking Havoc—Just as Trump Intended' (2019) *Policy Analysis*, Guttmacher Institute; Kinsey Hasstedt, 'What the Trump Administration's Final Regulatory Changes Mean for Title X' 4 March 2019 *Health Affairs Blog* Guttmacher Institute; Susan Milligan, 'Governors Take a Stand Against Trump's Title X Abortion Rule' The Report, from *U.S. News & World Report*, 3 August 3 2018; Adam Sonfield, 'Trump Administration Revives Title X "Domestic Gag Rule"' *Contraceptive Technology Update*, 2018; States News Service, 'Attorney General Becerra Joins Amicus Brief to Supreme Court in Support Of Women's Reproductive Rights', *States News Service Publisher*,3 December 2019.

64 The White House, 'Presidential Memorandum Regarding the Mexico City Policy' January 23, 2017 (online)

65 Kinsey Hasstedt, 'What the Trump Administration's Final Regulatory Changes Mean for Title X' Ann M Starrs, 'The Trump Global Gag Rule: An Attack on US Family Planning and Global Health Aid' (2017) 389 (10068) *The Lancet* 485,486.

66 See Kaiser Family Foundation, 'The Mexico City Policy: An Explainer' *Global Health Policy* 15 August 2019 (online).

67 Ibid.

68 Ann M Starrs, 'The Trump Global Gag Rule: An Attack on US Family Planning and Global Health Aid' (2017) 389 (1068) *The Lancet* 485.

## *2 Canada*

Unlike in the USA there is a 'right to health' under Canadian law.[69] However, despite this and despite abortion being decriminalised in Canada,[70] many women continue to find it difficult to access a safe and timely termination.[71]

Those provincial governments which have an anti-abortion policy are unable to criminalise abortion, but they have used other means to restrict access to reproductive services.[72]

Three inter-related difficulties, associated with governmental policy and funding, in accessing abortion in Canada will be discussed here. The first is the problem of provincial compliance with the *Canada Health Act* (*CHA*). The second is the problem of the geographical location of the population and its impact upon availability of services for women. Thirdly, the availability of RU-486 and its impact upon access to abortion for Canadian women.[73]

### a Compliance with the *Canada Health Act*

The *CHA* provides for the establishment of a national health scheme for Canada. Access to health and medical services is guaranteed. The funding of health and medical services is a federal responsibility. The federal government allocates funding to the provinces which are responsible for the administration and provision of health and medical services under the Constitution.[74] Where a service is *medically necessary* then it must be fully funded in both public and private medical facilities.[75] Abortion has been deemed to be essential for reproductive health and therefore the provinces are required to allocate

69 *Canada Health Act*, RSC 1985, c C-6.

70 See Chapter 3 — The Legal Regulation of Abortion.

71 Mark Gollom, 'Abortion barriers in Canada are back in spotlight following passage of abortion bans in US' *CBC News* 18 May 2019; Richard Cairney, 'Leak of Abortion Information Creates Turmoil at Foothills' (1999) 161 *Canadian Medical Association Journal* 424, 425.

72 Christabelle Sethna et al, 'Choice, Interrupted: Travel and Inequality of Access to Abortion Services since the 1960s' (2013) 71 *Labour/Le Travail* 29.

73 Anon, 'Access at a Glance in Canada: Abortion Services in Canada' *Action Canada for Health and Sexual Rights* 19 September 2019.

74 *Constitution Act, RSC 1867,* s 92(7) (jurisdiction over hospitals).

75 *Canada Health Act*, *RSC 1985*, c C-6.

funding and provide the requisite medical services.[76] However, provincial governments which have an anti-abortion policy have allocated their funds and administered their services in a manner which has severely restricted access to abortion.

In 1988, in response to the decriminalisation of abortion nearly all provinces withdrew or restricted funding and abortion services.[77] Prince Edward Island (PEI) passed a resolution which meant that only an abortion to save the life of the mother could be performed on the Island.[78] Abortions were neither funded nor available on PEI, until the end of 2016, when a threatened constitutional court challenge resulted in a change to its governmental policy.[79] The advocacy group Abortion Action Now PEI (AAN) had written that 'It is clear to us that nothing short of a court order will prompt the government to comply with its obligations to PEI residents under the *Charter*'.[80] The *Charter* had been relied on successfully in a few court challenges to provincial laws restricting funding for abortion.[81] However the AAN (PEI) did not get to argue its case before the court.[82] In March 2016, Premier MacLaughlan, announced changes to governmental policy on abortion, including the opening of services on PEI.

76 Health Canada, *Federal Policy on Private Clinics* (1995) Minister of Health and Welfare; *R v Lewis* (1996) 139 DLR (4th) 480 (Supreme Court of British Columbia); Abortion Rights Coalition of Canada 'Abortion is a "Medically Necessary" Service and Cannot Be Delisted' Position Paper No 1, February 2017.

77 Joanna N Erdman, 'In the Back Alleys of Heath Care: Abortion, Equality, and Community in Canada' (2007) 56 *Emory Law Journal* 1093, 1094.

78 Debates (Hansard), 3d Session, 57th Gen. Assembly of Prince Edward Island. *'Resolution 17 Re Abortion' 1980 Journal of the Legislative Assembly,* 11, 90-91, 117.

79 See Joanna N Erdman, 'The Law of Stigma, Travel, and the Abortion-Free Island' (2016) 33 *Columbia Journal of Gender & Law* 29; Donalee Moulton, 'PEI to Finally Offer Abortions on the Island' (2016) 188 *Canadian Medical Association Journal* E17; Abortion Rights Network PEI, 'Abortion Access Now PEI Files a Notice of Application in the Supreme Court of Prince Edward Island against the Government of PEI (Minister of Health and Wellness)'.

80 Abortion Rights Network PEI, 'Abortion Access Now PEI Files a Notice of Application in the Supreme Court of Prince Edward Island against the Government of PEI (Minister of Health and Wellness)' (2016) (online).

81 Colleen M Flood and Y Brandon Chen, *'Charter Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation*' (2010) 19 *Annals of Health Law* 479, 526.

82 *Abortion Action Now PEI Inc v The Government of Prince Edward Island* [2016, Draft Application of Notice]

The outcome of the activism of AAN (PEI) may be seen as a success, in bringing about change, which may be a precursor to change elsewhere. That the Premier was prepared to recognise that the current governmental policy, accepted and defended for many years, discriminated against women's constitutional rights and therefore the policy would need to undergo a review, is significant. The absence of a Supreme Court ruling to trigger change of this sort is important because it clearly indicates change can be brought about by other means.

It may indicate that politicians are becoming aware of a need to consider the views of their constituents. Premier MacLaughlen's reason for what would seem a complete reversal of previous policy was reported as being: '[T]he character of all places changes and evolves…. It's one of those things that *comes at its time*.'[83] Women in PEI had waited a long time to have the 'change' acted upon.

Joanne Erdman notes the importance of the change in policy when she states

> AAN PEI's challenge is nonetheless an important constitutional case for abortion law in Canada, albeit one outside the paradigms of formal law making or adjudication, an often neglected form of constitutional change as mobilized citizens persuaded the government to adopt a new understanding of constitutional abortion rights, and so conferred upon it the authority to enforce these rights in new ways.[84]

Since *Morgentaler* some provinces have remained overtly defiant in refusing to provide and/or fund abortions. Others have channelled the funds to other services. New Brunswick and Ontario do not fully fund clinics and there have been disputes over funding between the federal government and almost all of provinces in the past 20 years.[85] The result has been that, for many Canadian women, access to publicly funded abortion is extremely restricted.

83 Sean Fine, 'PEI Drops Opposition to abortion, Plans to Provide Access by Year's End' *The Globe and Mail* 31 March 2016 (online).

84 Joanna N Erdman, 'A Constitutional Future for Abortion Rights in Canada' (2017) 54 *Alta L Rev* 727, 728-729.

85 Abortion Rights Coalition of Canada, 'Clinic Funding — Overview of Political Situation' Position Paper 3, May 2017 (New Brunswick has only one clinic); Abortion Rights Coalition of Canada, 'List of Abortion Clinics in Canada (and some hospitals)' 14 April 2020, contains information on funding at the clinics.

Abortion is reported as being the most frequent surgical operation and it has been estimated that approximately one in three women will have an abortion.[86] Most abortions are performed at clinics, with only 16% performed in hospitals. This is reportedly due to the lack of availability of services in hospitals.[87] It has been suggested that a reason some hospitals do not provide services is that many 'receive donations [from] or are sponsored by Catholic administrators, which refuse to provide abortion services despite the hospital being a public institution'.[88] Access to those hospitals which do provide abortion services would appear limited.[89] There may be waiting periods of several weeks and insufficient operating facilities and trained personnel.[90] That there are insufficient hospitals which perform abortions means that many women must rely upon clinics. Unfortunately, not all provinces have clinics, and some provinces have insufficient clinics, not all of which are fully funded.[91]

86 Action Canada for Sexual Health and Rights, 'Common Myths About Abortion' 7 September 2019; Sheila Dunn and Rebecca Cook, 'Medical Abortion in Canada: Behind the Times' (2014) 186 *Canadian Medical Association Journal* 13; Abortion Rights Coalition of Canada, 'Statistics – Abortion in Canada' (online) 27 March 2020.

87 Abortion Rights Coalition of Canada, Position Paper 3 above n 87.

88 Ibid 1.

89 Abortion Rights Coalition of Canada, 'The Canadian Abortion Provider Shortage: Now and Tomorrow', Position Paper No 5, May 202

90 Joanna N Erdman, 'In the Back Alleys of Heath Care: Abortion, Equality, and Community in Canada' (2007) 56 *Emory Law Journal* 1093, 1094 (except for Ontario and Quebec); Abortion Rights Coalition of Canada, 'Training of Abortion Providers/Medical Students for Choice' Position Paper No 6, February 2018; Christabelle Sethna et al, 'Choice, Interrupted: Travel and Inequality of Access to Abortion Services since the 1960s' (2013) 71 *Labour/Le Travail* 29; Action Canada for Health and Sexual Rights, 'Access at a Glance in Canada: Abortion Services in Canada' 19 September 2019. (online)

91 Abortion Rights Coalition of Canada, 'Problems with Hospital Access to Abortion' Position Paper No 8, April 2017; Abortion Rights Coalition of Canada 'Hospitals versus Clinics: Comparisons of Abortion Care' Position Paper No 9, February 2017(online); Action Canada for Health and Sexual Rights, 'Access at a Glance in Canada: Abortion Services in Canada' 19 September 2019 (online); see Mark Gollom, 'Abortion barriers in Canada are back in spotlight following passage of abortion bans in US' *CBC News,* 18 May 2019.

### b Geographical location

It is well known that Canada is a large continent and sparsely populated.[92] Most of Canada's population is urban. Australia like Canada is also a large, sparsely populated country where around ninety per cent of the population is urban. In effect the size and population distribution has made it difficult for women in both countries to access abortion services due to the lack trained medical professionals in their region.[93] Shaw has pointed out that:

> In Canada, most abortion clinics and hospitals that provide abortion services are located within 150 kilometres of the Canada-United States border, having to travel to access abortion services is often a reality.[94]

Those women living in remote areas may need to travel quite some distance and/or to a different province to obtain an abortion[95] because their local medical facilities do not include abortion providers.[96] There may be some funding in Canada. 'Travel grants may

92 Anon 'This Is How Empty Canada Really Is (PHOTOS)', *The Huffington Post Canada*, 17 April 2014 (online).

93 Ibid. The pictures show that Australia and Canada have a similar population distribution. See Statistics Canada, 'The Canadian Population in 2011: Population Counts and Growth' (21 December 2015); see Statistics Canada. 2017, *Canada [Country]* (table); *Census Profile* 2016; In 2018 the population of Canada was 36,916,662 (82.3 %of the population was urban 30,413,451) see 'Canada Populations', *Worldometers*. In 2018, the population of Australia was 24, 735,978 (90.0 % of the population was urban, 22,301,673), 'Australia Population' *Worldometers* (online)

94 Jessica Shaw, 'Full-Spectrum Reproductive Justice: The Affinity of Abortion Rights and Birth Activism' (2013) 7 *Studies in Social Justice* 143, 152.

95 Joanna N Erdman, 'In the Back Alleys of Heath Care: Abortion, Equality, and Community in Canada' (2007) 56 *Emory Law Journal* 1093, 1094 (except for Ontario and Quebec); 'Training of Abortion Providers/Medical Students for Choice' (Position Paper 6, Abortion Rights Coalition of Canada, February 2018) <http://www.arcc-cdac.ca/postionpapers/06-Training-Abortion-Providers-MSFC.PDF>.

96 M Silva, R McNeill and T Ashton 'Factors Affecting Delays in First Trimester Pregnancy Termination Services in New Zealand' (2011) 35 *Australian and New Zealand Journal of Public* Health 140; Abortion Rights Coalition of Canada, 'Access to Abortion in Rural/Remote Areas' Position Paper 7, October 2017; Lauren Vogel, 'Abortion Access Grim in English Canada'(2015) *Canadian Medical Association Journal* 17; Christabelle Sethna et

be available for some women [but] they are generally offered as reimbursements rather than as funding that is provided in advance.'[97] For these women this means delay, inconvenience, additional expense and stress. Those who do not have the financial ability, or are otherwise unable to pursue this option, may be denied a safe termination altogether.[98]

Joanne Erdman points out 'the associated costs of travel disproportionately affect vulnerable and marginalized women, contrary to the right to health standard'.[99]

Better provision and distributions of health services is no doubt required.[100] However, given the problems of the allocation of scarce resources which Canada and other countries face, this did not seem to be readily forthcoming. As recently as 2017, Eliseo Orrantia and Stephanie St Armand asked 'How can Canadian rural practitioners provide better access for women to terminate unwanted pregnancies?[101] One partial solution was to make RU-486 more readily available to all Canadian women.[102]

### (c) Provision of RU-486

RU-486 will not be suitable for all terminations but given that the majority of abortions occur in the earlier stages of pregnancy, making it readily available allows a majority of women to actually exercise their autonomy on a practical as distinct from a rhetorical level. By doing so they gain recognition as self-directed individuals.[103]

al, 'Choice, Interrupted: Travel and Inequality of Access to Abortion Services since the 1960s' (2013) 71 *Labour/Le Travail* 29.

97 Jessica Shaw, 'Full-Spectrum Reproductive Justice: The Affinity of Abortion Rights and Birth Activism' (2013) 7 *Studies in Social Justice* 143, 152.

98 Vogel, above n 97.

99 Joanna N Erdman, 'In the Back Alleys of Heath Care: Abortion, Equality, and Community in Canada' (2007) 56 *Emory Law Journal* 1093; see Vogel, above n 97.

100 See Vogel, above n 97.

101 Eliseo Orrantia and Stephanie St Armand 'The Occasional Medical Termination of Pregnancy' (2017) 22 *Canadian Journal of Rural Medicine* 21.

102 Wendy V Norman et al, 'Could implementation of mifepristone address Canada's urban-rural abortion access disparity: a mixed-methods implementation study protocol' (2019) 9 *BMJ* 1.

103 See Chapter 2 — Theoretical Underpinnings; Patrici b a Campbell, 'Making Sense of the Abortion Pill: A Sociotechnical Analysis of RU486 in Canada' (2018) 27 (2) *Health*

In 2015,[104] RU-486, called Mifegymiso, was approved for use by Canadian women.[105] RU-486 had been regarded as safe and legally used in many other countries.[106] RU-486 was finally dispensed in early 2017.[107] Initially its cost and the strict eligibility criteria for prescription hampered access.

Public funding took time.[108] Finally the restrictive criteria which included the performance of ultrasounds, limiting its availability to pregnancies of under seven weeks and requiring that doctors undergo a training course before being able to prescribe the drug, were lifted.[109] Currently, RU-486 is readily available and funded in

*Sociology Review* 121, 133.

104 Barbara Sibbald 'Fear of Black Market Means no RU-486 for Canada until US Approves Drug' (1999) *160* C*anadian Medical Association Journal* 1753; Susan Jenks 'Feminist Group Plans "Economic Pressure Campaign" for Access to RU 486' (1992) 84 *Journal of the National Cancer Institute* 562; Sheila Dunn and Rebecca Cook, 'Medical abortion in Canada: Behind the Times' (2014) 186 *Canadian Medical Association Journal* 13;

105 J Weidner, 'Abortion Pill RU-486 Approved in Canada', *Waterloo Region Record* (Waterloo) 31 July 2015.

106 K LaRoche and A Foster '"It gives you autonomy over your own choices" A qualitative study of Canadian abortion patients' experiences with mifepristone and misoprostol' (2020) 102 Contraception 61; Sally Sheldon, 'How Can a State Control Swallowing? The Home Use of Abortion Pills in Ireland' (2016) 24 (48) Reproductive Health Matters 90, 93; Francine Coeytaux et Or'Bold Action to Meet Women's Needs: Putting Abortion Pills In U.S. Women's Hands' (2015) 25 (6) *Women's Health Issues* 608; Barbara Sibbald, 'Will Canada Follow US Lead on RU 486? (2001) 164 *Canadian Medical Association Journal* 82.

107 Anon, 'Mifegymiso (RU-486 abortion pills) Official Update', *Newswire* 12 December 2016 (online); Ashley Csanady, 'Abortion Pill Available in Less than Half of All Canadian Provinces Three Months after Rollout', *The National,* 30 March 2017 (online). Women's College Hospital, '*What is the Abortion Drug RU 486, and How Does It Work?*' *Women's Health Matters*, 23 March 2017 (online).

108 Patricia Campbell, 'Making Sense of the Abortion Pill: A Sociotechnical Analysis of RU486 in Canada' (2018) 27 (2) *Health Sociology Review* 121,133. Unknown, 'BC to cover cost of abortion pill Mifegymiso' *CBC News,* 2 January 2018*;* Holly McKenzie Sutter, 'Newfoundland and Labrador facing renewed pressure to cover abortion pill Mifegymiso' *The Canadian Press*, 16 May 2018

109 Sheryl Ubelacker, 'Health Canada Eases Restrictions on Abortion Pill Mifegymiso' *The Canadian Press* (Toronto), 7 November 2017.

nearly all provinces. A prescription can be written by a doctor or nurse practitioner and may be taken without supervision.[110] It was reported that the easing of the restrictions led to a high demand for the abortion pill and more than 4000 prescriptions being dispensed in the first year of its availability, which reflected its popularity.[111] Decriminalisation of and relatively good access to abortion is working well for the autonomy of Canadian women. [112]

### *3 The UK and New Zealand*

The funding of abortions has not been used to directly control access to abortions in the UK and NZ. Termination of pregnancy, for the purposes of funding, is treated similarly to other health services. A woman can access a termination procedure if she meets the requisite criteria discussed previously in Chapter 3 – The Legal Regulation of Abortion. All persons who are citizens or are ordinarily resident in the UK[113] and have National Health System registration have most health services provided without payment or contribution.[114] Similarly, NZ residents and citizens are entitled to free medical care which includes lawful abortions.[115]

110 Ashley Bancsi and Kelly Grindrod, 'Update on medical abortion' (2020) 66 (1) *Canadian Family Physician* 42.

111 Susan Lunn, 'Abortion pill prescribed more than 4,000 times in Canada last year' *CBC* News, April 27 2018; Wendy V Norman, Sarah Munro, Melissa Brooks, Courtney Devane, Edith Guilbert, Regina Renner, Tamil Kendall, Judith A Soon, Ashley Waddington, Marie-Soleil Wagner, and Sheila Dunn, 'Could Implementation of Mifepristone Address Canada's Urban–rural Abortion Access Disparity: A Mixed-methods Implementation Study Protocol' (2019) 9 (4) *BMJ Open* E028443.

112 Abortion Rights Coalition of Canada, 'Why Abortion Needs No Legal Restrictions (Canada as a model for other countries)' Position Paper No 64, January 2019; W V Norman and J Downie, 'Abortion Care in Canada Is Decided between a Woman and Her Doctor, without Recourse to Criminal Law' (2017) 356 *BMJ* 1506.

113 In 2017 payment under the NHS was finally extended to NI women seeking an abortion in the UK; Anon, 'Northern Ireland Women to Get Free Abortions in England' *BBC News* 29 June 2017 (online); Anon, 'UK government says Northern Irish women can get abortions free on NHS in England' *The Journal IE,* 23 October 2017.

114 This may include immigrants and students who are studying at a University.

It should not be assumed however, that public funding by itself ensures timely access to abortion. There are other obstacles, which may combine with or act independently of funding, to hinder access to a termination procedure which are discussed later in this chapter.[116] The most that may be concluded is that paying for the treatment is an obstacle that the woman, provided she meets the other requirements, does not have to overcome.

## *4 Australia*

### (a) *Funding and Policy*

In Australia funding of health services is within the jurisdiction of the federal government but it has not directly used this power to limit access to safe abortions by women who are unable to afford private health insurance. It is argued here that the issue of control over terminations using governmental policy and funding remains a probability and cannot be ignored but is not as significant a threat as in the USA.[117] One simple explanation is the role of abortion in the political process. In Australia, federal and state governments are not elected upon a pro- choice or anti-abortion platform.[118] Since political parties have a cross-section of views about contentious moral issues it is rare to find either the federal government or the opposition promoting debate or legislation in respect of abortion and like concerns.[119] Federal legislation which is directed against the funding of abortion is usually introduced by private members.

115 Martha Silva, Toni Ashton and Rob McNeill, 'Improving Termination of Pregnancy Services in New Zealand' (2011) 124 *The New Zealand Medical Journal* 83.

116 See Anonymous, 'The Independence of Private Versus Public Abortion Providers: Implications for Abortion Stigma' (2012) 38 *Journal of Family Planning and Reproductive Health Care* 262. These obstacles include factors such as the availability of the service in the area in which the woman lives; having to travel to have the procedure undertaken and the lengthy procedure involved under the consultation process which may militate against a timely safe termination.

117 Petersen (n 17).

118 Helen Pringle, 'Urban Mythology: The Question of Abortion in Parliament' (2007) 22 *Australasian Parliamentary Review* 5.

119 Sushi Das, 'Mr Abbott, Minister for Meddling', *The Age* (Melbourne), 24 Nov 2005.

There have been attempts to make changes to the national health system so as to restrict access to abortion. Medibank (now known as Medicare) came into operation on the 1st October 1975. It was originally established to provide a universal health system and was part of a package of social reforms by the Whitlam government. Under this funding policy, all health services were provided free of charge.[120] Terminations of pregnancy had been included on the Medicare rebate list in 1974, thus enabling women access to abortions carried out by medical professionals, without incurring a financial burden.[121] After the sacking of the Whitlam government in 1975, the Fraser government made modifications and alterations to Medibank. Of significance for women needing access to an abortion, the medical rebate was reduced across the board to 75% of the fee and bulk billing was only available to holders of Health Benefit Cards.[122] Access to free hospital and medical care was also restricted to those with an eligible Health Benefits Card.[123] However, abortion was not removed from the rebate list.

In 1979, independent MP, Stephen Lusher, launched a campaign to have abortions removed from the rebate list. This was for the express purpose of limiting access to abortion.[124] After an extensive debate the 'Lusher Motion' was defeated by ten votes.[125]

With the election of the Hawke Labour government in 1983, the Fraser changes were partially reversed and the Medibank system restored, under the name of Medicare.[126]

120 See Commonwealth, *Parliamentary Debates*, House of Representatives, 29 November 1973 (Bill Hayden).

121 The inclusion of abortion in health scheme complemented the effect of the Menhennit ruling so that abortion was regarded as legal and openly available.

122 For information about Health Care Cards and services for those deemed eligible because of economic disadvantage or ill health see *Concession and Health Care Cards* Australian Department of Health and Human Services, 2 March 2018. (29 October 2004)

123 See Amanda Biggs, *Medicare — Background Brief* Parliament of Australia, *12 July 2016*; Amanda Biggs, *Medicare: A Quick Guide Parliament of Australia, 2016; Lauren Cook and Amanda Biggs, Health in Australia – a quick guide Parliament of Australia, 2018*.

124 Known as the 'Lusher Motion'. See Commonwealth, *Parliamentary Debates*, House of Representatives, 21 March 1979, 963 (Stephen Lusher).

125 62-52 votes.

126 See *Health Legislation Amendment Act 1983 (Cth)*, *see* second reading speech Dr Blewett September 1983, it amended the *Health Insurance Act 1973 (Cth),* the *National Health Act 1953 (Cth)* and the *Health Insurance Commission Act 1973 (Cth).*

Free hospital treatment and bulk billing were reinstated. However, the requirement for patient contributions continued. Subsequently, there have been general economic strategies to reduce the overall cost of healthcare to the government and to have the patient contributions increased. The result is that women undergoing terminations (as with any other medical procedure) may face financial burden if they are unable to make their contributory payment or do not have private health insurance.

It is not only independent parliamentarians who have attempted to restrict access to abortion. In 2005, Tony Abbott and Christopher Pyne, the then Parliamentary Health Secretary, attempted to alter access to funding for abortion. The Health Amendment Legislation Bill 2005 (Cth) was introduced with the intention of amending section 19A of the *Health Insurance Act 1973* (Cth). Had the legislation passed, it would have given the Minister for Health power to 'by legislative instrument, determine that Medicare benefits are not payable in respect of professional services rendered in specified circumstances'.[127] The Doctors Reform Society warned that a Bill giving the Minister for Health the power to decide whether some medical procedures, including abortion, would be removed from Medicare funding, might be 'a backdoor way for the Catholic minister to push his private agenda of banning abortions'.[128] The threat to abortion funding was recognised at the committee stage and consequently the proposed amendment removed. Kate Gleeson has argued that 'Abbott and Pyne attempted a restructure of Medicare that constituted the greatest threat to abortion funding . . .since the Fraser era from 1975 -1983.[129]

In 2008, independent Tasmanian Senator Guy Barnett [130] gave notice that he would put a motion to withdraw Medicare funding for 'late-term' abortions. [131] The Senate Finance

127 Unknown, 'Doctors Warn Medicare Bill Aimed at Stopping Abortions', *AAP General News Wire* 21 September 2005 (online),

128 Ibid.

129 Kate Gleeson, 'Let's Be Clear on Tony Abbott's Attacks on Abortion', *The Conversation*, 29 October 2012 (online).

130 Commonwealth, *Parliamentary Debates*, Senate, Guy Barnett, 'Motion to disallow item 16525 in Part 3 of Schedule 1 to the Health Insurance (General Medical Services Table) Regulations 2007', 18 June 2008.

131 *Health Insurance (General Medical Services Table) Regulations 2017* (Cth) sch 1 pt 3 medicare item 16525 allows a rebate for the 'Management of second trimester labour,

and Public Administration Committee conducted an inquiry. Labor Senator Helen Polley presented the committee's report to the Senate.

> This could have been a much more emotive issue to deal with. It was not and nor was it ever intended to be a debate on abortion. We have been there; we have had that debate. It was purely relating to financing using taxpayers' money.[132]

The committee recommended that there needed to be consistent and accurate 'perinatal' and 'neonatal' data collection throughout Australia. Senator Polley considered this would:

> ensure that this very complex issue of second trimester terminations will continue to be discussed and debated once a uniform method of gathering data is established and clear definitions are used throughout the country.[133]

Senator Barnett had withdrawn his motion when it was referred to the committee.[134]

Independent Senator Madigan proposed the Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013 (Cth). Its purpose was the removal of funding for abortions for sex selection. The Bill lapsed in April 2016.[135]

Most of the calls for changes to Medicare have been to reduce the amount of rebate payable for abortions or remove the rebate from the schedule. The rationale that this will reduce the incidence of abortion at any stage of pregnancy is open to doubt. Abortions occur irrespective of their legality and irrespective of whether there is a rebate provided by the government. The difference for women is important. Where they cannot pay for the available services, they may be denied a timely safe abortion.

with or without induction, for intrauterine fetal death, gross fetal abnormality or life-threatening maternal disease'.

132 Commonwealth, *Parliamentary Debates*, Senate, 13 November 2008, 13 (Helen Polley).

133 Ibid.

134 Commonwealth, *Parliamentary Debates*, Senate, 13 November 2008, 14 (Guy Barnett), (he made no further submission and subsequently became the Minister for Resources for the Tasmanian Government).

135 Health Insurance Amendment (Medicare Funding for Certain Types of Abortion) Bill 2013, Parliament of Australia.

In effect the issue of the funding of reproductive services should be directed towards provision of these by the public system with no or minimal cost to the woman.[136] At present the cost of an abortion is expensive.[137] Surgical abortions are not readily available in the public health system in all Australian jurisdictions. Many women must use private hospitals and clinics and find that their out-of-pocket expenses are very high.[138] It has been reported that women who have been unable to obtain a surgical abortion in Tasmanian have had to pay the additional costs of travel to obtain an abortion in Melbourne.[139] Regional areas in Victoria have few abortion services.[140] A woman who requires a later gestation abortion has additional difficulties and challenges in accessing the requisite medical procedure. It has been reported that there is only one private clinic, which is in Melbourne, Victoria, that will provide this service and only four doctors who are prepared to perform the procedure. In addition, these doctors do not reside near the clinic and must be flown from interstate.[141] The overall experience, including the cost, is debilitating for the women involved and denies them their individuation.

### (b) *Access to RU-486*

Federal government policy and the domination of male politicians have had a profound impact upon pregnant women's ability to have access to RU-486 (medical abortion).[142] It

136 Judith Ireland, 'Labor pledges to tie hospital funding to abortion services' *The Sydney Morning Herald*, 6 March 2019 (online)

137 Mridula Shankar, Kirsten I. Black, Philip Goldstone, Safeera Hussainy, Danielle Mazza, Kerry Petersen, Jayne Lucke and Angela Taft, 'Access, Equity and Costs of Induced Abortion Services in Australia: A Cross-sectional Study' (2017) 41 (3) *Australian and New Zealand Journal of Public Health* 309.

138 M Shankar (n 137).

139 This problem is evident in other jurisdictions and may be identified as a global problem.

140 See eg, Caroline Moel-Mandel, Melissa Graham and Ann Taket, 'Snapshot of Medication Abortion Provision in the Primary Health Care Setting of Regional and Rural Victoria' (2019) 27 (3) *The Australian Journal of Rural Health* 237.

141 Hagar Cohen and David Lewis, 'Inside Australia's only private clinic providing late surgical abortions' *ABC News,* circa 10 Sep 2018.

142 AJ Dawson, R Nicolls, D Bateson et al, 'Medical termination of pregnancy in general practice in Australia: a descriptive-interpretive qualitative study' (2017) 14 (1) *Reproductive Health* 39; Caroline de Costa, 'Medical Abortion: The Australian Experience'

is regarded as a safe alternative to surgical abortions especially when used in the early stages of pregnancy,[143] when it may be prescribed by a medical professional (either in person or via teleconference), delivered to the woman or dispensed by a pharmacist and taken by the woman at home if she so wishes.[144] A major advantage of RU-486 is that when available without undue conditions, it empowers women; giving them the ability to control and plan pregnancy termination with minimal dependence on others and free from unwanted intervention.[145]

The history of the use and availability RU486, in Australia,[146] shows how the health of women has been subordinated to political expedience and the personal viewpoints of some politicians.[147] It took more than 20 years before women had more than a very limited access to it. The ongoing battle to make it available to women reveals the sexism, outmoded stereotyping of women and the disapprobation which occurs when

(2012) 7 *Expert Review of Obstetrics & Gynecology*, 25; Children by Choice, 'Medical Abortion in Australia', 18 July 2016; see Therapeutic Goods Administration, 'Australian Public Assessment Report for Mifepristone' *Report*, 31 October 2012, 4.

143 Heather D Boonstra, 'Medication Abortion Restrictions Burden Women and Providers — and Threaten US Trend Toward Very Early Abortion' (2013) 16 *Guttmacher Institute Policy Review* 18, 19.

144 Marie Stopes Australia, *Medical Abortion by Phone (Tele-Abortion)* (online); see, eg, *Abortion Law Reform Act 2008* (Vic); Paul Hyland, Elizabeth G Raymond and Erica Chong, 'A Direct-to-patient Telemedicine Abortion Service in Australia: Retrospective Analysis of the First 18 Months' (2018) 58 (3) *Australian and New Zealand Journal of Obstetrics and Gynaecology* 33.

145 Sally Sheldon, 'Empowerment and Privacy? Home Use of Abortion Pills in the Republic of Ireland' (2018) 43 (4) *Signs: Journal of Women in Culture and Society* 823-824; C de Costa, KI Black & DB Russell, 'Medical abortion: it is time to lift restrictions' (2019) 211 (9) *Medical Journal, of Australia* 428; C de Moel-Mandel and M Graham, 'Medical abortion: it is time to lift restrictions' (2019) 211(9) *Med J Aust* 428 [Letter in reply to the C de Costa article at the same citation].

146 Barbara Baird, 'Medical Abortion in Australia: A Short History' (2015) 23 (46) *Reproductive Health Matters* 169

147 Linda Trimble, 'Julia Gillard and the Gender Wars' (2016) 12 (2) *Politics & Gender* 296; Sid Maher and Lauren Wilson, 'Julia Gillard Fires Abortion Salvo in Gender War' *The Australian*, National Affairs, 12 June 2013. (online).

'female' politicians do not follow the expected code of conduct.[148] In particular it indicated an emergence of the ridicule of women responding to criticism.[149] When Julia Gillard, as Prime Minister, rebuked and censored the male attitudes, the Australia Press was quick to castigate her.[150]

RU-486 was never illegal in Australia. In 1994, it was trialled in Australia in conjunction with the World Health Organisation.[151] In 1996, the *Therapeutic Goods Amendment Act 1996* (Cth)[152] (the Harradine amendment) was passed. What is significant about this amendment is that it prevented Australian women from accessing RU-486. The role of one independent Senator and the political dealings between him and the government of the day were central as to how this occurred. Brian Harradine held the balance of power in the Senate and was well known for his anti-abortion views. His objective was to prevent access to RU486. To this end he proposed changes the *Therapeutic Goods Act 1989 (Cth) (TGAct)*. The changes included that the power to grant a licence to import 'restricted drugs' would be transferred from the Therapeutic Goods Administration (TGA) to the Minister for Health. 'Restricted goods' were defined to include RU-486 as meaning 'drugs intended for use in women as abortifacients'.[153] To gain support for the legislation he agreed to vote for, the then Prime Minister John Howard's privatisation of Telstra legislation in the Senate.[154] The Harradine amendment was passed and remained in

148 Trimble, above n152, 297.

149 Trimble above n152, 308; see Cheryl N Collier, Tracey Raney, 'Understanding Sexism and Sexual Harassment in Politics: A Comparison of Westminster Parliaments in Australia, the United Kingdom, and Canada'(2018) 25 (3) *Social Politics: International Studies in Gender, State & Society* 432.

150 Sid Maher and Lauren Wilson, 'Julia Gillard fires abortion salvo in gender war' *The Australian*, National Affairs, 12 June 2013.

151 David L Healy, 'Mifepristone: An Overview for Australian Practice' (2009) 32 *Australian Prescriber* 152 (online).

152 ABC Radio National, 'Senator Proposes Amendments to the Importation of RU486', *Daybreak*, 20 May 1996 (Senator Brian Harradine) (emphasis added).

153 Ibid, Harradine's other demand was the introduction of guidelines prohibiting advice or counselling on abortion by agencies in developing countries in receipt of Australia funding.

effect for the next 10 years.[155] During that time, no applications were made to the Minister. The expense of applying for a licence which was unlikely to be approved by the Minister has been thought to have provided a major disincentive to companies.

In 2005, after Senator Harradine decided not to stand for re-election, there were numerous efforts from those supporting women's rights, medical professionals and members of Parliament to repeal the 1996 amendment.[156] However, the then Federal Minister for Health Tony Abbott made known his anti-abortion views and stated that he would not approve the use of RU-486. As a response to what may have been perceived to be very high support for having RU-486 made available to Australian women, the Prime Minister allowed the introduction of a private member's bill and a conscience vote thereon. The *Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Act 2006* (Cth) was passed in 2006. The Act withdrew ministerial power over approval of RU-486 and returned it to the TGA. Nevertheless, RU-486 did not become immediately readily available; it was not until 2012 that the TGA issued a licence to import RU-486.[157]

In 2013, RU-486 was finally listed on the Pharmaceutical Benefits Scheme, which subsidises expensive medicines. Prior to the listing women had been paying over $800 for RU486. Many could not afford this cost. The reduction of the cost to $50 for Medicare Card holders and around $15 for Health Card holders improved access to RU-486 at least in the public health care arena. In the private sector the cost is estimated as upwards of $350 which includes services in addition to RU-486.[158]

154 A Summers, 'Abortion and federal policy: here are the facts' ABC, *The Drum* 12 June 2013, (online).

155 CM De Costa, KI Black and DB Russell, (2019) 211 (9) 'Medical abortion: it is time to lift restrictions' *Medical Journal of Australia* 428.

156 Natalie Zirngast, 'RU486: Women, Not Politicians, Should Choose', *Green Left Weekly* (Sydney), 17 November 1993, (online); 'Lib MP to Rebel over Abortion Pill', *Sydney Morning Herald*) 16 November 2005, (online); Children by Choice, 'Medical Abortion in Australia'18 July 2016 (online).

157 See Therapeutic Goods Administration, 'Australian Public Assessment Report for Mifepristone' (Report, 31 October 2012) 4–5.

158 Children by Choice 'Medical Abortion in Australia', (18 July 2016), (online); Anna Livsey, 'How much do abortions cost across Australia?' *The Guardian* 22 August 2017.

Medical abortion is more readily available since the Marie Stopes organisation introduced a 'tele – consultation'. Except in SA, women may have a consultation with a doctor via the phone and be prescribed and receive RU-486.[159] They must be in the early stages of pregnancy/ have access to the Internet and be 'within one hour of 24-hour emergency medical care'.[160]

A suggestion that RU-486 be available for purchase over the counter of a pharmacy could be advantageous to women in the early stages of pregnancy.[161] This is possibly likely in the very near future given the impact of the Covid 19 pandemic and the move to limit unnecessary personal interaction in the medical/patient relationship.

Nevertheless, are there bureaucratic restrictions on the use of the RU-486 which should be removed?[162] At present doctors who wish to prescribe RU-486 are required to do a training course. This has been considered a disincentive given that doctors are not required to do additional training to prescribe other medication.[163]

Currently for some women, RU-486 provides a timely, effective, safe, private, affordable and above all legal method of termination.[164] This is positive. But effectively, political

159 Marie Stopes Australia, *Medical Abortion by Phone (Tele-Abortion)*(online) https://www.mariestopes.org.au/abortion/home-abortion/; Vic, Tas, NT, ACT, NSW, Qld and WA. However, in WA a referral from a GP is necessary. Ibid.

160 women living in the NT have access to these since the *Termination of Pregnancy Reform Act 2017* (NT) came into effect.

161 Wendy V Norman and Judith A Soon, 'Requiring physicians to dispense mifepristone: an unnecessary limit on safety and access to medical abortion' (2016) 188 (17-18) *Canadian Medical Association Journal* E429-E430; C Devane et al 'Implementation of mifepristone medical abortion in Canada: pilot and feasibility testing of a survey to assess facilitators and barriers' (2019) 8 (5) *Pilot Feasibility Studies* 126

162 JEI Henney and HDI Gayle, 'Time to Re-evaluate U.S. Mifepristone Restrictions'(2019) 38 (7) *New England Journal of Medicine* 597.

163 Marie Stopes, 'Become a Prescriber or Dispenser' https://www.mariestopes.org.au/become-a-prescriber/

164 Therapeutic Goods Administration, 'Australian Public Assessment Report for Mifepristone' (Report, 31 October 2012) 4–5; it can and has also be used for late terminations — see Caroline de Costa, 'Medical Abortion: The Australian Experience' (2012) 7 *Expert Review of Obstetrics & Gynecology* 25.

policy delayed access to timely safe and legal medical abortions for at least 20 years and in doing so has denied women their full autonomous rights to decide not to proceed with a pregnancy.[165]

### *5 Overview*

Section B has considered the role played by government funding and policy and its impact upon access to abortion which places practical limits upon women's autonomy. Section C considers how the policies and beliefs of the medical profession and its monopoly over the administration and provision of abortion services may militate against the availability of abortion services.

## C Medical Monopoly and withholding services

### *1 Background*

There are two direct influences of the medical profession which impact upon access to abortion and women's reproductive autonomy. The first is that the medical profession is not only the gatekeeper of but also has a monopoly over the provision of lawful abortions. The second is that the medical professionals may refuse to provide reproductive services.

The abortion laws which have effectively given the medical profession control over legal abortions were discussed in the previous chapter. It was seen that the medical profession is the law's proxy or 'gatekeeper' in deciding who is and who will not be eligible to have a lawful abortion. One common requirement of the laws is that an abortion must be performed by qualified medical professionals. This grants them a monopoly over the provision of lawful abortions. Consequently, the processes by which they decide upon how reproductive services are to be provided will impact upon women's autonomy by impeding or preventing timely access to a safe lawful termination procedure.[166]

165 There is room for further improvement in making RU-486 more widely available: CM De Costa, KI Black & DB Russell (2019) 211 (9) 'Medical abortion: it is time to lift restrictions' Medical Journal of Australia 428; Julia Medew, 'Doctors Call for More GPs to Provide Abortion Drug RU-486', *The Age* (Melbourne), 27 August 2016;

166 Australian Institute of Health and Welfare, 'How does Australia's health system work?' *Australia's Health 2016*. Chapter 2, series no 15,10; Donna Barry and Julia Rugg,

In addition to being the only provider of medical services they can also refuse to provide abortion services. A medical professional's refusal to perform an abortion can deny a woman access to a legal, safe and timely abortion. This undermines her the right to be treated as equivalent with all persons.[167] The refusal to perform reproductive services is usually supported by their professional association and reinforced by law. It is the aspect of refusing to perform reproductive medical procedures that will be the main focus in the following part.

### *2 Anti-Abortion Beliefs and Withholding Services*

#### (a) Introduction

Women's autonomy requires access to abortion services. It should follow that they are entitled to receive this procedure. However, there are both hospitals and medical professionals who are against abortion.

Problematic for women seeking access to an abortion is that many medical professionals will refuse to perform an abortion and seek to justify the refusal by reference to their stance against abortion.[168] They claim that to oblige them to perform an abortion would deny them their autonomy. It is argued here that to require a medical professional to perform procedures which are legal but contrary to his/her beliefs does not impinge upon his/her autonomy.

Medical professionals in their capacity as persons have autonomy and this should be respected because this is part of their individuation.[169] However, the autonomy of the person who is by occupation a medical professional is not to be confused with his/her autonomy as a person.

'Improving Abortion Access by Expanding Those Who Provide Care' *Centre for American Progress*, 26 March 2015 (Online).

167 Drucilla Cornell, Drucilla, *The Imaginary Domain: Abortion, Pornography and Sexual Harassment*, (Routledge, 1995)

168 Udo Schuklenk, 'Conscientious objection in medicine: accommodation versus professionalism and the public good' (2018) 126 *British Medical Bulletin* 47 for an overview of the various arguments for and against recognising conscientious objection.

169 Ibid 50; M Wicclair, Conscientious Objection in Health Care: An Ethical Analysis. Cambridge: Cambridge University Press, 2011.

> No one is forced to be a physician, nurse, pharmacist, or other health care professional or to choose a subspecialty within their larger field. It is a voluntary, individual choice. By entering a health care profession, the person assumes a professional obligation to place the well-being and rights of patients at the center of professional practice.[170]

It is argued here that the medical practitioner should not be entitled to refuse to provide services when the refusal is based upon his/her personal moral, religious and/or cultural beliefs. To do so severely undermines the rights of pregnant women to a timely, safe and legal abortion.

The words of Sheldon identify the concern with allowing the medical profession to have an unfettered right to exercise a moral objection and refuse to perform an abortion. She states that:

> [t]he crucial difference here is that no other member of society is legally granted the right to impose his views over those of the pregnant woman.[171]

In effect the medical professional is refusing to fulfil his/her contract of service and do his or her job. The termination of a pregnancy is a part of a woman's right to decide on her medical treatment. Should a person, who for whatever reason dislikes and does not want to be involved with a medical service, consider alternative employment whether within the medical profession or not?[172]

170 Ronit Y Stahl and Ezekiel J Emanuel, 'Physicians, Not Conscripts — Conscientious Objection in Health Care' (2017) 376 (14) *New England Journal of Medicine* 1380,1382

171 Sally Sheldon, *Beyond control: Medical power and abortion law* (Law and social theory) (Chicago, Ill.: Pluto Press1997) 58.

172 Julian Savulescu and Udo Schuklenk, 'Doctors Have No Right to Refuse Medical Assistance in Dying, Abortion or Contraception' (2017) 31 *Bioethics* 162, 165; Ronit Y Stahl and Ezekiel J Emanual, 'Physicians, Not Conscripts — Conscientious Objection in Health Care' (2017) 367 *The New England Journal of Medicine* 1380, 1381; Christian Fiala and Joyce H Arthur, '"Dishonourable Disobedience" — Why Refusal to Treat in Reproductive Health Care is Not Conscientious Objection' (2014) 1 W*oman — Psychosomatic Gynaecology and Obstetrics* 12, 16; Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *British Medical Journal* 294; Jonathan Montgomery, 'Conscientious Objection: Personal and Professional Ethics in the Public Square' (2015) 23 *Medical Law Review* 200; Rose Stewart, 'Conscience "Not Always a Force for Good' (2012) 19 *Kai Tiaki Nursing New Zealand,* 30;

This is not a frivolous suggestion. Stahl and Ezekiel note that

> The health care professional who wants to prioritize personal values over professional duties must choose a less personally fraught occupation. Making this choice constitutes a substantial penalty. However, it emphasizes that physicians' personal commitments cannot outweigh the interests of patients, and it underscores that, unlike a conscripted soldier, no one is forced to enter the health care profession.[173]

To single out abortion from other medical procedures is difficult to justify. The many women who undergo an abortion at least once in their lifetime indicates that it is routinely performed as an essential part of women's health Where abortion is lawful a person who requires that treatment ought to be able to expect that it will be provided. A refusal to treat should be based upon objective criteria relating to the treatment required and not upon the personal beliefs of the medical practitioner. This especially so given that the medical professional has sworn or agreed to uphold the ethics of the profession.

**(b) Refusal of services (Conscience and Objection)**

Refusal of medical treatment based upon personal beliefs is frequently referred to as *conscience objection*.[174] The use of that term gives the refusal an imprimatur of respect which is assumed and adopted rather than actual and deserved. A consideration of development and meaning of what it is to hold a *conscientious objection* and to be a *conscientious objector* show that they have acquired a special meaning which does not fit comfortably with what a medical professional does when they refuse to perform medical services.

The analysis of the medical professional's autonomy with respect to the refusal to provide treatment commences with a consideration of the derivation and the

Julie Cantor, 'Conscientious Objection Gone Awry — Restoring Selfless Professionalism in Medicine' (2009) 360 *The New England Journal of Medicine*1484.

173 Ronit Y Stahl and J Emanual and Ezekiel, 'Physicians, Not Conscripts — Conscientious Objection in Health Care' Care' (2017) 367 *The New England Journal of Medicine* 1380, 1382.

174 It is argued here that this nomenclature is misleading in that it fails to identify, and legitimises, what is really a failure to fulfill the duties of the medical practitioner

development of what is commonly but inaccurately known as *conscientious objection*. Although the section focusses upon the refusal to provide abortions and related services there are many other medical procedures to which there may be strongly held objections. These include: blood transfusions; sterilisation; stem cell treatment; contraception; treating obese patients; in vitro-fertilisation, treating Lesbian, Gay, Bi-sexual, Transgender patients (LGBT); and even vaccinations.[175] There are no doubt others.

Many of these beliefs may be categorised as racist, gender biased, misogynist, ill-informed or otherwise discriminatory. None of these should be relevant to a decision about the treatment a patient is entitled to receive. To allow their consideration would reflect adversely upon the profession.

Stahl and Ezekie rightly point out that it is wrong to allow personal beliefs to intrude in professional decision making. They note that there is nothing noble about decisions made upon the basis of personal beliefs[176].

> No matter how sincerely held, objections to treating particular classes of patients are indefensible — regardless of whether the objections are based on race, gender, religion, nationality, or sexual orientation.[177]

Nevertheless, generally medical professionals are permitted to refuse to provide medical services if they have a strongly held belief or objection to the service. Most jurisdictions restrict the protection to registered medical practitioners, some include registered nurses, midwives and pharmacists. The right has on occasions been granted to hospitals and medical institutions. In some cases, the right has been very general and applying to those involved in the provision of ancillary support services.

Before considering the way the codes of conduct of the medical profession and the legislation, operate to recognise a right to refuse to perform medical services, it useful to explain the terminology used to describe the basis of the refusal and identify why this is important.

175 See Stahl and Ezekie (n 170) The majority of those who exercise a conscientious objection do so in the context of reproductive health, particularly abortion and contraception, and this has had an adverse impact upon women's health, autonomy and human rights.

176 Stahl and Ezekie (n 170).

177 Ibid 1382

It will be seen from the language in the literature, some of the professional codes of conduct[178] and in legislation, that different adjectives are used to describe the reason for the refusal. Terms such as *conscientious objection* and *conscious objector* are most common but are not universally used. The terms have been adopted here because their meaning is well established, but it will be argued that they are value laden and give an impression of correctness, rightness and approbation of the refusal, implying that the views should be accepted without question. It is argued here that they ought to be subjected to scrutiny. A refusal to perform medical services based on the holding of personal views, beliefs and opinions results in limiting access to such services.[179] Such views pertain to the individual rather than representing the views of the profession or society.[180] As such it would appear unjustifiable to continue recognising a right of doctor acting in her/his capacity as a medical professional to refuse to perform medical services.

The term *conscientious objection* refers to a medical professional's claim that they have a right not to render medical services which they consider to be morally wrong and in breach of their religious and/or other beliefs.[181] It provides a convenient shorthand and without further contemplation appears to satisfy the dictionary definition of the words 'conscience', 'conscientious', 'objection' and/or 'objector'.

However, the background to the present understanding of who is a *conscientious objector* and what is a *conscientious objection* raises questions over whether the term as evolved is likely to be misleading and problematic, when applied to a refusal to provide medical services.[182] Ronit Stahl and Ezekiel Emanual argue that conscientious objection in medical law

178 For example, the terms *conscientious objection* and *conscientious objector* have been used in the UK by the General Medical Council.

179 Fiala and Arthur (n 172) 17.

180 See Savulescu and Schuklenk, (n 172) 134.

181 The Merriam-Webster dictionary defines the adjective 'conscientious' as 'governed by or conforming to the dictates of conscience': *Conscientious*, Merriam-Webster and the noun 'objection' as 'an act of objecting' or 'a feeling or expression of disapproval': *Objection*, Merriam-Webster (online).

182 Stahl and Emanual (n 170) 1380; Fiala and Arthur, (n 172).

> ostensibly mimics that of military conscientious objection, [but] it diverges considerably. Viewing conscientious objection in health care as analogous to conscientious objection to war mistakes choice for conscription, misconstrues the role of personal values in professional contexts, substitutes cost-free choices for penalized decisions, and cedes professional ethics to political decisions.[183]

The existence of *conscientious objection* may be traced, at least, to the origins of Christianity. Jesus has been identified as one of the earliest pacifists and *conscientious objectors*.[184] Historically, the term *conscientious objector* was used to describe a person who held a strong moral and/or religious belief that the killing of people was never justifiable and, who refused to do so under any circumstances.[185] *Conscientious objectors* would refuse to participate in war or related activities.[186] They accepted that they would be punished or even executed for the refusal to serve their country.[187]

In more modern times, the term *conscientious objector* has been closely aligned to anti-conscription beliefs held by individuals and groups. One commonality of the images evoked by using the term is one struggling against authority, of suffering, punishment and even martyrdom.[188] The recognition of medical practitioners as being *conscientious objectors* has been described as an 'historical irony' because medical objectors are invariably seen as figures of authority and power.[189] Equally important is the fact that the doctor who refuses to treat because of his or her beliefs is not as a result at risk of punishment.[190]

183 Stahl and Emanual (n 170) 1384.

184 'Statement on the Catholic Conscientious Objector' (Division of World Justice and Peace United States Catholic Conference, 15 October 1969).

185 Don Woodside, 'A Brief History of Conscientious Objection in Canada' [2015] (Fall) *Conscience Canada*.

186 Stahl and Emanual (n 170) 1380.

187 UN Office of the High Commissioner for Human Rights (OHCHR), *Conscientious Objection to Military Service*, HR/PUB/12/1 (January 2012) 2.

188 Stahl and Emanual (n 170) 1380.

189 Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *BMJ* 294; Alvan A Ikoku, 'Conscience, Values, and Justice in Savulescu' (2013) 15 *Virtual Mentor 208.*

190 Fiala and Arthur (n 172).

Savulescu has alleged that medical professionals, who may have other motives, give strongly held moral or religious beliefs as their reason for refusing to treat.[191] Ikoku asserts that

> conscience has increasingly been seen as a way to reclaim space for physicians, as a possible opt-out—or at least a pause—in bioethics' employment of ethical progress as the empowerment of patients and their families[192]

Ikoku refers to the increasing expansion of ethical codes and the focus upon increased involvement of the patient in decision making which some medical professionals may see as adding, perhaps unnecessarily, to their already difficult task of providing treatment. Another reason why some medical professionals refuse to perform abortions is the stigma attached to this procedure and the possible negative impact upon professional advancement.[193]

### (c) Refusal and Medical Ethics

The right of medical professionals to refuse medical services, which are contrary to their religious or moral beliefs, is recognised by many western medical professional bodies.[194] The conscientious objection provisions in the professional codes are usually of a general application rather than applying specifically to abortion.[195]

191 Julian Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *BMJ* 294, 294.

192 Ibid 332; the word emplotment is usually associated with literature and may be understood as the compilation of a succession of occurrences into a story; see J A Cuddon, *A Dictionary of Literary Terms and Literary Theory* (Penguin Reference Library, 2015); Alvan A Ikoku, 'Conscience, Values, and Justice in Savulescu' (2013) 15 *Virtual Mentor 208.*

193 See generally, below Part E — Stigma and Access.

194 Cf The Society for the Protection of Unborn Children *Swedish Parliament Votes to Campaign against Conscientious Objection to Abortion* (11 May 2011) (online); see Christian Fiala, 'Yes we can! Successful examples of disallowing "conscientious objection" in reproductive health care' (2016) 21 (3) *The European Journal of Contraception & Reproductive Health Care* 201.

195 See, eg, American College of Obstetricians and Gynecologists Committee on Ethics, 'The Limits of Conscientious Refusal in Reproductive Medicine' (Position Statement No 385, 2007, Reaffirmed 2016); Medical Code (Ire) [48] & [49]. American Medical Association, 'Abortion' (Policy H-5.995, 2010) recognises refusal for reproductive procedures but does not go into detail.

Stahl and Ezekiel note that 'although abortion is politically and culturally contested, it is not medically controversial. It is a standard obstetrical practice.'[196]

Generally, all medical ethical codes of practice have similar principles.[197] Their overarching philosophy is that the medical welfare of the patient is to be considered of paramount importance.[198] It is 'based on four common, basic prima facie moral commitments - respect for autonomy, beneficence, non-maleficence, and justice - plus concern for their scope of application'.[199]

Gillon has asserted that

> [t]he four principles plus scope approach claims that whatever our personal philosophy, politics, religion, moral theory, or life stance, we will find no difficulty in committing ourselves to four prima facie moral principles plus a reflective concern about their scope of application. Moreover, these four principles, plus attention to their scope of application, encompass most of the moral issues that arise in health care.[200]

196 Ronit Y Stahl and J Emanual Ezekiel, 'Physicians, Not Conscripts — Conscientious Objection in Health Care' (2017) 367 *The New England Journal of Medicine* 1380, 1383 (citing the AMA Code of Medical Ethics [Opinion 4.2]).

197 The term medical codes will be used here in the generic sense and applies to the medical associations of all of the jurisdictions and includes health professionals generally such as nurses and midwives: see, eg, Australian Nursing & Midwifery Federation, 'Conscientious Objection' (ANMF Policy, Reviewed and Re-endorsed February 2017); Australian Nursing and Midwifery Council, Australian College of Nursing, Australian Nursing Federation, 'Code of Ethics for Nurses in Australia' (2008) *Value Statement 1: Nurses value quality nursing care for all people*.

198 World Medical Association, *International Code of Medical Ethics* (22 March 2017); Australian Medical Association*, Code of Ethics* (2004, Editorially Revised 2006, Revised 2016), 2.1.1; Canadian Medical Association, *Code of Ethics*, Principle 1; American Medical Association, *Principles of Medical Ethics*, VIII; New Zealand Medical Association, *Code of Ethics for The New Zealand Medical Profession*, 5.

199 R Gillon, 'Medical Ethics: four principles plus attention to scope' (1994) 309 (6948) *BMJ* 184.

200 Ibid.

The origin of the principles may be traced back to Hippocrates and the Hippocratic Oath which some medical professionals still take upon admission to the profession.[201] The oath remains symbolic in reinforcing the principle of beneficence; whereby the medical professional is required to do no harm.[202] Originally the oath stated, 'I will not give a woman a destructive pessary'.[203] It was asserted that Hippocrates specifically required that abortions would not be performed. Others stated that it referred only to abortion by a particular means and not to the practice of abortion. The reference to abortion has been omitted from the modern forms of the oath[204] which commit to the patient as the primary concern and to the ethical practice as a medical practitioner. Reproductive health is one part of the care which medical professionals provide and therefore one to which the oath equally applies[205] There is nothing in the modern oath which supports an exception to the high ethical standards of medical profession and sanctions the refusal of medical treatment during pregnancy.

In Australia, the AMA (Aus) justifies recognising the existence of a right to refuse to treat on the basis that:

> Doctors (medical practitioners) are entitled to have their own personal beliefs and values, as are all members of society. There may be times, however, where a doctor's personal beliefs conflict with their peer-based professional practice. In *exceptional circumstances* and as a *last resort*, a doctor may refuse to provide, or

201 See Saurabh Gupta, 'Hippocrates and the Hippocratic Oath' (2015) 1 (1) *Journal of the Practice of Cardiovascular Sciences* 81-86.

202 M Walton and I Kerridge, 'Do no harm: is it time to rethink the Hippocratic Oath?' (2014) 48 (1) Med Educ 17-27; Roger J Bulger and Anthony L Barbato, 'On the Hippocratic Sources of Western Medical Practice' (2000) *The Hastings Center Report* S4; MT Lysaught, J Kotva, et al (Eds.) *On moral medicine: Theological perspectives on medical ethics* (ProQuest ebook, 2012).

203 Kyle Mathews and Hazel Anne Thompson, 'History Taking: The Hippocratic Oath' (2018) 11 (2) *InnovAiT* 122.

204 M Walton and I Kerridge, 'Do no harm: is it time to rethink the Hippocratic Oath?' (2014) 48 (1) *Med Educ* 17, 23; John M Riddle, Contraception and Abortion from the Ancient World to the Renaissance (Harvard University Press, 1992) Chapter Eight 'Greek and Roman Medicine from Hippocrates to Galen' 82

205 Saurabh Gupta, 'Hippocrates and the Hippocratic Oath'(2015) 1 (1) *Journal of the Practice of Cardiovascular Sciences* 81; MT Lysaught,and JKotva (Eds) (n 201).

> participate in, certain medical treatments or procedures that conflict with his or her own [sic] personal beliefs.[206]

That a refusal to provide medical services occurs infrequently may be an ideal rather than what actually occurs in practice. Certainly it ignores the vocal opposition of the Catholic Church in Australia to abortion and their ban on the performance of abortion in Catholic Hospitals.[207]

The American Medical Association (AMA-USA) has taken the view that physicians must be seen in the broader context as persons who 'like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs'.[208]

> Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.[209]

Some professional codes require that medical practitioners ensure that the patient will be able to receive the treatment from another practitioner. Advice is given about how the doctor should proceed where there is a conflict between her/his conscience and a request for medical treatment.[210]

In contrast to other medical associations the American Congress of Obstetricians and Gynecologists (ACOG), provides detailed advice to its members upon the acceptable

206 Australian Medical Association, 'Conscientious Objection' (Position Statement, 2013) 1 (emphasis added), citing Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (AMA, 2013); see World Medical Association, *Declaration on Therapeutic Abortion* (October 2006).

207 Anne O'Rourke, Lachlan De Crespigny and Amanda Pyman, 'Abortion and Conscientious Objection: The New Battleground' (2012) 38 *Monash University Law Review* 87

208 Australian Medical Association, *AMA Code of Medical Ethics* (2016) 1.1.2(a) 2. (The AMA did not use the term conscientious objection.).

209 Ibid 1.1.7, 5; Medical Board of Australia 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (2014) reviewed frequently, 2.5.

210 Ibid.

practice when refusing to perform reproductive services.[211] Although it uses the terms conscience and conscientious it does not use them in conjunction with objection but have opted for terms such as refusal instead.[212] The overall tenor of the ACOG advice is that whilst the right to refuse medical services is to be accommodated as far as possible, the 'well-being of the patient is paramount'.[213] The ACOG recommendations to the medical professional, who has a conscientious belief, include: providing accurate and unbiased advice; providing timely notice of refusal; providing a referral; not imposing the practitioner's beliefs upon the patient; practising in a manner and in localities where the beliefs will not interfere in the provision of

211 American College of Obstetricians and Gynecologists Committee on Ethics, 'The limits of conscientious refusal in reproductive medicine', *Position Statement* no. 385: 2007, reaffirmed 2016,

212 Ibid.

213 Ibid.

services; and providing the necessary services in an emergency.[214] The policy statement has caused controversy.

The right to refuse medical treatment based upon strongly held beliefs is not absolute and generally a medical professional cannot exercise a right to objection where the situation is one of emergency.[215] The AMA (Aus) states that, a doctor should always provide medically appropriate treatment in an emergency situation, even if that

214 ACOG, 'Respect for conscience is one of many values important to the ethical practice of reproductive medicine. . . . [T]he ACOG . . . proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.

Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.

Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.

Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.

In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.

In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.'

treatment conflicts with the doctor's personal beliefs and values'.[216] The word 'emergency' becomes problematic when informed by medical professionals who are anti-abortion. A view to the effect that an abortion will never or only rarely be required as an emergency has been expressed by some groups.[217]

### (d) Legislative Protection of 'Conscientious Objectors'

Enacting legislation to recognise conscientious objection reflects two agendas. The first may be identified as being partly political. Its purpose is to recognise the position and views of the anti-abortion proponents [218] and to provide protection in the legislation on abortion for the strongly held opinions of these influential groups within society.[219] The second is that it guarantees that the medical professional has control as to whether a request for an abortion is granted or denied. Both purposes require a closer analysis in the context of why and how the right to refuse perform medical treatment has been protected as a component of the legal regulation of abortion.[220]

Those jurisdictions which have enacted legislation to alter and/or reform their abortion laws concurrently endorsed the right of medical professionals to refuse to perform

215 American College of Obstetricians and Gynecologists Committee on Ethics ANF Policy – Conscientious objection, reviewed and re-endorsed February 2015; General Medical Council (UK) Conscientious Objection [13]; Australian Nursing and Midwifery Council; Royal College of Nursing Australia; Australian Nursing Federation (2008). Value statement 1: Nurses value quality nursing care for all people, No 1 – Self. In Code of ethics for nurses in Australia, 6,7. Canberra: ANMC, RCN, ANF.

216 AMA(Aus), 'Position Statement 2013– Conscientious Objection' [4]; AMA Council on Ethical and Judicial Affairs, AMA Code of Medical Ethics (2016) AMA, [1.1.7] 5.

217 Kim Painter, 'Doctors say abortions do sometimes save women's lives' Special for *USA Today* Published 19 October 2012 (online).

218 Sally Sheldon, *Beyond Control (n 171)* 56,161–3.

219 Victorian Law Reform Commission, *Law of Abortion*, Final Report No 15 (2008).

220 Christian Fiala and Joyce H Arthur, 'There is no defence for 'Conscientious objection' in reproductive health care' (2017) 216 *European Journal of Obstetrics and Gynecology* 254

medical treatment and/or services. England, Scotland and Wales,[221] NI,[222] Ireland[223] and NZ [224] have legislation which upholds the rights of medical practitioners to exercise a conscientious objection.

Similarly, in Australia, the ACT, NSW, the NT, Qld, SA, Tas, Vic and WA have provisions that allow medical practitioners to refuse to medical treatment in certain circumstances.[225]

221 The A*bortion Law Act 1967* (UK) s 4(1) refers to abortion or termination of pregnancy. (This Act does not apply to Northern Ireland which has separate legislation); See also Conscientious Objection (Medical Activities) Bill [HL] 2017-19 currently before parliament.

222 *The Abortion (Northern Ireland) (No. 2) Regulations 2020* (UK) no 503 s12 (operation 14th May 2020).

223 *Health (Regulation of Termination of Pregnancy) Act 2018* (Ire) s22.

224 *Contraception Sterilisation and Abortion Act 1977* (NZ) s 46.

225 *Health Act 1993*(ACT) s 84A; *Abortion Law Reform Act 2019* (NSW) s 9, see Minister for Health, Ministry of Health, 'Pregnancy – Framework for Terminations in New South Wales', Policy Directive, Doc No: PD2014,2 (NSW, July 2014); *Termination of Pregnancy Law Reform Act 2017* (NT)ss11,12 & 13, Health (Miscellaneous Provisions) Act (NT) s334; *Termination of Pregnancy Act 2018* (QLD) s 8; *Criminal Law Consolidation Act 1935* (SA) s82A (5)-(6); *Reproductive Health (Access to Terminations) Act 2013* (Tas) s6; *Abortion Law Reform Act 2008* (Vic) s 8; *Health (Miscellaneous Provisions) Act 1911* (WA) s334(2). In Canada the Federal Government does not have legislation regulating abortion but see *TS v Adey*, 2017 ONSC 397.

In the USA,[226] at both federal[227] and state[228]level there is legislation which protects medical professionals who refuse to provide their services.[229] Legislation was enacted as a reaction to the legal right to abortion recognised in *Roe.*[230] The wording of the provisions varies as between jurisdictions. It conflicts with the recommendation of the ACOG that the

> [l]awmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.[231]

226 The USA is complex and will not be addressed separately here. See Anon, 'Refusing to Provide Health Services' *Guttmacher Institute*, 1 January 2020 (online); Douglas Nejaime and Reva B Siegel. 'Conscience wars: complicity-based conscience claims in religion and politics' (2015) *Yale Law Journal* 2552.

227 See the 'Church Amendments' - 42 U.S.C. 300a-7; 'Coats-Snowe Amendment' - 42 USC 238 n 'Supplementary Information' in Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed Reg 23170 (21 May 2019) (to be codified at 45 CFR pt 88)

228 *Refusing to Provide Health Service State Laws and Policies* (1 January 2017); Jody Feder, 'The History and Effect of Abortion Conscience Clause Laws' (Report for Congress, Congressional Research Service, 14 January 2005), eg, South Dakota referred to in Adam Sonfield, 'Provider Refusal and Access to Reproductive Health Services: Approaching a New Balance' (2008) 11 *Guttmacher Policy Review* 4.

229 Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88); Mark R Wicclair, 'Preventing conscientious objection in medicine from running amok: a defense of reasonable accommodation', (2019) 40 (1) *Theoretical Medicine and Bioethics* 539–564; See Guttmacher Institute, 'Refusing to Provide Health Services' *State Laws and Policies* (1 December 2016); R Alta Charo, 'Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience' (2007) 1 *Advance* 119, 120–1.

230 *Anne O'Rourke, Lachlan De Crespigny and Amanda Pyman, 'Abortion And Conscientious Objection: The New Battleground' (2012) 38 Monash University Law Review 88; Rebecca J Cook et al, 'Healthcare Responsibilities and Conscientious Objection' (2009) 104 International Journal of Gynecology and Obstetrics* 249; J Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *BMJ* 294.

231 American College of Obstetricians and Gynecologists, ACOG Committee Opinion Number 385, November 2007, Reaffirmed 2016, 'The limits of conscientious refusal in

Under the *Abortion Act 1967* (UK) 'no person shall be under any duty … to participate in any treatment authorised by this Act, to which he has a conscientious objection'.[232]

The Victorian and NT legislation allow pharmacists to refuse to dispense prescriptions if they believe that the medicine is for the purposes of an abortion and they have a *conscientious objection*.[233] The provision would appear to unjustifiably treat women as lesser persons. It would appear to be discriminatory in that a pharmacist who believes in the sanctity of life must provide services for contraception but not for an abortion pill.[234] The refusal may cause embarrassment to the pregnant woman because chemists are busy places which lack privacy.[235] It may even delay her termination because she is required to go elsewhere. Cornell's prohibition against degradation has also been contravened. This results in interference with the woman's 'project of becoming a person'.[236]

Not all jurisdictions base their provisions upon the existence of a moral or religious objection. In WA it is provided that

> No person, hospital, health institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of any abortion. .[237]

There is no need to demonstrate a conscientious of religious objection or indeed refer the patient to someone who is willing to perform the termination.[238]

reproductive medicine', Recommendation 7.

232 *Abortion Act 1967* (UK) s 4(1); The Act refers to abortion or termination of pregnancy.

233 *Abortion Law Reform Act 2008 (Vic)* ss 3–8; *Termination of Pregnancy Law Reform Act 2017* (NT) s 12; see the RHATA 2013 (Tas) the s6(1) states '. . . no individual has a duty. . .'.

234 Rebekah Yeaun Lee, Rebekah Moles and Betty Chaar, 'Mifepristone (RU486) in Australian Pharmacies: The Ethical and Practical Challenges' (2015) 91 *Contraception* 25, 26; Henrietta Cook with Jonathan Swan, 'Chemist Chain Axes Devout Catholic in Pill Fuss' *The Age* (Melbourne, 15 February 2014) 6.

235 Rebekah Yeaun Lee, Rebekah Moles and Betty Chaar, 'Mifepristone (RU486) in Australian Pharmacies: The Ethical and Practical Challenges' (2015) 1 *Contraception* 25, 28.

236 Drucilla Cornell, Drucilla, *The Imaginary Domain: Abortion, Pornography and Sexual Harassment*, (Routledge, 1995) 4, 9.

237 *Health (Miscellaneous Provisions) Act 1911* (WA) s334 (2).

238 Cf *Termination of Pregnancy Law Reform Act 2017* (NT);

Although varying in detail the right to refuse to assist in abortions is not confined to the doctor but would also apply to nurses, midwives and other support staff. However, the precise meaning of 'participate' or 'assist' in this context has not been judicially determined in Australia.[239] It has however, been considered in the UK and will be discussed in the following section.

### i. England, Wales and Scotland

The *Abortion Act 1967* (UK),[240] which applies in England, Scotland and Wales, provides for persons to exercise a *conscientious objection*. Under section 4 a person is not under a duty to 'participate' in termination procedures based upon a *conscientious objection*.[241] The person refusing his/her services has the burden of proving that s/he holds a *conscientious objection*.[242] A refusal to 'participate' will not be valid where the situation is one of emergency.[243]

The right to refuse to 'participate' is personal and does not apply to institutions or health services. However, it is not only the doctor who can exercise a *conscientious objection*. 'Participate' may be interpreted to include a wide range of persons who are working in the medical profession and are against abortion. 'Participate' was interpreted to apply to those who 'take part' in the actual treatment but not to administrative and support staff in *R v Salford Health Authority, Ex parte Janaway.*[244]

Here, the House of Lords considered the meaning of 'participate in any treatment' in. The applicant was a secretary of a health service who refused to type a letter of referral for a termination of pregnancy. She refused her employer's request that in future she would fulfil her duties and relied upon her beliefs as a Catholic. She was dismissed and applied to the court for reinstatement. It was argued, on her behalf, that typing the referral was one of 'criminal' complicity, in the crime of abortion, and that therefore she

239 See *R v Salford Health Authority, Ex parte Janaway [1989] AC 537.*

240 See proposed Conscientious Objection (Medical Activities) Bill [HL], HL Bill 14, 2017–19 lapsed.

241 *Abortion Act 1967* (UK) s 4(1).

242 Ibid s4(1); in Scotland, this burden is satisfied by the 'person giving evidence, as to her/his *Conscientious Objection* on oath', s 4(3).

243 *Abortion Act 1967* (UK) s 4(2).

244 *[1989] AC 537.*

was entitled to the benefit of section 4. Her application was dismissed. It was held that 'participate'… 'in its ordinary and natural meaning referred to actually taking part in treatment administered in a hospital'.[245]

The meaning of 'to participate in any treatment'[246] was considered, in a different context, in 2014, in *Greater Glasgow Health Board (Appellant) v Doogan and Another (Respondents)(Scotland).*[247] Two midwives, Doogan and Wood, had registered their objections as devout Catholics with their employer. They worked as Labour Ward Co-ordinators. Their duties included:

> the management of resources within the ward, booking in patients from the Fetal Medicine Unit, allocating staff to patients, providing guidance, advice, and support to midwives, and on occasions taking a direct part in patient care.[248]

Until a restructuring of medical services within the hospital the women avoided being involved in the limited number of abortions performed. The women requested the hospital administration to accommodate their beliefs. However, the management considered that the right to refuse to 'participate' did not apply to the women. The midwives then underwent an unsuccessful grievance procedure and subsequently applied for judicial review. This was unsuccessful at first instance but was granted on appeal. The Court of Appeal deemed that there should be a broad interpretation of the meaning of 'participate'.[249] The Greater Glasgow Health Board then appealed to the Supreme Court. The appeal was granted.

It was held that 'participate' applies to the whole course of medical treatment bringing about the termination of the pregnancy.[250] However the tasks of 'delegating, supervising and/or supporting staff to participate in and provide care to patients throughout the termination process' were not within the meaning of 'participate' in s 4(1)'. Lady Hale, who delivered the unanimous judgment of the court, considered that parliament had intended that 'participate' be narrowly construed and said that:

245 Ibid.

246 *Abortion Act 1967* (UK) s 4.

247 *[2014] UKSC 68.*

248 Ibid [18].

249 [2013] CSIH 36.

250 [2014] UKSC 68 [34].

> It is unlikely that . . . Parliament had in mind the host of ancillary, administrative and managerial tasks that might be associated with those acts. Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital, . . . the caterers who provide the patients with food, and the cleaners who provide them with a safe and hygienic environment.[251]

Lady Hale applied a distinction, between ancillary tasks and 'hands on' matters, in respect of treatment, to a list of duties required by ward co-ordinators. She indicated which would and would not be covered by the *conscientious objection* provision and recognised that potentially everything that has to do with running a hospital may indirectly relate to the performance of the abortion. The applicants' roles were more related to the efficient running of the wards than they were to the actual performance of the termination procedure. Her Honour concluded that '"Participate" in my view means taking part in a "hands-on" capacity'.[252]

The exercise in classification is informative in that it indicates that it will be a matter of context and detail whether a task is being covered or not covered by the *conscientious objection* provision. Some tasks such as allocating beds and staff to patients would be administrative and would not be covered. Neither would a request for assistance, per se. Nevertheless, it would depend upon the nature of the help needed. If it was part of the treatment for the termination the refusal would be valid.[253] There are some twelve examples given but most of these are unclear as to how they apply without further details of the actual situation.[254]

What can be said in respect of the meaning of 'participate' is that the category of persons who may refuse to perform termination services is not restricted to registered medical professionals who perform the operation. For example, it may apply to someone who cleans the surgery and is called upon to dispose of the foetus.[255] The relevance of this for the autonomy of pregnant women is twofold.

251 Ibid 68, [38].

252 Ibid 68, [38]

253 Ibid,68, [34].

254 Ibid 68, [38]-[39].

255 See the now repealed s11(6) of the *Medical Services Act 1974* (*NT).*

First, the doctor may refuse to perform the termination and/or any of those who have a 'hands on' role may refuse to assist. The latter may include nurses, anaesthetists as well as those who have ancillary roles within the room where the procedure occurs. The only observation, which can be made with any degree of certainty, is that the greater the number of persons who are permitted to refuse to participate, the greater the likelihood of having the procedure delayed or not performed. As a result, the refusal is likely to impact adversely upon the woman's health.

Second, the greater the number and variety of persons who exercise the objection may increase the stressful nature of the experience for the woman. The disapproval of abortion may be directly conveyed through these people and may add to the stigma which the woman already suffers, and which is addressed later in this chapter.

### ii. Australia

In Australia, all jurisdictions have legislation allowing for medical professionals to refuse to provide, assist or participate in termination services. In Vic,[256] SA,[257] Tas,[258] the NT,[259],the ACT,[260] Qld,[261] and NSW[262] the refusal must be based upon an objection. Except for the ACT, the term *conscientious objection* is not defined. The ACT provides a limited definition which requires that the refusal is based '. . .on religious or other conscientious grounds (conscientious objection)'.[263] In SA, the onus of proving the existence of the objection is placed upon the person refusing to participate.[264] In Victoria, it is only

256 *Abortion Law Reform Act 2008* (Vic) s 8(4).

257 *Criminal Law Consolidation Act 1935* (SA) s 82A (5).

258 Ibid s 6(1).

259 *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11–12.

260 *Health Act 1993* (ACT) s84A.

261 *Termination of Pregnancy Act 2018* (Qld) s8 (1)

262 *Abortion Law Reform Act 2019* (NSW) s9; *conscientious objection* was previously recognised in the NSW Government's guidelines on abortion and applied to medical professionals in the public sector and not the private sector; see Ministry of Health, NSW, *Pregnancy — Framework for Terminations in New South Wales Public Health Organisations* (Policy Directive, 2014).

263 *Health Act 1993* (ACT) s84A (1)

264 *Criminal Law Consolidation Act 1935* (SA) s 82A.

registered health practitioners, including pharmacists, who may refuse their services.[265] In WA there is no duty upon any person to participate in an abortion[266] and the exemption extends to medical institutions and services.[267]

Except in WA the refusal to treat is a personal one and does not extend to hospitals and medical services on an institutional level. Elsewhere in Australia, a doctor within an institution may refuse his/her services in respect of abortion however hospitals which have an anti-abortion policy are not protected by the section.[268] Catholic hospitals have considered that the right to exercise a *conscientious objection* should be able to be exercised at institutional level. Since Catholic and other hospitals which have anti-abortion policies are unlikely to employ medical practitioners who are not 'anti-abortion' their criticism might be regarded as being hypothetical rather than real.[269] Nevertheless, the Catholic clergy have made it quite clear that Catholic hospitals will not perform and will not refer patients to other institutions or individuals for abortions.[270]

265 *Abortion Law Reform Act 2008 (Vic)* s 8; a registered health practitioner is defined to include a nurse and a pharmacist but not 'a student' s 3 (definition of 'registered health practitioner'); see *Termination of Pregnancy Law Reform Act 2017* (NT) ss 11–12.

266 *Health Act 1911* (WA) s 334(2).

267 *Ibid.*

268 *Ibid.*

269 Frank Brennan, 'Totalitarian Abortion Law Requires Conscientious Disobedience' (2008) 18 *Eureka Street* 11.

270 Michael Quinlan, '*When the State Requires Doctors to Act against Their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales'* (2016) *BYU Law Review* 1237, 1288; Anne O'Rourke, Lachlan De Crespigny and Amanda Pyman,*'Abortion and Conscientious Objection: The New Battleground'* (2012) 38 *Monash University Law Review* 87, 119; LA Keogh., L Gillam et al, 'Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers. (2019) 20 (1) *BMC Medical Ethics* 11.

In Vic,[271] the ACT,[272] Tasmania,[273] SA,[274]the NT,[275] Qld, [276] and NSW[277] the legislation specifically provides that there is a duty to treat where the situation is one of emergency. The legislation in WA is silent upon whether there is a duty to treat in an emergency. However, as noted earlier, the AMA (Aus) *Code of Conduct* specifies that a medical practitioner has a professional obligation not refuse to treat where the situation is one of emergency.[278] This provision, although present in almost all jurisdictions and reflective of the expectation that medical practitioners will provide medical treatment in emergency situations, has been strongly criticised and is considered repugnant to the strict beliefs of conservative Catholicism.[279]

The refusal to treat provisions give the medical professionals the power to override the woman's right not to proceed with a pregnancy. The *Abortion Law Reform Act 2008* (Vic)[280] imposes a duty on the medical professional to advise his/her patient of the objection and refer her to a practitioner who performs termination procedures. [281] The *Termination of Pregnancy Reform Act 2017* (NT) has adopted a 'duty to refer' which is similar to that in Victoria.[282]

The 'duty to refer' has been the subject of controversy.[283] The Catholic Church has interpreted this as akin to forcing disobedience to their religion by 'killing' the foetus.

271 *Abortion Law Reform Act 2008* (Vic) s 8(2) – (4).

272 *Health Act 1993* (ACT) s 84A (2).

273 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 6 (3) – (4).

274 *Criminal Law Consolidation Act 1935* (SA) s 82A(6).

275 *Termination of Pregnancy Reform Act 2017* (NT) s 13.

276 *Termination of Pregnancy Act 2018* (Qld) s 8(4).

277 *Abortion Law Reform Act 2019* (NSW) s9 (5).

277 a *Abortion legislation Act 2020* (NZ) s14(4).

278 Australian Medical Association*, Code of Ethics* (2004, Editorially Revised 2006, Revised 2016).

279 See Mark Rankin, 'The Roman Catholic Church and the Foetus: A Tale of Fragility' (2007) 10 *Flinders Law Journal* 271.

280 Ireland has a 'duty to refer'; see *Health (Regulation of Termination of Pregnancy) Act 2018* (Ire) s 22.

281 *Abortion Law Reform Act 2008* (Vic) s 8(4).

282 *Termination of Pregnancy Reform Act 2017* (NT) ss 11–12; See also *Termination of Pregnancy Act 2018* (Qld) s8(2)-(3*); Abortion Law Reform Act* 2019(NSW) s 9 (1)-(4).

Others have criticised the requirement as forcing medical professionals who are anti-abortion, to be accessories to what they view as the crime of murder.[284]:

In *R v Salford Health Authority, Ex parte Janaway,*[285] it was submitted by the applicant that preparing a letter of referral for an abortion was an act of criminal complicity.[286] This argument reflected anti-abortion rhetoric and Catholic dogma rather than being based on legal argument.[287]

> I do not consider that Parliament can reasonably have intended by its use [complicity] to import all the technicalities of the criminal law about principal and accessory, which can on occasion raise very nice questions about whether someone is guilty as an accessory. Such niceties would be very difficult of solution for an ordinary health authority.[288]

Lord Keith was clear that the use of 'participate' in the *Abortion Act 1967* was not to be interpreted by reference to its use in the criminal law.[289]

In Tasmania the legislation provides that medical practitioners, as well as other persons, are under no duty to 'participate' in termination procedures if they hold a *conscientious objection*. Nor is there an obligation to *provide a referral* as such.[290] However, on 'becoming aware' that the woman is seeking advice on or considering a termination, the

283 For a discussion of the issues related to the 'duty to refer' see J Howe and S Le Mire, (2019). 'Medical Referral for Abortion and Freedom of Conscience in Australian Law' (2019) 34 (1) *Journal of Law and Religion* 85; Michael Quinlan, '*When the State Requires Doctors to Act against Their Conscience: The Religious Freedom Implications of the Referral and the Direction Obligations of Health Practitioners in Victoria and New South Wales*' (2016) *BYU Law Review* 1237, 1288; Anne O'Rourke, Lachlan De Crespigny and Amanda Pyman, *'Abortion and Conscientious Objection: The New Battleground'* (2012) 38 *Monash University Law Review* 87, 119.

284 Mark Rankin, 'The Roman Catholic Church and the Foetus: A Tale of Fragility' (2007) 10 *Flinders Law Journal* 271.

285 *[1989] AC 537.*

286 Ibid.

287 Ibid.

288 Ibid.

289 Ibid.

290 Clause Notes, Reproductive Health (Access to Terminations) Bill 2013 (Tas) clause 7.

medical practitioner must provide the woman with a list of prescribed health services where she may seek advice, information or counselling on the full range of pregnancy options.[291] Provided the medical practitioner has given the requisite information s/he may continue to treat or counsel the woman in 'matters other than a termination or advice regarding the full range of pregnancy options'.[292]

In Australia, the adoption of the *conscientious objection* provisions has not been subjected to objective scrutiny by the legislature or courts. When included in the Victorian legislation in 2008, there was a great deal of debate and criticism of the duty to refer the woman to a doctor who did not hold an objection.[293] The inclusion in legislation, of the right to refuse to perform or participate in abortion, reinforces the role of medical profession as 'medical gatekeepers'.[294] It is the medical professionals who are anti-abortion who have the ability to delay or prevent access to a timely, safe and legal abortion and thus undermine women's autonomy.

### iii. New Zealand

NZ legislation protects the right of medical professionals to refuse reproductive procedures.[295] The *Contraception Sterilisation and Abortion Act 1977* (NZ) (*CSA Act 1977*) was amended by the *Abortion Legislation Act 2020* (NZ). One purpose of the amendment was to revise and clarify the law providing for the exercise of a conscientious objection. Section 2 of the amended *CSA Act 1977*[296] defines a conscientious objection as 'an

291 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(2).

292 *Reproductive Health (Access to Terminations) Act 2013* (Tas) s 7(4); Ronlii Sifris, 'Tasmania's *Reproductive Health (Access to Termination) Act 2013*: an analysis of conscientious objection to abortion and the "obligation to refer". (2015)22 (4) *Journal of Law and Medicine* 900.

293 *Abortion Law Reform Act 2008* (Vic) s 8; see Wendy Larcombe, 'Rights and Responsibilities of Conscientious Objectors under the *Abortion Law Reform Act 2008* (Vic)' (Paper presented at 25th Annual Law and Society Conference of Australia & New Zealand, University of Sydney, 10–12 December 2010).

294 Victorian Law Reform Commission, *Law of Abortion*, Final Report No 15 (2008).

295 See the *Abortion Legislation Act 2020* (NZ) c 3 which came into operation in March 2020.

296 See the *Abortion Legislation Act 2020* (NZ) c 3 which came into operation in March 2020.

objection on the ground of conscience to the provision of contraception, sterilisation or abortion services'.[297]

Section 46 of the previous legislation was repealed and replaced by the current section 14 and 15 of the *Contraception Sterilisation and Abortion Act 1977* (NZ). Section 14 provides that a person who is requested to provide or assist in the provision of abortion services or of 'information or advisory services about whether to continue or terminate a pregnancy and who has a conscientious objection must inform the patient and advise her how she can obtain the services elsewhere.[298] This must be done at the earliest opportunity and the information must include how to access the details of the closest provider. There is a duty to provide the services where the situation is one of emergency.[299]

Section 15 imposes a duty upon on the employer or prospective employer to accommodate the right to exercise a conscientious objection where this is possible. Provisions of this nature are not commonly contained in the legislation on abortion. An employee who has been the subject of prohibited treatment by an employer in contravention of the *Contraception, Sterilisation and Abortion Act 1977* (NZ) may bring an action under the *Human Rights Act 1993* (NZ) or the *Employment Relations Act* (NZ) but not both.

### *ii* ***The Republic of Ireland***

In the Republic of Ireland, terminations of pregnancy are lawful if performed in accordance with the *Health (Regulation of Termination of Pregnancy) Act 2018* (Ireland) (*HRTPA*).[300] The Act recognises a right of a medical practitioner, nurse or midwife to

297 *Contraception, Sterilisation and Abortion Act 1977* (NZ) s2 Amended by the *Abortion Legislation Act 2020* (NZ); See *Hallagan and Anor v Medical Council of NZ* HC WN CIV-2010-485-222 [2 December 2010] where Judge MacKenzie interpreted the amended section as meaning there was no duty to refer.

298 Amended by the *Abortion Act 2020* (NZ); See *Hallagan and Anor v Medical Council of NZ* HC WN CIV-2010-485-222 [2 December 2010] where Judge MacKenzie interpreted the then current section as meaning there was no duty to refer.

299 *Contraception, Sterilisation and Abortion Act 1977* (NZ) S 14 (2) (3) (4).

300 See Chapter 3 – Legal Termination of Pregnancy.

exercise a *conscientious objection* in respect of terminations.[301] However, there is a duty to participate in a termination procedure when there is 'an *immediate risk* to the life, or of serious harm to the health, of the pregnant woman'.[302] Section 22 (3) requires the person with the objection to 'as soon as may be, make such arrangements for the transfer of care of the pregnant woman concerned as may be necessary to enable the woman to avail of the termination of the pregnancy concerned'.[303] Where the situation is not an extreme emergency the objector must arrange for the pregnant woman to access the requisite medical treatment, elsewhere.[304]

Given the recent nature of the Irish legislation the 'duty to refer' remains problematic.[305] The duty to refer was also provided for in the previous legislation, that is, the *Protection of Life During Pregnancy Act 2013*(Ire).[306] The past history of abortion in Ireland would suggest that to allow a medical professional to refuse to participate in the provision of an abortion but provide that s/he has a duty to refer may remain controversial.[307]

301 Section 22(1) provides that [s]ubject to subsections (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to participate in carrying out, a termination of pregnancy in accordance with section 9, 11 or12 to which he or she has a conscientious objection. 'Conscientious objection' is not defined. See s 13 of the *Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995* (Ire) which provides that there is no obligation to provide information about the availability of termination procedures. See s13 of the *Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995* (Ire) which provides that there is no obligation to provide information about the availability of lawful termination services.

302 *HRTPA* s10.

303 *HRTPA* s22(3).

304 *HRTPA* s17 (2) - (3). Section 17(1) provides that 'subject to subsections (2) and (3), nothing in this Act shall be construed as obliging any medical practitioner, nurse or midwife to carry out, or to assist in carrying out, any medical procedure referred to in section 7(1) or 9(1) to which he or she has a conscientious objection'.

305 Anon, 'Conscientious-Objection Opposition to Ireland Abortion Legislation' (2018) 39 (3) *Conscience* 1.

306 *HRTPA* s 17(3).

307 See above 4 (b), for the discussion of the duty to refer in Australia where the Catholic clergy made their objections to it quite vocal. See Victorian Law Reform Commission, *Law of Abortion*, Final Report No 15 (2008); C Cowley, 'Conscientious objection in healthcare

Despite the depth of support reform of abortion law, as evidenced by the passing of the 36th Referendum there remain the objections of anti-abortionists, particularly Catholics, who hold strong beliefs and consider that a duty to refer constitutes a facilitation of abortion and thus forms part of their refusal to provide medical treatment.[308]

It has been suggested that anti-abortionist medical professionals may undermine access to abortion, whenever they are able. Enright suggests that the provision for conscientious objection and a duty to refer may assist in minimising this.

> A regime for open advance declaration of conscientious objection, and enforcement of the statutory obligation to refer the patient to a colleague willing to perform the procedure, will be necessary to avoid this difficulty. In order to respond to wrongful denial of access it is important that abortions refused as well as abortions granted are monitored and reported, so that any patterns of obstruction or refusal can be addressed.[309]

The duty to refer has been of little assistance in the past and may be unlikely to assist women who seek abortions in Ireland in the near future.[310] A requirement that medical professionals, hospitals, practices and clinics are clearly identified as not offering or offering particular medical treatment would reduce the need for a patient to do research on where to seek those services. However, it is argued that abortion should not be singled out but should be included in the monitoring of health services in general.

and the duty to refer' (2017) 43 *Journal of Medical Ethics* 207.

308 See comment of Victorian Law Reform Commission, *Law of Abortion*, Final Report No 15 (2008).

309 M Enright, 'Abortion Law in Ireland: Reflecting on Reform' in L Black & P Dunne (Eds.) *Law and Gender in Modern Ireland: Critique and Reform* (2019, Oxford,: Hart Publishing) 55,69.

310 See United Nations Human Rights Committee*, Views adopted by the Committee under article 5 (4) of the Optional Protocol, concerning communication* No. 2324/2013, 17 November 2016 *(Amanda Jane Mellet v Ireland) 2.1, 3.8 – 3.14,* although the case predates the *Protection of Life During Pregnancy Act 2013* (Ire) and the *Health (Regulation of termination of Pregnancy) Act* 2018 (Ire). It is suggested that the lack of effective referral and support remain a problem, see Caelainn Hogan, 'Why Ireland's battle over abortion is far from over' The Guardian 3 October 2019*;* Max Bearak, 'UN judgment says Ireland's anti-abortion laws are a violation of human rights.' *Washington Post*, 9 June 2016.

Given that the reformed abortion legislation has only been in operation since 2019 attention will need to be focussed upon increasing the numbers of medical professionals willing to perform and be trained in reproductive services. and the few abortions performed in Ireland. Otherwise it may be difficult to find sufficient medical professionals to provide abortions and this will place restrictions on access thereto.[311]

**(e) Review**

The refusal of treatment provisions fail to respect women's autonomy by giving the medical professional the right to refuse to perform termination procedures. This means that where a woman is refused the services of a medical professional she must go elsewhere. This will cause a delay to her receiving services. The delay may be either minimal or lengthy, but it will impact upon her ability to have a timely, safe and legal abortion. It will also add to the costs involved in obtaining the procedure.

Alternatively, she may not be able to access the services of a medical professional who will perform the procedure. In this situation, she may be forced to continue with an unwanted pregnancy, the consequences of which will impact upon her long-term health and well-being. The alternative to a continuance of the pregnancy is that she may resort to obtaining an unlawful abortion with the attendant risks to her life.

The denial of medical treatment ought to be recognised as a significant life changing factor for women. Allowing conscientious objection disproportionately privileges the medical professional's personal views at the expense of women's autonomy. It should not be routinely granted which appears to be the situation in the jurisdictions considered here.[312]

311 See *Amanda Jane Mellet v Ireland* above n 333; although the UN Committee only handed down its report in 2016 the case and the disapproval of Irish Policy by the UN has been apparent for quite some time, eg, in *A, B & C v Ireland, A & B* 2006 ECHR 210, were unsuccessful because they had not exhausted the remedies under the laws of NI.

312 Joyce Arthur et al, 'The dishonourable disobedience of not providing abortion' (2017) 22 (1) *The European Journal of Contraception & Reproductive Health Care* 81; Fiala and Arthur (n 172); Christian Fiala, 'Yes we can! Successful examples of disallowing "conscientious objection" in reproductive health care' (2016) 21 (3) *The European Journal of Contraception & Reproductive Health Care* 201.

Section D which follows considers the role of stigma in limiting women's ability to access abortion.

## D Stigma and Access

A theme throughout this thesis has been the role of stigma in controlling the behaviour of pregnant women in all legal systems considered here.[313] It was argued in Chapter 3- The Legal Regulation of Abortion that the location of the regulation of abortion in the criminal law has significantly contributed to the stigma associated with abortion.[314] In Chapter 5 – Medical Treatment-Consent and Refusal, it is argued that the pregnant woman, who refuses to consent to medical treatment deemed necessary for the well-being of the foetus, is stigmatised as a 'bad woman' cannot be trusted to make decisions.[315] This section analyses the way that abortion stigma hinders access to the procedure. It will be argued that stigma operates on three main levels. The first, is at a societal level, where stigma renders the process of obtaining an abortion less open and less supportive than that for accessing other medical treatments. The second, is the effect of abortion stigma upon women who decide or are considering not to continue with a pregnancy. The third, is the response of the medical professionals who may be discouraged from providing the necessary termination procedures because of abortion stigma.

313 A Kumar, 'Disgust, stigma, and the politics of abortion' (2018) 28 (4) *Feminism & Psychology* 530–538; Sarah K Cowan, 'Enacted abortion stigma in the United States' (2017) 177 Social Science & Medicine 260; Anuradha Kumar, 'Disgust, Stigma, and the Politics of Abortion'(2018) 28 (4) Feminism & Psychology 530-38; A Kumar, L Hessini, EMH Mitchell, ' Conceptualising abortion stigma' (2009) 11(6) *Culture, Health and Sexuality* 625-39; Lisa A Martin et al, 'Measuring Stigma Among Abortion Providers: Assessing the Abortion Provider Stigma Survey Instrument'(2014) 54 (7) *Women & Health*, 641-661; Anonymous, 'The independence of private versus public abortion providers: implications for abortion stigma' (2012) 38 *JFam Plann Reprod Health Care* 262-263; L Hoggart, 'Internalised abortion stigma: Young women's strategies of resistance and rejection' (2017) 27 (2) *Feminism & Psychology186*–202.

314 See also Chapter 1 – Introduction, Overview and Structure and Chapter 2 – Theoretical Underpinnings.

315 Rebecca Stone 'Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care' (2015) 3 *Health and Justice* 1.

### *1 Society and Abortion Stigma*

The term abortion stigma describes 'a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood'.[316]

Kumar has argued that:

> This definition is linked to ideals of womanhood such as female sexuality being solely for the purpose of procreation, that women are not "real women" until they are mothers, and the idea that all women at all times wish to be mothers. The feature, which distinguishes abortion stigma from other types of reproductive stigmas, is that women who seek to end a pregnancy are making an active decision to end a potential life.[317]

Stigmatization of women who do not meet the accepted stereotype of 'good wife' and 'good mother' is discussed extensively in the literature.[318] The stigma attached to being different from the stereotype devalues the worth of the woman as a person by attacking her self-esteem.[319]

Stigmatisation is a process, informal and formal, which in conjunction with stereotyping, typecasting and other negative labelling devices, defines the social expectations or norms which must be adhered to. Stigma is seen as mechanism of control which is imposed on and reinforced by all levels, but not all members, of the society in which it

316 Anuradha Kumar, L Hessini and EMH Mitchell, 'Conceptualising abortion stigma' (2009) 11(6) *Culture, Health and Sexuality* 625; Nataasha Mehta et al. "The Association Between Reproductive Autonomy and Abortion Stigma Among Women Who Have Had Abortions in the United States' (2019) 4 (4) *Stigma and Health* 377.

317 Anuradha Kumar, 'Everything is Not Abortion Stigma' (2013) 23 (6) *Women's Health Issues* e329.

318 See Lisa C Ikemoto, 'The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law' (1992) 53 *Ohio State Law Journal* 1205; Paula Abrams, 'The Bad Mother: Stigma, Abortion and Surrogacy' (2015) *Journal of Law, Medicine and Ethics* 179,180; A O'Rourke, 'The discourse of abortion law debate in Australia: Caring mother or mother of convenience' (2016) 56 *Women's Studies International Forum* 37.

319 Tara Culp-Ressler, 'Abortion Stigma Is Hurting Women, But Here's How We Can Start Getting Rid of It' *Think Progress* 22 October 2013.

exists.[320] There is little consensus on the effectiveness of stigmatisation as a means of general deterrence on anti-social behaviour and behaviour which is viewed as deleterious to health.[321]

Although controversial, abortion is not criminal when performed in accordance with the law of the state. Abortion stigma does not serve the same social purpose of stigma against criminal activities such as, violence,[322] theft, drink driving,[323] and drug taking.[324] It is difficult to establish that abortion stigma serves any worthwhile objective. The

320 Kate Cockrill, Ushma D Upadhyay, Janet Turan and Diana Greene Foster 'The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma' (2013) 45 (2) *Perspectives on Sexual and Reproductive Health* 79.

321 For example: altering attitudes – to smoking drinking and driving; violence against women; child abuse; Somewhat paradoxically Britta Wigginton and Christina Lee, 'A story of stigma: Australian women's accounts of smoking during pregnancy' (2013) 23(4) *Critical Public Health* 466 found that in respect of pregnant women 'critical public health campaigns, and the associated social stigma, may actually make it harder for some to stop smoking [and] move away . . .from the assumption that pregnant women need to be coerced into healthy decision-making, might better assist some pregnant smokers to seek cessation support; A Grant et al, 'Smoking during pregnancy, stigma and secrets: Visual methods exploration in the UK.' (2018) *Women and Birth - Journal of the Australian College of Midwives*; Patrick W Corrigan et al, 'Addressing the Public Health Concerns of Fetal Alcohol Spectrum Disorder: Impact of Stigma and Health Literacy' (2018) 185 *Drug and Alcohol Dependence* 266.

322 Kate Seymour, '"Cowards" and "Scumbags": Tough Talk and Men's Violence' (2018) 7 (4) *International Journal for Crime, Justice and Social Democracy* 132; Jennifer Schumann, 'Australian Deaths Involving Coward's Punches' *Research Update, Victorian Institute of Forensic Medicine* 27 June 2109.

323 G Mitchell, 'Changing the speeding culture' (2009) *Insurance Age* 58.; Kiptoo Terer and Rick Brown, 'Effective drink driving prevention and enforcement strategies: approaches to improving practice' (2014) 472 *Trends & Issues in Crime and Criminal Justice* 1; Magdalena Cismaru, Anne M Lavack and Evan Markewich, 'Social marketing campaigns aimed at preventing drunk driving: A review and recommendations', (2009) 26 (3) *International Marketing Review* 292-311.

324 K Bell, A Salmon, M Bowers, J Bell and L McCullough, 'Smoking, stigma and tobacco "denormalization": Further reflections on the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health

relationship between a woman exercising her autonomy by having a termination, and those who seek to ostracise her, would appear tenuous or non-existent. How does the termination directly impact upon those who stigmatise the pregnant woman? Rather the harm of stigmatism impacts upon the pregnant woman.[325] If a society's stigmatisation of abortion is expected to deter, it is difficult to prove that abortion stigma achieves its purpose in dissuading women from having termination procedures. Rather it may result in women resorting to unsafe and illegal abortions, hiding that that they have had an abortion and/or travelling to unfamiliar places so that their abortion will go undetected.[326]

Kumar suggests that 'abortion is one of the most common gynaecological experiences; many women will undergo an abortion in their lifetimes'.[327] Nicole Stone states that 'around one in three *sexually active* women in Britain will have an abortion during their lifetime and a third of those women will experience more than one' abortion.[328] Although there are no national statistical information on abortion in Australia it has been estimated 'that between one quarter and one third of Australian women will experience an abortion in their lifetime'. [329]

Special Issue 67 (3)' (2010) 70 (6) *Social Science & Medicine* 795; M Farhangmehr, MS Jalali, and CL Silva, 'Anti-smoking themes - what works best for adolescents?' (2015) 12 (1) *International Review on Public and Non - Profit Marketing* 17.

325 Kate Cockrill, Ushma D Upadhyay, Janet Turan and Diana Greene Foster 'The Stigma of Having an Abortion: Development of a Scale and Characteristics of Women Experiencing Abortion Stigma' (2013) 45 (2) Perspectives on Sexual and Reproductive Health 79.

326 Alison Norris et al, 'Abortion Stigma : A Reconceptualization of Constituents, Causes and Consequences'(2011) 21 (3) *Women's Health Issues* S49; Aisling T O'Donnell, Tara O'Carroll and Natasha Toole, ' Internalized Stigma and Stigma-Related Isolation Predict Women's Psychological Distress and Physical Health Symptoms Post-Abortion (2018) 42 (2) *Psychology of Women Quarterly* 220; Katherine Gillespie, 'Stigma and Silence: Welcome to Abortion in Rural Australia' *Broadly VICE* 12 Sep 2016 (Online)

327 Anuradha Kumar, L Hessini and EMH Mitchell, 'Conceptualising abortion stigma' (2009) 11(6) *Culture, Health and Sexuality* 625.

328 Nicole Stone and Roger Ingham, 'Who presents more than once? Repeat abortion among women in Britain' (2011) 37. *J Fam Plann Reprod Health Care* 209–215.

329 Children by Choice, 'Abortion Statistics', See eg, A Chan, W Scheil, J Scott, A-M Nguyen and L Sage, *Pregnancy Outcome in South Australia 2009* Pregnancy Outcome Unit, SA Health,

On the other hand, the Guttmacher Institute released figures which indicate that the abortion rate had declined. Anti-abortion groups suggested that reasons for the decrease included their role.[330] It was countered by the Guttmacher Institute that the decrease was more likely to be the result of better contraceptive measures.[331]

There is evidence to suggest that women who are unable to access abortion in their country or state will travel elsewhere, if able, to obtain the procedure.[332] Historical accounts of 'backyard abortion', in Australia and elsewhere, support the argument that making abortion illegal does not stop women from having the procedure.[333] Where women seeking terminations are denied access to a timely and safe abortion, because of

(Government of South Australia, 2011) 55.

330 Samuel Smith, 'US abortions at lowest level since *Roe v Wade*, Guttmacher finds; pro-lifers say it's incomplete' *The Christian Post* 20 September 2019.

331 Rebecca Wind, 'U.S. Abortion Rate Continues to Decline, Hits Historic Low Improvements in Contraceptive Use Are Likely Contributing to the Decline, But Punitive Abortion Restrictions May Also Be a Factor' *Guttmacher Institute News Release* Jan17, 2017; Elizabeth Nash and Joerg Dreweke, 'The U.S. Abortion Rate Continues to Drop: Once Again, State Abortion Restrictions Are Not the Main Driver'(2019) 22 *Guttmacher Policy Review* 41.

332 See Christabelle Sethna and Gayle Davis, Eds. *Abortion across Borders: Transnational Travel and Access to Abortion Services*. (2019, Baltimore) for a cross-section of articles about intra and international abortion travel; Frances Chapman. "'Butcher of Women': Abortion Tourism, Canadian Abortion Access and the Cautionary Case Study of Kermit Gosnell' (2015) 25 (1) *Texas Journal of Women, Gender and the Law* 1-23.Fiona Bloomer and Kellie O'Dowd, 'Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform', (2014) 16 (4) *Culture, Health and Sexuality* 366, 375; Kari White, Janet M Turan and Daniel Grossman, 'Travel for Abortion Services in Alabama and Delays Obtaining Care' (2017) 27 (5) *Women's Health Issues* 523; Health Editor; "'Abortion Tourism" Thriving in Victoria' *The Age* (Melbourne, Australia*)*, 2015.

333 Elizabeth Nash and Joerg Dreweke, 'The U.S. Abortion Rate Continues to Drop: Once Again, State Abortion Restrictions Are Not the Main Driver' (2019) 22 *Guttmacher Policy Review* 41; cf Michael J New, 'How the Legal Status of Abortion Impacts Abortion Rates' *Charlotte Lozier Institute* May 23, 2018.

illegality or some other reason, they put their health at risk by resorting to unsafe and unqualified abortion providers.[334]

However, abortion stigma is prevalent and has negative impacts, particularly upon pregnant women's ability to access a safe and timely abortion. Before looking at how it affects women it is useful to understand the manner in which abortion becomes stigmatised. It 'is affected both by legislative initiatives that establish fetal personhood and gestational age limits and by discourses that influence cultural values'.[335] Its sources are heterogeneous coming from an interaction between law, medicine, politics, media, culture, religion, class, gender and other factors within any society. Abortion stigma reflects firmly entrenched beliefs of some groups and individuals within society. These include: regarding the foetus as a person with rights and in need of protection; considering abortion as murder and a serious criminal offence; there is a duty to take positive and even violent action to prevent abortion; the idea that women who have abortions are 'whores' and 'unclean'; the idea that the woman who conform to the role of a perfect mother is the appropriate model for women to follow and that stigma is a useful and justifiable method of achieving their objectives of as anti-abortion activists. It follows from the belief that abortion is iniquitous and therefore those who undergo or perform abortions are rightly deserving of social ostracism and severe punishment.

Abrams has captured the essence of abortion stigma in the following account.

> Negative political framings of abortion [and surrogacy] rely on the bad mother archetype, drawing on embedded social taboos, such as identifying abortion with murder. Pro-life social movements have effectively connected abortion to broader social themes of family values, emphasizing the significance of traditional maternal roles to family stability.[336]

334 Caroline De Costa, *Never, Ever, Again: Why Australian Abortion Law Needs Reform* (Boolarong Press, 2010); Gideon Haigh, *The Racket: How Abortion became legal in Australia (MUP,2008);* Jo Wainer, *Lost: Illegal Abortion Stories* (MUP,2006); Caroline De Costa, *Never, Ever, Again: Why Australian Abortion Law Needs Reform* (Boolarong Press) 39; Gideon Haigh, above n 286, *18.*

335 Alison Norris, Danielle Bessett, Julia R. Steinberg, Megan L. Kavanaugh, Silvia De Zordo, Davida Becker, 'Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences' (2011) 21 (Sup 3) *Women's Health Issues* 1,6.

Anti-abortionists have been active stigmatising abortion processes. They have been instrumental in promoting societal recognition of the foetus as a person and that abortion is 'murder'. The endowment of the foetus with the attributes of personhood and the use of 'foetal imagery' are used as tactics to 'taint women who have chosen to end "innocent lives"'.[337]

Social and religious stigma was central to but not the only factor which resulted in the criminalisation of abortion.[338] The continued location and/or nexus with the criminal law remains important in validating and perpetuating stigma. The criminal law is society's ultimate weapon of condemnation. The use of the stigma of 'criminality' is both symbolic and real.

Those convicted and punished for a crime are 'officially stigmatised' through being denounced by the criminal justice system. Those who are associated with criminal behaviour but not formally sanctioned are stigmatised by society. Both groups are shamed, shunned and humiliated. Women who undergo abortions are publicly identified as a group of miscreants. Individual women who have an unintended pregnancy are aware of how society treat this group.

When a pregnant woman is considering her options about continuing or discontinuing her pregnancy she is likely to be aware that she is unlikely to find information and support from the broader social group to which she belongs. She may be unsure as to

336 Paula Abrams, 'The Bad Mother: Stigma, Abortion and Surrogacy' (2015) *Journal of Law, Medicine and Ethics* 179,180; see eg, Paula Abrams, 'The Scarlet Letter: The Supreme Court and the Language of Abortion Stigma' (2013) (2) 2 *Michigan Journal of Gender & Law* 293for an analysis of judicial language and abortion stigma; see eg, Carrie Purcell, Shona Hilton and Lisa McDaid, 'The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010, (2014) 16 (9) *Culture, Health & Sexuality* 1141 for media contribution to abortion stigma in England and Scotland.

337 Anuradha Kumar, L Hessini and EMH Mitchell, 'Conceptualising abortion stigma' (2009) 11(6) *Culture, Health and Sexuality* 625,627.

338 Agnès Guillaume and Clémentine Rossier,(translated by Paul Reeve) 'Abortion Around the World. An Overview of Legislation, Measures, Trends, and Consequences' (2018) 73(2) *Population* 217-306; See Julia Hughes, 'Perfectly Legal, But Still Bad: Lessons for Sex Work from the Decriminalization of Abortion' (2017) 68 *University of New Brunswick Law Journal* 1-9.

the reactions of those who are close to her. A woman's reaction to abortion as being stigmatised may be to keep her pregnancy and abortion, if she undergoes it, a secret.[339] Women who overtly seek information about abortion have been labelled morally blameworthy and even criminal despite abortion being legal in the jurisdiction in which they reside.[340]

The outcome of abortion stigma is that abortion is not discussed openly. Unwanted pregnancies are not usually considered to be a matter for social conversation. Unwanted pregnancies are usually not openly discussed, and neither are the options for the woman and her family. Etiquette and political correctness require that abortions are not discussed, advertised or promoted as a normal health option for the women concerned.[341] Research indicates the need for non-confrontational forums promoting an ongoing discourse which dispels the untruths upon which abortion stigma is founded'[342]

### *2 Impact on Women*

An immediate observation on the impact of abortion stigma is that it has 'silenced' the voices of many women.[343] This is understandable if one considers the context in which women seek abortions. Fiona Bloomer and Kellie O'Dowd have pointed out that the way stigma is used, to negatively portray women, overlooks the fact that a termination of abortion is not undertaken without careful thought and consideration.[344] Many women

339 Kate Cockrill and Antonia Biggs, 'Can stories reduce abortion stigma? Findings from a longitudinal cohort study' (2018) 20 (3) Culture, Health & Sexuality 335, 347.

340 Abrams (n 143).

341 Katha Pollitt, 'Speak Louder for Abortion Rights' International New York Times (Paris), 1 January 2015t

342 Fiona K Bloomer et al 'Breaking the Silence on Abortion: the Role of Adult Community Abortion Education in Fostering Resistance to Norms' (2017) 19 (7) *Culture, Health & Sexuality* 709,

343 Alison Norris, Danielle Bessett, Julia R. Steinberg, Megan L. Kavanaugh, Silvia De Zordo, Davida Becker, 'Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences' (2011) 21 (Sup 3) *Women's Health Issues* 1,8; stigma not only silences women but silences all conversation and discussions in a social context.

344 Fiona K Bloomer et al 'Breaking the Silence on Abortion: the Role of Adult Community Abortion Education in Fostering Resistance to Norms' (2017) 19 (7) *Culture, Health & Sexuality* 709, 718; Fiona Bloomer and Kellie O'Dowd, 'Restricted access to abortion in the

would like to continue their pregnancy to full term but are unable. Bloomer and O'Dowd explain that:

> The negative stereotypes of women who access abortion mask the fact that many abortions are undertaken to preserve the health and well-being of family members including other children, and that many women who access abortion services continue with other pregnancies.[345]

The woman who terminates a pregnancy is labelled at fault for two instances of misbehaviour arising out of one event. First, she declines to fulfil her role as a provider of 'life' and second she becomes a murderer who causes the death of an innocent. [346] Her supposed fault is exacerbated because of the emotive portrayal of the foetus as a person from the time of conception. The woman may experience self-doubt, guilt and other negative responses to abortion stigmatisation. The stigmatisation will add to what is already a stressful situation and one likely be detrimental to women's health.[347] Steinberg argues that research indicates that 'depressive, anxiety, and stress symptoms are higher just before an abortion than anytime after'.[348]

Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform', (2014) 16 (4) *Culture, Health and Sexuality* 366

345 Fiona Bloomer and Kellie O'Dowd, 'Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform', (2014) 16 (4) *Culture, Health and Sexuality* 366, 375.

346 Ibid 375.

347 Sarah K Cowan, 'Enacted abortion stigma in the United States', (2017) 177 *Social Science & Medicine*, Volume 259, 260, 268-269.

348 Julia R Steinberg, Jeanne M Tschann, Dorothy Furgerson and Cynthia C Harper, 'Stigma, Psychosocial factors and pre-abortion psychological health: The significance of stigma' (2016) 150 *Social Science & Medicine* 67.

Women who have an abortion may feel stigmatised even when the abortion is legal.[349] As a result the woman may hide the fact that she has had an abortion. In one study of stigma it was found that as 'long as having an abortion is stigmatizing, the price of either disclosure or concealment can be high'.[350] Alison Norris et al have developed this idea.

> Abortion stigma is usually considered a "concealable" stigma: It is unknown to others unless disclosed. Secrecy and disclosure of abortion often pertain to women who have had abortions, but may also apply to other groups including abortion providers, partners of women who have had abortions, and others who must also manage information about their relationship to abortion. As with women who have had abortions, none are fully in control of whether their status is revealed by and to others. Consequently, those stigmatized by abortion cope not only with the stigma once revealed, but also with managing whether or not the stigma will be revealed.[351]

Bloomer and O'Dowd agree that it is not only stigma but the fear of stigma that causes stress to women.

> Silence and fear of social ostracism stop other women speaking out to support those who have availed of abortion, and discrimination against those who have accessed it completes the stigma process.[352]

349 *A v Peters & Ors* [2011] VSC 478 (23 September 2011); see also *AAA v BBB* (Unreported, Supreme Court of Victoria , Ashley J, 26 August 1994, BC9406139)[10]-[15]; J P Maksymiuk, 'The Abortion Law a Study of R v Morgentaler' (1974-1975) 39 *Sask L Rev* 265 ; *Morgentaler, Smoling and Scott v The Queen* (1988) 44 DLR (4th) 385 (SCC) (*Morgentale*r); Anonymous, 'The independence of private versus public abortion providers: implications for abortion stigma'*(*2012) 38 *JFam Plann Reprod Health Care* 262-263

350 Brenda Major and Richard H Gramzow, 'Abortion as Stigma: Cognitive and Emotional Implications of Concealment' (1999) 77(4) *Journal of Personality and Social Psychology* 735 ,743.

351 Alison Norris, Danielle Bessett, Julia R Steinberg, Megan L Kavanaugh, Silvia De Zordo, Davida Becker, 'Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences' (2011) 21 (Sup 3) *Women's Health Issues* 1,3.

352 Fiona Bloomer and Kellie O'Dowd, 'Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform', (2014) 16

Additionally, it has been argued that some women who have had abortions not only hide the fact but stigmatise other women who have abortions. This demonstrates 'that concealing abortion is part of a vicious cycle that reinforces the perpetuation of stigma'.[353]

### *3 Service Providers*

Importantly, abortion stigma may influence the provision of abortion.[354] Those who are involved with provision of terminations are exposed to abortion stigma and are targeted as being complicit in the 'murder' of the foetus. The methods employed to stigmatise the service providers replicate and amplify those used to stigmatise women who seek an abortion. However, for the service providers there is little hope of secrecy and anonymity. Further, they are routinely 'named, shamed and blamed' by anti-abortionists who regularly demonstrate outside their workplace. The stigmatisation is not restricted to their workplace. There have been reports that threats have been made against service providers' lives, their families and their homes. The objective is to dissuade medical professionals from providing abortions. In addition, the killing of medical professionals has occurred on several occasions.[355] The publicity received may make medical professionals, who have not been directly targeted, feel both vulnerable to violence as well as to stigmatisation.[356] Stigma and violence, threatened or actual, have resulted in providers withdrawing their services.[357]

(4) *Culture, Health and Sexuality* 366,375.

353 Alison Norris, Danielle Bessett, Julia R. Steinberg, Megan L. Kavanaugh, Silvia De Zordo and Davida Becker, 'Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences' (2011) 21 (Sup 3) *Women's Health Issues* 1,3; 5.

354 Lisa A Martin, Michelle Debbink, Jane Hassinger, Emily Youatt, and Lisa H Harris, 'Abortion Providers, Stigma and Professional Quality of Life.' (2014) 90 (6) Contraception 581.

355 David S Cohen and Krysten Connon, 'Living in the Crosshairs: The Untold Stories of Anti-Abortion Terrorism' (Oxford University Press, 2015); Kelly Jo Popkin, 'FACEing Hate: Using Hate Crime Legislation to Deter Anti-Abortion Violence and Extremism' (2016) 31 *Wis J L Gender & Soc'y* 103, 111.[ENT

356 Jocelyn Downie and Carla Nassar, 'Barriers to Access to Abortion Through a Legal Lens' (2007) 15 *Health Law Journal*, 143,146-147.

357 Jocelyn Downie & Carla Nassar, 'Barriers to Access to Abortion Through a Legal Lens'(2007) 15 *Health Law Journal*, 143,146-147; Lisa A Martin, Michelle Debbink, Jane

Furthermore, abortion stigma provides a significant disincentive to work or be in any way involved in the provision of abortion services. Norris has argued:

> One pernicious effect of abortion stigma may be that physicians are unable to receive training in abortion procedures, decline to be trained, or, if trained, face barriers to providing abortions.[358]

Stigma has had a detrimental impact upon the number, locality, availability and access to abortion services.[359] Downie and Nassar, in the context of USA but relevant to all the jurisdictions considered here, suggest that '[o]ne reason that doctors may be unwilling to provide abortions is the fear of anti-choice harassment and violence that plagues abortion practice'.[360]

They add that:

> [t]he threat of harassment, compounded by the sense that the government and law enforcement officials will not provide adequate support to prevent this harassment, has led providers to cease performing abortions.[361]

Research by Sifris and Penovic included interviews with service providers which demonstrated that they are severely impacted by the actions of anti-abortion activists. Working was highly stressful because of fears: of 'unpredictable' behaviour; and, of acts and threats to physical and mental safety.[362] It also impacted upon the private lives of the service providers.

Hassinger, Emily Youatt, Meghan Eagen-Torkko and Lisa H Harris, 'Measuring Stigma Among Abortion Providers: Assessing the Abortion Provider Stigma Survey Instrument'(2014) 54 (7) *Women & Health* 64; see this chapter Part E .– 2

358 Alison Norris et al, 'Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences' (2011) 21 (Sup 3) *Women's Health Issues* 1, 8.

359 Lisa A Martin et al, 'Measuring Stigma Among Abortion Providers: Assessing the Abortion Provider Stigma Survey Instrument' (2014) 54 (7) *Women & Health* 641.

360 Jocelyn Downie and Carla Nassar, 'Barriers to Access to Abortion Through a Legal Lens' (2007) 15 *Health Law Journal* 143,146-147.

361 Ibid.

362 Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 (2) *Monash University Law Review* 317.

> Interviewees observed a link between the presence of protestors outside clinics and the targeting of health professionals' private and family lives. One health professional recounted warnings from colleagues that protestors 'were quite in your face; they liked to scream and shout, and carry around pigs' organs, and thrust them at people'. They would target staff engaged in abortion services by throwing red paint or pigs' blood at their houses and threatening to 'ring doctors' children's schools and say that they're murderers'.[363]

The actions of the anti-abortionists not only stigmatise and disrupt the lives of service providers but they also provide a useful mechanism to prevent physical access to premises which provide reproductive services including abortion.[364] The next section considers the way in which anti-abortion activists promote their cause by impeding or preventing access to the premises which provide reproductive services. Section E addresses the role of anti-abortion protests and protestors in attempting to influence pregnant women, public attitudes and governmental policies. It draws attention to anti-abortion activities aimed at restricting the provision of abortion services and preventing women from physically accessing the premises at which abortions are performed. Sub-section 1 addresses the role of the freedom of movement, speech and religion in the context of the claims of anti-abortion protestors. Sub-section 2 focusses upon the use of violence and intimidation by the anti-abortion lobby. It commences with the USA and Canada which is followed by Australia and the UK. Sub-section 3 looks briefly at the dilemmas and concerns caused raised by protest outside abortion premises. Sub-section 4 outlines legislation enacted by the USA and Australia to address the problems of safe access to abortion premises.

## *E Access to Premises*

### *1 Freedom of Movement, Speech and Religion*

Freedom of movement and freedom from undue interference, are important in both the provision of and access to medical services. It is routinely accepted as a part of the exercise of the autonomy of all persons in everyday life that no one will hinder those

363 Ibid 322.

364 Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 (2) *Monash University Law Review* 317; L Ross, 'Get Ready for Anti-Abortion Terrorism' (2018) 42(9) *In These Times* 16.

who wish to consult with their medical professional and/or undergo treatment.[365] It is assumed that any patients, medical providers, their staff, and associates can enter premises without interference. However, where reproductive services, particularly abortions, are provided, unimpeded access cannot be guaranteed. This is because the premises provide a forum to promote an anti-abortion agenda.

Anti-abortion groups use the public spaces surrounding the premises to bring their cause to public attention and simultaneously prevent the provision of reproductive services. Anti-abortion proponents employ a range of strategies in promoting their dogma.[366] These include praying, holding silent vigils, distributing pamphlets, blocking entrances, graffiti, stalking, holding placards, giving speeches, demonstrating and harassment.[367] They have been efficient in using the media to draw political and public attention to their message.[368]

Some anti-abortion groups and/or individuals have been extremely vocal and even violent in furthering their objectives.[369] They regard their methods as a legitimate exercise of the right to freedom of speech and/or political protest.[370] It would appear that many of the activities are those of 'abortion vigilantes' or 'abortion terrorists' than concerned citizen's wanting to bring about changes in the laws of abortion.[371] These acts are perpetrated against people who are acting entirely in accordance with the law

Women who decide not to proceed with a pregnancy ought to be able to attend medical premises on the same basis as anyone else. They should not have to fear for their safety and health by pursuing a normal activity; visiting their doctor. This section analyses the

365 Ibid.

366 See Kelly Jo Popkin, 'FACEing Hate: Using Hate Crime Legislation to Deter Anti-Abortion Violence and Extremism' (2016) 31 *Wis J L Gender & Soc'y* 103.

367 See Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 (2) *Monash University Law Review* 317, 320-325 for disturbing accounts of the lengths employed by the groups.

368 Deana A Rohlinger, 'Friends and Foes: Media, Politics, and Tactics in the Abortion War' (2006) 53 (4) *Social Problems* 537, 538.

369 Kimberly Hutcherson, 'A brief history of anti-abortion violence' *CNN*, 1 December 2015.

370 Marshall H Medoff, 'The impact of anti-abortion activities on state abortion rates' (2003) 32 (3) *The Journal of Socio-Economics* 265.

371 L Ross, 'Get Ready for Anti-Abortion Terrorism' (2018) 42(9) *In These Times* 16.

extent to which pregnant women's rights are undermined by anti-abortionists who hinder access to premises provide abortions. It also considers the legal responses to the dilemma posed, when freedom from interference and freedom of speech conflict.[372]

Freedom of speech[373] is considered a fundamental right in a democratic society and is legislatively protected in the USA, the UK, Ireland, Canada and NZ.[374] In Australia there is an implied freedom of political communication under the Constitution.[375] It has been well established that 'everybody is free to do anything, subject only to the provisions of the law'[376]

Problems occur when the exercise of the right to freedom of speech interferes with other democratic rights, particularly the rights of people to move freely without undue interference from others.[377] In addressing what ought to be the balance

372 Anonymous, 'Law banning protests near abortion clinics faces constitutional challenge' *The Guardian* 3; Mitchell Landrigan, 'Protests Outside Abortion Clinics: Constitutionally Protected Speech?' (2016) 41 (1) *Alternative Law Journal* 8; Anna Walsh, 'Freedom of Expression, Belief and Assembly: The Banning of Protests Outside of Abortion Clinics in Australia' (2018) 25 *JLM* 1119.

373 Here freedom of speech is used to include freedom of religion in so far as the anti-abortionists are expressing their religious beliefs.

374 In the USA it is a Constitutional Right under the 1st Amendment; *Human Rights Act* (UK): *Constitution of the Irish Free State (Saorstát Eireann) Act 1922*, Art 9; *Charter of Human Rights and Freedoms 1982* (Can) s2 (b*)*; *New Zealand Bill of Rights Act 1990* (NZ) s14, 15, 16, 17; Eleanor Jones, 'Comment: Implementing Protest-free Zones Around Abortion Clinics in Australia' (2014) 170 *Sydney Law Review* 169.

375 *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; *McCloy v New South Wales* [2015] HCA 34; see Anthony Gray, 'Bloody Censorship: Swearing and Freedom of Speech' (2012) 37 *Alternative LJ* 37; see eg, *Charter of Human Rights and Responsibilities Act 2016* (Vic) s15 freedom of expression; *Human Rights Act 2004* (ACT) Part 3 – Civil and Political Rights eg, ss13-16.

376 *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520, 564 (Brennan CJ, Dawson, Toohey, Gaudron, McHugh, Gummow and Kirby JJ); see Dan Meagher, 'Is There a Common Law "Right" to Freedom of Speech? (2019) 43(1) *Melbourne University Law Review* 269.

377 This is a complex and controversial issue in the USA where the right to freedom of speech and religion are protected by the First Amendment to the Constitution.

between freedom of speech and freedom of movement, anti-abortion protestors claim that their actions should be classified as the exercise of their right to freedom of speech. However, it is argued that some of the methods adopted by anti-abortionists exceed what is regarded as free speech. This is because they unduly involve harassment, violence and other actions which impinge upon the rights of others. The methods used in anti-abortion campaigns are intended to bring their message to public and political attention.[378] They range from peaceful demonstrations, aimed at minimal disruption, to highly active and deliberately troublesome, disturbing, frightening and sometimes extremely violent actions.[379]

Central to their message is their assertion that the foetus is a person, its destruction is murder and those who participate in abortion ought to be punished by the criminal law. The support their claim with highly detailed and graphic images which focus upon the likeness of the foetus to a baby. The objective is to equate the foetus with a person who may be a victim of homicide and abortion with murder. The pictures and details are presented in a manner that is deliberately unpleasant and disturbing. It is immaterial to the anti-abortion objective that the jurisdictions in which they may be active do not recognise the foetus as a legal person until it is *born alive*.[380] Nor do the anti-abortion protestors acknowledge that abortion is legal.[381] For the most part, the anti-abortionist proponents consider it is the 'law' which wrongly contravenes their devout beliefs and that they must follow a higher moral command.[382] Catholic anti-abortion protestors

378 See Deana A Rohlinger, *Abortion Politics, Mass Media, and Social Movements in America* (Cambridge University Press, 2014). The media (including social media) assists in broadcasting and otherwise drawing the anti –abortion message to public attention. Likewise, the media draws attention to the pro-choice opinions [80]. The difference may lie in the use of language and pictures in 'humanising' the foetus.

379 See Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 (2) *Monash University Law Review* 317, 320-325; Marshall H Medoff, 'The impact of anti-abortion activities on state abortion rates' (2003) 32 (3) *The Journal of Socio-Economics* 265. Here the discussion will focus upon those which are aimed at directly disrupting access to medical premises which offer reproductive services.

380 See above Chapter 2 – Theoretical Underpinnings, III, A.

381 See Chapter 3 – Legal Regulation of Abortion.

adopt the decree of the late Pope John Paul II which presents opinion as incontrovertible truth.

> Abortion and euthanasia are thus crimes which no human law can claim to legitimize. There is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection.[383]

At protests outside clinics, demonstrators contend that murder being carried out on the premises. The use of language and visual imagery of the foetus as human establishes the woman as a murderer who has abdicated her role as nurturer, giver of life and protector. Established also is that those, who perform, and assist in, her abortion are guilty of murder. It becomes the self-professed duty of the protestors to ensure that the criminal law is enforced. The authority for them to act is to be found in the Bible. For the extremists this not only justifies violent action but also the killing of abortion providers.

Some methods used by the anti-abortion protestors arguably go beyond what is socially acceptable. It may be regarded as, and intended to be, intimidating and goes beyond what is protected by the right of free speech. This not only has a negative impact upon the women attempting to access the premises but also adversely affects all those involved in the provision of reproductive services at the premises. It also serves as a disincentive to those who might contemplate attending the premises in the future, even when they are not seeking an abortion.[384]

382 Carol Off, 'Thou shalt not kill' *The National Magazine – CBC Television*, Toronto Transcript, 19 January 1999) 2; see Marge Berer, 'Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: An analysis of the death of Savita Halappanavar in Ireland and similar cases' (2013) 21 (41) *Reproductive Health Matters* 9; Michael Bray, *A Time to Kill: A study concerning the use of force and abortion,* (Reformation Press, 1994); Reverend Bray spent time in prison for bombing clinics, see Sue Anne Pressley, 'From Prison to P.G. Pulpit' *The Washington Post*, 26 July 1989; Mark Juergensmeyer, *Terror in the Mind of God: The Global Rise of Religious Violence* (University of California Press, 4th Ed, 2017) 29.

383 Pope John Paul II, The Evangelium Vitae – *The Gospel of Life* (1995) 73 Encyclical (online).

384 See generally Julie Tulbert, 'Anti-Abortion Violence and Harassment Was Already Bad. Right-Wing Media Are Making It Worse' *Alternet -Media Matters for America* 22 September 2017 (online).

The next section considers the background to and the use of violence to prevent women from physically accessing premises to obtain the medical treatment of her choice.[385] This in turn will give some insight into how these occurrences can impact adversely upon pregnant women's ability to undergo a safe and timely procedure and to an evaluation of the legal responses to problems posed by anti-abortion protests. This leads into an examination of the legal responses to protecting women's autonomy.

### *2 Intimidation and Violence*

The use of intimidation and violence in promoting the objectives of the right to life campaigns has not been restricted to one country.[386] Concerns about violence are apparent in Australia,[387] NZ,[388] the UK[389] and Ireland.[390] However, physical violence has been more prevalent in the USA and Canada.[391] It has been almost 'normalised'[392] in the USA where it is being identified as a form of 'domestic terrorism'.[393]

385 It is noted here that the activities impinge upon all persons who need to access these premises.

386 The term 'violence' is used to include physical violence and also emotional violence and including intimidation unless otherwise indicated.

387 See eg, *R v Knight* [2002] VSC 498; Georgie Gardner, 'Violent protest: Melbourne CBD had been brought to a standstill during a crash between pro-choice and anti-abortion campaigners' *National Nine News* (RMIT Publishing, Melbourne (Vic), 2013) (online).

388 Dame Margaret Sparrow, 'Creaking at the seams: changing New Zealand's access to abortion care' (2013) *Conscience* 19, 20.

389 Sian Harrison, Cathy Gordon, 'Create protest-free 'safe zones' outside every abortion clinic, campaigners urge Priti Patel' Independent, UK; 21 August 2019 (online).

390 Unknown, 'What could Ireland's abortion exclusion zones look like? Irish News *The Journal IE* 23 February 2019 (online); Ailbhe Conneely, Social Affairs & Religion Correspondent, 'Renewed call for safe access zones for abortion services'. News RTE 6 January 2020 (online).

391 See National Abortion Federation, 'Violence Statistics & History' 2018 (online); Jocelyn Downie and Carla Nassar, 'Barriers to Access to Abortion Through a Legal Lens' (2007) 15 *Health Law Journal*, 143,146-147.

392 David S Cohen and Krysten Connon, *Living in the Crosshairs: The Untold Stories of Anti-Abortion Terrorism* (Oxford University Press, 2015) 378; Bray, *Time to kill*, above n 407.

393 L Ross, 'Get Ready for Anti-Abortion Terrorism' (2018) 42 (9) *In These Times* 16, 17; Kimberly Hutcherson, 'A brief history of anti-abortion violence' *CNN Wire* 30 November

### a The USA and Canada

The USA and Canada provide starting points for a consideration of how the violence of anti-abortionist protagonists hinder access to abortion and impinge upon pregnant women's autonomy. A brief background to the situations in those countries gives an indication of why violence was adopted as an anti-abortion tactic, what the governmental responses have been to the problem, and the likelihood that violence will continue or even escalate in the future.[394]

The recognition of a woman's right to abortion as a constitutional right to privacy, in *Roe v Wade,* in the USA in 1973, has been identified by some as being the impetus for increased anti-abortion activism.[395] After *Roe* v *Wade*, anti-abortion proponents, in the USA and Canada, became more vocal and less passive in their efforts to prevent abortion.[396] In 1994, Canadian Adams J, in a case involving anti-abortion protest, provided an historical context which gives an insight into the problematic nature of the dispute between those who support women's autonomy and the anti-abortion groups.[397] Adams J considered that the liberalisation of abortion provided the motivation, for persons whose morals and/or religion prohibited abortion, to use all means necessary to return abortion to what they considered its appropriate status; 'simply wrong' and murder. To some, violence was not only appropriate, but it was necessary to promote a return of abortion to its former status as a criminal offence.[398]

2015, (online); Marshall H Medoff, 'The impact of anti-abortion activities on state abortion rates'(2003) 32 (3) *The Journal of Socio-Economics* 265; see Ronli Sifris, *Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinisation of Torture* (Routledge, 2014) 1.

394 Mireille Jacobson and Heather Royer; 'Aftershocks: The Impact of Clinic Violence on Abortion Services' (2011) 3 (1) *American Economic Journal: Applied Economics* 189.

395 Ibid; Jacobson and Faye Ginsburg, 'Rescuing the Nation: Operation Rescue and the Rise of Anti-Abortion Militance' in Rickie Solinger (ed) *In Abortion Wars: A Half Century of Struggle 1950-2000*. (University of California Press, 1998) 227.

396 See National Abortion Federation, 'Violence Statistics & History', these statistics include both the USA and Canada. 2018 (online).

397 *Ontario (Attorney General) v Dieleman* (1994) 117 DLR (4th) 449,452 – 473.

398 *Ibid.*

> Violence and intimidation became widespread. Well organised protest blocked access to abortion clinics and other premises. The resulting situation was that all the anti-abortion campaigns were having an impact but that this impact, had by 1994, become a threat to national security and the existing legislation was deemed inadequate to control this problem.[399]

By 1994, the American government needed to protect those attending places where abortions were performed. However, at the same time, laws which impinged upon the constitutional right of 'freedom of speech', could not be enacted. Thus, the rights 'to bodily integrity'[400] and to 'freedom of expression' were directly in conflict. In response, the Federal government passed the *Freedom of Access to Clinic Entrances Act* (FACE) to protect those who accessed the medical premises, from anti-abortion demonstrations.[401]

### b Australia and the UK

Australia and the UK have not experienced the extreme level of physical violence as that in the USA or Canada.[402] Nevertheless, the controversy over abortion would not appear to be decreasing. The trend towards 'global' anti-abortion activism is considered to be increasing and is no longer restricted to a particular geographical region. Rather protestors are becoming active in promoting the anti-abortion cause worldwide. In this they are facilitated by modern technology which allows for the almost instantaneous

399 See Heather J Blum-Redlich, 'Validity, construction, and application of Freedom of Access to Clinic Entrances Act (FACE) (18 USCA § 248)' (1996) 134 *ALR (Database)* 507 for cases on constitutional challenge; see also Dane E Johnson, 'Cages, Clinics, and Consequences: The Chilling Problems of Controlling Special-Interest Extremism' (2007) 86 *Or L Rev* 249, 250, 263-264, 267-272.

400 Being able to access premises without interference is also a right to bodily integrity or freedom of movement; it is a human right and was held to be a right to privacy under *Roe v Wade.*

401 *Freedom of Access to Clinic Entrances Act of 1994* (*FACE*) (18 USCA § 248) discussed below under 4 – Legislation; see National Abortion Federation, FACE Fact Sheet for a summary of and information on the Act (online).

402 The discussion here will not include NZ and Ireland which face similar problems as Australia and the UK.

dissemination of their activities. Australia, the UK and elsewhere are likely to see increased anti-abortion activity that brings with it the potential for violence.[403]

Australia has experienced violent incidents which indicate that there is a possibility that further violence will occur. This may be seen from an incident which occurred in 2001. Peter Knight shot and killed a security guard at a well-known fertility clinic in East Melbourne, Victoria.[404] Knight had an anti-abortion obsession and involved in demonstrating against abortion in both Sydney and Melbourne. He considered that any person who had anything to do with abortion clinics were part of the 'abortion racket'.[405] He went to the clinic armed with a rifle and an assortment of flammable and other devices concealed in two bags. His intention was to massacre both staff and patients at the clinic. Some 41 people could have been killed. A security guard challenged Knight who shot and killed him. Knight was eventually overpowered by people in the clinic.

In sentencing Knight to 23 years' imprisonment, Justice Teague noted that the impact upon those present and affected was serious. He said that:

> [T]hey speak of depression, anxiety, fear, anger and more. They speak of sleepless nights, nightmares, hypervigilance, and other devastating consequences.[406]

Knight's case was tragic and showed the potential for fatal violence where beliefs become obsessions. It illustrates the irony of using murder as a method to promote the 'right to life' and that devout beliefs which result in killings are not restricted to any particular group, individual or location.

Adams J had correctly noted that 'abortion has troubled almost all societies'[407] not only Canada and America. *Knight* reaffirmed that violence may occur irrespective of geographical location and local culture.[408] It also revealed that there are some common social mores; particularly the stereotypical attitudes to women who have abortions as abnormal, selfish and failing to fulfil their role as mother and home maker. It is clearly

403 See Part 5 of this Chapter.

404 *R v Knight* [2002] VSC 498 (*Knight*).

405 Ibid [16].

406 *Ibid* [15]; Rebecca Dean and Susie Allanson, 'Abortion in Australia: Access Versus Protest' (2004) 11 *Journal of Law and Medicine* 510, 512.

407 *Ontario (Attorney General) v Dieleman* (1994) 117 DLR (4th) 449,452 [7].

408 Rebecca Dean (n 409).

perceived that anti-abortionists believe that abortion is murder and that the woman and the people who assist in the abortion are guilty of murder. What is not made clear however is the claim that they believe in and promote the sanctity of life. The question remains how can murder of people at a reproductive rights clinic law claim to be promoting the value of life.

Aggression by anti-abortion protestors in Australia was not novel before or after *Knight*. There had been other instances of violent protest. A well-known example of violence was that directed at Dr Bertram Wainer, who from at least 1967 up until his death in 1987, had been active in seeking the decriminalisation of abortion. He was well-known for promoting the rights of women to have free and safe access to legal abortion and as the founder of Fertility Control Clinic (FCC) in Melbourne in 1972.[409] Dr Wainer had received death threats and there were attempts on his and other's lives during the time he operated the clinic. [410] Knight was known to have demonstrated at these premises before he murdered a security guard in 2001.[411]

The FCC was integral to the establishment of safety zone access. It had been subjected to protests and threats since it commenced operation in 1972. [412] The impact of the almost daily protests outside clinics became the central focus of *Fertility Control Clinic v Melbourne City Council* in 2014.[413]

409 Jo Wainer, 'Lost: Illegal Abortion Stories' (2007) 15 (29) *Reproductive Health Matters* 155, 159; Sarah Stephen, 'Abortion rights under threat' *Green Left Weekly* 25 July 2001 (online).

410 Richard Evans, 'Wainer, Bertram Barney (1928–1987)', Australian Dictionary of Biography, National Centre of Biography, (Australian National University, 2012); P Anderson, 'Death threat charges' *Herald Sun* 27 July 2006, 7.See photo and caption in Neil McMahon, 'Voyage Around My Father' *The Age* 4 November 2012. His wife Dr Jo Wainer was also subjected to death threats and attempts on her life. Not all of these threats were from anti-abortionists. Some were as a result of allegations of police corruption and backyard and doctors who performed illegal abortions for profit.

411 Knight [6] – [8]; see (n 455).

412 Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 (2) *Monash University Law Review* 317, 322-325

413 *Fertility Control Clinic v Melbourne City Council* [2015] VSC 424.

The clinic has always provided a wide range of services which are unrelated to abortion.[414] It provides pregnancy termination and other health services including contraception, vasectomies, treatment for spontaneous miscarriages, pap smear tests, sexually transmitted infection screening and treatment, pregnancy ultrasounds, counselling, infertility treatment, and health referrals. Thus it focusses upon various health needs of which abortion is one. Nevertheless, anti-abortion groups and individuals maintained a regular and ongoing campaign against abortion at the clinic. Although the number varied there were protestors on the footpath outside the clinic almost every day it was open. On one day each month there were around 100 protestors. Over the years, the protests caused a great deal of stress, anxiety and nuisance to those needing to access the clinic.[415]

In March 2013, the FCC wrote a letter to the Melbourne City Council (MCC) reporting that the protestors were causing high levels of distress, anxiety, intimidation, fear and anger.[416] They wrote again later that year and attached several statements from witnesses who worked at, were patients at, or otherwise visited the clinic.[417] They noted that the protests had been going on for many years and had become intolerable. Their complaint was that the protestors maintained a high presence at the site:

> at all times during its operating hours, of harassing and imposing unwelcome attention on people entering the premises; engaging in confrontational behaviour; blocking and otherwise preventing access; displaying highly graphic posters and photos; engaging in confrontational behaviour; singing and chanting where they could be heard inside the clinic; and behaving in a manner which was injurious to the safety and comfort to anyone who was in the vicinity'.[418]

The result of the behaviour was to 'make patients and people accompanying patients to feel high levels of psychological distress, including feeling uncomfortable, annoyed and hurt'.[419] The council declined to act advising that the complaint, if substantiated, was a private nuisance and the appropriate action was to report the behaviour to the police.

414 See Fertility Control Clinic (online).

415 Jo Wainer, *Lost: Illegal Abortion Stories* (MUP, 2006).

416 *Fertility Control Clinic v Melbourne City Council* [2015] VSC 424, [14].

417 Ibid.

418 Ibid.

419 Ibid.

In March 2014, the FCC applied to the Supreme Court of Victoria for an order that the MCC perform their duties and remove the protestors, whose actions constituted a nuisance, from outside the premises.[420] In handing down his decision, in August of 2015, Justice McDonald recognised the public element of the behaviour when he said:

> prima facie, such conduct is a private nuisance by reason of impeding the Clinic's enjoyment of its property and a public nuisance by reason of the elements of annoyance, inconvenience or hurt to members of the public.[421]

However, his Honour did not order the MCC to remove the protestors, holding that although the MCC had been wrong in their advice that the nuisance was a matter for the police, it had not failed to perform its duties.

Having been denied a remedy in the courts the issue became political and the government was called upon to enact legislation to solve the problem of access to the clinics posed by the anti-abortion protestors. The Victorian Parliament responded by enacting the *Health and Wellbeing Amendment (Safe Access) Act 2016* (Vic)[422] which made protesting outside premises which provided reproductive services an offence.[423]

Violence by anti-abortion protestors has not been prominent in the United Kingdom. However, it has been asserted that the issue of abortion protest has had detrimental effects upon both women seeking abortion services and others visiting or working at institutions which provide abortion services.[424] Allegedly, American anti-abortion

420 Ibid [3].

421 Ibid [18] 5A.

422 *Public Health and Wellbeing Act 2008* (Vic) s185A (1) (i), the legislation is to protect all those who need to attend the premises for reproductive services, employment or some other valid reason, s185 (1) (ii).

423 This legislation is discussed below at F 2 (d) (ii).

424 Claire Murphy, 'Miss-information: increased scrutiny reveals the deceptions and aggressions of antiabortion activists in the UK' (2017) 38 (1) *Conscience* 21.

groups are helping to fund protests in the UK[425] which were clearly intended to cause disruption. .[426]

Methods reportedly used by protestors in the UK are unsettling rather than physically violent. The protests are usually quiet and peaceful, but they include the distribution of plastic life-sized foetuses to those who attend the clinic. Pamphlets with detailed information and pictures of foetuses and abortions are handed out. Protesters counsel women who attend the clinics. Some anti-abortion protestors have gained employment in clinics where the NHS has referred women who seek abortions.[427]

One such anti-abortionist appears in a documentary giving advice to pregnant women that abortions cause breast cancer.[428] The political campaign for legislation to provide for 'bubble zones' to protect women s has been gaining support.[429]

In April 2018 the Ealing City Council unanimously voted to impose 'a public spaces protection order (PSPO)' to protect those attending the Marie Stopes Clinic from

425 Janice Turner, 'Charlie Gard and the pro-life lobbyists - The US right has elbowed its way to a British baby's bedside and it has a troubling agenda' *The Times,* (London, England) 12 July 2017, 2-3; Cathy Newman, *Undercover – Britain's Abortion Extremists*, TV, Documentary, 5 October 2016 (online).

426 David Sanderson, 'Abortion protesters force clinic to close' *The Times* 21 July 2015.

427 Nick Craven, 'NHS sends vulnerable women to a pregnancy advice service run by anti-abortion fanatics' The Mail on Sunday, *Australia Daily Mail* 2 October 2016.

428 Kelly-Anne Phillips, Fiona J Bruinsma and Roger L Milne, 'Abortion and Breast Cancer Risk for Australian Women' (2014) 201 (17) *Medical Journal of Australia* 381; Huazhang Tong et al 'No association between abortion and risk of breast cancer among nulliparous women' (2020) 99 (19) Medicine e20251 (online) Analysis by Bazian 'Abortion and breast cancer controversy' NHS Website, 8 October 2007 (online); cf Joel Brind, 'Abortion-Breast Cancer Link (ABC Link): Review of Recent Evidence from Asia' (2017) 32 (2) *Issues in Law & Medicine* 325

429 Cathy Newman, 'Cathy Newman: What happened the day I confronted a zealous anti-abortion protester', *The Telegraph*, 5 October 2016; Claire Murphy, 'Miss-information: increased scrutiny reveals the deceptions and aggressions of antiabortion activists in the UK' (2017) 38 (1) *Conscience* 21.

intimidation and harassment from ant-abortion protesters. [430] The order was the first of its kind in the UK and more may be implemented by other councils.[431]

In May 2018 the validity of the PSPO was challenged in the courts by two representatives of the Good Counsel Network (GCN) an anti-abortion local organisation which may have 'some connection' with 'a charity known as the Guild of Our Lady of Good Counsel'.[432] This was an interim hearing before Holman J asking to suspend the PSPO until the full hearing of the challenge to its validity.[433]

Turner J delivering his judgment on 2nd July 2018 declined to quash the PSPO either 'in whole or in part on this challenge' [434] but stated that:

> [m]y conclusions in this case do not give the green light to local authorities to impose PSPOs as a matter of course upon areas in the immediate vicinity of abortion clinics. Each case must be decided on its own facts.[435]

In August 2019 the Court of Appeal unanimously upheld the validity of the PSPO.[436] The decision received support for unified legislation to be enacted for the UK.[437] In their joint judgment Sir Terence Etherton MR, Lady Justice King and Lady Justice

430 Frances Gibbs and Jonathan Ames, 'Protest ban at abortion clinic is challenged' *The Times* 28 April 2018.

431 Jessica Elgot and Nicola Slawson, 'Ealing council votes for UK's first 'safe zone' around abortion clinic' *The Guardian*, 11April 2018; Sarah Marsh, 'Abortion clinic buffer zones being considered by more councils' *The Guardian,* Mon 23 Apr 2018; Katie Frost, 'A second abortion clinic 'safe zone' has been imposed by a London council -Anti-abortion campaigners have been banned from demonstrating outside the clinic.' *Cosmopolitan* 6 March 2019.

432 *Dulgheriu & Anor v London Borough of Ealing* [2018] EWHC 1302 (Admin) (24 May 2018) Holman J [62].

433 Ibid [12]-[14].

434 *Dulgheriu & Anor v London Borough of Ealing* [2018] EWHC 1302 (Admin) (24 May 2018) (Holman J); *Dulgheriu & Anor v The London Borough of Ealing* [2018] EWHC 1667 (Admin) (02 July 2018) (Turner J) [98].

435 *Dulgheriu & Anor v The London Borough of Ealing* [2018] EWHC 1667 (Admin) (02 July 2018) (Turner J) [99 (iii)].

436 *Dulgheriu & Anor v The London Borough of Ealing* [2019] EWCA Civ 1490 (21 August 2019).

Nicola Davies identified two important issues. The first involved whether the PSPO was a valid exercise of the local authority's powers. The Court found that it was within the council's powers. Having decided the first question in the affirmative the Court addressed the respective rights under Articles 8, 9, 10 & 11 of the ECHR.

Article 8 provides for the right to privacy and family life. The Court stated.

> There is no right to protection, however, unless there is a reasonable expectation of privacy or, which the authorities treat as synonymous, a legitimate expectation of protection[438]

After considering the reasons for the visits by the women to the clinic and reviewing the uncontradicted and lengthy list of behaviours by the protestors their Honours concluded that the demonstrators

> engaged the article 8 rights of those visiting the Centre both from the perspective of the right to autonomy on the part of service users in wishing to carry through their decision to have an abortion and from the reasonable desire and legitimate expectation that their visits to the Centre would not receive any more publicity than was inevitably involved in accessing and leaving the Centre across a public space and highway.[439]

However, that did not conclude the matter. It was necessary to consider the rights to religion, freedom of expression and assembly under articles 9, 10 and 11 respectively and assess whether or not PSPO was 'both a necessary and proportionate restriction' so as to fulfil 'the article 8 rights of women visiting the centre'.[440] The appeal was dismissed.

Both before and after *Dulgheriu & Anor v The London Borough of Ealing* there were calls for the UK government to pass uniform legislation to provide for safe access to clinics.[441] Formerly, these had resulted in inaction. In 2018 the former Home

437 Jessica Carpani, 'Abortion clinic buffer zones ruled legal by Court of Appeal as it says protesters can be forced 100m away', *The Telegraph* 21 August 2019.

438 *Dulgheriu & Anor v The London Borough of Ealing* [2019] EWCA Civ 1490 [57] (21 August 2019).

439 Ibid [58].

440 Ibid [63].

Secretary, Amber Rudd, conducted an enquiry into the need for access zones. The current Home Secretary dismissed the need for buffer zones reportedly stating that:

> These activities are not the norm and, predominantly, anti-abortion activities are more passive in nature," [he said]. "The main activities reported to us that take place during protests include praying, displaying banners and handing out leaflets. Having considered the evidence of the review, I have therefore reached the conclusion that introducing national buffer zones would not be a proportionate response.[442]

As could be expected there has been anger at this decision.[443] It will be of interest to see whether the government changes its approach.[444]

441 Sajid Javid, (The Secretary of State for the Home Department), 'Outcome of the Abortion Clinic Protest Review: Written statement' - HCWS958 (13 September 2018); Sophie Goodchild, '120,000 back protest 'buffer zones' to protect abortion clinic visitors' *The London Evening Standard* 10 March 2015, 26; Francesca Robinson, 'Should doctors support restrictions on anti-abortion protests? The idea of buffer zones to prevent picketing around abortion clinics is gaining traction.' (reports on the feelings of doctors on both sides of the fence) (2017) 359 *British Medical Journal* 5070.

442 Anon, 'Buffer zones at abortion clinics dismissed by Javid' *Times* [London, England], 14 September 2018 (online); Katie Frost, 'Second abortion clinic 'safe zone' has been imposed by a London council. Anti-abortion campaigners have been banned from demonstrating outside the clinic' *Elle News* 6 March 2019 (online).

443 United Kingdom Parliament, 'Diane Abbott response to Sajid Javid's rejection of abortion clinic buffer zones' *MENA Report*, 2018; L Hughes, 'UK rejects calls for buffer zones outside abortion clinics' *The Financial Times Limited* 13 September 2018; Annabel Sowemimo, 'I provide abortions, and can confirm the UK doesn't have it much better than the US' *The Independent* (London, England), 22 May 2019.

444 Vincent Wood, 'Government review of abortion clinic buffer zones 'misrepresents impact of protestors on patients: Renewed call for better protections comes after targeted campaign against Labour MP by anti-abortion activists' *The Independent* 8 October 2019; Unknown, 'In the face of anti-abortion groups, we must stand up for the right to be pro-choice' *The Independent* [London, England], 7 October. 2019, 22.

### *3 Protection, Dilemmas and Concerns*

The foregoing analysis of anti-abortion activities clearly illustrates that they deliberately adversely affect pregnant women's autonomy, as well as interfering with the rights of other persons attending reproductive clinics. The targets of the protests are usually, but not always, clinics or individual medical practices. In other words, they are not located within or are part of larger institutions and may be considered 'easy targets. [445] The security they can provide is often minimal. They are usually easy to locate which is necessary for women using the services.

Clinics, by their very nature must be and are easily identified as providing reproductive services. Names such as 'fertility clinic', 'family planning', 'planned parenthood', and/ or a name which is synonymous with the provision of reproductive service are used; for example, 'Marie Stopes' directs attention to the nature of the medical services provided. Any attempts to make the clinics location and the services they offer 'anonymous' would be unsatisfactory and may give the appearances of a return to the era of the furtiveness of the backstreet or backyard abortionist'.[446] Further it may exacerbate rather than remove the stigma attached to those involved in terminations of pregnancy.[447]

It is often not as easy to identify those hospitals which provide terminations. However, once an institution has been identified as performing termination procedures it may become a target of protest. This was evidenced by the demonstrations against the Royal Women's Hospital in Victoria in 2000.[448]

Doran et al have argued that the procedures should be provided 'as part of a multidisciplinary clinic so they are less stigmatised and better integrated with a mainstream service'.[449] This would be appropriate when the institution is a hospital.

445 Eg, Marie Stopes International Clinics, https://www.mariestopes.org .

446 Gideon Haigh, *The Racket: How Abortion became Legal in Australia* (MUP,2008): Caroline De Costa, *Never, Ever, Again: Why Australian Abortion Law Needs Reform* (Boolarong Press, 2010).

447 *Health (Patient Privacy) Bill 2015* (ACT) Mr Rattenbury, Presentation Speech to Legislative Assembly 17 September 2015, 3155.

448 Paul Gerber, 'Late-term abortion: what can be learned from Royal *Women's Hospital v Medical Practitioners Board of Victoria*?' (2007) 186 (7) *Med J Aust* 359.

449 France Doran and Susan Nancarrow, 'Barriers and facilitators of access to first-trimester abortion service for women in the developed world: a systematic review', (2015) 41 J *Fam*

However, independent or isolated clinics, as pointed out above, routinely perform a wide variety of health and reproductive services but anti-abortionists tend to ignore this fact. People ought to have the choice of where they wish to receive medical treatment. Therefore what is required is that their patients should be able to access these without intimidation.

### *4 Legislation*

The response to the problems posed by the protestors has been to create 'access', 'bubble', 'buffer' or 'no-go' zones or areas where certain behaviours are deemed criminal.[450] The provisions of the jurisdictions have the same objective of allowing unhindered access to premises where reproductive services are offered and but vary in detail. USA and Australia are considered here as being representative of the approaches taken. The development of the USA's legislation to allow for unhindered access to premises that provide reproductive services was occurring earlier than in Canada and Australia so it will be considered first.

#### a The USA

The response of the USA Federal government was to enact the *Freedom of Access to Clinic Entrances Act of 1994* (*FACE*).[451] *FACE* makes it illegal to use force, threats or obstruction to hinder or prevent access to clinics providing 'reproductive health services'.[452] A person who contravenes the Act may be held criminally and/or civilly liable. Since 1994, there have been numerous challenges, by anti-abortionists, to the constitutionality of the Act. The challenges have been based upon the right to freedom of speech, the right to privacy, freedom of religion and the freedom of movement. *FACE* has

*Plann Reprod Health Care* 170, 178.

450 The language used and the content of the provisions vary as between jurisdictions.

451 18 USCA §248; See Kelly Jo Popkin, 'FACEing Hate: Using Hate Crime Legislation to Deter Anti-Abortion Violence and Extremism'(2016) 31 *Wis J L Gender & Soc'y* 103; In BC, Canada there have been exclusion areas since 1996 under the *Access to Abortion Services Act* (Bill 482), the legislation survived a constitutional challenge in the Supreme Court, see Joseph Brean 'Abortion protesters who thought they found loophole in 'bubble zone' law lose BC appeal' *National Post* Canada 29 April 2013.

452 Jennifer N Toussaint, 'Abortion Protesting' (2007) 8 *Geo J Gender & L* 129.

been found to be a valid exercise of Federal power,[453] although there are recent decisions to the contrary.[454]

Whether *FACE* has been successful in its objective of allowing unhindered access to abortion is unclear.[455] The imposition of sanctions may have brought about a decrease in the number taking part in 'violent' protest.[456] What has occurred is that there has been a change in the conduct of the anti-abortion campaigns. Blanchard suggests that the legal sanctions have left a smaller, but more radical, core of anti-abortion activists.[457]

As social movements decrease in popular support, they also tend to suffer from political sanctions. The increase in political sanctions and punishments for violations of law tend to lead to a decrease in the numbers of persons willing to suffer those sanctions. This, in turn, tends to further radicalize the remaining (but fewer) movement activists. Thus, such activists normally turn to more surreptitious but effective forms of protest, and

453 Ibid 134 – 137; Eg, *In American Life League v Reno* (1995, CA4 Va) 47 F3d 642, 134 ALR Fed 735, cert den (US) 133 L Ed 2d 19, 116 S Ct 55, held *FACE* did not violate the 1st,10th Amendments nor the *Religious Freedom Restoration Act*; *Hill v Colorado* 530 US 703 (2000); cf *Hoffman v Hunt* (1996) 923 F Supp 791 (WD NC) *FACE* violate 1st & 10th Amendments; *Madsen v Women's Health Ctr, Inc*, (1994) United States Supreme Court No 93-880

454 Eg, *Scheidler v National Organization for Women, Inc, Et Al* (2006) USSC No 04-1244; MAss GEN LAWS ch 266, § 120E /2 (2007), held unconstitutional in *McCullen v Coakley* 134 SCt 2518 (2014), repealed 2014 Mass Legis Serv ch 197 (West); see Susan L Gogniat, *'McCullen v Coakley* and Dying Buffer Zone Laws' (2015) 77 *U Pitt L Rev* 235 for discussion of the extent of the invalidity; see also use of injunctions in Jennifer N Toussaint (n 482) 137 – 140; see also use of anti-racketeering laws in Jennifer N Toussaint (n 482) 140 – 144.

455 Scott Lybarger, 'The Freedom of Access to Clinic Entrances Act: Regulating Violence or Restricting Expression' (1997) 35 *Free Speech Year Book* 56.

456 Kelly Jo Popkin, 'FACEing Hate' above n ,105; Dallas A Blanchard, The Anti-Abortion Movement and the Rise of the Religious Right: from Polite to Fiery . (Twayne Publishers ; Maxwell Macmillan Canada ; Maxwell Macmillan International, 1994.) Deana A Rohlinger, *Abortion Politics, Mass Media, and Social Movements in America* (Cambridge University Press, 2014).

457 Blanchard (n 460) 76.

frequently assume the tactics of small cells of radicals resembling the militia tactic of a 'leaderless resistance'.[458]

The numerical diminution of violent protestors does not necessarily mean that the overall number of those who oppose abortion has diminished. It does show that *FACE*, whilst having an impact upon those who do not want to be prosecuted, has not solved the problem of violence. What is problematic is identifying further measures that will prevent violence by a 'fanatical' anti-abortion campaigner.[459]

**b Australia**

In Australia, the ACT,[460] Tasmania,[461] Victoria,[462] the NT,[463] NSW,[464] and Qld[465] have legislation to protect those who require access to premises where reproductive services are provided. Currently South Australia has legislation before parliament which will provide for safety zones[466] and WA is conducting an inquiry into the establishment of safe access zones.[467]

458 Jennifer L Jefferis. Armed for Life the Army of God and Anti-abortion Terror in the United States. PSI Guides to Terrorists, Insurgents, and Armed Groups. Santa Barbara, Calif.: Praeger, 2011.) xiv,92.

459 Susan Ronn, '*FACE-ing RICO: A Remedy for Antiabortion Violence*' (1995)18 *Seattle U L Rev* 357, 388; Joy Hollingsworth McMurtry and Patti S Pennock '*Ending the Violence: Applying the Ku Klux Klan Act, RICO, and FACE to the Abortion Controversy*' (1995) 30 *Land & Water Law Rev* 203, 230.

460 *Health Act 1993* (ACT) part 6.2, ss85-87.

461 *Reproductive Health (Access to Terminations) Act 2013 (Tas) s9.*

462 *Public Health and Wellbeing Act 2008* (Vic) Part 9A – ss185A-185H.

463 *Termination of Pregnancy Reform Act 2017* (NT) Part 3, ss14-16; Anonymous, 'Australia's Northern Territory Decriminalises Abortion, Introduces Buffer Zones Around Abortion Clinics' *States News Service* 24 March 2017.

464 *Public Health Act 2010* (NSW) Part 6 A; Lisa Visentin, 'NSW Upper House passes abortion exclusion zones bill' *Sydney Morning Herald* 24 May 2018.

465 *Termination of Pregnancy Act 2018* (Qld) Part 4, ss11-16.

466 Health Care (Safe Access) Amendment Bill 2020, 2nd Reading 22 July 2020, Committee stage adjourned 2 September 2020

467 *Safe access zones – A proposal for reform in Western Australia* Department health WA 10 February 2020;Roger Cook, MLA & Simone McGurk, MLA, 'Safe access zones around sexual health clinics in Western Australia move a step closer' Western Australian Government

Tasmania was the first state to provide for safety access zones. In 2013, the government included provisions to ensure safe access to medical premises in the *Reproductive Health (Access to Terminations) Act 2013*, which also legalised abortion.[468] It 'indicated that patients experience considerable distress, shame and anxiety' and 'stigma as a result of the behaviour of the protestors'.[469]

Previously, in 2007, the Law Reform Commission of Victoria (VLRC*)* [470] discussed the implementation of 'safe access zones'.[471] Whilst not formally recommending legislation for safe access zones the Commission encouraged the government to consider the matter.[472] It took almost another nine years before the government acted on the issue. The *Fertility Control Clinic v Melbourne City Council*[473] case in 2014, discussed earlier, provided the impetus for the introduction of 'safe access zones' in Victoria, in 2015.[474]

In 2002, the ACT decriminalised abortion but did not provide for safety zones. In 2015, it passed the *Health (Patient Privacy) Act 2015* (ACT) in response 'to community concerns about particular intimidating and harassing conduct occurring outside approved health facilities'.[475] In doing so the government recognised that the behaviours of the anti-abortionists were likely to be stressful for all persons who needed to access the clinic. Pregnant women's autonomous rights were regarded as highly important. It

Media Release, 17 April 2019;Human Rights Law Centre, 'Safe Access to Abortion in Western Australia – Response to the Department of Health Discussion Paper on Safe Access Zones' 31 May 2019; The government had been awaiting the decision in *Attorney-General for the State of Victoria v Clubb & Anor; Clubb v Edwards & Anor; Preston v Avery & Anor* [2018] (23 March 2018) [2018] HCA Transcript 060; *Clubb v Edwards; Preston v Avery* [2019] HCA 11 (10 April 2019).

468 *Reproductive Health (Access to Terminations) Act 2013* (Tas) *s9.*

469 *Reproductive Health (Access to Terminations) Bill 2013* (Tas), 2nd Reading Speech. 16/04/2013

470 VLRC, *Law of Abortion, Final Report No15*; See Chapter 3 – The Legal Termination of Pregnancy.

471 VLRC, *Law of Abortion, Final Report No15*, 8.266.

472 Unfortunately, this was not included in the terms of reference of the VLRC.

473 *Fertility Control Clinic v Melbourne City Council* [2015] VSC 424.

474 See Sifris and Penovic, 'Anti-abortion' (n 364) 320-321. .

475 Mr Rattenbury, *Health (Patient Privacy) Bill 2015* (ACT) Presentation Speech to Legislative Assembly, Hansard 17th September 2015, 3155.

was noted that the protestors 'at worst, could prevent women from accessing a *legal* and medically recognised procedure'. [476]

In 2017 the Northern Territory enacted the *Termination of Pregnancy Reform Act 2017* which similarly provides for safe access zones.[477] Recently the NSW government passed the *Public Health Amendment (Safe Access to Reproductive Clinics) Act 2018(NSW)* which inserted Part 6A into the *Public Health Act 2010* (NSW) to provide safe access to health premises.

The safe access laws in Tasmania, Victoria, the NT, NSW and Qld are somewhat similar. In Tasmania it is an offence to 'engage in prohibited behaviour within an access zone'.[478] An 'access zone' is defined as 'an area within a radius of 150 metres from premises at which terminations are provided'. [479] 'Prohibited behaviour' is defined as including a variety of methods used by anti-abortionists in hindering and preventing people from freely entering medical premises. Such things as: 'besetting, harassing, intimidating, interfering with, threatening, hindering… impeding'; protesting; blocking the footpath; videoing or recording; and other, like behaviour, are included within the offence.[480] The offences are punishable by a fine of 75 penalty units and/or imprisonment for 12 months.[481] The NSW excludes the operation of the safety access provisions from places

476 Ibid.

477 *Termination of Pregnancy Reform Act 2017* (NT) ss4, 14, 15, 16.

478 *Reproductive Health (Access to Terminations) Act 2013* (Tas), S 9 (2); *Public Health and Wellbeing Act 198*0 (Vic) s185D; *Public Health Act 2010* (NSW) s98C-98D.

479 *Reproductive Health (Access to Terminations) Act 2013* (Tas), *Public Health and Wellbeing Act 198*0 (Vic) s185D; *Termination of Pregnancy Reform Act 2017* (NT) s4; *Public Health Act 2010* (NSW) s98A.

480 *Reproductive Health (Access to Terminations) Act 2013* (Tas), s9 (1); *Public Health and Wellbeing Act 1980* (Vic) S185B; *Termination of Pregnancy Reform Act 2017* (NT) s 14 (4); *Public Health Act 2010* (NSW) s98C-98D.

481 *Reproductive Health (Access to Terminations) Act 2013* (Tas), s9(2)-(4); *Public Health and Wellbeing Act 1980* (Vic) s185D provides for a maximum penalty of 120 penalty units or 12 months' imprisonment. See Div 6-2, ss85-87; *Termination of Pregnancy Reform Act 2017* (NT) s14(1) provides for a maximum of 100 penalty units or 12 months' imprisonment; *Public Health Act 2010* (NSW) provides for a maximum penalty of 50 penalty units and/or 6 months' imprisonment for a first offence and a maximum penalty of 100 penalty unit and/or 12 months' imprisonment for a subsequent offence.

of religious worship,[482] the environs of Parliament House[483] and activities such as the conducting of opinion polls on and distributing material relevant to elections.[484]

The ACT legislation is slightly different. Section 86 of the *Health Act 1993* (ACT) now provides that an area around approved medical premises may be declared, by the Minister for Health, as protected. This allows the needs of each premises to be assessed individually. It is an offence for any persons to behave in a manner which contravenes the legislation. 'Prohibited behaviour'[485] in the declared area and publishing 'visual data'[486] contravene the Act. The actions which constitute these offences are similar to those in Tasmania, Victoria, the NT, Qld and NSW include such things as: harassing, preventing or attempting to prevent people from entering the premises; filming of people in the defined area; publishing visual data of persons entering; and/ or protesting at 'declared premises'.[487]

It was predicted that the legislation could be challenged in the High Court as unconstitutional because of the implied right to freedom of political communication.[488] Jones noted that political communication has been considerably robust and at times insulting and offensive.

482 *Public Health Act 2010* (NSW) s98F (1)(a).

483 Ibid s98F (1)(b).

484 Ibid s98F (1)(c).

485 *Health Act 1993* (ACT) s87(1) a fine of up to 25 penalty units may be imposed.

486 *Health Act 1993* (ACT) s87(2) a fine of up to 50 penalty units and/or sentence of up to 6 months imprisonment may be imposed; *Termination of Pregnancy Reform Act 2017* (NT) s15 makes it an offence to publish material the penalty for which is up to 100 penalty units or 12 months' imprisonment; see also *Public Health Act 2010* (NSW) s98E.

487 *Health Act 1993* (ACT) s85(1).

488 See *Clubb v Edwards and Another (Clubb); Preston v Avery and Another (Avery)* (Matter No H2 of 2018) [2019] HCA 11; (2019) 366 ALR 1; Eleanor Jones, 'Comment: Implementing Protest-free Zones around Abortion Clinics in Australia' (2014) 170 (36) *Sydney Law Review* 169; see Adrienne Stone, 'Tasmania's Abortion Protest Law is Probably Constitutionally Valid' *The Conversation* 25 November 2013; cf Michael Stokes, 'Tasmanian Ban on abortion Clinic Protests May Not Be Constitutionally Valid' *The Conversation* 23 November 2013.

The High Court is unlikely to hold that the safety zone provisions are entirely unconstitutional as that would be allow unfettered protest to occur.[489] However the legislation provision may arguably impinge upon the '[f]reedom of communication on matters of government and politics'.[490]

The concept of the 'unwilling listener' has been used in the USA to justify a prohibition on speech where an individual has 'no ready means of avoiding the unwanted speech'.[491] This 'captive audience' approach has been widely accepted under Canadian law and applied in the context of 'bubble zones'.[492] It was recently raised in Australia in *Clubb v Edwards and Another* (*Clubb*); *Preston v Avery and Another* (*Avery*).[493]

Adams J, in the context of an injunction to prohibit abortion protests outside a clinic in Ontario explained

> that freedom of expression assumes an ability in the listener *not* to listen but to turn away if that is her wish. The *Charter* does not guarantee an audience and, thus, a constitutional right to listen must embrace a correlative right *not* to listen.[494]

489 Eleanor Jones, 'Implementing Protest-free Zones around Abortion Clinics in Australia' (2014) 36(1*) Sydney Law Review* 169, 178; *Reproductive Health (Access to Terminations) Act 2013* (Tas) (*RHAT Act 2013* (Tas)), s 9(1) (definition of 'Prohibited Behaviour' (b) a protest in relation to terminations that is able to be seen or heard by a person accessing, or attempting to access, premises at which terminations are provided; *Termination of Pregnancy Reform Act 2017* (NT) s14(4)(b).

490 *Lange* (1997) 189 CLR 520 at 559; see also at 557-559 per curiam (Brennan CJ, Dawson, Toohey, Gaudron, Mchugh, Gummow and Kirby JJ).

491 Eleanor Jones, 'Implementing Protest-free Zones around Abortion Clinics in Australia' (2014) 36(1*) Sydney Law Review* 169, 172, 181; referring to the case of *Frisby v Schultz*, 487 US 474, 487 (1988).

492 See *R v Spratt* (2008) BCCA 340; Black Jr, 'He Cannot Choose but Hear: The Plight of the Captive Auditor' (1953), 53 *Columbia L Rev* 960, 967 referred to by Madam Justice Ryan in *R v Spratt* [78].

493 *Clubb v Edwards and Another* (Matter No M46 of 2018) *Preston v Avery and Another* (Matter No H2 of 2018) [2019] HCA 11; (2019) 366 ALR 1,27 [98] per Kiefel, CJ, Bell,J, and Keane J 47-48 [193]-[195] per Gageler J; The approach was alluded to in *Attorney-General (SA) v Adelaide* (2013) 87 ALJR 289, 308 [54] (French CJ).

494 *Ontario (AG) v Dieleman* (1994) CanLII 7509 (ON SC),117 D.L.R. (4th) 449 (Ont Gen Div).

The argument is that protests near clinics would make those entering them 'unwilling listeners' and compelling people to listen 'destroys and denies, practically and symbolically, that unfettered interplay and competition among ideas which is the assumed ambient of the communication freedoms'.[495]

WA and SA have not as yet enacted safety zone legislation and therefore need to use existing laws which control behaviour in public places.[496]

Similar laws were used in Queensland prior to the 'bubble zone' legislation.[497] Preston is a very active anti-abortion whose conduct has resulted in several court appearances dating to early this century.[498]

In 2010 in *Preston v Parker,* [499] Preston appealed against a conviction in the Magistrates' Court for trespass under the *Summary Offences Act 2005* (Qld).[500] He sat on the steps of a clinic to prevent access to it. Constable Parker requested he move. Preston refused and was subsequently charged with trespass. Preston was not charged with failing to comply with the lawful directions of police because it was private property. His appeal was dismissed and his sentence of 4 months' imprisonment was confirmed.

495 See *R v Spratt* (2008) BCCA 340.

496 Eleanor Jones, 'Implementing Protest-free Zones around Abortion Clinics in Australia' (2014) 36(1*) Sydney Law Review* 169, 172-174; E.g., *Summary Offences Act 1953* (SA) 6A Violent disorder, s7 disorderly or offensive conduct or language, s17A Trespassers on premises,s18 Loitering, s58 Obstruction of public places and see PART 14B--Declared public precincts; *Criminal Code Compilation Act 1913* (WA) s74A. Disorderly behaviour in public, s 5A out-of-control gathering, s70A Trespass, Unlawful assembly, breach of the peace ss 62-64.

497 Mark Bowling, 'Graham Preston facing arrest if he continues his pro-life activism for the unborn in Queensland' The Catholic Leader (21 November 2018)

498 *Police v Preston*, unreported, Irwin CM, Bris-Mag 00028810; Mag 00174208/03(4), 3 March 2004.

499 [2010] QDC 264 (24 June 2010).

500 *Summary Offences Act* 2005 (Qld) s 11(2)provides (2) A person must not unlawfully enter, or remain in, a place used for, a business purpose.

In 2012, Preston was reportedly sentenced to eight months in jail for not paying accrued fines of around $8000.[501] He continued to be a zealous campaigner for the anti-abortion cause and did not restrict his protesting activities to QLD.

In 2014, Preston was seen breaching the access zone laws by holding up placards and distributing leaflets within a 150m area of the clinic in Hobart. He was again arrested in 2015. On this occasion he was accompanied by two other protestors. They were holding up placards which promoted their anti-abortion message and were pictorially very graphic. A police officer directed them to leave the area for a period of 8 hours. They refused and were eventually charged with an offence under the *Reproductive Health (Access to Terminations) Act 2013* (Tas) and failing to obey police directions. In 2016 all three were found guilty by the Hobart Magistrates' Court. Preston and fined $3000 under section 9 (2) of the Act.[502]

Preston challenged the Tasmanian safety zone legislation as unconstitutional.[503] His appeal was one of two cases which raised constitutional questions and were heard simultaneously by the High Court.[504] The other matter was that of an appeal against the conviction of Clubb under section 185D of the *Public Health and Wellbeing Act 2008* (Vic).[505]

In 2016 Kathleen Clubb, an active anti-choice protestor, was arrested when she attempted to hand out leaflets to a couple outside the Fertility Control Clinic in East Melbourne. On the 11th October 2017 she was convicted and fined $5000.

Penovic and Sifris have stressed the importance of the conviction.

501 Kathy Sundstrom, 'Pro-life protester jailed' *Sunshine Coast Daily*, 3 May 2012.

502 S9; Unknown 'Aussie fined for violating 'bubble zone' at Tasmania abortion facility' *LifeSite News* 28 July 2016; Angela Shanahan, 'Free speech against abortion hasn't got a prayer' *The Australian*, 30 July 2016;

503 See *Preston v Avery & Anor* (2018) H2/2018; Patrick Billings, 'Pro-life protester John Graham Preston in court challenge' *Mercury* 18 October 2016.

504 *Attorney-General for the State of Victoria v Clubb & Anor; Clubb v Edwards & Anor; Preston v Avery & Anor* [2018] (23 March 2018) [2018] HCA Transcript 060.

505 Edwards v Clubb M/46 2016 Unrep.

> The court's decision is a victory for women's right, upholding the right to access health services free of intimidation or harassment and with due respect for women's privacy, dignity and reproductive autonomy.[506]

Clubb filed a notice of appeal in the Victorian Supreme Court and since the case involved questions of constitutional law it was removed to the High Court and was heard together with the appeal by Preston.[507]

In April 2019 the High Court handed down its decision in *Clubb v Edwards (Clubb); Preston v Avery (Preston).*[508] Clubb had challenged the validity of section 185D of the *Public Health and Wellbeing Act 2008* (Vic) which made it an offence to communicate 'by any means' in respect of abortion within a safe access zone. Preston claimed that section (9) (2) of the *Reproductive Health (Access to Terminations) Act 2013* (Tas) breached the implied freedom of political communication. He had raised this argument in the Courts below.[509]

The High Court had to decide whether the relevant laws in each case, 'unduly burdened' the implied freedom of political communication under the Constitution.[510] The Court unanimously upheld the validity of the laws. However, this does not mean that there will be no further challenges to the safety zone legislation. There are numerous issues which may be relevant in predicting the occurrence of a further successful/unsuccessful appeal to the High Court on the questions of constitutionality. Two will be considered here. The first has to do with the decision of the Court itself and the extent to which it has settled the law. The second has to do with differences between the legislation of the states and territories and whether the lack of uniformity may have an adverse impact upon safety zone legislation.

506 Tania Penovic and Ronli Sifris, 'Anti-abortion protesters have acted with impunity for decades. That ends now' *The Guardian* 13 Oct 2107; Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317, 328-329.

507 *The Judiciary Act* 1903 (Cth) s40.

508 [2019] HCA 11 (10 April 2019); (2019) 366 ALR.

509 (2019) 366 ALR 1,

510 *Clubb v Edwards and Another* (Matter No M46 of 2018) *Preston v Avery and Another* (Matter No H2 of 2018) [2019] HCA 11; (2019) 366 ALR 1,38-39 [155]-[156].

First, it may be accepted that their Honours were unanimous in holding that the impugned sections were valid and in upholding the convictions in *Clubb* and in *Preston*. However, the differences in reasoning and analysis may be of importance in future challenges. As Alex Deagon has pointed out that:

> The uniformity in the final outcome belies the complexity and balancing with which the Court engaged, and the Judges' different methods of doing so.[511]

The High Court delivered five judgments: Kiefel CJ, Bell and Keane JJ (joint judgment); Gageler J; Nettle J; Gordon and Edelman JJ. It is well established there is an implied recognition of freedom of political communication under the Australian Constitution.[512]

The threshold question for the Court, in both cases, was whether the appellants' conduct was 'political communication' because if it did not satisfy the definition, the issue of constitutionality of the Tasmanian and Victorian legislation would not arise.

***Clubb – Political Communication***

Clubb was close to an East Melbourne abortion clinic and holding pamphlets about abortion. She approached a young woman and young man, spoke to them and tried to hand them one of the pamphlets. They moved. It is not known what was said or whether there was any reply.

She was charged under section 185D which provides that '[a] person must not engage in prohibited behaviour within a safe access zone'. 'Safe access zone' is defined in s 185B(1) as being 'within a radius of 150 metres' from the clinic. Prohibited behaviour includes 'communicating by any means in relation to abortions in a manner that is able to be seen or heard by a person accessing, attempting to access, or leaving premises at which abortions are provided and is reasonably likely to cause distress or anxiety'.

The joint judgment analysed her behaviour and came to the conclusion that Clubb's behaviour did not amount to 'political communication' and therefore she had been

511 Alex Deagon, 'There and Back Again? The High Court's Decision in *Clubb v Edwards; Preston v Avery*' [2019] HCA 11' on AUSPUBLAW (3 May 2019) 2.

512 *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520; *McCloy v New South Wales* [2015] HCA 34 *R v Brown* (2017) 91 ALJR 1089; [2017] HCA 43; See Anna Walsh, 'Freedom of Expression, Belief and Assembly: The Banning of Protests Outside of Abortion Clinics in Australia' (2018) 25 *JLM* 1119 which considered the implications of *R v Brown* for High Court challenges to the safety zone provisions.

rightly convicted. Rather it was an interaction between three people about choices to do with reproduction.[513] Their Honours stated:

> the communication effected by the handing over of the pamphlet by Mrs Clubb lacked any evident connection with the electoral choices to be made by the people of the Commonwealth. It was designed to persuade a recipient against having an abortion as a matter for the individual being addressed. It was not addressed to law or policy makers, nor did it encourage the recipient to vote against abortion or to take part in any public debate about the issue. It may therefore be accepted that the proscription of this communication did not involve an interference with the implied freedom.[514]

The plurality rejected a submission that the Court should not proceed to consider the question of the constitutionality of the Victorian legislation. The general practice of the Court is to refuse to engage in questions of the validity of laws based upon hypothetical situations.[515] They then considered whether the impugned legislation was unconstitutional and found that it was not.[516]

***Preston – Political Communication***

The conduct of Preston included the holding of placards and signs which contained 'right to life' slogans and pictures of an eight-week-old foetus.[517] He was within the access zone, that is, within 150m of the Hobart Clinic. It was clear that his behaviour was political communication'.

***Clubb and Preston – Constitutionality***

However, did the Victorian and Tasmanian legislation unduly burden the implied freedom of political communication of the defendants Clubb and Preston, respectively?

Kiefel CJ, Bell J and KeaneJ stated that the answer to this would be provided by applying the test as expressed in the cases of *Lange*, *Mc Cloy* and *Brown* (the *McCloy Test*).[518] This

513 Ibid [29]-[31].

514 Ibid [31] per Kiefel CJ, Bell and Keane JJ (joint judgment).

515 Ibid [32]-[33].

516 Ibid [32]-[40].

517 Ibid [106].

518 Ibid [4]; see also *Coleman v Power* [2004] HCA39; (2004) 220 CLR 1.

required addressing three sequential questions in respect of the laws of Tasmania and Victoria. The third of these included addressing the issue of proportionality. Put very generally the questions involved whether the implied freedom is burdened and if so, is its purpose legitimate in terms of compatibility with our system of representative government? If compatible, then is the law appropriate in advancing its objectives?[519]

It was the unanimous opinion of the Court that the Tasmanian laws unequivocally prohibited 'protest in relation to terminations'[520] and therefore burdened the implied freedom.[521]

Their Honours found that both laws provided a 'burden'. The Victorian laws, whilst targeted at abortion protests, could also apply to demonstrations which are directed at political change.[522]

Having found that both laws imposed a burden the next issue was to consider whether the laws had a legitimate purpose. Similar considerations applied to both laws. Kiefel CJ and Bell and Keane JJ noted that 'the purpose of the challenged legislation relates to the privacy and dignity of women accessing abortion services.[523] Further

> the prohibition is to protect the safety and wellbeing, physical and emotional, of persons accessing and leaving abortion clinics and to ensure that women may have unimpeded access to, and doctors may provide, terminations.[524]

A submission that the legislation had an illegitimate purpose in that it targeted the views of the anti-abortion supporters was rejected by the plurality and Gordon J who considered that it was 'viewpoint neutral' in that it applied to the conduct of all parties in the abortion controversy.[525] Gageler J and Edelman J also concurred that, as written, the provisions were content neutral and in theory apply to both pro and anti-abortion views. However, in practice they were more likely to target anti-abortionist protest

519 Ibid [5].

520 *RHATA (2013)* (Tas); S9(1)(b).

521 *Preston* [118]-[119].

522 Ibid [43].

523 Ibid [47]-[51].

524 Ibid [122].

525 Ibid [55] per plurality; 98 [375] per Gordon J.

because it was that group which would be expressing a contrary view to the those going to the abortion premises

Justice Gageler pointed out that:

> although it is facially neutral in its effect on protest, the human experience described in the Second Reading Speech is one of anti-termination protests outside premises at which terminations are provided: "standing on the street outside a medical facility with the express purpose of dissuading or delaying a woman from accessing a legitimate reproductive health service". . .The legislative effect will be, and is intended to be, most deeply felt by anti-termination protesters.[526]

According to the plurality judgment, answering the third question was facilitated by applying a 'proportionality analysis'.[527] The 'McCloy' test or analysis, as their Lordships called it, required examining whether the law was both 'suitable' in that is capable of achieving its purpose and 'necessary' in that there is no effective alternative which would be less burdensome.[528] Here the activities of the protestors involved 'an attack upon the privacy and dignity of' those seeking or providing reproductive services at the location of the demonstrations, the clinics. [529] In effect the law was required.

> It is within those zones that intrusion upon the privacy, dignity and equanimity of persons already in a fraught emotional situation is apt to be most effective to deter those persons from making use of the facilities available within the safe access zones.[530]

If the law was deemed both suitable and necessary, the final determinative of its constitutionality is whether it is 'adequate in its balance'.[531] Put simply, this requires a balancing exercise, whereby the consequences of the desired objective are measured against the limitations placed upon the 'implied freedom of political communication'.

In deciding that the law was valid their Honours said

526 Ibid [481] citation omitted.

527 Ibid [6]; Nettle J also applied *McCloy* as accepted by *Brown* [266].

528 Ibid [6].

529 Ibid 24 [83].

530 Ibid 24 [82].

531 Ibid 21 [69] per Kiefel CJ, Bell and Keane JJ.

> The burden on the implied freedom is slight in respect of both its subject matter and its geographical extent. Within the safe access zones, the only burden on the implied freedom is upon communications about abortions, and that burden is limited to preventing the capture of an audience.[532]

Thus, Kiefel CJ, Bell and Keane JJ found that the purpose of the law was achieved with only a slight restriction on the 'implied freedom'. By noting that, 'the purpose of protecting the dignity of the people' is central to the democratic process,[533] they acknowledged the need to recognise the autonomy of pregnant women and their right to be treated as equal persons.

Both appeals were dismissed. Of importance the validity of legislation as not unfairly burdening the implied freedom political communication was upheld. This is a hopeful outcome for pregnant women and all others requiring safe access to places where reproductive services are provided.

It is likely that all jurisdictions in Australia will have safe access zones in the near future. It would no doubt be preferable to have uniform rather than 'similar' legislation throughout Australia. A law which applies equally to all irrespective of their location at any given time is preferable given that all people are expected to know the law. Having eight pieces of legislation, if nothing else, makes for confusion and the law and its enforcement unnecessarily unwieldy.

The consequences of different laws for different jurisdictions may become important when appeals against convictions go to the High Court. The likelihood of future appeals to the High Court, on the grounds that a particular provision(s) of one of the Acts unconstitutional, is likely. This is especially so given that the decision in *Clubb* leaves questions unanswered.

A more important issue to be addressed by those with expertise in the area of Constitutional law is the relationship between reproductive rights and the implied freedom of religion and political expression. It may be argued that the test of the validity of abortion access zones ought not to be decided upon principles of neutrality and minimisation of restriction but upon matters which are unique to the controversial issue of reproductive rights and women's autonomy. The issue of abortion may be

532 Ibid [98].

533 Ibid 28 [101].

controversial but whether or not an individual woman has autonomy over her body should not be political. There are at least two separate issues. First, the debate on abortion at a societal level which is directed at the views which are held may come within the arena of politics. Second, directing disapprobation, harassing or seeking out individual women wish to access legal medical treatment seems somewhat removed from lobbying to change the law. These matters ought to be carefully addressed whenever there is a decision to recognise the implied right of political expression.

It is hoped that *Clubb* and *Preston* signal the need for action leading to uniform legislation not only for safe access zones but for all reproductive services. However, given the background and history of legislation on abortion in Australia, this is no certainty.

Nevertheless, there was another small but very significant step forward for the recognition for women's autonomy. The High Court granted leave for an *amica curiae* to make submissions.[534] This is unusual as the High Court is 'conservative' in respect to the use of the amicus Curiae.[535] The importance here is that evidence of women's negative experiences and the detrimental impact upon their well-being was put before the Court by experts on women's experiences, health and needs. The material was extremely unlikely to be within the knowledge of the Justices and was independent. [536] Women's perspective has been historically absent from courts and this may well point towards a way in which to redress this imbalance.

Since *Clubb*, there been little judicial consideration of the legislation. In 2018 *Bluett v Popplewell & Ors (Bluett)*[537] three defendants were found not guilty of an offence under the *Health Act 1993* (ACT) s 87(1). The section, inter alia, prohibited protesting by any means in respect of terminations whilst in a 'protected area' and during a 'protected time'.

534 *Clubb*; *Preston* [281].

535 Josh Gibson, '*Clubb v Edwards; Preston v Avery*: The High Court and the Role of Amicus Curiae' Aus Pub Law (Online) 3 May 2019 1, 2.

536 *Clubb v Avery* [281]; See Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44(2) *Monash University Law Review* 317.

537 [2018] ACTMC 2 (9 March 2018).

The defendants had been in the 'protected area' or safety zone at the requisite time and they had very strong views against abortion. Their conduct was basically silent prayer and one sat with rosary beads in his hands. The defendants were acquitted because their conduct did not amount to 'protest, by any means'.[538] They had also disputed the validity of legislation, claiming it 'impermissibly breaches the implied freedom of political communication'[539]. The magistrate decided that the legislation did not do so.[540]

## II CONCLUSION

This chapter has argued that legal systems regulate whether an abortion will be lawful but that is not the only factor which determines whether a woman can access a safe, timely and legal abortion The additional factors which operate to determine access to abortion have important implications for the exercise of women's autonomy. Section A summarised the legal frameworks which influence access to abortion. Section B considered governmental policies, including funding, which come into play to impact upon pregnant women's autonomy. Section C considered the governmental grant of a monopoly over abortion procedures to the medical profession and the impact of this upon women's rights. It also considered the medical professional's right to refuse to perform abortions. Section D dealt with the overarching problem of the stigmatisation of abortion and its impact upon access to termination procedures and ultimately women's autonomy. Section E focussed upon the impact of anti-abortion protest and the ability to safely access premises to undergo a termination procedure.

The legal right to access a timely and safe abortion is only a first step in protecting women's autonomy to make reproductive choices. The next chapter considers their right to consent to or refuse medical treatment and whether the medical profession accommodates this right in principle and in practice.

538 Ibid [86]

539 See also *Elzahed v Kaban* [2019] NSWSC 670 (7 June 2019).

540 *Bluett* [42].

# CHAPTER 5 MEDICAL TREATMENT CONSENT AND REFUSAL

*'I start with the fundamental principle, now long established, that every person's body is inviolate.'* (Lord Goff)[1]

## I INTRODUCTION

Chapter 2 outlined the theories of autonomy, personhood and the women/foetal inter-connection or 'relationship'. Chapter 3 considered the different laws used to regulate abortion and how these impacted upon women's autonomy. Chapter 4 identified quasi-legal and non-legal obstacles to women's ability to obtain a safe and timely abortion. These were: government policy and funding; medical monopoly over services; refusal by medical professionals to perform services; the role of stigma in undergoing an abortion; and, physical access to premises where abortions are performed.

This chapter considers the extent to which the application of the laws regulating medical treatment affect the autonomy of women during pregnancy.[2] Part I commences with an analysis of the general legal principles applicable to the right to consent to or refuse medical treatment. This is followed by an examination of whether the laws as they currently apply to pregnant women differ from their usual application in relation to consent and refusal of medical treatment. Part II considers the ways in which the judiciary has applied the principles applicable to the exercise of the right to bodily integrity when pregnant women refuse to consent to medical treatment.

## II THE GENERAL PRINCIPLES

This part analyses the general principles of the laws relating to the consent to and refusal of medical treatment. It considers the way in which they uphold the fundamental right to bodily integrity which is essential to being respected as a person. In the countries discussed, the law will rarely, and reluctantly, interfere with this right. Section A considers the right to bodily integrity as it applies to all legal persons. Section B considers whether there are exceptions to the general principles applying to consent to

1 *Re F (mental patient: sterilisation)* [1990] 2 AC 1, 72.

2 As in the other chapters the laws analysed are selected from the United Kingdom, Australia, Canada, New Zealand, Ireland and the United States of America.

and refusal of medical treatment as frequently quoted with approval by the courts [3] and academic articles [4] in the jurisdictions considered here.[5]

The findings provide a measure by which to assess the extent to which the principles as applied interfere with the autonomy of women because of the status of being pregnant.

## A Bodily Integrity

### *1 Autonomy*

The autonomy of the person has been central to the development of medical law and consists of various rights.[6] The central principle is that a person has a right to bodily integrity, that is, 'the right in an individual to choose what occurs with respect to his or her own person'.[7] The corollary of choice or consent to treatment is that of refusal of

3 See eg, *F v R* (1983) 33 SASR 189, 193; King CJ upheld the principle that 'the paramount consideration [is] that a person is entitled to make his own decisions about his life' *Rogers v Whitaker* (1992) 175 CLR 479, 487; *Department of Health & Community Services v JWB & SMB* (*Marion's Case)* (1992) 175 CLR 218 (6 May 1992) quoted with approval by Mason CJ, Dawson, Toohey and Gaudron JJ [12]; *BS v McC: W v W* [1972] AC 25,43; *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218[11]; *Malette v Shulman* (1990) 67 DLR (4th) 321, 327-328; *Right to Life New Zealand Inc v The Abortion Supervisory Committee Unrep Judgment Miller J, HCNZ 09 June 2008 (Bc200861316); Abortion Supervisory Committee v Right to Life New Zealand Inc [2012] 1 NZLR 176; New Health New Zealand Inc v South Taranaki District Council* [2014] 2 NZLR 834 (Affirming the right but holding that fluoridation of the water supply was not 'medical treatment') [2017] 2 NZLR 13; [2018] 1 NZLR.59,60.

4 Sheena Meredith, *Policing Pregnancy: The Law and Ethics of Obstetric Conflict* (Ashgate, 2005) 7; Malcolm Smith, Medical Law (LexisNexis Butterworths, 2014)17-30; Andrew Hockton, *The Law of Consent to Medical Treatment* (Sweet & Maxwell, 2002) 5-29.

5 The principles usually refer to the right to consent. However, most cases, but not all, have come before the court because of the refusal to follow the advice of the medical practitioner. Here the term 'refuse' is sometimes used preceding the term 'consent' or alone so as to reflect the nature of the cases which have come before the court.

6 See Chapter 2 – Theoretical Underpinnings.

7 *Department of Health & Community Services v JWB & SMB* (*Marion's Case*) (1992) 175 CLR 218 [9] Mason CJ, Dawson, Toohey and Gaudron JJ [10] (6 May 1992); *Rogers v Whitaker* (1992) 175 CLR 479, 487 [12] quoting King CJ's statement in *F v R* (1993) 33 SASR

medical treatment. It is this latter right, refusal, which usually brings the patient into conflict with the medical profession and hence, sometimes, before the courts.[8]

Autonomy is not absolute but may be subject to limitations imposed by law.[9] Here it is sufficient to note that limitations on autonomy are unclear and subject to controversy but that the right to autonomy is to be assumed to exist until the contrary is legally established. The rights of autonomy particularly that of bodily integrity, are entrenched in the jurisprudence of the jurisdictions under consideration. Whilst there is consensus as to the importance of the right there are several differences in the detail and application of the laws of consent to medical treatment.[10] Nevertheless the importance of and the few exceptions to the right to bodily integrity reinforce the presumption that pregnant women should have the equal right to make decisions in respect of their bodily integrity.

189,193 that 'the paramount consideration [is] that a person is entitled to make his own decisions about his life'; *X v The Sydney Children's Hospitals Network* [2013] NSWCA [12]; *Sidaway v Bethlem Royal Hospital and Maudsley Hospital* [1985] AC 871,882; *Airedale Trust v Bland* [1993] AC 789, 864; *Re F (in utero)* [1988] 2 AC 1, All ER 19; *Re D (unborn baby*) [2009] EWHC 446 (Fam), (Transcript: Cater Walsh Transcription Ltd); *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385; *Mallette v Shulman* (1997) 47 DLR (4th)18; see Norman Siebrasse, '*Malette v Shulman*: The Requirement of Consent in Medical Emergencies', (1989) *CanLIIDocs* 52 (updated in 2020) *McGill Law Journal* for a critique of this case); *Smith v Auckland Hospital B*oard [1965] NZLR 191; *Auckland Area Health Board v Attorney-General (Re L)* [1993] 1 NZLR 235; Right to Life New Zealand Inc v The Abortion Supervisory Committee Unrep judgment Miller J, HCNZ 09 June 2008(Bc200861316); Abortion Supervisory Committee v Right to Life New Zealand Inc [2012] 1 NZLR 176; *New Health New Zealand Inc v South Taranaki District Council* [2014] 2 NZLR 834; *Union Pacific Railway Co v Botsford* 141 US 250, 251 (1891).

8 It would appear significant that where the woman agrees with her physician her 'capacity', discussed below, is rarely assessed in any but a rudimentary way.

9 See below 1A2 - *Limitations on the right to refuse medical treatment*; see Cornell, *The Imaginary Domain* (Routledge, 1995) where bodily integrity is an integrative and continuous process of becoming a person, discussed in Chapter 2 – Theoretical Underpinnings.

10 Andrew Hockton, *The Law of Consent to Medical Treatment* (Sweet & Maxwell, 2002).

Although the right has been recognised since early times it is not necessary to go further back than the eighteenth century when Blackstone wrote that

> [t]he law cannot draw the line between different degree of violence, and therefore totally prohibits the first and lowest stage of it; every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner.[11]

Thus, the least unjustified touching is prohibited, and such prohibition is enforced through criminal and civil sanctions. The use of the criminal law in addition to the civil law underscores the importance of the right, as does its inclusion as a human right under international law.[12]

The importance placed upon the right to autonomy has been confirmed in Constitutions,[13] Charters and Conventions on Human Rights[14] and in court decisions.[15] In 1891, in the USA, the court noted that:

> [n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from restraint or interference of others, unless by clear and unquestionable authority of law.[16]

11 William C Sprague, *Blackstone's Commentaries, Abridged* (1915) Book III, Ch VIII 323; (Vol 1 Blackstone, Commentaries on the Laws of England, Vol 1 (1765).

12 *See for example, Convention for the Protection of Human Rights and Fundamental Freedoms Article 8.*

13 USA *Constitution*, Fourteenth Amendment states that - 'no state shall "deprive any person of life, liberty or property without due process of law"' has been interpreted as protecting the right to bodily integrity.

14 *New Zealand Bill of Rights Act* 1990 (*NZBORA*) s11; *Canadian Charter of Rights and Freedoms s7; Fleming v Reid (1991) 4 OR (2d) 74* held that the right of a psychiatric patient to refuse medical treatment was included in the liberty interest in s7*; Charter of Human Rights and Responsibilities Act 2006 (Vic)* ss7,10,21(1); *Human Rights Act 2004* (ACT*); Human Rights Act 2019 (Qld); Human Rights Act 1988* (UK); *Convention for the Protection of Human Rights and Fundamental Freedoms.*

15 See (n 5).

16 *Union Pacific Railway Co v Botsford* 141 US 250, 251 (1891).

The statement by Justice Cardoza in the New York of Appeals that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his body'[17] has been frequently quoted with approval by the courts within the jurisdictions considered here,[18] as well as in academic writings.[19]

**(a) Consent**

The right to consent to or refuse medical treatment is an important aspect of the general right to bodily integrity and freedom from interference. Without consent, medical practitioners may render themselves liable to a civil suit or even criminal prosecution.[20]

17 *Schloendorff v Society of New York Hospital* 211 NY 125, 129 (1914); cited with approval in *Secretary, Department of Health and Community Services VJWB. and SMB* (*Marion's Case*) (1992)175 CLR 218; *X v The Sydney Children's Hospitals Network* [2013] NSWCA [12]; *Airedale NHS Trust v Bland* [1993] UKHL 17 (04 February 1993); *F v West Berkshire HA* [1991] UKHL 1 (17 July 1990).

18 See eg, *F v R* (1983) 33 SASR 189, 193 King CJ upheld the principle that 'the paramount consideration [is] that a person is entitled to make his own decisions about his life' *Rogers v Whitaker* (1992) 175 CLR 479, 487; *Department of Health & Community Services v JWB & SMB* (*Marion's Case)* (1992) 175 CLR 218 (6 May 1992) quoted with approval by Mason CJ, Dawson, Toohey and Gaudron JJ [12]; *BS v McC: W v W* [1972] AC 25,43; *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218[11]; *Malette v Shulman* (1990) 67 DLR (4th) 321, 327-328; *Right to Life New Zealand Inc v The Abortion Supervisory Committee Unrep Judgment Miller J, HCNZ 09 June 2008 (Bc200861316); Abortion Supervisory Committee v Right to Life New Zealand Inc [2012] 1 NZLR 176 6 New Health New Zealand Inc v South Taranaki District Council* [2014] 2 NZLR 834 (Affirming the right but holding that fluoridation of the water supply was not 'medical treatment').

19 Andrew Hockton, *The Law of Consent to Medical Treatment* (Sweet & Maxwell, 2002); Maclean, *Autonomy, Informed Consent and Medical Law -A Relational Challenge;* Ben White, Fiona McDonald and Lindy Wilmott, *Health Law in Australia*, (Lawbook Co, 2018); Baroness Brenda Hale et al *Mental Health Law* (Sweet & Maxwell 6th Ed 2017) Edward F Sweat, 'Francis L Cardoza--Profile of Integrity in Reconstruction Politics (1961) 46 (4) *The Journal of Negro History* 217.

20 See Chapter 4 – The concept of consent in Alasdair Maclean, *Autonomy, Informed Consent and Medical Law -A Relational Challenge* (University Press, 2009) 110; J Manning, 'Informed Consent to Medical Treatment: The Common Law and New Zealand's Code of

In effect it is consent which 'transforms what would otherwise be unlawful into acceptable'.[21]

Alasdair Maclean identified the important role of consent when he stated that '[c]onsent raises issues of liberty, power, control and responsibility; all of which are also relevant to the importance of autonomy'.[22] The concept of consent is important to an analysis of which interferences with the person may be justified and which interferences will not be justified.

Many forms of medical treatment, certainly those of a lifesaving nature, require some physical contact with the body of the patient. The starting point in considering the legality of this kind of treatment is that any touching of a person's body without that person's consent is a battery which is both a tort (a wrong for which compensation may be ordered from the wrongdoer) and a crime, unless the touching is justified or excused by law. It is well established that any touching without consent may amount to a battery. It makes no difference that the touching is without 'malice' and even with beneficence.[23]

Often the lifesaving treatment will require use of a knife or a needle, but there is no need to prove any particular degree of injury. The slightest contact with a person would be sufficient to constitute a battery.[24]

Consent to the specific medical procedure is what will make most treatments, that would otherwise attract civil and/or criminal liability, legal.[25] In cases of negligence it is the obtaining of informed consent, including an explanation of any risks involved, which will absolve the medical professional from liability. Informed consent will not be present where a person has consented to one operation, but an operation of a different type is performed. Where a procedure is performed in addition to the one consented to then

Patients' Rights' [2004] 12 *Medical Law R*eview 181.

21 *Marion's Case* Mason CJ, Dawson, Toohey and Gaudron JJ (n 6) 233.

22 Maclean, *Autonomy, Informed Consent and Medical Law -A Relational Challenge*, (n16), 9.

23 *R v Hallett [1969] SASR 141.*

24 *Wilson v Pringle* [1987] QB 237; *Collins v Wilcock* [1984] 3 All ER 374; *R v Thomas* (1985) 81 Cr App R 331; *R v Day* (1845) 1 Cox 207; Ben White, Fiona McDonald and Lindy Wilmott, *Health Law in Australia*, (Lawbook Co, 2018) 138 -140; David Lanham, *Taming Death by Law* (Longman Professional, 1993).

25 See *Reeves v The Queen* [2013] HCA 57; *R v Reeves* [2013] NSWCCA 34 (Consent in criminal law).

the medical professional will be liable for performing the second unauthorised procedure. For example, a woman consents to a caesarean and the surgeon performs a hysterectomy as well. The surgeon would be criminally and civilly liable for the performance of the hysterectomy because it was performed without informed consent.

Informed consent may be obtained for the particular procedure, eg, a caesarean or an abortion. The medical professional will attract civil liability if s/he performs the operation in a manner which does not meet the standards of the reasonable doctor.[26] If s/he is grossly negligent and causes death manslaughter charges could be brought under the criminal law.[27]

That consent is not assumed but must be given is essential to the exercise of autonomous rights. All persons equally, irrespective of their sex, have the right to consent to or refuse medical treatment. In theory, and upon general principles, there is no obvious reason to treat a woman differently because she is or may become pregnant.

**(b) Defining Consent**

In *Re F (Mental Patient: Sterilisation)*[28] Lord Donaldson MR stated:

> In the absence of *consent* all, or almost all medical treatment and all surgical treatment of an adult is unlawful, however beneficial this treatment might be. This is incontestable.[29]

This statement immediately raises the issue of how to define and determine whether consent existed or was absent in respect of a medical procedure. What is meant by consent? There are several adjectives which have been used by the courts to explain or

26 White et al (n25) 150-153; Owen Bowcott, 'Hysterectomy inquiry reveals 25-year scandal of silence' *Guardian* 1 March 2006;

27 *Patel v The Queen* [2012] HCA 29; [43]-[53]; *R v Adomako* [1995] 1 AC 171; see *R v Sood* [2006] NSWSC 695 (10 July 2006); *R v Sood* (Ruling No 3) [2006] NSWSC 762 (15 September 2006) [43]-[53] where Dr Sood was found not guilty of manslaughter by an unlawful and dangerous act and manslaughter by criminal negligence.

28 [1990] 2 AC 1.

29 [1990] 2 AC 1, 12 [emphasis added]; See also Lord Goff, 73, who says that necessity not emergency is the principle applicable, 75.

qualify the meaning of consent. The words valid,[30] voluntary,[31] informed,[32] sufficiently informed,[33] real,[34] effective,[35] true,[36] free,[37] and similar have been used to elucidate the concept.

Various writings have addressed the elements of consent. Emma Cave identifies three main attributes of consent saying:

> [t]he first refers to the freedom of the consent. Hence any physical force applied by the physician without voluntary consent may constitute a battery in English tort and criminal law. The second aspect involves supplying the patient with sufficient information and failure to do so may lead to a successful negligence claim. The third, which is of greatest concern to this debate, is whether or not consent was actually given and when the courts should ignore the requirement of consent and order the physician to proceed with the treatment regardless of its absence or

30 Hockton, (n 9) 13-14.

31 *Re T (An Adult) (Consent to Medical Treatment)* [1992] EWCA Civ 18; [1992] 4 All ER 649; [1992] 3 WLR 782, Lord Donaldson 799 [E]; Hockton, (n 9) 7.

32 *Couch v Attorney-Genera*l [2010] NZSC 27; 3 NZLR 149; *Code of Health & Disability Services Consumers' Rights* (NZ*)* Rights 6 &7*;* Rhonda Powell, Shawn Walker and Alison Barrett, 'Informed consent to breech birth in New Zealand' (2015) 128 (1418) *The New Zealand Medical Journal* 85, 88; *Schloendorff v Society of New York Hospital* (1914) 211 NY 125, 129-130.

33 Hockton, (n 9) 6; Smith, 19; M Jones, *Medical Negligence* (Sweet & Maxwell,1991) 200; *Rogers v Whitaker* (1992) 175 CLR 479, 489 stated that 'informed in broad terms of the nature of the procedure which intended' is enough and preferable to 'informed consent' which may mislead;

34 Benjamin Grant Chojnacki, 'Pushing back: protecting maternal autonomy from the living room to the delivery room' (2010) 23 (1) *Journal of Law and Health* 45, 53; Powell, above n 26, 91.

35 John Seymour, *Fetal Welfare and the Law*, (The Australian Medical Association,1995) 66.

36 *Re T (An Adult) (Consent to Medical Treatment)* [1992] EWCA Civ 18, 34 Lord Justice Staughton.

37 Smith, n 15, 18,

express declination. Hence the patient has not only a right to consent, but also a right to withhold consent.[38]

Similarly, Jones identifies three interrelated requirements of consent. These are volition, explained information and capacity.[39]

Consent to or refusal of medical treatment does not exist unless all elements are present.[40]

Seymour, in analysing the approach of Donaldson MR in *Re T (An Adult) (Consent to Medical Treatment) (Re T)* [41] identified the requirements which needed to be satisfied before consent or refusal is valid.

The person giving consent must have:

I capacity or competence to consent to or refuse treatment;

II intended the consent or refusal to apply in the existing circumstances; and,

III made the decision without undue influence, that is, it is the patient's decision.[42]

The approaches of Cave, Jones and Seymour, albeit expressed differently, have three basic requirements. These are capacity, knowledge and voluntariness.

### i. Capacity

At common law a person is presumed to have capacity to consent.[43] Skegg [44] has attributed the presumption to Justice Donaldson MR in the frequently cited case of *Re T*

38 Emma Cave, *The Mother of All Crimes: Human Rights, Criminalization and the Child Born Alive* (Ashgate, 2004) 65.

39 See also, M Jones, *Medical Negligence*, (Sweet & Maxwell,1991) 200, who identifies three interrelated requirements of consent: volition, explained information and capacity.

40 See 'Chapter 4 – The concept of consent' in Alasdair Maclean, *Autonomy, Informed Consent and Medical Law -A Relational Challenge* (University Press, 2009) 110.

41 *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18.

42 Seymour, *Fetal Welfare and the Law*, (n34) 66.

43 PDG Skegg, 'Presuming Competence to Consent: Could Anything be Sillier?' (2011) 30(2) *University of Queensland Law Journal* 165.

44 Ibid.

*(Adult Refusal) (Medical Treatment) (Re T*)[45] and regards it as having been adopted without any extensive critical analysis by the courts, academics and/or medical profession. He argues that the presumption is an illogical and inadequate concept which is difficult to apply in many medical situations. Skegg queries the usefulness of it in the clinical context and argues that it would make better sense to have a limited rebuttable presumption of 'incapacity'[46] when the situation giving rise to medical treatment signals concerns for patient capacity. He considers that medical practice 'presumes' capacity only where it is not contraindicated.

*Re T*, was a UK case decided prior to the passing of the *Mental Capacity Act 2005* (UK) (*MCA*) which replaced the common law and put the test of capacity into statutory form. [47] It is used here to the demonstrate what is meant by capacity, knowledge and voluntariness and how these requirements have informed medical law in jurisdictions such as Australia, Canada and NZ[48] and in the UK prior to the enactment of the *MCA*.[49]

45 *Re T (Adult Refusal) (Medical Treatment*) [1992] EWCA Civ 18; [1993] Fam 95,102 (CA) (*Re T*); *Cruzan by Cruzan v Director, Missouri Dept. of* Health (1990) 497 US 261, 110 S Ct 2841*Cruzan by Cruzan v Director, Missouri Dept of Health* 497 US 261, 110 S Ct 2841(1990); The *Mental Capacity Act 2005* (UK) s 1 (2) has put the presumption into statutory form.

46 Skegg, (n 37) 165-169,187. See also, Kerri Eagle and Christopher Ryan, 'Mind the gap: The potentially incapable patient who objects to assessment' (2012) 86 *ALJ* 685.

47 See also *Mental Health Act 2013* (Tas); *Mental Health Act 2014* (Vic); *Mental Health Act 2014* (WA); Mental Health Act 2015 (ACT); *Mental Health Act 2007* (NSW); *Mental Health Act 2016* (Qld);

48 *B v Mental Health Tribunal* [2020] TASSC 10; *PBU & NJE v Mental Health Tribunal* [2018] VSC 564; *Hunter and New England Area Health Service v A* [2009] NSWSC 761; *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229; *Starson v Swayze* [2003]1 SCR 722; *Nancy B v Hotel-Dieu de Quebec* (1992) 86 DLR (4th) 385; *Malette v Shulman* (1990) 67 DLR (4th) 385; *New Health New Zealand Inc v South Taranaki District Council* [2014] 2 NZLR 834;

49 *Re T* 1312; although the *MCA* (UK) provides a definition of capacity Baroness Brenda Hale et al *Mental Health Law* (Sweet & Maxwell 6th Ed 2017) 74, argue that the statutory test 'expands upon rather than contradicts, the existing common law' and reflects the cases prior to 2005; see also *Aintree University Hospital NHS Foundation Trust v Ja*mes [2013] UKSC 67.

In *Re T,* T was a 34 weeks' pregnant woman who was in hospital having been diagnosed as suffering from pneumonia. She was given medication but her condition deteriorated.

She told a nurse that she had been a Jehovah's Witness and would refuse a blood transfusion. She agreed to a caesarean but refused a blood transfusion. Her baby was stillborn and she became critically ill and needed an urgent blood transfusion. Her father and her partner brought an application before Ward J who granted a declaration stating that it would not be unlawful to administer a blood transfusion. The blood transfusion was successfully administered. Two days later Ward J conducted a complete enquiry who found that she had capacity when she told the nurse that she would refuse a blood transfusion but 'she was not fully rational at the time of signing the refusal'.[50]T had neither consented nor refused. This was a 'classic "emergency" situation in which it was lawful for the doctors to treat her in whatever way they considered . . .to be in her best interests'.[51]

The matter was then appealed. Lord Donaldson MR did not approve the findings of fact made by Ward J but did dismiss the appeal. He considered that it had 'a wider purpose, namely to give guidance to hospital authorities and to the medical profession on the appropriate response to a refusal by an adult to accept treatment'[52] and took the opportunity to set down the applicable principles when the right to refuse medical treatment again came before the court'.[53] He stated:

> The patient's interest consists of his right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount.[54]

For the purposes of later discussion it is noted here that there is a presumption of capacity which is not rebutted because a person suffers a mental illness or is in a mental

50 Ibid [19].

51 Ibid [20].

52 [1992] 4 All ER 649, 660.

53 Ibid 661-665.

54 Ibid 661.

institution.[55] *In re C (Adult refusal of medical treatment) (C)*[56] C was detained in a mental health facility in England. C suffered gangrene in one of his feet and was transferred to hospital for treatment. He was advised that his lower leg should be amputated to save his life. C refused his consent. The hospital administration arranged for a solicitor to see him. In the interim emergency treatment averted the threat of an impending death. The hospital, however, refused to give the solicitor an undertaking that it would abide by C's wishes should an amputation be necessary at a later stage. An application was made to the High Court requesting an injunction to restrain the hospital from performing the amputation without consent.

In deciding, Thorpe J had to assess the mental capacity of C. He considered whether it 'is so reduced by his chronic mental illness that he does not sufficiently understand the nature, purpose and effects of the proffered amputation'.[57] Capacity here was determined by whether C could competently process the information needed to make a valid decision to refuse this medical treatment. Thorpe J noted that the requirements were 'first, comprehending and retaining treatment information; second, believing it; and third, weighing it in the balance to arrive at a choice'.[58] The general principle that patients have the right to self-determination and to consent to or refuse medical treatment was held to apply to C even though he suffered from and was incarcerated because of a mental illness. In explaining that the presumption had not been displaced Thorpe J noted:

> Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and

55 Brenda Hale et al *Mental Health Law* (Sweet & Maxwell 6th Ed 2017) [2-022] 72-73; PDG Skegg, 'Presuming Competence to Consent: Could Anything be Sillier?' (2011) 30(2) *University of Queensland Law Journal* 165; it ought to be noted that the *Mental Capacity Act 2005* (UK) put the law on capacity into statutory form. The cases prior to 2005 remain relevant to an understanding of the general principles and are referred to in some judicial decisions in Australia, NZ and Canada. For an application of the principles of the capacity currently applied in England the decisions post the coming into operation of the MCA 2005 should be referred to as appropriate.

56 *In re C (Adult: refusal of medical treatment) [1994] 1 WLR 290.*

57 Ibid.295 C.

58 Ibid. 294.

> effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice.[59]

Mental disability does not preclude the ability to consent to or refuse medical treatment. The existence of refusal or consent depends upon whether a person can process the information and make a voluntary decision about the treatment in question.[60] At this stage, it is noted that a pregnant woman who suffers from a mental illness is presumed like all other persons to have capacity to consent to medical treatment.[61]

Legislation and medical guidelines apply to the issue of consent in all jurisdictions.[62] In the UK the common law was replaced by the *Mental Capacity Act 2005*. Section 1 provides that a 'person must be assumed to have capacity'[63] and 'is not to be treated as unable to make a decision because he makes an unwise decision'.[64]

Section 2(1) of the Act states:

> a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

The guidelines of mental health authorities are clear that capacity must be assessed at the time of making the decision. For example, in Victoria

59 Ibid 295.

60 See *Re SB (A patient; capacity to consent to termination*) [2013] EWCOP 1417; *Royal Free NHS Foundation Trust v AB* [2015] EWCOP 50;*St George's Healthcare NHS Trust v S; R v Collins and Others, ex parte S* [1998] 3 WLR 936.

61 See *Re AA: In the Matter of* [2013] EWCOP 4378; *Re SB (A patient; capacity to consent to termination*) [2013] EWCOP 1417

62 For example; s 36(2) of the *Guardianship and Administration Act 1986 (Vic)provides*-: 'a person is incapable of giving consent to the carrying out of a special medical procedure if the person —*(a) is incapable of understanding the general nature and effect of the proposed procedure; or (b) is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure'*; *Mental Health Act 2014* (Vic) ss68-70; see also British Medical Association, *Code of Conduct*; *Mental Health Act 2016* (QLD) - s5(b).

63 *Mental Capacity Act 2005* (UK) s1(2).

64 Ibid s1(4).

> [a] patient's capacity to make a treatment decision can fluctuate. A patient may not have capacity to make a particular treatment decision today, however they may be able to make the treatment decision tomorrow. The clinician should try to obtain informed consent at a time and in an environment when the patient is most likely to be able to give informed consent.[65]

Here, as under the common law, consent requires the ability to consent to a specific decision. The *Mental Capacity Act 2005* (UK) refers to the inability to make a specific decision and does not speak of the inability to make decisions in general. Any 'disturbance' is something that affects the thought processes; it could be a trauma or condition or something else.[66] The loss of capacity may be partial, permanent or merely transient. Therefore, a person may lose capacity to make decisions on a temporary or permanent basis.[67] This too is consistent with the judicial decisions on capacity.[68]

### ii. Knowledge, Information and Circumstances

The second requirement for a valid consent is that of knowledge. It is noteworthy that Seymour refers to 'existing circumstances' rather than information or knowledge.[69] This raises the issue of whether this is an additional requirement or it is part of the requirement that the patient must be appropriately informed. The existing circumstances indicates a need to locate the decision-making process in the immediate context in which it is made. This is implicit in the other approaches and for the purpose of this analysis 'existing circumstances' will be used in conjunction with knowledge and information where relevant. That the relevance of information and its influence upon the decision maker may vary depending upon the context in which it is given may be seen from in *Re T.*[70]

65 Health Victoria – 'Presumption of capacity'.

66 *Mental Capacity Act 2005* s 2 (1); see *Re A (in utero)* (1990) 72 DLR (4th) 722, 551.

67 *MCA* s 2 (2).

68 *Guys and St Thomas' NHS Trust v X* [2019] EWCOP 35 9027]; *Norfolk and Norwich Healthcare (NHS) Trust v W* [1997] 1 FLR 269, 273; *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274; *In re C (Adult: refusal of medical treatment)* [1994] 1 WLR 290; *St George's Healthcare NHS Trust v S, R v Collins and Others, ex parte S* [1998] 3 WLR 936.

69 John Seymour, *Fetal Welfare and the Law*, (n 34),66-67.

Knowledge and circumstances were taken into account in *Re T* [71] where T was found to have lacked consent. The extent of the information which she received was relevant on at least two occasions. At the time she first made known that she did not want a blood transfusion she may have had capacity. On the other hand, the response of the nurse was more in the nature of reassurance than of information upon which a decision could be made. The nurse gave evidence that the statement had been volunteered 'out of the blue' and that to calm T she had said that she did not think a transfusion would be needed. She was told that there were alternatives but they were not as effective. T signed a form but there was evidence that the contents were neither read, explained or witnessed. The judges considered all of these factors indicated that the circumstances were such that T was not appropriately informed and did not, in the circumstances, have the knowledge to make a valid refusal.

### iii. Voluntariness

The third requirement for a valid consent or refusal requires that it is given voluntarily, freely and without force, coercion or undue influence. *In Re T* there was evidence to suggest that T was not a devout Jehovah's Witness but was deemed to be under the influence of her mother, a devout Jehovah's Witness. The influence which combined with the impact of the drugs she had been given could have meant that her refusal was 'involuntary'. On appeal Lord Donaldson, in addressing external influence on voluntariness, said that there were two matters of 'crucial importance'. These were 'the strength of the will of the patient' and 'the relationship of the "persuader" to the patient'.[72] He considered that even if T had had the capacity and the requisite knowledge at the requisite time of the decision her refusal would not have been voluntarily given because 'the influence of her mother was such as to vitiate the decision which she expressed'.[73]

70 *Re T (Adult Refusal) (Medical Treatment*) [1992] EWCA Civ 18; 1993] Fam 95(CA); this case pre-dates the *MCA* 2005.

71 *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18; [1993] Fam 95,102 (CA); *Cruzan by Cruzan v Director, Missouri Dept of Health* (1990) 497 US 261, 110 S Ct 2841.

72 *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18;[1993] Fam 95,102 (CA).

73 Ibid.

The judgment reinforces the principle that the refusal of medical treatment may be based upon religious beliefs[74] but it was implicit here that the appellate court doubted that T held those beliefs. The case shows that there is an absolute right to refuse medical treatment. Nevertheless, the refusal or consent may be vitiated if it is involuntary because of coercion or 'undue influence'. In other words it is not truly 'consent'.

Nevertheless, as previously stated, all the requirements are interrelated. It is the contextual situation in which the decision is made that will be relevant to voluntariness and competency, as well as to knowledge. Irrespective of the way the elements of consent are expressed the notions of voluntariness, knowledge and capacity are central in assessing whether a patient has given a valid consent.

From the foregoing, it may be concluded that consent to or refusal of medical treatment requires knowledge, voluntariness and capacity. The precise meaning of these requirements varies between the jurisdictions. However, the principle, that 'consent' must exist before medical treatment is lawful, is pervasive.

If there is a distinction between a failure to consent and a refusal of consent, it is because a refusal can take the form of a declaration of intention never to consent in the future or never to consent in some future circumstances.[75]

The next section considers the extent of the consent condition. Is it an absolute prerequisite or are there circumstances when it may be dispensed with?

### *B Limitations on the Right*

The exercise of autonomous rights may come into conflict with the rights of others. A right may conflict with the *compelling interests* of the state, and/or other individuals and/or groups. The nature of the interests of the state and/or others, whose interests

74 It is apparent that deeply held religious beliefs which are the reason for refusing treatment are frequently treated with suspicion and/or disbelief; see *Qumsieh v Guardianship and Management Board and Pilgrim* [1998] VSCA 45 where the court was of the opinion that the woman's belief was not an issue of sufficient importance to grant a declaration & where the court considered it would cause family conflict; see Cameron Stewart, 'Qumsieh's Case, Civil Liability and the Right to Refuse Medical Treatment' (2000) 8 *Journal of Law and Medicine* 56,58.

75 *Re T*, Lord Donaldson MR [25].

should prevail and the justifications for elevating one interest over another are significant, particularly when considering the autonomy of the pregnant patient.

In what situations might the requirement of consent be dispensed with? The law is not always consistent in this area. There is one recurrent theme, however, and that is, that 'there are a few rare exceptions to'[76] the principle that '[m]edical treatment may not be given to an adult person of full capacity without his or her consent'.[77]

This section generally considers whether there are exceptions to the rule that there is a fundamental right to consent to or refuse medical treatment. It identifies the possible exceptions, if any, and briefly discusses two of these, the rights of others and medical emergencies, which are relevant to the thesis.[78] These themes will be developed in Part II with specific reference to cases involving the pregnant woman and her right to refuse or consent to medical treatment.

### *1 The Rights of 'Others'*

It would appear well established that the court will not compel a person to undergo medical treatment for the purposes of saving the life of a third party.[79] This is so even when there is a familial, blood or close relationship between the potential donor and recipient. The procedures requested may involve the donation of blood, human tissue, organs or bone marrow.[80] The rationale is illustrated in the famous thought experiment of Judith Jarvis Thompson which illustrates the difference between a failure to rescue and a duty not to kill. Her scenario involves a woman who is kidnapped and rendered unconscious. She wakes up to find that she is lying in bed and an unconscious famous violinist who suffers from a rare kidney disease has been attached to a life support system which in turn relies upon it being attached to her. She is advised that if she detaches herself from the support system the violinist will die but if she remains attached to the system for nine months he will live. The dilemma posed is whether the

76 *Re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 IR 79, Denham J.

77 Ibid.

78 The issue of the prevention of suicide is not discussed here.

79 William Edward Hearn, 'The Theory of Legal Duties and Rights' [1883] *Australian Colonial Law Monographs* 3, 62-64.

80 On the problems of medical ethics see T Rulli and J Millum, 'Rescuing the duty to rescue' (2016) 42 *Journal of Medical Ethics* 260-264.

woman is morally required to stay attached to the violinist. Thompson considers that she is not. However, Thompson points out that should the violinist survive this does not allow the woman to actively cause the death of the violinist. The distinction she seeks to draw is that there is no obligation to be a good Samaritan and rescue a person in need. On the other hand, there is a duty not to perform a positive action which kills or injures another person. There is no general 'duty to rescue' under the common law irrespective of whether the rescue involves no inconvenience, little inconvenience or major inconvenience to the 'rescuer'.[81] The common law also follows Thompson's approach and distinguishes between positive acts and omissions in both torts law[82] and criminal law.[83]

The pre-eminence accorded to the right of the individual to consent or refuse medical treatment remains, irrespective of the fact that the intrusion and risk to that person may be very slight and the benefit to the other person might be highly beneficial and even lifesaving.[84] In *Curran v Bosze*[85] the Illinois Supreme Court refused to make an order to force twins, who were minors, to donate bone marrow to a half-sibling. The procedures involved very little risk to the twins but were essential to preserve the life of the half-sibling. The court also refused to order a blood test to assess the issue of donor

81 Judith Jarvis Thompson, 'A Defense of Abortion' 1971) 1(1) *Philosophy and Public Affairs* 47,48-49; cf Amel Alghrani and Margaret Brazier, 'What is it? Whose it? Re-positioning the Fetus in the context of Research' (2011) 70 (1) *The Cambridge Law Journal* 51; Jessica Flanigan, 'Obstetric Autonomy and Informed Consent' (2016) 19 *Ethic Theory Moral Prac* 225, 235-237.

82 The state may impose a duty in the interests of public health and safety e g see discussion in J Flanigan, A Defense of Compulsory Vaccination. HEC Forum: An Interdisciplinary Journal on Hospitals' (2014) 26 (1) Ethical and Legal Issues 5; blood testing can be ordered under road safety legislation*, Road Safety Act 1986* (Vic) s56; and DNA samples ordered in respect of criminal prosecutions *Crimes Act 1958* (Vic) s464SC.

83 *R v Russell* [1933] VLR 59.

84 Cf Julian Savulescu, 'Future People, Involuntary Medical Treatment in Pregnancy and the Duty of Easy Rescue' (2007) 19 (1) *Utilitas* 1.

85 *141 Ill 2d 473(1990); see also McFall v Shimp* 10 Pa D and C 3d 90 (1978); *In Re Richardson* 284 SO 2d 185, La (1973).

compatibility. No other donors were located and the half-sibling Jean Pierre died in late 1990.[86]

That, generally, there is no duty to rescue has been accepted by the courts[87] and in legal and medical discourse as stating the law, but not without criticism.[88] Savulescu argues that the law ought to recognise 'easy duty to rescue' which has been described as 'a moral obligation to benefit others, or to prevent harm to others, when doing so entails a small cost to them'.[89] He argues 'that respect for autonomy is not unrestricted'[90] and persons are obligated to undergo medical treatment which will markedly assist other persons and provides a minimum inconvenience to themselves.[91] The 'easy duty to rescue' an idea which he promotes,[92] has problems particularly when applied to pregnant women.

The issues relate directly to the importance given to the person's right to bodily integrity and freedom from interference. It also accords with the rule that absent a duty imposed by law there is no duty to save or rescue.[93] Given that there is no duty to undergo medical treatment to save even family members it would be inconsistent to impose such an obligation on a pregnant women in respect of her foetus. To compel her to undergo medical treatment would be to accord greater rights to the foetus than to legal persons,

86 *Currran v Bosze* 141 Ill 2d 473 (1990).

87 See *Stovin v Wise* [1996] AC 923, 931, Lord Nicholls.

88 See an argument for forced vaccination in A Giubilini 'Vaccination and Herd Immunity: Individual, Collective, and Institutional Responsibilities' in Palgrave Studies in Ethics and Public Policy, *The Ethics of Vaccination* (Palgrave Pivot, Cham, 2019) 29, 55-56; see also J Flanigan, 'A Defense of Compulsory Vaccination, (2014) 26 (5) HEC Forum 25; A Giubilini et or, 2018. 'Quarantine, isolation and the duty of easy rescue in public health' (2018) 18 *Developing World Bioethics*182.

89 Savulescu, Julian 'Future People, Involuntary Medical Treatment in Pregnancy and the Duty of Easy Rescue' (2007) 19 (1) *Utilitas* 1,3.

90 Savulescu, Julian 'Future People, Involuntary Medical Treatment in Pregnancy and the Duty of Easy Rescue' (2007) 19 (1) *Utilitas* 1,3.

91 Rulli (n 80).

92 Savulescu (n 88) 5.

93 See e g, *R v Russell* [1933] VLR 59; for a case on consent see *Re GWW and CMW* (1997) FLC 92-748.

including her children.[94] To impose upon a woman even a 'duty of easy rescue'[95] would mean that she would owe a greater duty to a foetus who lacks personhood than to her children who have legal personality and whom she is required to protect.[96]

### *2 Medical Emergencies*

Although, there is no duty to rescue others, even in a life-threatening situation, there is one situation in which consent to medical treatment may be overborn. Consent may be dispensed with in the context of a medical emergency and thus an unlawful battery becomes lawful.[97] Authority for this proposition is to be found in both the common law[98] and legislation.[99] It applies to some extent in all the jurisdictions under consideration.[100] The rationale is that, in an emergency, consent cannot be obtained because the patient is not in the position to make a decision. The patient may die or suffer serious health problems and the state has an interest in maintaining the well-being of its people. The

94 Michele Goodwin, 'If Embryos and Fetuses Have Rights' (2018) 11(2) *The Law & Ethics of Human Rights* 189.

95 See Savulescu (n 89).

96 Emily Jackson, *Regulating Reproduction Law, Technology and Autonomy* (Oxford; Portland, Or: Hart, 2001) 133.

97 In *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18, 3 WLR 120, discussed above concluded that this was an emergency situation in which it was lawful for the medical practitioners to use their judgment as to the appropriate treatment. It is a defence to assault rather than an exception to the general rule.

98 *Rogers v Whitaker* (1992) 175 CLR 479, 489 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ; *Re F (Mental Patient Sterilisation*) [1990] 2 AC 1; *Re T (Adult Refusal) (Medical Treatment)* [1992]; *Murray v McMurchy* [1949] 2 DLR 442; CanLII 220 (BC SC); *Marshall v Curry* [1933] 3 DLR 260, 262-263 per Chisholm CJ; *Guys And St Thomas NHS Foundation Trust (GSTT) & Anor v R* [2020] EWCOP 4 (29 January 2020).

99 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s13 puts the common law principle in statutory form; See also *Emergency Medical Operations Act 1973* (NT) s3; *Criminal Code 1899* (Qld) s282; *Criminal Code Act 1913* (WA) 259; *Criminal Code 1924* (Tas) s51 and s149; *Medical Treatment Planning and Decisions Act 2016* (Vic) s53; *Mental Health Act 2007* c 12(UK) s64G

100 See eg, *H Ltd v J* (2010) 107 SASR 352.

doctor can act on behalf of the state to fulfil the obligation.[101] There is no need for the doctor to obtain the consent of an adult patient's family.[102]

However what if a patient has previously made a fully informed decision that s/he would not consent to a particular treatment if it was needed at some stage in the future and the decision may result in death?[103] The right to provide for consent or refusal of medical treatment in case of incapacity to consent in the future has been provided for by statute in some jurisdictions.[104] It is often called an 'advance directive', a 'living will' or something similar. Who may make it,[105] the precise form in which it may be made and the particular medical treatment which may be refused, and other operational details, vary between jurisdictions.[106]

Where the situation is one of emergency, an advance directive has been executed and the medical professional knows of its existence, the right of the patient to refuse treatment usually prevails. The professional who ignores the directive and administers treatment may be liable for an assault. For example, the Canadian case of *Malette v Shulman*[107] involved an emergency where an unconscious woman needed a blood transfusion. A nurse found a card which was signed by the plaintiff. It included that as she was a devout Jehovah's Witness and she did want any blood or blood products to be

101 Kurt M Hartman and Bryan A Liang, 'Exceptions to Informed Consent in Emergency Medicine' (1999) *Hospital Physician* 53.

102 See eg, *Hospital Authority v C* [2003] 1 HKLRD507; but see *Medical Treatment Planning and Decisions Act 2016* (Vic) s53, s55.

103 See *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18, 3 WLR 120.

104 Eg, *Medical Treatment Planning and Decisions Act 2016* (Vic) Part 2; *Advance Personal Planning Act 2013* (NT); *Mental Capacity Act 2005* (UK) ss24-26*; Advance Health Care Directives Ac*t, S NFLD, ch A-4.1 (1995) (Can); *Substitute Decisions Act*, S O, ch 30 (1992) (Can); *Medical Consent and Natural Death Act*, IC §§ 39-4501 to 39-4515 (USA); Texas, *Tex Health & Safety Code* Ann § 166.049 (Vernon 2001 & Supp. 2004).

105 Eg, in many USA states such directives are invalid if the woman is or becomes pregnant; Katie Rinkus, 'The Pregnancy Exclusion in Advance Directives: Are Women's Constitutional Rights Being Violated?' (2014) 19 (2) *Public Interest Law Reporter* 94, 97; Find Law, 'Living Wills – State Laws'. Web.

106 Eg, *Medical Treatment Planning and Decisions Act 2016* (Vic), *Advance Care Directives Act 2013* (SA) *Mental Capacity Act 2005* (UK) c9 s25 (6).

107 *(1990) 67 DLR (4th) 321.*

given to her 'under any circumstances'. There was also a statement to the effect that she fully realised the possible implications of refusing treatment with blood products but was resolute in her decision to obey her faith. Notwithstanding the instructions on the card, the doctor administered blood transfusions. The woman sued. It was held that the doctor should have abided by the patient's wishes as made clear on the card. Robins JA stated that the doctor 'had no authorisation under the *emergency doctrine* to override the patient's wishes'. He concluded that she had the right 'to reject in advance of an emergency a medical procedure inimical to her religious values'.[108] This decision was approved by Beazley P in *X v The Sydney Children's Hospitals' Network*.[109]

Robin's JA decision may appear problematic for the medical professional given her/his commitment to save lives and 'do no harm'. However, the autonomous right of the individual to refuse medical treatment takes precedence and reinforces the importance given to the autonomy of the person. It also indicates that an application of these principles to pregnant women is necessary so that their right to be treated as equivalent with other legal persons is upheld. Unfortunately, there are jurisdiction where advanced directives are not recognised or not valid when a woman is pregnant.[110]

## III PREGNANCY AND INTERVENTION

### *A Background*

The previous section analysed the legal principles applicable to the right of all legal persons to consent to or refuse medical treatment. This part examines cases,[111] in which there has been unwanted intervention in the lives of pregnant women, which indicate that the women involved were treated differently from persons who were not pregnant. These cases illustrate that the laws of consent, refusal and choice of medical treatment apply to all persons, including pregnant women. However, they revealed that pregnancy was considered as relevant to the application of the principles and was important in reaching decisions.

108 (1990) 67 DLR (4th) 321,336 [emphasis added].
109 (2013) NSWSCA 320 [58]; (2103) 85 NSWLR 294, [58].
110 Angela Fagerlin and Carl Schneider, 'Enough: The Failure of the Living Will (2004) 34 *Hastings Center Report* 30.
111 It is noted that, although important in providing the overall context it is not possible to give in depth analysis of the cases within the thesis.

Cases where judicial intervention was sought to override the consent or refusal of the pregnant woman and the manner in which the foetus is taken into consideration by the medical profession, welfare agencies and the judiciary which are the primary focus here. Cases where women have sued doctors because of negligence in performing a procedure or because there had been consent to a procedure such as a caesarean and the doctor had also performed a hysterectomy are not discussed here although the issue of consent is relevant in the context of these civil suits and perhaps criminal prosecutions.

In the cases considered here legal intervention into the lives of pregnant women has taken two forms. The first is where the woman refuses to take medical advice and the medical profession seeks judicial intervention to permit the treatment to be performed without the need for her consent. In addition, to direct judicial intervention to directly override consent, welfare laws and/or the criminal law have been invoked to coerce the pregnant woman so as to protect the foetus.[112] Some cases illustrated that both methods were used to achieve compliance.[113]

112 In Wisconsin Alecia Beltran was arrested, shackled and confined when 14 weeks pregnant because of past, but not current, use of illicit drugs, *Beltran v Loenish,* United States District Court for the Eastern District of Wisconsin 2013, Judge Charles Clevert; Erick Eckholmoct, 'Case Explores Rights of Fetus Versus Mother' *New York Times*, 23 October 2013; Bruce Vielmetti,, 'Pregnant woman fights Wisconsin's fetal protection law' *Milwaukee Journal Sentinel* 24 October 2013; Linda C Fentiman, 'Pregnant Women and Mothers Are Being Criminalised By Their Care Providers', *In These Times* 16 March 2017.

113 See eg, Lynn M Paltrow and Jeanne Flavin, 'Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health' (2013) 38 (2) *Journal of Health Politics, Policy and Law* 314-315; 299, which discussed the case of Zimmerman where 'medical staff decided to contact the police and characterize her as a criminal only after she refused to consent to fetal monitoring and cesarean surgery' (*State v. Zimmerman*, File No 96-CF-525, Transcript of Preliminary Hearing (Racine County Circuit Court, July 3, 1996) at 115); see *In re Unborn Child Cornea*u, No. CP-00-A-0022 (Mass. Juv. Ct. Attleboro Div. Aug. 29, 2000) also discussed at 325.

### *1 Judicial intervention*

Judicial intervention to compel pregnant women to have medical treatment has been sought most frequently in the USA,[114] to a lesser extent in the UK[115] and elsewhere.[116] The cases in this chapter raise questions for all women of child-bearing age because they have highlighted the potential that the courts may impose medical treatment upon them should they fail to adhere to the advice of their medical professionals. The cases involve women from a variety of socio-economic statuses. The majority of those involved those of a disadvantaged socio-economic status, of colour and belonging to a racial minority.[117] There were cases in which the women were not socio-economically disadvantaged but nevertheless subject to court intervention to override the need for pregnant women's consent to medical treatment.[118]

114 Paltrow and Flavin, 'Arrests of and Forced Interventions' claim that the figures of forced interventions are underrepresented; see Rachel Roth, *Making Women Pay: The Hidden Costs of Fetal Rights* (Ithaca, NY, Cornell University Press, 2000) 95

115 The number of cases in the UK is not known. The cases reported by the Court of Protection have risen substantially in the past few years but because, prior to 2013, the court was closed, its proceedings were not available to the public. Thus, it is difficult to assess the number of cases with any accuracy.

116 There are few verified cases in Australia but there is anecdotal evidence that the number is greater than reports suggest; '"Women are feeling bullied and coerced": Australia's rising c-section rate' *SBS News* 7 July 2015; Aisha Dow 'Public patients forced into caesareans as ancient birth practice declines' *The Age* 18 January 2019.

117 M Paltrow and Jeanne Flavin (n 113) See *Burton v State* (2010) 49 So 3d 263; Kate Wevers, 'Recent case developments in health law: *Burton v Florida*: maternal-fetal conflicts and medical decision-making during pregnancy' (2010) 38 (2) *Journal of Law, Medicine & Ethics* 436;, 'Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health' (2013) 38 (2) *Journal of Health Politics, Policy and Law* 29

118 Eg, *Qumsieh v Guardianship and Management Board and Pilgrim* [1998] VSCA 45; *Munoz v John Peter Smith Hospital* 17th District Tarrant County Court Texas 1/14, Cause No 017-270080-14 /2014.*z*; Lynn M Paltrow and Jeanne Flavin (n113) whose research demonstrates the high proportion of socio-economically disadvantaged women who are targeted for intervention; see below Section 2 of this Part.

What constitutes medical treatment during pregnancy has a broad definition when looking at the court decisions and the types of *medical treatment* which have been the subject of judicial intervention are many and varied. Instances where women have not consented included: forced caesareans,[119] forced abortion,[120] blood transfusions;[121] emergency treatment,[122] medicine taken orally or through a needle; needles for purposes of anaesthesia;[123] ultrasounds;[124] forced ante-natal treatment,[125] forced hydration and feeding,[126] bedrest,[127] and forced induction.[128]

119 *In Re CA (Natural Delivery or Caesarean Section)* [2016] EWCOP 51 (08 December 2016)*Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr* 66 F Supp. 2d 1247, 1250 (N D Fla 1999); *Jefferson v Griffin Spalding County Hospital Authority* 274 SE 2d 457 (1981); *Re AA* [2012] EWHC 4378; *In re AC* (1990) 573 A 2d 1235; See *Ms Y v Health Services Executive & Ors* [2016] IEHC 136; *In re Madyun* (1986) 114 Daily Wash L Rep 2233, see Appendix to *In re AC* 573 A 2d 1235, 1262 (1990) (*In re Madyun*); see Ruth Fletcher, 'Contesting the cruel treatment of abortion-seeking women' (2014) 22(44) *Reproductive Health Matters* 10-21, discussed in Chapter 3 – The Legal Regulation of Abortion,

120 *Lefebvre v North Broward Gen Hospital* (1990) 566 So 2d (Fla. 4th DCA 1990) 568, 570 where a hospital sought a court order requiring a patient suffering from a mental illness to have an abortion against her wishes; *Re Application of Local Health District ; Re Patient Fay* [2016] NSWSC 624.

121 *Qumsieh v Guardianship and Management Board and Pilgrim* [1998] VSCA 45; *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson*201 A 2d 537 (1964); *The Application of Sydney Children's Hospita*l [2018] NSWSC 1259.

122 *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18;[1993] Fam 95,102 (CA).

123 *Re MB* [1997] EWHC Civ 3093

124 Sarah E Weber, 'An Attempt to Legislate Morality: Forced Ultrasounds as the Newest Tactic in Anti-abortion Legislation' (2009) 45 (2) *Tulsa Law Review* 359, 372-379; see facts in *In re Unborn Baby Kenner* (1979) Unrep 79 JN (ColoJuv Ct) 83 nv; see Nancy K Rhoden, 'The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans' (1986) 74 (6) *California Law Review* 1951( n 120).

125 *In re Unborn Child of Samantha Burton*, No. 2009 WL 8628562.

126 See *Ms Y v Health Services Executive & Ors* [2016] IEHC 136; see Ruth Fletcher, 'Contesting the cruel treatment of abortion-seeking women' (2014) 22(44) *Reproductive Health Matters* 10-21, discussed in Chapter 3 – The Legal Regulation of Abortion (n ).

127 *Burton* (n 124) ; see Susan Donaldson James, 'Pregnant Woman Fights Court-Ordered Bed Rest', ABC NEWS (Jan. 14, 2010).

128 See Julie Roberts, and Denis Walsh, '"Babies Come When They Are Ready": Women's Experiences of Resisting the Medicalisation of Prolonged Pregnancy' (2019) 29 (1)

Treatment and management, including the prevention of breast feeding by an HIV positive pregnant women has been granted.[129] The maintenance of a pregnant woman on life support comes within the rubric.[130] Tests assessing foetal development or problems therewith are continuously growing in number and considered important medical 'treatment'.[131] Interventions which require medical and surgical procedures on the foetus would be included in medical treatment.[132] In addition to authorising medical treatment courts have included ancillary measures so that the treatment may be carried out. Thus, shackling, restraint and even sedating have been authorised.[133] The courts

Feminism & Psychology 40 research which reported that where women passed their due date were pressured to have an induction; at this stage the research has not revealed and reported judicial intervention to compel a women to 'be induced' because of the due date having passed.

129 *State v Cannon*, No. C805783 (S.C. Ct. Gen. Sess. Spartanburg County Feb. 11, 1993); see also *Re Elm* [2006] NWSC 1137.

130 See for example *In Re AC*; Manny Fernandez, 'Pregnant, brain-dead woman Marlise Munoz has life support removed' *The Sydney Morning Herald* 27 January 2014; see also case of Benson in Sydney Lupkin, 'Brain Dead and Pregnant: Why One Baby Was Born and One Wasn't' *ABC News* 12 February 2014

131 See Josephine Johnson, 'Supporting Women's Autonomy in Prenatal Testing' (2017) 6 *The New England Journal of Medicine* 505.

132 Sheila AM Mclean, 'The Moral and Legal Boundaries of Fetal Intervention: Whose Right/whose Duty' (1998) 3 (4) *Seminars in Neonatology* 249; Cassandra Willyard, 'Tinkering in the Womb: The Future of Fetal Surgery. (NEWS)' (2008) 14 (11) *Nature Medicine* 1176; Mark Ferguson et al, 'British surgeons have performed an amazing operation repairing a baby's spinal deformity while she was still inside a mother's womb' *Seven News* (SEVEN NETWORK) 13 February 2019;(RMIT Publishing, Melbourne 2019).

133 See eg, *Re AA* [2012] EWHC 4378 (COP); *Re Elm* [2006] NSWSC 1137; *Queensland v D* [2004] 1 Qd R 426; Dan Sales, 'Secret C-Section: Judge authorised doctors to secretly drug pregnant woman and perform Caesarean section on her against her wishes' *The Star* 2 October 2019. (online)This also occurs when the criminal law is invoked to compel treatment. In Wisconsin Alecia Beltran was arrested, shackled and confined when 14 weeks pregnant because of past, but not current, use of illicit drugs, *Beltran v Loenish,* United States District Court for the Eastern District of Wisconsin 2013, Judge Charles Clevert; Erick Eckholmoct, 'Case Explores Rights of Fetus Versus Mother' *New York Times*, 23 October 2013; Bruce Vielmetti,, 'Pregnant woman fights Wisconsin's fetal protection

have also authorised that the woman is not to be advised of the order because her reaction may interfere with the performance of the medical treatments.[134] The categories of what constitutes *medical treatment* during pregnancy would appear open ended. It will no doubt vary according to the facts of the case. For example, the courts have declined to order that sperm be removed from a dying spouse because it was not medical treatment.[135]

In the USA, the UK and elsewhere, in addition to judicial intervention to compel medical treatment, there has been an extensive use of the criminal law;[136] child protection, social welfare and other laws, ostensibly to protect the foetus from the woman and to control and punish her for actions which may harm or kill the foetus.[137] Women have been incarcerated to 'protect' the foetus.[138] The criminal law has also used as an indirect

law' *Milwaukee Journal Sentinel* 24 October 2013; Linda C Fentiman, 'Pregnant Women and Mothers Are Being Criminalised By Their Care Providers' *In These Times*, 16 March 2017.

134 *Re AA* [2012] EWHC 4378 (COP); *Re Elm* [2006] NSWSC 1137; *Queensland v D* [2004] 1 Qd R 426;

135 *MAW v Western Sydney Area Health Service* (2000) 49 NSWLR 231, 240-242, where O'Keefe J decided that this was not therapeutic and therefore would not be authorised under the inherent *parens patraie* jurisdiction of the court.

136 Melissa Rowland refused to undergo a caesarean after an ultra-sound. She left the hospital. One of her twins was stillborn and the other was addicted to cocaine. She was originally charged with murder with the possibility of the death penalty but later convicted of 'child endangerment'; See H Minkoff and Lynn M Paltrow, 'Melissa Rowland and the rights of pregnant women' (2004) 104 (6) *Obstet Gynecol* 1234; *State v Rowland*, No 041901649 (Utah Dist Ct, 3d Apr 7,2004) (Fuchs, J) nv.

137 See *Burton v State* (2010) 49 So 3d 263; Kate Wevers, 'Recent case developments in health law: *Burton v Florida*: maternal-fetal conflicts and medical decision-making during pregnancy' (2010) 38 (2) *Journal of Law, Medicine & Ethics* 436; *Bei Bei Shuai v Indiana*, 966 N.E.2d 619, 622 (Ind. Ct. App. 2012) where a woman faced charges of murder of her foetus because of an attempted suicide; see Brown, Geneva, 'Bei Bei Shuai: Pregnancy, Murder, and Mayhem in Indiana' (2014) 17 *Journal of Gender, Race and Justice* 221

138 See, eg, *Loertscher v Anderson*, 259 F Supp 3d 902 (WD Wis 2017) vacated, 893 F 3d 386 (7th Cir. 2018); Ada Calhoun, 'A Wisconsin mother, imprisoned to protect her fetus, fought back in federal court: and won the first round' *The Atlantic* 12 October 2015; Kenneth A De Ville, and Loretta M Kopelman, 'Fetal protection in Wisconsin's revised child abuse law:

means of compelling medical treatment during pregnancy.[139] This is true in respect of welfare law as well.[140] The women who have been subjected to judicial intervention have an obvious common denominator in that they were pregnant and, in some way, came to the attention of the authorities. The question is: Was the intervention and punishment they received based upon their status as pregnant?

The pregnant women who are likely to become the defendants in criminal and welfare intervention cases are heterogeneous, but it is most likely that the vast majority will be socio-economically disadvantaged, from a racial minority, and, likely to come to the attention of the welfare and police authorities.[141] Paltrow and Flavin have claimed that

> Our research also revealed that in some cases making a report to child welfare authorities was no different than making a report directly to law enforcement officials.[142]

This is not surprising given the interaction and inter co-operation between the welfare agencies the police and the hospitals.[143]

The pregnant woman may have problems with alcohol or other drugs which will exacerbate the negative manner in which they are viewed and consequently their autonomy being disregarded and undermined.[144] Further for these women their disadvantage is compounded. They are not only vulnerable because of their social

right goal, wrong remedy' (1999) 37 (4) *Journal of Law, Medicine & Ethics* 332.

139 Lynn M Paltrow and Jeanne Flavin (n 113), 304.

140 Ibid.

141 According to Paltrow and Flavin, (n 113) 311, nearly all of the defendants were socio-economically disadvantaged, and women of colour were disproportionally represented being more than 70%.

142 See Paltrow and Flavin (n 113) 327.

143 Michele Goodwin, 'Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront' (2014) 102 *California Law Review* 781, 789; M Goodwin, 'Changing Roles of Doctors and Nurses: Hospital Snitches and Police Informants. In *Policing the Womb: Invisible Women and the Criminalization of Motherhood* (Cambridge: Cambridge University Press; 2020) 78.

144 Shaylih Muehlmann, 'The Gender of the War on Drugs'. (2018) 47 *Annual Review* of Anthropology 315–330; ND Campbell & D Herzberg, 'Gender and Critical Drug Studies: An Introduction and an Invitation' (2017) 44 (4) *Contemporary Drug Problems 251*–264.

situation; they lack access to programs of support available to others who may have problems with substance abuse, and they lack the resources to withstand their decisions being overridden by the courts.[145] Compounding their vulnerability is that they suffer the additional stigma of being stereotyped as unfit for the role of motherhood.[146]

These women may be given sentences or longer sentences of incarceration because they are pregnant; they may also be thought to be deserving greater punishment because they had failed to look after their foetus; or they may jailed to prevent drug and substance abuse or other activities which are deleterious to the foetus; and/or the judiciary may assume that the women may get the healthcare, including rehabilitation programs.

Where pregnant women are physically detained, either in a gaol or otherwise institutionalised, they suffer the distinct probability that social welfare will, upon birth, immediately remove the neonate from the woman.[147] There is a greater likelihood of this occurring where she has existing children who are 'in care'.[148]

In common with the women who *refuse treatment*, the women who are *incarcerated* may also be forced to undergo medical treatment. Michelle Goodwin[149] has summed up what is required to protect women's autonomy and their chance at individuation.[150]

145 Michele Goodwin, 'Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront' (2014) 102 *California Law Review* 781, 784-786; Dorothy Roberts, 'Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy' (1991) 104 *Harvard Law Review* 1419.

146 See Lisa C Ikemoto, 'The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law' (1992) 53 *Ohio State Law Journal* 1205; Paula Abrams, 'The Bad Mother: Stigma, Abortion and Surrogacy' (2015) *Journal of Law, Medicine and Ethics* 179,180;

147 *DYFS v VM*, 974 A2d 448 (NJ Super Ct App Div 2009)

148 Eg, *Re AA* [2012] EWHC 4378 (COP); Jeanne Flavin, *Our Bodies, Our Crimes: The Policing of Women's Reproduction in America* (New York: NYU Press, 2009).

149 Michelle Goodwin, 'How the Criminalization of Pregnancy Robs Women of Reproductive Autonomy' in Just Reproduction: Reimagining Autonomy in Reproductive Medicine, special report (2017) 47 (6) *Hastings Center Report* S19.

150 Cornell, (n 7).

> Reproductive autonomy must be understood to encapsulate not only the right to end a pregnancy without civil and criminal intervention, entrapment, and punishment by the state.[151]

This next section will commence by considering, by way of illustration, cases which involve direct intervention to compel particular medical treatments. It will provide examples of how the criminal and civil laws have been instrumental in compelling *protection* of the foetus at the expense of the woman's autonomy. [152]

## B Consent and Pregnancy

The UK, Australia, Canada and NZ retain the *born alive rule* and have generally adopted the *absolute right approach*[153] which in principle has meant that since the foetus has no legal rights the woman's rights cannot be overborne to compel medical treatment to protect the health of the foetus.[154] The Courts in the USA have held that in some circumstance there is an exception, mostly at lower court level, to the fundamental right to bodily integrity when the medical treatment is necessary to fulfil, what is characterised as, a *compelling state interest*.[155] Recognising a limitation upon the right to refuse medical treatment is referred to here as the *limited right approach* and has been applied by the courts to compel pregnant women to undergo medical treatment in the interests of the foetus. In these cases, it may be seen that the fundamental right to refuse medical treatment may be overridden by the compelling state interest in its future

151 Goodwin, 'Criminalization of Pregnancy' (n 140) S20.

152 Theresa Morris and Joan H Robinson, 'Forced and Coerced caesarean sections in the United States' (2017) 16 (2) *Contexts* 24, 26.

153 *A reference to the UK includes Australia, Canada and NZ except where the context requires otherwise; see Chapter 2 – Theoretical Underpinnings, Section III.*

154 These are predominantly decisions of lower level courts, see *Loertscher v Anderson*, 259 F Supp 3d 902 (WD Wis 2017) vacated, 893 F 3d 386 (7th Cir. 2018)

155 See Kristin M Lomond, 'An Adult Patient's Right to Refuse Medical Treatment for Religious Reasons: The Limitations Imposed by Parenthood' (1993) 31 *University of Louisville Journal of Family Law* 665, 666, who noted that the four compelling interests of the state which warranted the 'overriding' of the right were 'the protection of the patient's life, the prevention of suicide, the integrity of the medical profession and the protection of innocent third parties'; the state interest in the foetus once viable may be seen as coming within these or it might be seen as being a separate interest see e g, *Planned Parenthood of Southeastern Pennsylvania v Casey 505* U.S. 833, 846 (1992).

population. Under the *limited right approach,* the courts have been willing to accept, depending upon the facts of the case, the existence of a foetal exception to the right to bodily integrity.[156] What follows is an analysis of some of the judgments which have considered the right to refuse or consent to medical treatment and applied a *limited* or an *absolute* right approach.

### *1 The USA and a limited right approach*

The USA in eschewing the *born alive rule* and recognising that the state has an interest in the welfare of the foetus in some cases has applied a *limited right approach*. Once again there is little consistency between the states as to how this in applied. There are few reported cases of judicial intervention to override the refusal of medical treatment in the mid-20th Century.[157] One such case was *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson*.[158] In1964, a pregnant woman who was a devout Jehovah's Witness refused a blood transfusion. The court appointed a guardian for the foetus so that the state's compelling interest could be discharged.[159]

*In re Unborn Baby Kenner* [160]*.*a Colorado Hospital obtained a court order to perform a caesarean section upon a woman who had refused treatment. She had refused because of her experience of previous surgery. She was 'morbidly obese', a factor which increased the risk to her health. She was also described as 'angry and unco-operative'.[161] Her labour was not progressing and there was evidence of foetal distress. The order was

156 This approach has been used to make women criminally responsible if she causes harm to her foetus or even where she is allegedly putting her foetus at risk; Morris and Robinson (n 149).

157 The number of cases around this time and even previously is hard to determine since there is a lack of officially reported cases and some cases were not reported at all; See NK Rhoden, (n 121); Morris and Robinson (n 149) 25.

158 *Raleigh Fitkin-Paul Morgan Memorial Hospital v Anderson* 201 A 2d 537 (1964).

159 *Jefferson v Griffin Spalding County Hospital Authority* 274 SE 2d 457 (1981); see also *Crouse Irving Memorial Hospital, Inc v Paddock*, 485 NYS 2d 443 (1985); *Mercy Hospital, Inc v Ernestine Jackson* 306 Md 556 (1985); *In re Madyun* (1986) 114 Daily Wash L Rep 2233.

160 *In re Unborn Baby Kenner* (1979) Unrep 79 JN (Colo Juv Ct) 83 nv; see NK Rhoden (n 121) 1959-1960..

161 NK Rhoden (n 121).

granted on the basis of the state's compelling interest in the preservation of the foetus which was declared to be a neglected child.[162]

In 1981, *Jefferson v Spalding County Hospital Authority (Jefferson)*[163] Jesse Mae Jefferson was ordered to undergo a caesarean and have a blood transfusion, despite having objected to these on religious grounds. Her doctor had advised her that, 'it is a 99% chance that the child cannot survive natural childbirth'.[164] In refusing to consent to a caesarean Jesse Mae said that 'the Lord has healed my body and that whatever happens to the child will be the Lord's will'.[165] Nevertheless, the court balanced the interests of the foetus and the woman and concluded that 'the intrusion involved into the life of Jesse May Jefferson and her husband ... is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live'.[166] They ordered that if necessary she should undergo a caesarean and have a blood transfusion, which was against her strongly held religious beliefs. Subsequently, the sonogram revealed that she no longer required a caesarean. She later gave birth vaginally to a completely healthy baby.[167] Apparently, the earlier diagnosis had been incorrect due to a technical problem with the sonogram.[168]

By applying the balancing of the interests of the state against the autonomy of the pregnant woman the Court in *Jefferson* considered that any intrusion was justified by the obligation of the state to ensure the healthy birth of the foetus. The balancing of interests test would appear to lack objective principles in its application and the courts have been inconsistent when adopting it[169].

162 Ibid.

163 *Jefferson v Griffin Spalding County Hospital Authority* 274 SE 2d 457 (1981). 4.

164 Ibid

165 Ibid.

166 *Jefferson v Griffin Spalding County Hospital Authority* 274 SE 2d 457 (1981).

167 Ibid 460.

168 Ibid; see also *In re Baby Jeffries* Unrep No 14004 Jackson County, Mich P Ct May 24, (1982), see report Detroit Free Press, June 16, 1982, at 3A, 7A where the court ordered treatment refused on religious grounds, the woman went into hiding and vaginally delivered a healthy baby. See report Detroit Free Press, June 16, 1982, at 3A, 7A.

169 Lidia Hoffman and Monica K Miller, 'Inconsistent State Court Rulings Concerning Pregnancy-Related Behaviors' (2009) 22 JL & Health 279, 287.

The extent or degree of invasiveness of the treatment on the pregnant woman has been used in deciding whether the woman's autonomy should be overridden in favour the interests of the foetus. Unfortunately, as is seen from the following examples there is little agreement as to which procedures are minimally intrusive, marginally intrusive, extensively intrusive or, as in *Jefferson*, any intrusion is warranted to protect the viable foetus. The test has been criticised for lacking objectivity and is clearly value laden.[170]

*In Re Madyun*,[171] Ayesha and Yahya Madyun wanted a natural childbirth. They did not believe a caesarean to be necessary and referred to the absence of evidence of sepsis. The matter was brought before Levie AJ who considered that a caesarean was not sufficiently invasive to allow the woman's autonomy to prevail. He decided that:

> All that stood between the Madyun fetus and its independent existence, separate from its mother, was, *put simply, a doctor's scalpel*. In these circumstances, the life of the infant inside its mother's womb was entitled to be protected.[172]

The caesarean was performed, and a healthy baby was born. There was no sign of any infection.[173]

Additionally, the consideration of whether a particular treatment or procedure is intrusive has not always been related to the situation of the women involved. But rather it has been based upon the subjective opinion of the judiciary.[174] In *Re AC*[175] the US Supreme Court was clear that a court must not decide upon whether they considered that a treatment was minimally or extensively invasive but must consider the entire evidence. The focus should be upon any written or oral information about the patient

170 Erin P Davenport, 'Court Ordered Cesarean Sections: why courts should not be allowed to use a balancing test' (2010) 18 (1) *Duke Journal of Gender Law & Policy* 79, 80.

171 *In re Madyun* (1986) 114 Daily Wash L Rep 2233, see Appendix to *In re AC* 573 A 2d 1235, 1262 (1990) (*In re Madyun*).

172 *In re Madyun* (1986) 114 Daily Wash L Rep 2233, see Appendix to *In re AC* 573 A 2d 1235, 1262 (1990); cf *Royal Free NHS Foundation Trust v AB* [2014] EWCOP 50[ ]; P [2013] EWHC 4581[15] (COP) where a caesarean was considered an invasive procedure; see also *In Re Baby Boy Doe* 632 NE 2d 326 (Ill App Ct1994) 327.

173 Ibid; The Court of Appeals of the District of Columbia subsequently affirmed the order in an unreported judgment. (See appendix *In re AC* (573 A2d 1235 (1990).

174 See *Re Madyun* .

175 *In re AC* 573 A 2d 1235 (1990).

which may have been given or made known to family, friends, and health-care professionals. A patient's past decisions regarding medical treatment were relevant as were her values, goals, and desires. What would the patient decide if competent?[176]

*In re AC* made it quite clear that the right to refuse medical treatment was fundamental but not absolute.

> We do not *quite* foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be *extremely rare* and *truly exceptional*. This *is not* such a case.[177]

Some state courts have continued to consider the extent of 'invasiveness' in deciding whether to intervene. *In re Fetus Brown*,[178] it was held 'that a blood transfusion is an invasive medical procedure that interferes with a competent adult's bodily integrity'.[179] Three years earlier in *In Baby Boy Doe*,[180] the Supreme Court of Illinois, although not deciding the point, had considered obiter that a blood transfusion was 'relatively non-invasive'.[181] *In re Baby Boy Doe* court intervention was sought when a woman refused a caesarean because it conflicted with her strongly held religious beliefs.[182]

176 Ibid 1251.

177 *In re AC* (1990) 573 A 2d 1235, 1252.[emphasis added], Therry J; See *Burton v State* (2010) 49 So 3d 263; Kate Wevers, 'Recent case developments in health law: *Burton v Florida:* maternal-fetal conflicts and medical decision-making during pregnancy' (2010) 38 (2) *Journal of Law, Medicine & Ethics* 436; Howard Minkoff and Anne Drapkin Lyerly 'Samantha Burton and the Rights of Pregnant Women Twenty Years after "In re AC"' (2010) 40 (6) *The Hastings Center Report* 13.

178 *In re Fetus Brown*. 689 NE2d 397 (Ill Ct App. 1997).

179 *In re Fetus Brown*. 689 N.E.2d 397 (Ill Ct App 1997); see *Pemberton v Tallahassee Regional Medical Center, INC (1999) 66 F Supp 2d 1247 (District Court, Florida)* where a woman was 'forcibly returned' to the hospital to have a caesarean which was considered no more invasive than a vaginal birth.

180 *In re Fetus Brown* 689 NE 2d 397 (Ill Ct App 1997);

181 *In Re Baby Boy Doe* 632 NE 2d 326 (Ill App Ct1994); cf *In re Fetus Brown* 689 NE 2d 397 (Ill. Ct. App. 1997); Faith Lagay, 'When a Parent's Religious Belief Endangers Her Unborn Child' (2005) 7 (5) *Virtual Mentor Ethics Journal of the American Medical Association* 528

182 *In Re Baby Boy Doe* 632 NE 2d 326 (Ill App Ct1994) 327, 328.

However, in both *In Baby Boy Doe* and *In Re Fetus Brown* the Appellate Court of Illinois considered that the cases before them were not to be decided upon the balancing test. In doing so they applied the principles expounded in *Stallman v Younquist*,[183] a case which was concerned with and upheld the 'pregnancy immunity doctrine' whereby a woman is not liable in tort for injuries to her foetus.

In Illinois*, In Re Baby Boy Doe*[184] reaffirmed the principle that the woman's autonomy may only be overborne where there is a compelling interest of the state in protecting the foetus. The Court stated that this principle had been clearly articulated and in strong terms by the courts.[185]

> The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature *that she can exercise when she is not pregnant*. The potential impact upon the fetus is not legally relevant; to the contrary, the *Stallman* court explicitly rejected the view that the woman's rights can be subordinated to fetal rights.[186]

According to this view a woman is under no duty to guarantee the mental and physical health of her child at birth, and thus cannot be compelled to do or not do anything merely for the benefit of her unborn child.[187] *In Baby Boy Doe* the right of the woman to refuse a caesarean based upon strongly religious grounds was upheld and a healthy although underweight baby was born vaginally.

In *In Re Foetus Brown* the court ordered blood transfusion had occurred before the Appellate Court of Illinois decided that the pregnant woman's autonomous right to refuse medical should prevail. The court confirmed that the correct approach in Illinois was:

183 *Younquist v Stallman* 125 Ill 2d at 276, 126 Ill Dec 60, 531 NE 2d 355; see also *Thornburgh v American College of Obstetricians and Gynecologists* 476 US 747 (1986) for a strong statement upholding women's autonomy.

184 *In Re Baby Boy Doe* 632 NE 2d 326 (Ill App Ct1994)

185 *In re AC* (1990) 573 A 2d 1235,1251.

186 *In Re Baby Boy Doe*, 632 NE 2d 326 (Ill App Ct 1994) 332 [emphasis added]; *Younquist v Stallman,* 125 Ill 2d at 276, 126 Ill Dec 60, 531 NE 2d 355 was a negligence case involving the principle of maternal liability for negligent actions causing injuries to the foetus.

187 *In Re Baby Boy Doe*, 632 NE 2d 326,332 (Ill App Ct 1994).

> that the mother's rights and the fetus' rights may not be balanced, this case did not involve such a balancing. Instead, the issue as framed in this case involved the mother's right to refuse medical treatment as considered against the State's interest in the viable fetus.[188]

The decisions did not conclude that the women's autonomy to refuse medical treatment was absolute but said that 'the issue as framed in this case involved the mother's right to refuse medical treatment as considered against the State's interest in the viable fetus ' and a court is unable to 'impose a legal obligation upon a pregnant woman to consent to an *invasive* medical procedure for the benefit of her viable fetus'.[189]

Illinois adopts the position that the autonomy of the woman is equal to all other persons and is 'almost' absolute. Her rights are now legislatively protected.[190]

The application of the principle of autonomy shows that what constitutes a 'compelling state interest' varies as between the states. Generally, the USA recognises the right to autonomy with the proviso that it may be overridden on the basis of compelling state interests. How these compelling state interests are to be applied in any particular case remains unclear.

### *2 The absolute right approach in the born alive jurisdictions*

In the UK case of *Re T,* discussed above, the medical treatment was authorised because it was considered that the woman lacked capacity to consent to or refuse medical treatment. The case indeed involved a woman whose baby had been still-born and so the question of foetal interests was not in issue. The judges at first instance and in the appellate Court framed their ratios upon the general principles of the validity of consent.

Of relevance to this discussion is the obiter of Lord Donaldson.

> An adult patient who . . . suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it. . . The only *possible*

188 *In re Fetus Brown*. 689 NE 2d 397,400 (Ill Ct App. 1997).

189 Ibid 405.

190 See Public Act 101-0445 (410 ILCS 50/3.4) *The Medical Patient Rights Act* Sec. 3.4. Rights of women; pregnancy and childbirth. S9 'The right to accept or refuse any treatment, to the extent medically possible. (Effective – 1 January 2020).

> qualification is a case in which the choice may lead to the death of a *viable foetus*. That is not this case and, if and when it arises, the Courts will be faced with a novel problem of legal and ethical complexity.[191]

On the facts of the case there was no need to expand on this observation and he may not have thought about the potential ramifications of what was *obiter dictum*. It is a pity that having made such a statement his Lordship did not take an opportunity to clarify it and his position on such an important issue. Irrespective of his intentions and opinions on the existence of a *foetal exception,* his statement has been referred to in cases and academic writings.[192]

In the Australian case of *Hunter and New England Area Health Service v A*[193] McDougall J considered the validity of an advance directive refusing medical treatment. In summarising the principles to be applied he reiterated the well-established rule that 'it is at common law a battery to administer medical treatment to a person without the person's consent'.[194] Immediately following this statement he added a proviso which may have a potential to limit the rights of pregnant women to refuse or consent to medical treatment. He added that 'there may be a qualification if the treatment is necessary to save the life of a viable unborn child'.[195] In doing so he adopted of the words of Lord Donaldson, in *Re T* referred to above, but omitted the word 'possible'.

After referring to other judicial authorities which allowed the overriding of a patient's decision, McDougall J declined to pursue the issue further. He noted that '[s]ince the question does not arise in this case, it is neither desirable nor necessary that I should explore it further'.[196] Nevertheless his Honour's *obiter dicta* gives an indication of his probable decision should a relevant case be brought before him in the future. More

191 *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18; [1993] Fam 95,102 (CA). [emphasis added].

192 *Re S (Adult Refusal of Medical Treatment*) [1992]AC 649; Haberfield, Les, 'Pregnant Women: Intervention and the Right of Pregnant Women to Refuse Medical Treatment' (1995) 2 *James Cook U L Rev* 1.

193 *Hunter and New England Area Health Service v A* [2009] NSWC 761. (This was a case before a single judge of the New South wales Supreme Court); cf In *Re Elm.*

194 *Hunter and New England Area Health Service v A* [2009] NSWC 761[40].

195 Ibid [40].

196 *Hunter and New England Area Health Service v A* [2009] NSWC 761[20].

importantly it provides some authority to support those who would argue against pregnant women having the same right as others to refuse medical treatment.

Of concern, given McDougall J's approval of the principles outlined by Lord Donaldson and Brown P, is that the United Kingdom cases, subsequent to *Re T* and *Re S*, but before *Hunter v A*, had taken an opposite view. In *Re MB*[197] the position was stated by Lady Justice Butler-Sloss who delivered the verdict of the English Court of Appeal.

> The foetus up to the moment of birth does not have any separate interest capable of being taken into account when a Court has to consider an application for a declaration in respect of a Caesarean section operation. The Court does not have the jurisdiction to declare that such a medical intervention is lawful to protect the interests of the unborn child even at the point of birth.[198]

McDougall J did not refer to *Re MB,* which overruled Lord Donaldson's possible *foetal exception* to the general rule in *Re T*.[199]

In *State of Queensland v D*,[200] De Jersey CJ in exercising the Supreme Court's *parens patrie* jurisdiction considered that in authorising a hospital to perform a caesarean in the event it was necessary was 'in the interests of both the prisoner and her respective child'.[201]

The foetal health exception has been acknowledged in the context of clinical opinions. Callaghan et al noted that a person's right to refuse medical treatment should almost always be upheld unless there are exceptional circumstances which require that it be overridden.[202] According to Ryan and Callaghan, the situations which may justify

197 *Re MB* [1997] EWHC Civ 3093; see also *Paton v British Pregnancy Advisory Services Trustees* [1979] QB 276; Re F [1988] Fam 122; A-G*'s Reference (No 3 of 1994)* [1995] QB 581.

198 *Re MB* [1997] EWCA Civ 3093 [60].

199 *Ibid* [39]-[40].

200 [2004] 1 QdR 426.

201 Ibid 427.

202 Sascha Callaghan, Christopher Ryan and Ian Kerridge, 'Risk of suicide is insufficient warrant for coercive treatment for mental illness' (2013) 36(5–6) *International Journal of Law and Psychiatry* 374.

limitations on the right 'may include the state's interests in preventing suicide and the need to protect innocent third parties, such as dependent children and *even fetuses*' .[203]

Whether the NSW, Qld and other Australian courts would be prepared to acknowledge a *foetal exception* remains unanswered. It would appear that given the continued application of the *born alive rule* Australian jurisdictions are more likely to uphold the pregnant woman's right to autonomy, at least in theory.[204] However, as in the UK, the woman's capacity to refuse may be central to the actual decision.

John Seymour has come to the conclusion that the pregnant woman's right to refuse medical treatment 'should prevail'.

> This means that a doctor must respect the woman's decision to withhold consent to treatment, regardless of the nature of the intervention or the degree of risk to the woman or the fetus. This is a stark conclusion, but one which is compelled by acceptance of the principle of respect for maternal autonomy.[205]

Despite the suggestion of McDougall J of a 'foetal exception' in the case of pregnancy there are other influences or factors in operation which when taken collectively may support the autonomy of pregnant women in Australia. This may be inferred from the strong acceptance of the fundamental right to bodily integrity by both the legal and the medical professions.[206]

203 CR Ryan and S Callaghan , 'Refusing medical treatment after attempted suicide: rethinking capacity and coercive treatment in light of the Kerrie Wooltorton case' (2010) 193 (4) MJA 139, 241; (2011) 18 (4) *J Law Med* 811; Diana Ginn, 'Supreme Court of Canada rules on coercive state intervention in pregnancy' (1999) 19(1-2) *Canadian Woman Studies* 122-32, referring to *Re Baby R* (1987) 15 RFL 3d 225.

204 Ben White, Fiona McDonald and Lindy Wilmott, *Health Law in Australia*, (Lawbook Co, 2018) 152.

205 Seymour, *Fetal Welfare and the Law*, (n 34) 222; John Seymour, *Childbirth and the Law* (OUP, 2000); Les Haberfield, 'Pregnant Women: Intervention and the Right of Pregnant Women' (1995) 2 *James Cook U L Rev* 1.

206 *Department of Health & Community Services v JWB & SMB* (*Marion's Case)* [1992] HCA 15, (1992) 175 CLR 218 (6 May 1992) quoted with approval by Mason CJ, Dawson, Toohey and Gaudron JJ [12] in *BS v McC: W v W* [1972] AC 25,43; *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) 175 CLR 218[11]; *Malette v Shulman* (1990) 67 DLR (4th) 321, 327.

Importantly the principles that recognise the fundamental right of all competent persons to refuse medical treatment have been clearly articulated by the High Court.[207] There is no indication that the High Court, if an appropriate case came before it, would be prepared to make an exception to the fundamental right to bodily integrity upon the basis of pregnancy.

In *Qumsieh*, the High Court declined an opportunity to address the issue of the overriding of a refusal of a blood transfusion by a woman who had haemorrhaged after giving birth to a healthy baby.[208] Whilst the *born alive rule* remains entrenched in Australia law (except for the obiter dicta of McDougall J)[209] there is little indication that the courts would decide that the health of the foetus should take precedence over the rights of a competent pregnant woman.

The few cases which have been brought before the lower courts have not been directed at overriding the competent pregnant woman's autonomy. The decision in *Re Elm*[210] illustrates this point well.

In 2006, in *Re Elm,*[211] an *ex-parte* application involving a pregnant woman who was Human Immunodeficiency Virus (HIV) positive came before Brereton J of the NSW Supreme Court. Elm was an African refugee and a social-welfare recipient. She had only temporary accommodation and no family nor other social network to assist her. In

207 *Marion's Case.*

208 *Qumsieh v Pilgrim* M98/1998 [2000] HCA Trans 34; (2000) 21(4) Leg Rep SL3d (11 February 2000); In regards to the Supreme Court of Victoria see Cameron Stewart, 'Qumsieh's Case, Civil Liability and the Right to Refuse Medical Treatment' (2000) 8 *Journal of Law and Medicine* 56 and C Stewart, 'Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions' (1999) 23 *Melbourne University Law Review* 161.

209 *Hunter and New England Area Health Service v A* [2009] NSWC 761[40]; see *Queensland v D* [2004] 1QdR 426.

210 *Re Elm* [2006] NSWSC 1137; See also, *The Application of Sydney Children's Hospita*l [2018] NSWSC 1259 court authorised a blood transfusion on baby when and if born alive; *Director-General, Department of Community Services; Re Jules* [2008] NSWSC 1193 where parents refused treatment of baby at birth and a successful application for a vaccination for hepatitis's B was brought before the court soon after the baby was born.

211 [2006] NSWSC 1137.

March of 2006, she stopped taking medicine prescribed for her condition. She erroneously believed 'that God ha[d] miraculously healed her'.[212] Against medical advice she refused to take anti-HIV medication or have a caesarean section. She also said she would refuse medical treatment for her baby once born but that she did not intend to breast feed the baby. At that time, she was presumed to be competent under the mental health legislation.[213]

An application was made to the court seeking several orders in respect of the treatment of the child upon birth but not for any treatment of Elm or of the foetus. It was argued that the orders were necessary to prevent her from breast feeding or removing the baby from the hospital once born. The judge was also asked to make an order that the woman was not to notified of the proceedings until after she had given birth.[214] There was concern that if Elm became aware of the orders she would not present at that hospital or perhaps, any other hospital.[215]

The application was brought by the Department of Community Services of NSW. The applicant's counsel must have considered that the law was clear. They could not seek an order for medical treatment of the foetus until it was *born alive*. Nor was there a claim that Elm lacked capacity to make decisions as to her medical care. What was of concern was that there was medical evidence indicating that Elm's refusals of treatment would put the foetus and the baby, when born, at risk.[216] Her doctor had explained to her the need for medical treatment of the foetus and sought her consent for that treatment on two occasions. Caesarean sections are the preferred method of treatment to avoid the risk of the transmission of HIV to the foetus. Nevertheless, the treatment requested did not include a forced caesarean. The proposed treatment would only occur once there was a live birth and then it would be for the baby and not Elm.

Brereton J stated that he was not authorising 'any intervention in or invasion of the rights of the defendant' Elm.[217] He considered that 'short and long-term health and

212 *Re Elm* [2006] NSWSC 1137[1].

213 *Guardianship Act 1987* (NSW); see generally Victorian Law Reform Commission, 'Chapter 7 – Capacity and Incapacity' *Guardianship – Final Report 24* (2012).

214 *Re Elm* [2006] NSWSC 1137 [9].

215 *Re Elm* [4].

216 *Re Elm* [2006] NSWSC 1137, [3].

217 *Re Elm* [2006] NSWSC 1137 [25].

wellbeing, if not the life, of a child soon to be born is at stake'.[218] He considered that the only consequences of him being wrong would be the doctor's intervention on behalf of the baby when born. [219] On the other hand, he considered that the consequences of him not making a declaration would be detrimental to the health of the baby when born.[220] On that basis he was prepared to grant a temporary injunction to prevent breast feeding or removing the baby from the hospital.[221] There was nothing to force her to attend the hospital. If she did attend the injunction did not prevent her from leaving before the baby was born alive.

His Honour would have preferred that the proceedings were not held ex parte and that the defendant had been able to exercise her right to be heard.[222] Nevertheless it was ordered that the defendant not be served until 'a practicable and reasonable time soon after the defendant has given birth'.[223] What is of relevance here is that the application did not request that a caesarean be performed. Implicit in the case is the acknowledgement that the court had no jurisdiction to override the decision to refuse medical treatment which albeit irrational in the opinions of many was presumed to be competent. The decision is one which reflects the idea that '[d]octors, midwives, and childbirth educators must advise fully and honestly, may persuade, but may never coerce'.[224]

In *State of Queensland v D,*[225] a prisoner was due to give birth that afternoon. She had consented to a caesarean but there was concern that she might change her mind and act in a manner which could cause harm to her and her foetus during the birthing process. There was evidence from a senior psychologist that although D was competent, she

218 *Re Elm* [2006] NSWSC 1137[25].

219 *Re Elm* [2006] NSWSC 1137 [22].

220 Ibid, see also *Queensland v D* [2004] 1 Qd R 426; See also the *International Convention on Civil and Political Rights Art* 14(1).

221 *Re Elm* [26].

222 *Re Elm* [2006] NSWSC 1137[25]; However, once Elm was served with the Order she could apply to have it set aside (at least in theory) [26].

223 Ibid [26].

224 Sandra Goldbeck-Wood, 'Women's autonomy in childbirth-We may advise and persuade, but never coerce' (1997) 314 *BMJ* 1143.

225 [2004] 1 QdR 426.

suffered from a 'personality disorder' and could become suddenly and inexplicably irrational and emotionally unstable'.[226]

De Jersey CJ decided that if that did occur and if D, in the opinion of the doctor did 'unreasonably' refuse treatment then the ' . . . medical staff may render such treatment as the doctor considers appropriate, . . . including, if reasonably necessary, performing upon the prisoner a caesarean section.[227]

The use of physical restraint was also authorised.[228] De Jersey CJ held that he was able to make the order in respect of D by virtue of its *parens patriae* jurisdiction which extended to all persons 'unable to act with any proper and provident management'.[229] Here he considered that there was a risk that D would suffer from 'temporary incapacity' which would potentially harm the 'infant' and/or herself.[230]

As in *Re Elm,* the judge was concerned that the proceedings were held ex parte. D was not to be informed. However, he decided that the risk outweighed any injustice.[231]

Coronial Inquests give some insight into the importance of the respect for bodily integrity and freedom from interference and demonstrate that the *born alive rule* remains important in Australia as being an obstacle to the legal recognition of a 'foetal exception', which would undermine women's rights to consent to or refuse medical treatment.

The *Inquest into the death of NA*[232] illustrates the complex nature of decision making where pregnancy is involved. It also recognises that there is a general commitment throughout the legal and medical professions that the decisions of competent persons ought to be respected and as far as possible understood even though they may appear wrong in the opinions of those professionals.

226 Ibid 427

227 Ibid 428

228 Ibid.

229 Ibid 426-427.

230 Ibid.

231 *Queensland v D* 427.

232 *2015/60842 State Coroners Court, Glebe, 27-30 June 2016, 2September 2016, Findings of Magistrate Harriet Grahame, Deputy State Coroner.*

Here a couple, expecting their second child, were planning a home birth without a midwife or other medical profession in attendance. Their first child had been delivered by the husband, P, at their remote property in the vicinity of Nimbin in northern NSW. It had not been what would be regarded as an 'easy birth' but the child was healthy and there were no adverse complications. The couple distrusted hospitals and were confident that they had made the correct decision. No doubt their confidence was bolstered by P having also successfully delivered his children from a previous marriage. Additionally, a background as agriculturalists and strong local support network may have contributed to the couple adopting their birthing plan without any strategies to accommodate unforeseen events.

The woman had had pre-natal care and had consulted the local GP on several occasions. It was found that the foetus was lying in a 'transverse position' which could cause complications during birth. The local doctor advised that a homebirth, especially one without any medical professionals in attendance and away from appropriately equipped hospitals was highly risky and tried on several occasions to have the couple change their birthing plans. The birth took place at the property. It was extremely difficult and there were complications. The baby, although rushed to hospital, died as a result of brain injuries suffered during birth. The couple and all involved were understandably extremely upset.

The Coroner, whilst regretting the circumstances which led to the death of NA, was clear that:

> It is essential to remember that women have a right to decide how they will give birth. At common law all competent adults can consent to and refuse medical treatment, which includes prenatal care. Unless a lack of capacity or some kind of coercion is established, an adult mother has a right to birth at home, even if the prevailing medical advice deems the birth "high risk". Until the foetus becomes a person, the relevant medical care is understood as pertaining to the mother.[233]

In NSW, in 2015 a woman who was a devout Jehovah's Witness, refused treatment which could have saved her life and that of her foetus.[234] This case was reported by the medical professionals involved to provide an understanding of the complex nature of the care of

233 2015/60842 State Coroners Court, Glebe, NSW, 27-30 June 2016, 2September 2016, Magistrate Harriet Grahame, Deputy State Coroner.

pregnant women who refuse medical treatment and how best for medical professionals to address the difficult situation of acceding to a pregnant woman's refusal to consent to life saving treatment .

The woman was about 27 weeks pregnant and required treatment by chemotherapy for cancer. Blood products were necessary as part the treatment. She had executed an advance directive which stated that she was not to be given blood products. The medical staff respected her wishes. The foetus died in the womb and the woman died nearly a fortnight later. The staff at the hospital were reported as being 'distressed, grappling with what was perceived as two "preventable" deaths'.[235]

To those who are unaware of the faith and commitment of the Jehovah's Witness religion, the refusal of a blood transfusion may be difficult to comprehend. That the woman died and the foetus did not become a person is distressing. Nevertheless, as Sascha Callaghan points out

> [l]aw cannot prevent tragedy. And no one can fail to be moved by these most difficult of medical dilemmas. But for now we have accepted that a woman's right to refuse treatment will be the deciding factor in a choice between evils.[236]

A treating physician in this case was reported as saying, that she could understand the woman's decision, but that it was very hard for the obstetricians to watch in a country where they 'rarely see people die, or make a decision that will hasten death'.[237]

The analysis indicates that currently pregnant women who are competent have a right to refuse medical treatment and that a foetal exception is unlikely to be recognised in Australia.[238] Nevertheless, lacking any authoritative statements by the courts, the position remains uncertain and therefore unsatisfactory for women who wish to

234 A Biscoe and G Kidson-Gerber, 'Avoidable' death of a pregnant Jehovah's Witness with acute promyelocytic leukaemia: ethical considerations and the internal conflicts and challenges encountered by practitioners. (2015) 45 *Intern Med J* 461.

235 Ibid.

236 Sascha Callaghan 'When a mother's rights clash with the needs of her unborn child' *Sydney Morning Herald*, 9 April 2015.

237 Ibid.

238 This would appear to apply in NZ, Canada and the UK as well.

exercise their autonomy and make decisions about medical treatment during pregnancy.[239]

### a Capacity and the Refusal of Medical Treatment

In all jurisdictions, for consent to or refusal of medical treatment carried out to be valid, the person giving it or withholding it must be competent. In the UK, Australia, Canada and NZ the courts continue to apply the *born alive rule* in contrast to arguments based upon 'foetal rights'. They also consider the validity of the consent to or the refusal of medical treatment. In doing so they have focussed upon the capacity of pregnant women. In several cases the woman's refusal of medical treatment was overridden on the basis that she lacked capacity, rather than upon the basis of the recognition of a *foetal exception*. Nevertheless, in a majority of cases, the existence of the foetus was a factor in the court's decision-making process. What follows is analysis of the application of the relevant principles by the courts and the judicial reasons for intervention or non-intervention in pregnant women's decisions to refuse or consent to medical treatment.

*In Re F (in utero*), in 1988 the English Court of Appeal clearly approached the case as one which required the application of the legal principle that all competent persons may refuse medical treatment.[240] The local social services authority was concerned about the health of a pregnant woman who had suffered mental illness and was a drug abuser. They had tried to assist her but were unable to do so. When they could not find her, they applied to make her foetus a ward of the Court.

The application was rejected because of the well-established principle that a foetus is not a person and therefore the court lacked jurisdiction to hear an application for wardship. It was pointed out that once the foetus is born alive the court may determine an application on his/her behalf. But to do so before the woman and foetus are separate beings would have practical implications that would impinge upon F's bodily integrity.

239 The medical professionals who face the issue of patients who refuse to consent would like and benefit from clarification.

240 *Re F (in utero)* [1988] 2 ALL ER 193; approved in *Winnipeg Child and Family Services (Northwest Area) v G (DF)* [1997] 3 SCR 925 and in *Re Baby R* (1987) 15 RFL 3d 225 (Can); 1988 CanLII 3132 (BC SC)

The day to day care of the foetus would involve severe restrictions on the rights to the pregnant woman's freedom. Such restrictions were not permitted under law.[241]

May LJ's reasoning is enlightening. He commences by looking at the Court's powers and then continues with the consequences thereof. His reasoning is summarised in point form as follows:

1 It cannot make orders in respect of the foetus who is not a legal person.

2 It can only make orders in respect of the woman. These might include:

2.a An order for the authority to find the mother;

2.b Once found there may be a need for an order for where she reside and attend a local hospital.

3 The mother, presumed competent, may choose treatments which are different from medical advice.

4 The orders applied for, i.e. wardship of the foetus, would restrict the woman's 'liberty' (autonomy).

5 The outcome of the orders would be 'an inherent incompatibility between any projected exercise of wardship jurisdiction and the rights and welfare of the 'pregnant woman'.[242]

In the Canadian case of *Winnipeg Child and Family Services (Northwest Area) v G (DF*) *(Winnipeg v G)* [243] the appellate courts reasoned similarly. G was a 15-week pregnant woman who was addicted to glue sniffing. There was medical evidence to the effect that G was 'cognitively impaired; and suffered from 'cerebellar degeneration'. She had a history of attempted suicide and self-harm and it was likely that her continued substance abuse would result in her death. Shulman J, at first instance, held that G suffered from 'a substantial disorder of thought, mood and perception that grossly

241 *Re F* 194.

242 Ibid 194 f-g; Anonymous, 'Fetus as Ward of Court?' (1988) 331(8581) *The Lancet* 369-370.

243 *Winnipeg Child and Family Services (Northwest Area) v G (DF*) [1997] 3 SCR 925; *Medhurst v Medhurst* (1984) (1984) 9 DLR (4th) 252.

impairs her ability to meet the ordinary demands of life'[244] and ordered her detention in a health facility for treatment of her condition until her child was born.

She appealed. Twaddle J in delivering the unanimous judgment of the five members of the appeal bench considered that the *parens patriae* power did not extend to the protection of the foetus. Nor could the mental health legislation be used for the purposes of protecting the foetus. G did not suffer from a mental illness within the provisions of the legislation. To invoke her mental health as a reason to exercise control over her actions to protect the foetus was as approach which might be considered 'suspect from the start'.[245] The real issue was the status of the foetus and whether the court could interfere with the rights of women. It could not and her appeal was granted.

The welfare authorities subsequent appeal to the Supreme Court of Canada was rejected by a majority of seven to two. The majority, in a judgment delivered by MacLachlin J, was emphatic in stating that '…an order detaining a pregnant woman for the purpose of protecting her foetus would require changes to the law which cannot properly be made by the courts and should be left to the legislature'.[246]

As discussed in Part II capacity is presumed until rebutted.[247] Mental disability does not of itself prevent the ability to consent to or refuse medical treatment.[248] A valid refusal or consent will depend upon whether a person can process the information and make a voluntary decision about the treatment in question.[249]

The following analysis of the issues of women's capacity and the refusal of medical treatment will be considered under two headings. The first will be the situations where

244 (1997) 138 DLR. (4th) 238, 246-247.

245 (1997)138 DLR (4th) 254, 256 (Man. CA) [Note: in Manitoba there is no *parens patriae* jurisdiction over mentally incompetent adults.]

246 *Winnipeg Child and Family Services (Northwest Area) v G* (DF) [1997] 3 SCR 925[4]

247 See *Re T (Adult Refusal) (Medical Treatment)* [1992] EWCA Civ 18, 3 WLR 120; it should be noted that this case precedes the *Mental Capacity Act 2005* (UK) which replaced the common law.

248 See *Mental Capacity Act 2005* (UK); *Mental Health Act* 2014(Vic); *Mental Health Act* (Qld); *Protection of Personal and Property Rights Act 1988* (NZ) ss4 &5, 10(f); *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274.

249 See *St George's Healthcare NHS Trust v S, R v Collins and Others, ex parte* S [1998] 3 WLR 936.

the woman was not detained or otherwise subject to the mental health legislation. The second will look at those women who were currently under the purview of the mental health system.

### b Pregnant Women and Competency

In some cases, the woman was not suffering from a mental health illness, but she was unconscious. This situation is deemed one of medical emergency and any unwanted medical treatment would be covered by the common law defence of necessity[250] and/or the statutory defences of emergency, where they apply.[251]

Where the woman is conscious and able to communicate her wishes, the decision to override her volition becomes more complex. The general principles with regard to a valid consent are clear, as discussed earlier. Capacity, information and voluntariness are required, and the consent must be for the treatment specified. A general consent will be insufficient. It must be consent to the proposed medical treatment. Capacity must be present at the time of the refusal or consent, that is, when the decision is made.[252] Although the idea of pregnancy as a disease or illness has been rejected in recent times,[253] vestiges remain in both judicial and medical writings.[254] The courts have reasoned that pregnancy may be a time when women lack capacity to make a valid decision. They have however been able to continue to apply the *born alive rule* and say that the temporary incapacity of the woman made it necessary to make a decision based upon her bests interests which were frequently seen as identical with those of the foetus. The treatment was authorised not because the foetus was regarded as a person

250 Bernadette McSherry, 'Legal issues: The Doctrine of Necessity and Medical Treatment' (2002) 10 (1) Journal of Law and Medicine 10.

251 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s13 puts the common law principle in statutory form; See also *Emergency Medical Operations Act 1973* (NT) s3; *Criminal Code 1899* (Qld) s282; *Criminal Code Act 1913* (WA) 259; *Criminal Code 1924* (Tas) s51 and s149; *Medical Treatment Planning and Decisions Act 2016* (Vic) s53; *Mental Health Act 2007* c 12(UK) s64G

252 *Re T* [1992] 2 All ER 649; [1992] EWCA Civ 18 [28] Donaldson MR; *Re MB* [1997] 2 FCR 541, 553 Butler-Sloss LJ.

253 Ann Oakley, *Women Confined: Towards a Sociology of Childbirth* (Oxford University Press, 1980).

254 See *Re C*.

but because the Court decided that the woman lacked competency, albeit briefly, to consent.[255]

In *Re S (Adult Refusal of Medical Treatment) (Re S)* the principles of the defence of necessity were used to override the presumption of capacity as it applied to a pregnant woman.[256] S refused to consent to a caesarean because of her devout religious beliefs. The medical opinion was that she and her foetus would die unless a caesarean was performed. Her doctors applied to the court for a declaration that a forced caesarean section would be lawful. Sir Stephen Brown P, influenced by the sense of extreme urgency, authorised the surgery. His basis for doing so was the doctrine of necessity. His expressed opinion was that the medical professionals had failed in their best efforts to persuade her that:

> the only means of saving her life, and also, I emphasise, the life of her unborn child, is to carry out a Caesarean section operation. The consultant is emphatic. He says it is absolutely the case that the baby cannot be born alive if a Caesarean operation is not carried out.[257]

Brown P was invoking the doctrine of necessity whereby medical treatment may be administered to save a patient's life in a situation where there is a medical emergency, the patient is unable to consent and her wishes as to medical treatment are unknown.[258] However, this was not the situation. The decision to grant the declaration has rightly been called extraordinary.[259]

It may be observed that there was no evidence of S's capacity to consent or to any discussion of whether her refusal of medical treatment was valid. If Brown P had considered the requirements of a valid refusal, he may have concluded that her refusal was valid. Instead he relied on the medical evidence before him that this was an

255 *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274; *Norfolk and Norwich Healthcare (NHS) Trust v W* [1996] 1 FLR 269,

256 *Re S (Adult Refusal of Medical Treatment)* (1992) BMLR 69.

257 *Re S (Adult Refusal of Medical Treatment*) [1992] AC 649, 653.

258 See *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 54 HL, Lord Goff.

259 Sheila McLean and Kerry Petersen, 'Patient Status: The Foetus and the Pregnant Woman' (1996) 2(2) *Australian Journal of Human Rights* 229, 233.

emergency, and also on the existence of a possible foetal exception referred to, but not discussed, by one judge in *Re T*.[260]

That pregnancy is a time when a woman might be considered to act in manner which may indicate transient incapacity has also been used to override women's refusal of treatment. In *Rochdale Healthcare (NHS) Trust v C (NHS v C),*[261] C had refused to have a caesarean because of the pain and difficulties which she had continued to experience from a previous caesarean. She told her obstetrician: 'I would rather die than have a Caesarean section again'.[262] An application was heard and determined by Johnson J later that day. There was no psychiatric evidence before the court. Her obstetrician gave evidence that he considered that C was competent and fully understood the consequences of her decision.

Johnson J accepted that C was generally competent in that she had the 'ability to comprehend and retain information and to believe such information'.[263] However, he concluded that she was not capable of weighing-up this particular information (the advice that a caesarean was necessary). His Honour stated that:

> The patient was in the *throes of labour* with all that is involved in terms of *pain and emotional stress*. I concluded that a patient who could, in those circumstances, speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh-up the considerations that arose so as to make any valid decision about anything of even the most trivial kind, surely less one which involved her own life in terms of pain and emotional stress.[264]

His Honour's assessment of capacity would appear to be based upon his own assumptions about pregnant women and not upon any recognised research.[265] When C

260 See *Re T* Donaldson MR.

261 *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274; *Norfolk and Norwich Healthcare (NHS) Trust v W* [1996] 1 FLR 269, was heard by Johnson J on the same day.) (*NHS) Trust v C*).

262 *(NHS) Trust v C* [1997] 1 FLR 274, 275.

263 Ibid 275 [G].

264 Ibid 275 [G]-[H] emphasis added.

265 Jessica Flanigan, 'Obstetric autonomy and informed consent' (2016) 19 (1) *Ethical Theory and Moral Practice*, 225, 230-231.

had been asked who would care for her first child if she died her response was that her mother would do so. This may have indicated a degree of competency. Further, as Herring notes, since almost any labour involves stress and pain, this could mean that every woman in labour may be found incompetent.[266]

Jessica Flanigan has defended pregnant women's right to autonomy and suggested that stress and pain can have a positive impact upon pregnancy and birth.[267] She argues that

> pain during childbirth does not undermine competence to consent, insofar as pain mitigates responsibility it is not because pain undermines voluntariness but because pain can give a person a new reason that excuse his or her conduct. A woman in labour might experience significant pain that causes her to make different medical choices than she would have made in the absence of pain. In these cases, new information (e g, about how labour feels) changes the woman's judgment about what she has reason to do. Pain does not undermine a woman's ability to make a voluntary treatment choice.[268]

What is clear from the decision in C was the dilemma faced by the judge. He had little time in which to make the decision and had been 'acutely conscious that the time for carrying out the operation was almost elapsed'.[269] Further, having only the evidence of the medical professionals, the applicants, he noted 'I had only the scantiest information upon which to access the competence of the patient'.[270]

On the same day that he decided *NHS v C* Johnson J was faced with second case requesting court intervention to override a pregnant women's refusal of medical treatment. The second case was *Norwich Healthcare (NHS) Trust v W (NHS v W).*[271] The

266 John Herring, 'Caesarean sections and the right of autonomy' (1998) 57(3) *CLJ* 438; cw the USA case *Bankert v United States* 937 F Supp, 1169, 1174, 'nothing about pregnancy or the onset of the labour processes automatically renders a woman incapable of rational thought or unable to participate in competent decision making'.

267 See Jessica Flanigan, 'Obstetric autonomy and informed consent' (2016) 19 (1*) Ethical Theory and Moral Practice* 225.

268 Ibid 229-230.

269 *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274, 275 [D].

270 Ibid 275 [E].

271 *Norfolk and Norwich Healthcare (NHS) Trust v* W [1997] 1 FLR 269.

pregnant woman W had refused to consent to a caesarean. In *NHS v W* Johnson J emphasised that he was making his decision strictly in accordance with the principles applicable to the right to bodily integrity. Nevertheless, the underlying importance of the existence of the foetus and the value placed on the potential human life is clear in the reasons for granting the declaration. Johnson J considered that W's best interests were served by removing the threat to her physical health and her mental wellbeing, that is, having to go through a vaginal birth. He noted that despite W's view that she didn't care 'about the baby'[272] the forced delivery 'would avoid her having any feeling of guilt in the future were she, by her refusal of consent, to cause the death of the foetus'.[273]

Johnson J reinforced the principles that the right to refuse medical treatment was absolute where the person is competent, and that the state of being pregnant is only relevant in so far as it provides insight into what is best for the woman.[274]

It is clear that Johnson J was unable to ignore the existence of the foetus. He said that 'the reality was that the foetus was a fully formed child, capable of normal life if only it could be delivered from the mother'.[275] His concern for and value judgments about pregnancy and pregnant women requiring guidance is understandable. However, it does impinge upon their autonomy and their project of becoming a person because she is denied the opportunity to make her own decisions.[276]

In *Re MB*[277] a woman was 40 weeks' pregnant and had initially consented to a caesarean which was necessary to ensure the healthy birth of the foetus. The threat to the woman of a natural birth was minimal.[278] The woman refused to have the administration of

272 Ibid 273

273 Ibid 273.

274 The 'best interests' test used in the UK cases has been criticised as being applied in a paternalistic manner. See Hunter Rosemary Rosemary Hunter, 'Commentary on *Re W* [PPPR]: Caring for the Pregnant Woman ' in *Feminist Judgments of Aotearoa New Zealand: Te Rino: A Two-Stranded Rope*, Eds Elisabeth McDonald, Rhonda Powell, Mamari Stephens and Rosemary Hunter. (Oxford: Hart Publishing, 2017) 171,173-174.

275 *NHS Trust v W* 274.

276 Cornell, *The Imaginary Domain* (n 7).

277 *Re MB* [1997] EWCA Civ 3093.

278 Ibid [1]-[2].

needles which was necessary in preparation for the caesarean. At first instance, the court ordered her to undergo medical treatment.[279] She appealed.

The Court was clear that the competent person was entitled to refuse medical treatment and set out the principles to be applied in cases which sought to override a person's refusal of medical treatment. When referring to the role of the 'needle phobia' Lady Justice Butler-Sloss, delivering the judgment of the court, stated:

> Any evidence suggesting panic induced by fear must be carefully scrutinised since fear of an operation may be a rational reason for refusal to undergo it. By contrast, fear which has the effect of paralysing the will destroys the capacity to make a decision.[280]

They concluded that MB suffered from temporary incompetence and that since she wanted her foetus to be born alive and healthy a forced caesarean was in her best interests.

However, an alternative analysis was possible. First, the fear may be 'irrational'.[281] What was important was that she was able to understand the nature and consequences of her decision. Here she was well aware of her phobia of needles and of the court order to compel medical treatment, including needles. She also processed the information that the caesarean could not be performed without the use of needles. She knew that not undergoing the caesarean would likely kill or severely injure her foetus but her own health would be unlikely to be affected. She had decided that unless sedation could be performed without her being aware of the needles, she would not give permission to undergo a caesarean. It should not matter whether her decision is contrary to what is expected of the stereotypical pregnant woman. MB was aware of the negative consequences of refusing medical treatment and was prepared to take responsibility for her decision as the right to autonomy requires.[282]

279 Ibid [15]-[16]

280 Ibid [30 (6)].

281 Ibid [17] noting the general principles; [30] noting the difficulty of irrationality in assessing competence.

282 For a very good critical analysis of the decision see Ian Kennedy, 'Consent: Adult, Refusal of Consent, Capacity*: Re MB (Medical Treatment*)' (1997) 5 (3) *Medical Law Review* 317, 319 - 325.

*St George's Healthcare NHS Trust v S* (*NHS v S)*[283] was a 1999 decision of the UK Court of Appeal. S was a 36 weeks pregnant woman who sought treatment at a medical centre where she was advised that she needed urgent medical treatment. She refused because she wanted a 'natural birth'. She underwent a psychiatric evaluation and was admitted to hospital under the mental health legislation.[284] She was finally transferred to St George's Hospital. Her detention was without her consent and against her express refusal. The hospital authority then sought an *ex parte* declaration from the Family Division of the Court to dispense with her consent and allow the proposed medical treatment to be carried out. This was granted by Hogg J and a caesarean section was performed.

S appealed and applied for judicial review of her detentions at the hospitals. The Court of Appeal, constituted by Lady Butler-Sloss, Lord Justice Judge and Lord Justice Robert Walker, was extremely critical of the manner in which the matter had been handled.

The judgment then considered the question of capacity to consent commencing its review by stating that the *Mental Health Act 1983* (UK) could not be used unless a person suffered from a mental illness within the meaning of the Act.[285] Despite the treating doctor's advice, that S was 'probably depressed and would benefit from a period of assessment as well as the safety and containment needed to monitor and treat her physical condition',[286] at no stage was she treated for any mental disorder.[287]

It was insufficient that the pregnant woman's thinking was unusual and different from what is considered to be acceptable by the 'overwhelming majority of the community at large'.[288] In the opinion of the court S was quite able to understand the potential dangers to herself and her foetus and was well aware of the consequences of refusing medical

283 *St George's Healthcare NHS Trust v S, R v Collins and Others, ex parte S* [1998] 3 All ER 673,691.

284 This case predated the *Mental Capacity Act 2005* (UK) *(MCA 2005).*

285 *Mental Health Act 1983* (UK) s63; Under the *Mental Capacity Act 2005 (UK)* the test is no longer whether the treatment is for the mental illness. However, it is discussed here as background to *Re AA* the first reported case under the *MCA 2005*.

286 *St George's Healthcare NHS Trust v S, R v Collins and Others, ex parte S* [1998] 3 All ER 673,691.

287 Ibid.

288 *St George's Healthcare NHS Trust v S, R v Collins and Others, ex parte S* [1998] 3 All ER 673.

treatment. That she may be acting in way which was incomprehensible to others did not mean that she was suffering from a mental illness. They considered 'that she may be perfectly rational and quite outside the ambit of the Act and will remain so notwithstanding her eccentric thought process'.[289]

This decision would appear to be emphatic that a competent woman who happens to be pregnant retains an absolute right to refuse medical treatment. Perhaps this would be an acceptable reading of the judgment had the question on appeal been more than hypothetical. S had the satisfaction of the judicial recognition that she had been entitled to refuse medical treatment. However, was this an empty victory? S had been forced to have the unwanted caesarean before her appeal was heard thus leaving the question of whether the decision would have been the same had the appeal been determined before the operation had been performed, unanswered.

Mental health legislation and its implementation allow an insight into the impact of pregnancy upon autonomy where a woman suffers from a mental health issue. Therefore, the discussion will continue with a consideration of the principles which apply where the pregnant woman is suffering from a mental illness.

### c Capacity and Bodily Integrity

The general principles of consent have an overarching commonality which reflects their commitment to the human rights of all persons and within their mental health law. However, the legal frameworks and application differ to a lesser or greater extent between all jurisdictions[290] and within countries.[291] The focus of the discussion will be on the UK.[292] The decisions of the UK Court of Protection provide some interesting insight into the approach to pregnant women who have mental health issues.[293]

289 Ibid 707-708.

290 The USA is not considered as it generally overrides consent by generally using the limited rights approach and therefore usually does not have to question the validity of consent.

291 For example; generally, Australia relies heavily on its guardianship laws and the use of the administrative appeals tribunals for issues of capacity to consent to medical treatment, see QCAT; VCAT and the *Medical Treatment Planning and Decisions Act 2016* (Vic).

292 The Australian Mental Health Tribunals also decides cases in respect of the capacity of pregnant women/

293 As a result of *Re AA* [2013] EWHC 4378 (COP) and the public criticism of the lack of transparency of the COP.

In 2013, the highly controversial case of *Re AA*[294] was brought to the attention of the world. It engendered criticism of the lack of openness of the Court of Protection (UK) and brought about substantial changes in its protocols.[295] The current Court of Protection was established under the *Mental Capacity Act 2005.* Court proceedings are conducted in open court and its decisions published shortly thereafter.[296]

Alessandra Pacchieri, AA, was unknown to the public until early December 2013. This was despite court proceedings which had occurred more than a year previously.[297]

AA is an Italian national, who was on medication for a bi-polar disorder.[298] She 'suffered from psychotic episodes and delusional beliefs' if she did not take her medicine. In 2012 she travelled to the UK, on a visa, to complete a short training course in the airline industry.[299] She was pregnant and ceased taking her medication because of its potential impact on her foetus. Subsequently she suffered a psychotic episode and was detained under the *Mental Health Act 1983* (UK).[300] At that time, she was about 34 weeks

294 *Re AA* [2013] EWHC 4378 (COP); For critical analysis see Emma Walmsley, '*Mama Mia!* Serious Shortcomings with Another "(En) Forced" Caesarean Section Case *Re AA* [2013] EWHC 4378 (COP)' *Med Law Rev* (2015) 23 (1) 135.

295 For a detailed discussion of *Re AA* see Samantha Halliday, *Autonomy and Pregnancy* (Routledge, 2015) 64; Walmsley (n 291)

296 As a result of *Re AA* [2012] EWHC 4378 (COP) and the public criticism of the lack of transparency of the COP resulted in the publication of Sir James Munby's Practice Note of January 2014—Practice Guidance (Transparency in the Court Of Protection) [2014] EWCOP B2.

297 *Re AA* [2013] EWHC 4378.

298 In *Re AA* [2012] EWHC 4378 AA's mental illness was referred to as schizophrenia. In *Re P (A Child)* [2013] EWCC B14 (Fam) (01 February 2013) [3] Newton J referred to her mental illness as a 'bipolar affective disorder'. Medical opinion suggests that there are similarities in the symptoms and difficulties in diagnosing bi-polar and schizophrenia. See Berit Kerner, 'Genetics of bipolar disorder' (2014) 7 *The Application of Clinical Genetics* 33-42; Vivien K Burt, C Bernstein, WS Rosenstein and LL Altshuler, 'Bipolar disorder and pregnancy: Maintaining psychiatric stability in the real world of obstetric and psychiatric complications' (2010)167 (8) *The American Journal of Psychiatry* 892-7; cf Samantha Halliday, (n 293) 66.

299 [2013] EWCOP 4378 [2].

300 See the *Mental Health Act 2007* (UK)

pregnant. When she was 39 weeks pregnant when the NHS Trust applied to the Court of Protection for a declaration that AA's consent to a caesarean section, using restraint if necessary, could be dispensed with because she lacked capacity.[301]

The application came before Mostyn J who, because AA had been involuntarily detained in a psychiatric unit, was required under the *Mental Capacity Act 2005* (UK) to make a decision in her 'best interests' and having 'regard to the principle of least restriction' on her liberty.[302] This was the first case under the *Mental Capacity Act 2005* (UK). Cases under the former legislation[303] were decided upon whether the proposed treatment was for the 'mental illness' suffered by the defendant.[304]

That the focus must be upon the woman was emphasized by his statement that 'I remind myself that harsh though it is, the interests of this unborn child are not the concern of this court as the child has no legal existence until he or she is born' .[305] He referred to *Re MB* as stating the law in respect of an absolute right of a competent adult to refuse medical treatment.[306] Acknowledging that the fact of being detained under the *Mental Health Act 1983* did not automatically mean that AA lacked the capacity to consent, Mostyn J nonetheless decided that she did not in fact have the ability to consent to medical treatment.[307] He noted that the *Mental Capacity Act 2005* did not define 'best interests' and looked to the decision in *Re MB*[308] for guidance. He concluded that the caesarean section was in AA's best interest for two main reasons. The first was that she had had two caesarean sections previously and thus a third was necessary because of a 'significant risk' to both her physical and mental health. The suggestion that AA be allowed 'to go into spontaneous labour and doing an emergency C-Section if certain risks materialised'[309] was not fully explored. Mostyn J decided that the one percent risk of uterine rupture was too high in this situation.[310]

301 Ss 2, 3.

302 S1(5), *Re AA* [2013] EWCOP 4378 [3].

303 *Mental Health Act 1983 (UK)* s 63.

304 *R v Croydon Health Authority* [1995] 1 All ER 683 (CA); *Tameside and Glossop Acute Services NHS Trust v CH (a Patient) (CH)* [1996] 1 FLR 762; *Re C (Refusal of Medical Treatment*) [1994] 1 FLR 31.

305 *Re AA* [2013] EWCOP 4378 [1].

306 *Re MB (Medical Treatment)* [1997] 2 FLR 426,432 Lady Justice Butler-Sloss.

307 See *Mental Capacity Act* 2005 (UK).

308 *[1997] 2 FLR 426.*

309 *Re AA* [2012] EWHC 4378.

310 *Re AA* Transcript per Miss Burnham.

The second reason is worth noting in full.

> I would also add, I hope not at variance with *Re MB*, that I would have thought it was in her best interests, that her child should be born alive and healthy and that such result should be, if possible achieved, and such risks attendant should be avoided. I think, looked at from her point of view, there is also a significant mental health advantage in her unborn child not being exposed to risk during his or her birth. In those circumstances it seems – and I hope very much that restraint will not be necessary – that the procedure that is proposed is manifestly in her interests.[311]

In reaching his decision he accepted the uncontested evidence of AA's psychiatrist and a consultant obstetrician. He pointed out also that Lock QC, who had been appointed to represent AA, had neither sought an adjournment nor opposed the application and was in agreement that the performance of the operation was in her best interests. Neither Lock QC nor Mostyn J had spoken with AA.

His Honour was also concerned about the welfare of foetus once born. He noted that AA's two children were 'in care' (of AA's mother in Italy) and the local welfare authority wanted to remove the newborn from the mother at birth. Mostyn J noted correctly that the Court of Protection did not have jurisdiction over the foetus but foreshadowed that he would hear an application once the caesarean section had been successfully performed.

On the 24th August 2012 AA gave birth to a daughter by caesarean section. Later that day the Essex City Council, acting in accordance with the advice of Mostyn J relayed to it by the NHS Trust, made an application to the Chelmsford County Court. The application was granted and the baby removed immediately from her mother.[312] Lock QC, representing AA, had questioned whether there was a risk of significant harm 'if the

311 *Re AA* [2012] EWHC 4378 [5].

312 On 1st February 2013 Newton J made a care and placement for adoption order for the baby girl, now known as P, the daughter of AA who unsuccessfully challenged the proceedings. (*Re P* (A Child) [2013] EWHC 404); An order finalising the adoption of P was made in 2014 in *Re P (A Child)* [2014] EWHC 1145 (Fam) (15 April 2014).

child was kept under supervision in a Mother and Baby Unit following his or her birth'.[313] This option was not discussed further.

By early December 2013 the case had received a great deal of publicity both in the UK and worldwide.[314] Concern was expressed by Sir James Munby, President of the Family Division about the lack of openness in these matters. The accuracy of the reporting by the media was also of concern. On 6th December 2013 the judgment of Mostyn J, supplemented by his prefatory note which provided further details of the case was released to the public. The transcript of the proceedings and the Order were also made available.[315]

There were several concerns with the way this case was handled. It was not explained why a visitor to the country for the purposes of attending a training programme was not given access to her consulate nor deported. That she may have been illegally deprived of her liberty was not considered.[316] She was known to be pregnant from the time she was detained but the application for medical treatment was not brought until she was 39 weeks pregnant.

It is the manner in which the principles of consent were applied to AA's right to refuse medical treatment which raise issues in respect of her bodily integrity. Accepting that the matter was urgent Mostyn J did not consider whether AA had or lacked capacity to make this particular decision at the relevant time but accepted the evidence before him. There was no discussion as to the nature of AA's illness and whether there were times at which there could have been some discussion with her. This would be in compliance with the *Mental Capacity Act 2005* (UK).[317] There was an absence of evidence before the

313 *Re AA* [2012] EWHC 4378.

314 See Cole Moreton, 'Alessandra Pacchieri: Pitiful tale of a mother and her lost child' *The Telegraph* 7 December 2013.

315 *Re AA* [2012] EWHC 4378 (COP).

316 Samantha Halliday states that the court in *Re AA* 'failed to consider whether an order authorising a caesarean in the case of a woman detained under the *Mental Health Act 1983*(UK) might 'constitute a deprivation of liberty and thus fall outside the scope of the jurisdiction of the Court of Protection' and cites *An NHS Trust v Dr A* [2013] EWHC 2442 (COP) and s16A *Mental Capacity Act 2005* (UK), above (n 293)70, 71-72.

317 See a *Local Authority v TZ [2013]* EWCOP 2322 for a discussion of capacity under the *Mental Capacity Act* 2005 (UK) ss1-3 [16]-[37] and relevance of evidence from the

court as to what were her wishes in respect of the medical management of her pregnancy.

Mostyn J purportedly applied the test of 'best interests'.[318] His focus was upon her pregnancy and not her mental illness. By doing so he reached the conclusion that her best interests were the same as those of the foetus and therefore he could order medical intervention. It was assumed that a caesarean, an invasive procedure, was in the best interests of AA. It was also

assumed that having a healthy child which was destined to be removed from her shortly after birth was in her best interests. [319] There was no evaluation of these assumptions which whilst not ignoring AA's interests arguably made the interests of the foetus the focal point.

What was best for AA's mental health and wellbeing was only partially addressed. She was detained because she was suffering from a mental illness nevertheless there was no consideration of how her 'best interests' could be best served by failing to treat the mental illness which was the reason for her detention. [320]

Moysten J's reasoning reveals that he used his subjective assessment of 'best interests' which identified foetal interests as synonymous with AA's interests. Walmsley's assessment of the test is apt. She stated that:

> the rapid discharge of a patient with bipolar disorder after giving birth via an invasive surgical procedure to a new-born child who was then removed from her care, confirms how 'best interests' is something of *an illusion*.[321]

The evidence which was available showed that AA suffered from 'psychotic episodes and delusional beliefs'.[322] Counsel for the applicant told the judge that 'it is said that she

defendant [38], [45]-[49],[56].

318 *Mental Capacity Act 2005* (UK) s4.

319 What is of concern is that many women, particularly those brought up in an institution, or those who have foster parents or have never known their mother, would prefer not to have a child that they are unable to care for. The point is that the issue ought to have been addressed rather than assumed.

320 *Re AA* [2012] EWHC 4378; See *Royal Free NHS Foundation Trust v AB* [2014] EWCOP 50

321 Walmsley (n 292) 139.

322 *Re AA* [2012] EWHC 4378 [2].

suffers from a schizophrenic disorder'.[323] There was a suggestion that AA's mental illness was treatable or could be controlled by medication.[324] Nevertheless, there was no evidence before the court that she whilst detained, was undergoing any therapy or resumed taking any medicine for her mental illness. What is in the best interests of a person who suffers from a mental disorder which is effectively controlled by the ingestion of medicine and who ceases this abruptly was not considered by the court.

It is well known that pregnancy is a time when women are advised not to continue with certain medications which may risk the health of the foetus.[325] This is problematic for those who suffer illnesses which require ongoing treatment. Further there is no consensus between treating physicians as to what is the best way of managing 'bipolar disorder' or 'schizophrenic disorder' during pregnancy.[326] Nevertheless, it is possible with the appropriate clinical treatment to maintain both physical and psychiatric health during pregnancy.[327]

What is important is not whether AA could have been treated for her mental illness whilst pregnant. What was not considered was whether it was in the best interests of AA to undergo treatment for her mental disorder. It may have not been in the best interests of her foetus that she ingested medicine which improved her mental health but put foetal health at risk. However, the principle is that of the woman's best interests. Problematic for AA was that the application to the Court of Protection was made in the very late stages of her pregnancy and therefore at a time when any treatment may have been ineffective. There was little time for Mostyn J to fully consider whether, and if so

323 Ibid.

324 Ibid Transcript – Mr Locke QC.

325 Women are also advised not to smoke, drink alcohol, eat certain foods and maintain a lifestyle which is conducive to foetal health.

326 M Freeman, 'Bipolar disorder and pregnancy: Risks revealed' (2007) 164 (12) *The American Journal of Psychiatry* 1771.

327 Vivien K Burt, C Bernstein WS Rosenstein and LL Altshuler, 'Bipolar disorder and pregnancy: Maintaining psychiatric stability in the real world of obstetric and psychiatric complications' (2010)167 (8) *The American Journal of Psychiatry* 892; Richard A Epstein, Katherine M Moore and William V Bobo, 'Treatment of bipolar disorders during pregnancy: maternal and fetal safety and challenges' (2015) *Drug Health and Patient Safety* 7.

how, the replacement of the common law through the enactment of the *Medical Capacity Act 2005* had changed the meaning of concepts such as 'best interests'.[328]

In 2013, *In Re P*[329] a case involving the interpretation of 'best interests' came before Mr Justice Peter Jackson. It was an application in respect of P who had three children, was described as 'heavily pregnant and about to deliver her fourth child'[330] She had a history of mental illness combined with diabetes 2 which required medication. A few weeks before the application she had been 'compulsorily committed to a psychiatric hospital'.[331] The NHS were worried that, although she was calm and co-operative at that time, she may become difficult and require a caesarean. They proposed a course of action whereby if vaginal birth and induction were ineffective, they would be able to perform a caesarean.

The application was granted. Importance was placed upon what was in the 'best interests' of P as required under the legislation. It was considered that a vaginal birth risked serious and avoidable injury to the foetus. It was not in the best interests of AB, in her circumstances, to have to care for a child with disabilities.[332] Once again, the issue of discontinuing medicines necessary for the woman's health but likely detrimental to foetal health was not considered in applying the test of 'best interests' test.

In *Royal Free NHS Foundation Trust v AB,*[333] AB was a 32 weeks' pregnant woman who had a mental illness (probably paranoid schizophrenia) [334] and suffered from type II diabetes. She was suffering from psychotic episodes. This was a wanted birth. If she ate appropriately, her diabetes was controlled. By her not following her usual eating regime she had 'hugely varying blood glucose and electrolyte levels'.[335] As a result her physical and mental health were at risk

328 *Re MB; Re C*: *St George' s Healthcare NHS Trust v S, R v Collins and Others, ex parte S* [1998] 3 WLR 936.

329 [2013] EWHC 4581.

330 Ibid [1].

331 Ibid.

332 Ibid [17].

333 [2014] EWCOP 50.

334 Ibid [2].

335 Ibid [3].

An application was made to the Court of Protection that she be declared to lack capacity to consent to a caesarean; to regulate her dietary requirements; and to make decisions about treatment for her diabetes.[336]

Of interest is that the application was made without directly focussing upon the foetus. AB's obstetrician who was an expert in the field of pregnancies where the patient has another illness, gave evidence that the 'pregnancy was jeopardizing the optimal care of AB's serious psychotic illness, which was proving increasingly dangerous to her life'.[337] The 'evidence that delivery at 32 weeks would not in any way significantly compromise the foetus' was referred to but not discussed.[338]

The application was made before Haydon J, who concluded that '[t]he driving imperative behind the application is to keep AB alive'.[339] He was also cognisant that AB had previously attempted suicide and might do so again. The application was granted. His Honour added a postscript.

> I have been informed that AB has had a Caesarean Section and gave birth to a healthy baby boy. There was no need to consider restraint. When Miss Tuck went to see her, AB hugged her.[340]

In 2014, *X County Council v M & Ors (X County Council)* and *NHS Trust & Ors v FG (NHS v FG)*[341] came before Justice Keehan. His Honour was clear that the two decisions should be read in conjunction with each other. The same pregnant woman was the subject of the applications to the court in both cases. *X County Council* was heard in the Family Court. M who was expected to give birth in late May had been detained under the *Mental Health Act 1983* since February 2014 when she was diagnosed with a 'schizoaffective disorder'. On May the 16th X County Council applied for 'permission not to disclose' to M their care plan which included the removal of the baby once born and a Reporting Restrictions Order (ROR). There was a real concern about how M would react if she found out about the care plan. Justice Keehan adjourned the matter and was 'satisfied

336 Ibid [4].

337 Ibid [11].

338 Ibid [13].

339 Ibid [12].

340 Ibid [29].

341 [2014] EWHC 2262 (Fam) (27 June 2014).

that there was a very real risk of physical harm to the mother and/or her unborn child' and granted the non-disclosure and ROR. He then adjourned the matter and directed that an assessment be made as to M's capacity. In the event that that she did not have the requisite capacity an application was to be made to the Court of Protection. On the 20th May *NHS v FG* came before Justice Keehan in the Court of Protection. FG (formerly M in *X County Council v M*) was found to lack capacity and the non-disclosure and ROR applications were granted. In addition comprehensive alternative care and medical plans in respect of FG were permitted.

On June 1st M (FG) gave birth to baby C by natural means and without the need for intervention or restraint. On June 2nd an emergency protection order was granted to X City Council and C was removed from his mother. The application of the X City Council for care was adjourned by Justice Keehan on the 3rd June because he was not satisfied with the evidence upon which the council wished to rely; C's mother and putative father had not been notified; and there was an allegation in respect of the use of the evidence of M's psychiatrist. He was also critical of the way in which this case was handled. An interim care order was made and the parents given access rights. As a result of Justice Keehan's criticisms of the manner in which this case had been handled and of criticisms which had been directed at other cases, he was requested provide guidance for future litigants. As a result in August 2014 *NHS v FG* Keehan J gave comprehensive directions of the procedures to be followed when local authorities or medical professions have concerns about a pregnant woman who suffers from mental health problems and may lack capacity to make decisions in respect of her welfare and medical treatment.[342]

In *Guys and St Thomas' NHS Foundation Trust v X*,[343] the NHS sought a declaration of capacity and that X undergo caesarean. X was around 45 weeks' pregnant. The application was made out of hours, by telephone. X participated and Theis J noted that

> she was able to articulate the parts [of the application documents] that she disagreed with and confirmed she wanted her baby to be delivered well and safely,

342 *NHS Trust & Ors v FG (Rev 1*) [2014] EWCOP 30 *(*28 August 2014) Annex (Practice Notes), see also *X County Council v M & Ors* [2014] EWHC 2262 (Fam) (27 June 2014).

343 [2019] EWCOP 35 (25 July 2019).

> she had strong views about wanting to have a natural birth and was very concerned about any medical intervention against her wishes.[344]

The matter was adjourned so that she could obtain legal representation. The hearing was unusual in that X wanted to be at the hearing and wanted to be represented. She was complimented because she conducted herself with 'admirable dignity'.[345]

According to the evidence of NHS, X had

> multiple previous admissions to hospital with psychotic symptoms and has had various different diagnoses, including Acute and Transient psychotic disorder; bipolar disorder; schizoaffective disorder and personality disorder.[346]

Her ability to be a party to the hearing did not reflect this. Her apparent ability to make decisions on the advice given to her by the NHS would arguably indicate that she did have capacity.

> Over the previous 24 hours or so the clinical team explained to X that they considered the baby was compromised and there was a high risk of a still birth. They discussed with X the interventions (Induction of Labour and/or Caesarean section) that may be required to secure a safe delivery of the child due to the level of difficulties and risk.[347]

X agreed to start treatment for the 'induction of labour' immediately.[348] The applicant then submitted that this would cause foetal distress.
Theis J decided that

> X lacks capacity in relation to the matter, namely the medical intervention that may be necessary for X to give birth to a baby who is safe and well. On the evidence the court has from Dr Y, which I accept, his assessment is X is unable to reconcile her conflicting beliefs (on the one hand of wanting a natural birth and also wanting a

344 Ibid [21].
345 Ibid [7].
346 Ibid [12].
347 Ibid [16].
348 Ibid [24].

> live, well and safely born baby) in a way that she is able to balance the pros and cons.[349]

The focus of the case was clearly the foetus. X was assessed with this in mind. It would appear that this case reinforces the statement of Moysten J, in *Re AA*.[350]

> I am struggling to envisage a circumstance where . . . an inpatient with a diagnosed mental illness has got capacity[351]

The statement reflects an idea that a person who suffers a mental illness is to be 'presumed' to lack capacity to consent to medical treatment until the contrary is proved and that this will rarely happen. It would appear to apply to pregnant women and all other persons. This goes against the spirit of the legislation in protecting the bodily integrity of mental health patients. It also contrary to the legislation itself.[352]

What is evident is that the courts in the UK deny that the foetus has legal rights before birth and adhere to the absolute right to refuse medical treatment, at least in theory. The courts deny the existence of a *foetal exception* to autonomy but the majority of the judgments are replete with references to and take the existence of the foetus into account in their decision making.[353]

There are a relatively small number of cases where court intervention occurs to compel medical treatment. There are many more cases where women have sued the medical profession in negligence, for battery and for wrongful birth.[354] In these cases the issue may be whether the physician was negligent or whether her consent was valid. The focus here is upon pregnant women who have reached the age of majority, who refuse to

349 Ibid [27].

350 *Mental Capacity Act 2005* (UK).

351 [2013] EWHC 4378 (COP) Transcript; c/w Holman J in *Re SB (A Patient; Capacity To Consent To Termination)* [2013] EWCOP 1417 (21 May 2013) [43]–[44].

352 *Mental Capacity Act 2005* (UK) s1.

353 Cf the USA where capacity is required but the decision to order treatment allows consideration of foetal interests without necessarily determining the issue of the pregnancy woman's competency.

354 *Rogers v Whittaker (1992) 175 CLR 479; Cattanach v Melchior (2003) 199 ALR 131 CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR.

consent to the medical treatment which their medical professional has recommended, and where subsequently there has been judicial intervention.

Where the woman is a minor recourse to the court may operate in a different manner and one which undermines the pregnant minor's autonomy and puts her at a greater disadvantage than she would be if she had attained the age of majority. Unlike the pregnant woman who has attained her majority there is no presumption of capacity.[355] It was seen that in the Queensland case of *Q,* discussed previously, the young age of the minor was detrimental to the issue of capacity and therefore the hospital sought a court determination in respect of her medical treatment. The result of this process Q experienced delay in treatment and a high level of stress.[356]

What is common throughout the cases, considered here, is that they arose because the woman had refused to follow medical advice. Where a woman agrees to undergo the required treatment her competence is not frequently considered. No doubt the medical practitioner in consultation with her/his colleagues is unable to comprehend that a woman would not follow advice. Indeed the refusal of life saving treatment such as a blood transfusion would appear to make little sense to many people.

The decision to override the woman's choice over medical treatment and also identifying her as lacking capacity, albeit transient fails to respect women. The inclusion of orders which allow the proceedings to be kept from her and for restraint and any other measures to facilitate the assist with the procedure being carried out, is highly degrading. The woman's project of becoming an equivalent person is seriously undermined.[357] The entire process of intervention and coercion raises concerns for women who may become pregnant in the future and wish to make their own decisions about every aspect of her pregnancy.

It does more than that. If the principle of autonomy is to be upheld then does it needs to be reconsidered? The examples of a phobia, stress, pain, under sedation and the like are disrespectful to all persons.[358]

355 See above A 1(b) (ii).

356 *Central Queensland Hospital and Health Service v Q* [2016] QSC 89 (24 April 2016) (McMeekin J)

357 Drucilla Cornell, *The Imaginary Domain*, Chapter 1.

358 Ibid.

Applying a paradigm of equivalence, it becomes obvious equating phobia to transient incompetence is unrealistic. Women and men have equal competency to make decisions. They are equally likely to have phobias, to suffer pain, to be depressed, to be under undue influence or other fleeting or transient condition. Does it flow from this that the consent of person to refuse an injection which is consider necessary for their health may be overridden because of a needle phobia. If such a dramatic change of this fundamental right should occur there would no doubt be widespread controversy. Using transient conditions to justify the overriding of a pregnant woman's consent should be the invoke the same response.

It is the medical profession including appropriately accredited nurses and midwives, which is appointed as gatekeeper in respect of treatment. Nurse practitioners and midwives have become increasingly important the role in the management and care of pregnant women during pregnancy and the birthing process. The medicalisation of pregnancy has meant that the medical profession has a virtual monopoly over medical treatment during pregnancy. There are few realistic alternatives to the pre-natal care and birthing methods provided by the medical profession. Home births are frequently regarded by obstetricians as high risk and inappropriate even with a fully qualified and experienced midwife present. Their advice is that women should give birth in hospital with a doctor in attendance.[359] Women are not routinely offered alternatives to a hospital birth.[360] This is despite home births being the norm until the early 20th Century.

The medical profession is also is of central importance to the conduct of proceedings. The judge relies heavily on the testimony of the medical professionals. Many of the cases were urgent. in some cases the woman had been in care or known to be pregnant for some time before the application is filed.[361] This indicated that there had been sufficient time for the applicant to apply to the court in sufficient time to avoid the judge having to

359 Michael Gannon, 'Home Birth' (2012) 52 (1) *Medicus* 41; John Svigos, 'Home births: What say the baby?' (2012) 52 (1) 36-39; Frank A Chervenak and Laurence B McCullough, 'The Professional Responsibility Model of Perinatal Ethics' (De Gruyten Inc 2014) Chapter 5, 56; Anonymous, 'Home Birth' (2012) 2 (1) *International Journal of Childbirth* 66.

360 Mary Steen (ed), *Supporting Women to Give Birth at Home: A Practical Guide for Midwives* (Taylor & Francis Group, 2012); Steve Ford, 'More women report 'good experience' at midwife units' *NursingTimes*.net; London (May 22, 2014).

361 See *Re AA; NHS v C; NHS v W.*

make a speedy determination. Urgent hearings have a flow on effect. The court usually has to rely on the expert testimony of the medical professional who has a close association with the Hospital, NHS Trust or welfare agency bringing the proceedings. The urgency of the proceedings often meant that the woman was regarded as an invisible party. Some cases under the UK approach showed that the woman was not represented or inadequately represented. Many proceedings were held *ex parte* and the woman was not informed of the decision until it was too late. She had little or no opportunity to get representation or otherwise prepare her case. In cases where she was able to speak with the judge her evidence was virtually disregarded. Clearly the pregnant woman was denied a fair hearing. In effect the total experience would be one which denied her freedom to pursue her project of individuation. She was not treated as an equivalent person with a right to respect. The disregard for her as a person may be seen from the Judge's rebuke in *Re Madyun.*[362] He said/

> To ignore the undisputed opinion of a skilled and trained physician to indulge the desires of the parents where, as here, there is substantial risk to the unborn infant, is something the Court cannot do.[363]

That the judge placed a higher value on the expertise of the medical professional than on autonomy is evident. His remark contravenes Cornell's prohibition on degradation.

## III CONCLUSION

The right to refuse medical treatment is a fundamental right of all competent legal persons, including pregnant women. The importance of the right is emphasised by the reluctance of the courts to allow exceptions or place limitations upon the right. Pregnancy alone is recognised as insufficient to warrant overriding a woman's right to refuse medical treatment. In the cases where judicial intervention was sought and granted it was shown that, whilst the principle was upheld, the judiciary was prepared to find that there were good reasons for overriding the pregnant women's refusal of medical treatment. There were differences as to the reasons given by the UK courts and the USA courts. The English courts, adhering to the concept of legal personality, confirmed that the right to refuse medical treatment was absolute. The woman's right

362 Ibid.

363 Ibid 1263.

can only be overborne if she lacks the competency to give a valid refusal to medical treatment.

The American courts, in ordering intervention, have held that although the refusal of medical treatment was fundamental, it was subject to compelling state interests. They were prepared to order that the pregnant woman undergo medical treatment where the *state interest* in the preservation of its future population outweighs the rights of pregnant woman to bodily integrity. Pregnant women were compelled to undergo medical treatment in both countries.

# CHAPTER 6 FINDINGS AND IMPLICATIONS

## I INTRODUCTION

*'Freedom to transform oneself cannot be given, let alone guaranteed and certainly not by law.'*[1]

The aim of the previous chapters was to address the central research question: to what extent are pregnant women's rights to reproductive autonomy protected or restricted under the law and its application. This chapter considers the extent to which the findings of the research provided valid and useful answers to the main and subsidiary research questions.

Part II of this chapter gives an overview of the preceding chapters and their contents. Part III addresses the content covered by the chapters and the extent to which it supported the hypothesis.

## II CHAPTER OVERVIEW

The analysis in the previous chapters considered and identified the ways in which pregnancy may have an effect upon women's ability to be autonomous persons. Chapter 2 considered the nature of autonomy as a theoretical concept and argued that Cornell's theory of personhood provided a reference by which to assess whether and to what extent the operation of the law recognised women's autonomy. Her theory proved of particular utility when considering the laws of abortion and was also relevant to consent and/or refusal of medical treatment during pregnancy. This was because it allowed for an analysis that could avoid the circular arguments based upon the gender equality/difference debate, enabling the examination to be informed by concepts of women being equivalent with all other persons.[2] Cornell insists that judges and legislators invoke practical reason to ensure decisions are made objectively.[3] Assessing the impact of pregnancy upon autonomy from the principles of individuation and not upon the perceived role of women as procreators, allowed for the recognition of the value of pregnancy and how each woman must make the final decisions over matters which affect her project of becoming a person. The corollary is that, as free and equal

1 Cornell, *The Imaginary Domain* (Routledge, 1995); see above Chapter 2 II B.

2 Ibid 6.

3 Ibid 12, 18.

persons, women must also take responsibility for the consequences of their actions and decisions.[4]

Of central importance to the theoretical framework, outlined in Chapter 2, was that it makes the woman the central focus of the examination of autonomy and helps avoid misperceptions which may result from concentrating on the foetus and marginalising the woman. Considering the foetus as separate and in isolation from the pregnant woman, who remains in the background, has promoted the 'myth of the woman/foetus conflict' and the need to protect the foetus. It is the woman who was deemed to be the threat and who is perceived as selfish, self-interested and impervious to the well-being of the foetus.[5] Focussing upon the conflict diverts attention from the real objectives of maintaining power and control over pregnant women.[6]

An analysis which centres upon the pregnant woman provides greater balance and a better understanding of what it means to be an equivalent person.[7] Such a focus allows for an understanding that women care about and want to promote the health and well-being of their foetus.

To describe pregnancy as a 'woman/ foetus conflict' distorts the reality of pregnancy. It ignores the physical connection between the woman and the foetus and the psychological responses of the woman to her pregnancy.[8] It diverts attention from the inescapable practical difficulties in granting legal rights to the foetus. No matter how the needs of the foetus are addressed the foetus remains within and dependent upon the woman. The location of and gaining access to the foetus, whilst according women the

4 Ibid 78-80 for Cornell's discussion of this in the context of equality and abortion.

5 Lisa C Ikemoto, 'The Code of Prefect Pregnancy: at the Intersection of the ideology of Motherhood, the Practice of Defaulting to Science and the Interventionist Mindset of Law' (1992) 53 *Ohio St LJ* 1205.

6 Sheena Meredith, *Policing Pregnancy* (Ashgate, 2005) 132–4, 212–14.

7 Samantha Halliday, *Autonomy and Pregnancy: A Comparative Analysis of Compelled Obstetric Intervention* (Routledge, 2016) 220-231.

8 See Kate Parsons, 'Feminist reflections on miscarriage, in light of abortion' (2010)3 (1) *International Journal of Feminist Approaches to Bioethics* 1, 12; Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (Oxford University Press, 2011); Katherine Wade, 'Refusal of Emergency Caesarean Section in Ireland: A Relational Approach' (2014) 22 *Medical Law Review* 1

autonomy as equivalent persons, is both theoretically and practically difficult. It requires answers to difficult questions about how and why the foetus ought to take precedence over women's autonomy. To do so requires addressing issues and questions of who, how and why anyone other than the woman is in a better position to protect the rights of the foetus. It would also require a compelling and well-articulated justification for subordinating women's autonomy to the interests of the foetus. Cornell's theory supports the analysis of the research that there were no cogent reasons why competent women should not exercise full autonomy.[9]

Chapter 3 analysed the laws which regulate abortion in Australia, Britain, Canada, Ireland, New Zealand, Northern Ireland and the USA. It was found that there were fundamental differences between the laws as enacted and as applied by these legal systems. At some time in history abortion had been a criminal offence in all jurisdictions. In some jurisdictions abortion has been decriminalised and is regulated as a health concern.[10] None of the jurisdictions provide for abortion 'on demand' or 'as of right' by a woman.[11] The objective of the review of the laws was to determine whether the laws regulating abortion provided a legal framework which facilitated the exercise of women's autonomy as an equivalent person.

Reproductive autonomy includes the right not to reproduce. This requires that there should be a safe, timely and lawful access to abortion. Several features of the abortion laws were identified as operating in a manner which impinged upon women's autonomy. Implicit was a reluctance to accord women full autonomy when pregnant. The concern for protecting the foetus as a future person was evident in the development of the laws. The current laws in each of the jurisdictions continue to reflect stereotypical attitudes about women as being in need of protection and guidance. The laws provide criteria which the woman has to satisfy before she can obtain a legal abortion. Women are deemed unsuited to make the decision to terminate a pregnancy and therefore the law appoints the medical profession to oversee the implementation of the law. The laws in all jurisdictions made the medical profession the 'gatekeeper to abortion'.

9 See Cornell (n1).

10 In Canada and the Australian Capital Territory.

11 In Canada and the ACT the laws recognise an entitlement subject to the medical profession monopoly.

The jurisdictions varied as to the extent to which the law treated abortion as a health issue to be regulated like other requests for medical treatment. Nevertheless a trend towards abortion as a health issue has emerged. The laws varied as to whether abortion was criminal or decriminalised. Canada[12] and the ACT are the only jurisdictions which have completely decriminalised abortion.[13] In the USA abortion is legal up until 'viability'.[14] Victoria, Tasmania, the NT, Qld, NSW and NZ have decriminalised abortion apart from making it an offence for someone other than a medical practitioner to perform an abortion.[15] In Ireland abortion will be legal if it if it is performed in compliance with the recent legislation.[16] In England, Scotland and Wales abortion is illegal however the medical practitioner may perform a lawful abortion provided it complies with the *Abortion Act 1967*. In Northern Ireland the law has been reformed by regulations made by the Westminster Parliament which legalise abortions. [17] In the USA, abortions are legal in the early stages of pregnancy.[18]

The stage of pregnancy at which a woman requires an abortion will have an influence over whether or not it will be performed. Abortions may still be lawfully performed in the later stages of pregnancy but they are more strictly regulated and the decision is made by the medical professionals. In the later stages of gestation the woman must satisfy the criteria which have been established under the relevant legislation, if any.

None of the legal regimes regulating abortion meet the requirements of Cornell's analysis of freedom as outlined in Chapter 2 and applied in Chapter 3. This is because

12 *Criminal Code*, RSC 1970,

13 Health Act 1993 (ACT); For a brief period abortion was not a criminal offence in NI see *Northern Ireland (Executive Formation etc) Act 2019* (UK) '

14 *Roe* v *Wade* 410 US 113 (1973).

15 Qld has an offence of child destruction which does not specifically provide that the pregnant woman will not be liable under that section; see UK *Infant Life Preservation) Act 1929* c34; NZ; *Criminal Code 1983* (NT) s 170, see also s317; *Criminal Code 1913* (WA) s 271; *Criminal Consolidation Act 1935* (SA) s82A (7) makes killing an unborn child an offence. This could also apply to the woman. See Chapter 3.

16 *Health (Regulation of Termination of Pregnancy) Act 2018* (Ire).

17 *Abortion (Northern Ireland) Regulations 2020* (UK).

18 *Roe v Wade.*

the woman does not have full autonomy in making the decision not to proceed with a pregnancy.

The legal recognition of the right to access a timely, safe and lawful abortion is fundamental to the recognition of autonomy. Nevertheless, the laws which regulate abortion do not guarantee that a woman will be able to undergo a safe termination procedure. Chapter 4 considers the dynamics which may impede women's access to termination procedures., Funding of services, training of doctors, provisions of facilities, eliminating stigmatisation, protection from violence and harassment were found to be integral to the enabling women to exercise their autonomy. In practice there were barriers which militated against women achieving timely, safe and legal abortions.

For women who decide to continue with their pregnancy their autonomy requires that they should determine the type of medical treatment they receive. Chapter 5 considered the right to consent to or refuse medical treatment and whether the medical profession accommodates this right both in principle and in practice. A woman should decide which procedures she will undergo.[19] The research demonstrated that there is almost an absolute right to refuse medical treatment but it was frequently undermined when the woman was pregnant.[20]

The fundamental nature of the right to bodily autonomy is that the law regards any unauthorised touching as a battery. Where medical treatment is concerned unless there has been a valid consent obtained from the patient prior to undergoing treatment the medical professional may be held to have acted unlawfully.[21] That consent is not assumed but must be given is essential to the exercise of autonomous rights.[22] All competent persons equally, irrespective of their gender, have the right to consent to or

19 See introduction to Chapter 5 - And in Chapter 4 - a treatment of choice is implicit in the right to consent to or refuse medical treatment. The person may refuse all medical treatment or a particular medical treatment e.g. decide upon a natural birth or a caesarean or not to have a needle or an ultrasound.

20 Cf, 'Conscientious objection' – Autonomy requires that there should be an absolute right to undergo an abortion. The medical professional ought to be obliged to fulfil his/her duties. However, the laws and medical codes of practice recognise the right to refuse their services on the basis of their beliefs. The recognition of the 'right' to withhold services has been based upon an ill-founded and not properly analysed justification.

21 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

refuse medical treatment.[23] In theory, and upon general principles, there is no obvious reason to treat a woman differently because she is or may become pregnant.

Consent may only be dispensed with in the case of an emergency situation where the patient is unable to give or refuse consent, under mental health law or by order of the court. Where there have been applications for court intervention different approaches were discerned between the USA and the UK (and other jurisdictions which retain the *born alive rule)*.[24]

As discussed previously the USA decisions consider that the right to bodily integrity although a fundamental right of personhood may be overborne where compelling state interests so require. One such interest is in the protection of the foetus as a member of the future population. The USA no longer applies the *born alive rule* and has used the *foetal protection approach* to deny women rights to autonomy and to grant the foetus legal rights at a stage prior to being born alive. Laws have been enacted or interpreted in a way which limits women's rights to decide upon what medical treatment is appropriate during pregnancy. As a consequence this limits woman's autonomy, removes her chance at 'individuation' and threatens her freedom.[25] The UK approach and law considers that the right of a competent patient to consent to or refuse medical treatment is absolute.

However, it was observed that under both the *absolute right approach* and the *limited right approach* unwanted medical treatment has been authorised and /or performed on pregnant women. Both approaches have reached the same result but have done so using different laws and/or analyses. In applying either approach the woman's pregnancy features prominently in the judicial reasoning.

In the USA some courts focus directly upon the pregnancy in making their decisions. These cases were decided upon the basis of the compelling state interest in the foetus and/or whether the woman had the capacity to consent. Under the *absolute right approach*, taken in the UK, the decisions were not overtly based upon foetal welfare as

22 This applies whether it is consent or refusal of an abortion, a caesarean or any other reproductive procedure which involves interference with bodily integrity.

23 See Chapter 5 – Pt II General Principles'.

24 Here the UK is used to include Australia, Canada and NZ.

25 Drucilla Cornell, *The Imaginary Domain* (n 1) 20.

being a justification for overriding the woman's autonomy. However, it was clear that a connection was made between the woman being assessed as competent to consent/refuse medical treatment and her being pregnant. The woman's pregnancy clearly influenced the court's evaluation that she was not competent to give a valid refusal.[26] In both the USA and under the UK approach reasoning in the cases demonstrated that the pregnancy was an important determinant in the cases and that the foetus under either approach was pivotal to the decisions.

Chapter 5 considered the broader context in which the cases took place and identified concerns, about the manner in which some of the decisions were arrived at, for the autonomy of pregnant women. In particular, the role played by the medical profession in the court proceedings and the deference and respect accorded to them by the judiciary was central to the outcome of the case. In contrast the pregnant woman was the subject matter of the decision but did not play an integral role in the proceedings. In some cases, she was not legally represented or was represented but without adequate instructions being provided. The unquestioned necessity for haste in bringing the proceedings also operated in a manner which appeared to influence the hearing and decisions in some of the cases. These matters are directly relevant to the main thesis question and to the subsidiary questions which will addressed in the next part.

## III AUTONOMY AND THE RESEARCH QUESTION

Part III of this chapter returns to the hypothesis and research questions and relates the findings to the main content of the thesis. The hypothesis is that pregnant women's rights to reproductive autonomy are insufficiently protected and overly restricted under the law and its application.

The subsidiary questions were:

i Does, being pregnant alter the legal recognition of women's right to autonomy and its operation under the laws?

26 See *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274, 275 transient incompetency due to pain during 'throes of labour' discussed at Part II – 1. 1.6; *St George' s Healthcare NHS Trust v S, R v Collins and Others, ex parte S* [1998] 3 WLR 936; *Re MB* [1997] EWHC Civ 3093.

ii What are the roles of the legal and medical professions in promoting or diminishing pregnant women's right to autonomy?

iii To what extent does the view taken about and the status accorded to the foetus have an impact upon pregnant women's autonomy?

iv What factors, other than the recognition of foetal personhood, [27] promote or undermine women's right to autonomy?

These questions will be addressed under headings which reflect their relationship with autonomy.

### *A Autonomy and Legal Theory*

The theoretical framework adopted here provided an account of what it means to be an equivalent person who is worthy of respect and therefore autonomous. The application of Cornell's theory requires that laws ought to be assessed upon the basis of equivalence and requires that those responsible for law-making and judicial verdicts make their decisions 'as if' free and equal persons could make this decision, having assumed a veil of ignorance.

The research indicated that the laws were framed, for the most part, in terms of equality for all persons under the law. However there were strong indications that women continue to be treated as lesser and in need of overarching direction. For example, the laws on abortion were framed in a way which made the medical professionals the 'gatekeepers of abortion'. The analysis of principles applying to the equal right of all persons to bodily integrity indicated the importance of this right for all legal persons. In principle, the right to refuse medical treatment is upheld even if the consequences were the death of that person or another person and there is no general duty to rescue.[28] Nevertheless, the application of the law indicated that the presence of the foetus was used to justify the making of exceptions to the established principles and to authorise medical treatment without the consent of the woman involved. It was seen that whilst the theoretical right to refuse medical treatment under the UK approach was absolute, it

27 'Legal Personhood' is used in respect of the foetus here as a shorthand for the goal of the anti-abortion proponents and others who seek legal rights for the foetus. Legal personhood and legal personality are used interchangeably here.

28 See eg *McFall v Shimp* 10 Pa D and C 3d 90 (1978).

was limited by 'compelling state interests' in the USA. Nevertheless, in both jurisdictions the women's right to refuse medical treatment was overborne in the majority of cases which came before the courts.[29]

Applying Cornell's theory to the practical application of the law in these areas indicates that there are factors which inhibit the equal application of the law. What was common was the continued existence of paternalistic attitudes to and stereotyping of women, albeit underlying rather than overt. This is unsurprising given the difficulty, throughout history in recognising women as fully autonomous beings.[30]

Samantha Halliday has argued that:

> [w]omen must be allowed to exercise their rights to autonomy, even if that means they make decisions that appear morally repugnant, or that they may have to later face the guilt of knowing that the foetus died due to their refusal of treatment.[31]

The experience of the pregnancy is not the same for all women or for all pregnancies. Common to all births is the potential for pain. However, the experience of and the response to pain may arguably differ. Pain does not equate to a lack of capacity to consent or refuse treatment as is suggested by Johnson J's statement that giving birth is 'a time of acute emotional stress and physical pain in the ordinary course of labour'.[32] He alludes to a belief that the advent of labour lays a foundation for a conclusion of incapacity.[33]

### *B Autonomy and Reproduction*

The ability to decide to continue with or terminate a pregnancy was identified as an important reproductive decision and central to women's autonomy. The thesis analysed the laws and their application to abortion to assess the impact of these upon women's autonomy. The laws and their application to consent to or refuse a specific or general

29 Chapter 5 – Conclusion.

30 See Chapter 2 – Theoretical Underpinnings.

31 Halliday (n 7) 231.

32 *Norfolk and Norwich Healthcare (NHS) Trust v W* [1997] 1 FLR 269, 272.

33 Jessica Flanigan, 'Obstetric autonomy and informed consent' (2016) 19 (1) *Ethical Theory and Moral Practice*, 225, 230-231; see Chapter 5 – Pt II B (b) *Pregnant women and Competency.*

medical treatment during pregnancy were examined to assess their impact upon autonomy when women continue with a pregnancy. The research indicated that, in both these areas, legal regulation has impacted and has the potential to impact adversely upon autonomy during pregnancy.

### *1 Abortion*

The examination of the laws of abortion indicated that the legal systems considered here have at some time regarded abortion as a serious criminal offence. Abortion was recognised as a threat to social cohesion, organisation and the family. Early legislation was directed at both protecting the woman from the real risks posed by the 'back-street' or 'backyard abortionist' and punishing those involved. The heavy penalties which could be imposed, upon abortionists and the women if convicted, reflected the social disapprobation of abortion and was intended to act as a deterrent.[34]

The continued use of the criminal law to regulate abortion reflected the anti-abortionist view and the perception that intervention is needed to protect the foetus from the woman. It indicated the broader concerns prevalent throughout history of the need for laws and mechanisms to control women. Women who had abortions contravened the societal expectations of good wives whose duty it was to produce children. Designating abortion as criminal underscores a belief that it is wrong *per se* and ought to be punished.

Once the law identifies behaviour as criminal it is extremely difficult to remove the stigma which attaches to that behaviour. In the USA, since *Roe v Wade*, abortion is not a criminal offence. Nor is it criminal in Canada.[35] Nevertheless, many of those who oppose abortion continue to regard it as 'criminal' and 'murder'. Abortion remains highly stigmatised,[36] as do the women who refuse medical treatment which is needed for foetal health and/or the health of the woman. The decriminalising of behaviour is only the first stage in enabling women to have both a theoretical and a practical autonomy to decide not to continue with a pregnancy. It is acknowledged that this will require more than a change to the laws regulating abortion and it is unfortunate that the historical location

34 See Chapter 2 – UK.

35 See *R v Morgentaler.*

36 See Ch 4-Abortion Stigma, The existence of abortion stigma was apparent to some extent in all jurisdictions

of abortion in the criminal law helps to perpetuate the belief that abortion is wrong 'per se'. However, a first and important step in recognising and promoting autonomy is to decriminalise abortion completely and to locate it in the area of health. This will involve removing residual criminal activities, such as the offence of carrying out an abortion without being a licenced medical practitioner which be punished in the same way as other medical treatments which are performed by persons who are unlicensed.

The decriminalisation of abortion in those jurisdictions where it continues to be restrictive, although important, is but one step towards resolving the problems facing women's autonomy. Relaxing legal restrictions and allowing access to abortion has resulted in accelerated efforts to prevent and recriminalize abortion. Although discernible in other jurisdictions this is most apparent in the USA. The political lobbying and measures taken in pursuit of this aim cannot be ignored because of its potential, at least in some jurisdictions, to place greater limitations and restrictions upon abortion than currently apply.[37]

It is important to recognise that reproduction is a decision made by women who are presumed, like all legal persons, to be rational and reasonable. It is well established that most women do not decide to proceed or not to proceed with a pregnancy without considering all the ramifications and consequences of the decision. Sometimes the pregnancy has been planned. In this situation, the woman will face the decision-making process that forms the day to day routine of being pregnant. Sometimes the pregnancy will be unintended or have occurred earlier than intended. In these cases, there may be a variety of factors which are external to the issue of whether the woman would like to or decides to continue with the pregnancy. Factors which will heavily influence her decision include: her socio-economic situation; the number and needs of the children in her family; whether she is in a relationship which will accommodate an additional member; any available support network; her need to earn an income for the maintenance or partial maintenance of her family; her religious views; and, what she perceives to be in the best interests of her particular situation. Pregnancy is a process and the decision making and feelings of the woman will be part of this process.

37 But see the situation in Ireland where the backlash against the strict laws and diminishing of Catholic hegemony have led to a successful referendum to reform the laws on abortion.

However, the history of abortion laws and the way they currently operate reflect a residual distrust in women's decision making. Women in the 21st Century are recognised as legal persons. This is reflected in the reform of abortion laws in the last 20 years. However, the abortion laws in the jurisdictions considered here continue to reflect a distrust of women and a reluctance to accord women full autonomy once they are pregnant. The concern for protecting the foetus as a future person was evident in the development of the laws. It was the woman who was wrongly identified as being the danger to the foetus. The current laws in the jurisdictions considered here reflect attitudes of paternalism and misogyny but the degree to which they do so varies a great deal. For example, in Northern Ireland, abortion has been decriminalised but there remains staunch opposition to it. Although the law now provides that an abortion is legal there are insufficient doctors who are trained or willing to provide that procedure[38]

In the Australia abortion is legal and mostly, readily available at the early stages of pregnancy. However, none of the laws meet the requirements of Cornell who would no doubt argue that the woman's 'project of becoming a person' applies to all stages of pregnancy. This requires that it is she who ought to make all decisions. To remove decision making about termination of pregnancy 'severely curtails women's ability to develop an individuated self'.[39]

The difference, between the theoretical autonomy conceded in some but not other legal systems and the ideal that abortion should be viewed solely within the realm of the woman, reflects the limitations of the law. It also exposes the failures of the law to resolve controversial issues such as abortion.[40] The value judgments of those who make the law are evident in all of the legal systems considered here.[41] None of the jurisdictions provide that it is to be the woman's right to make the final decision over whether or not to reproduce.

38 See Chapter 3 – The Legal Regulation of Abortion.

39 Cornell, *Letter to the Editors*, Boston Review, http://bostonreview.net/archives/BR20.4/Cornell.html.

40 expresses the view that there ought not be overreliance upon the law, above n9,154

41 The NZ Parliament may be heralding a change to this. See Chapter 3 – NZ.

Cornell is clear that '[w]ithout the protection of the right to abortion, there can be no meaningful equality for women'.[42]

### *2 Medical Treatment*

The fundamental right to bodily integrity as it applies to medical treatment is also relevant to women's autonomy. Once a woman continues with a pregnancy, whether planned or not and irrespective of the reasons for her doing so, it follows that her right to bodily integrity ought to be respected and upheld. This means that, so far as practicable, she ought to be able decide to undergo or refuse to undergo particular medical treatments. It is the woman who ought to make the final decision as to all aspects of her pregnancy. Her autonomy requires that she decides whether and what pre-natal treatment she requires including: if and when to have an ultra-sound(s); treatment for the foetus; attending a hospital for the birth; engaging a gynaecologist or obstetrician; having a home birth, with or without a mid-wife or doula in attendance; having a vaginal birth; having a caesarean; allowing the use of blood products; taking medication; and undergoing any other treatment or procedure whether related to her pregnancy or not. In the majority of pregnancies women's decisions will be made after a full diagnosis by and comprehensive advice (including the pros and cons of the alternatives available to her) from her medical professionals. This is the situation for many women given the advancements in modern medical technology, the increased knowledge of foetal development and the medicalisation of pregnancy.

However, as was seen in Chapter 5, there have been several cases where the medical profession has sought to override the decision of the woman to refuse or withdraw her consent to medical treatment. The right to refuse medical treatment is a fundamental right of all competent persons. The importance of the right is emphasised by the reluctance of the courts to allow exceptions or place limitations upon the right. Pregnancy is recognised as not sufficient to warrant overriding a woman's right to refuse medical treatment. In the cases where judicial intervention was sought and granted it was shown that whilst the principle was upheld, the judiciary was prepared to find that there were good reasons for overriding the pregnant women's refusal of medical treatment. There were differences as to the reasons given by the UK courts and the USA courts. The English courts, adhering to the concept of legal personhood,

42 Cornell, *The Imaginary Domain*, (n 1) 33.

confirmed that the right of a competent person to refuse medical treatment was absolute. However, the woman's right could be overborne because she is assessed as lacking the competency to give a valid refusal to medical treatment. The UK courts were prepared to hold that even a transient incident could cause an interruption to the ability to reason sufficiently to make a competent decision. The pain of labour was identified as being sufficient to render a woman incompetent.[43] Equating pregnancy to incompetency breaches Cornell's prohibition against degradation and fails to treat women as free and equal persons.[44]

The American courts, in ordering intervention, have held that although the right to bodily integrity and consequently the right of a competent person to refuse or consent to medical treatment was fundamental, it was subject to the compelling interests of the state. The courts were prepared to order that the pregnant woman undergo medical treatment where the state interest in the preservation of its future population outweighed the rights of pregnant women to bodily integrity. Pregnant women were compelled to undergo medical treatment in both countries. The treatments included such procedures as, caesarean sections, blood transfusions, diagnostic testing, and injections. They also included requirements that the women have restraints placed upon them which were ancillary to the medical treatment. Thus arrests shackling, detention and prevention from feeding the neonate once born were authorised, if necessary

The difference between the two approaches was not solely explained by reference to the judicial application of the law to the cases. Under both approaches the reasoning commenced with the general rule that all persons have the right to refuse medical treatment. However, it was clear that the courts considered upholding a pregnant woman's right to refuse medical treatment may be detrimental to the wellbeing of the foetus. Although articulated differently, this was an important consideration. An analysis of the judgments revealed a philosophy that if the judges were to err in their decision making, it would be better to do so in a way which protects the foetus and the pregnant woman. What was overlooked was that this removed the exercise of autonomy from women and placed it in the hands of others. Doing so usurps the autonomy of women and fails to treat them as equivalent beings. It also ignores the principle that the exercise

43 See *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274 , 275.

44 Cornell, *The Imaginary Domain* (n 1) 12, 13.

of autonomy also requires taking responsibility and accepting the consequences of any decision.

What was apparent was that there was a reluctance to respect pregnant women's ability to make the correct decision. Her decision was only considered correct and to be upheld if it accorded with the view of the medical evidence as adopted by the judge. What was interesting was that under the *absolute right approach* the test should have been whether there was a valid consent or refusal. The decision itself should not have been the primary focus of scrutiny. The principle to be applied to the validity of consent or refusal by a competent person is not whether the decision was correct. The fact that the decision was irrational as measured by the judge did not mean it was invalid. Nevertheless, as seen in Chapter 5, an assessment of a decision as being irrational by the court was interpreted as evidence from which and inference of incapacity might be drawn. This allowed the decisions of the women to be countermanded and a denial of them being recognised as a legal person.

### *C Autonomy and the Professionals*

The judiciary and the medical professionals play an important role in defining the extent to which the autonomy of pregnant women is recognised in practice.

The analysis indicated medical professionals are regarded as the 'gatekeepers' of abortion and medical treatment and have a policing role to protect the interests of the foetus. When considering the manner in which the laws of abortion were framed the role was to ensure that the woman was not permitted to undergo a termination unless she could satisfy the legal requirements of the jurisdiction concerned. It was seen that none of the jurisdictions provide. for an abortion as a right. This is so even in Canada where abortion is not a criminal offence and is treated as a health matter. Terminations are under the effective control of the medical professionals who may provide or not provide an abortion depending upon the policies of the province in which they practice.[45]

The medical practitioner may refuse to perform the termination. Medical professionals in all of the jurisdictions considered here have the right to refuse to perform an abortion. The refusal to provide medical services is commonly called a 'conscientious

45 See Chapter 4 -Access to Legal Terminations.

objection' and the way in which each jurisdiction recognises this right varies. In some jurisdictions there is legislation which specifically provides that there is no duty to perform abortions.[46] In others, there is a general right not to perform medical services to which the medical professional has a deeply held objection. The right has been extended to other persons who may be requested to 'participate' in the termination. Refusing to perform medical services provides an impediment to the patient's autonomy. What is of note is that the medical profession has hegemony over medical treatment which is regarded as undermining the reproductive rights of all legal persons.

The judiciary, as the ones who must make the final decision as to whether or not the woman's autonomy will be overborne, are in an unenviable position which is reflected in several of the decisions.[47] The application for intervention is often brought at the last minute and therefore there is little time for the judiciary to adhere to the laws of procedure which among other things are in place to protect the right to due process of the respondent or defendant. The pregnant woman is usually not present, frequently she is not interviewed by the judge or even by anyone other than a medical professional, she may not be represented or adequately represented, and her input into the decision-making process may be negligible. She is for all intents and purposes invisible.[48]

The judiciary relies upon the expertise of the medical professionals. They usually provide the only evidence in a case upon which the judge must decide as a matter of urgency. The medical profession is highly regarded by the judiciary to whom they provide expert evidence. The medical professionals have formed an opinion as to what is the appropriate treatment for their patient(s).[49]

The judiciary must adhere to the fundamental principle of bodily integrity but are consciously aware of the threat to the woman and the foetus. To the judge, who may have little or no experience of pregnancy, the evidence from the medical profession has great weight. The judges would also prefer to err on the side of caution and act upon undisputed and seemingly incontrovertible evidence which requires the medical

46 See Chapters 3 and 5.

47 See eg. *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274.

48 BA Halliday and Burkstrand-Reid, 'The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence' (2010) 81 *Uni of Colarado Law Review* 97.

49 See eg *Re AA* [2013] EWHC 4378.

treatment to prevent both the woman and foetus from probable death. As with the medical professionals the judges may conclude that the woman cannot be trusted to make this decision. Logic suggests to the judge that the woman is acting irrationally, and it may be inferred from this that she lacks capacity.[50] Therefore her fundamental right to bodily integrity may be impinged upon by what the court considers is her 'best interests'. That judges have concerns over whether they have reached the correct decision may explain why notes such as the woman had later apologised for *being difficult* [51] are added to the published judgment.

### *D Autonomy and Foetal Personhood*

In the United Kingdom,[52] Australia, Canada, Ireland and NZ the *born alive rule* remains determinative of when a foetus becomes a legal person Initially, the granting of rights through *foetal protection laws* appeared to be decisive in placing strict limitations upon women's autonomy. The *born alive rule*, that is, the fact that the foetus is not a legal person, appears to support women's autonomy. However, in some cases discussed in Chapter 5, her autonomy is undermined by other means. She is interpreted, by the judiciary, as lacking the mental capacity required for a valid refusal or consent. In some instances, it is her contradiction of the doctor's opinion and disagreement over the advice given that leads to the judicial decision that she is incompetent.

The USA approach of defining the beginning of life at a stage earlier than 'live birth' has meant that the foetus has been recognised as a person within a person.[53] Under the *foetal protection approach*, the foetus has legal rights which are enforceable under the law.[54] What is problematic with this analysis it that it begs the question of who should be responsible for enforcing these rights, against whom are they to be enforced and how is this to be done in practical terms. Both the woman and the foetus as legal persons have

50 This is so even though 'irrationality' of a decision is not supposed to equal incompetence; see *Re MB (Medical Treatment)* [1997] 2 FLR 426; [1997] EWHC Civ 3093.

51 See *Rochdale Healthcare (NHS) Trust v C* [1997] 1 FLR 274, 276.

52 *Paton v British Pregnancy Advisory Service Trustees* [1979] 1 QB 270; *C v S* [1988] QB 135; *Kelly v Kelly* [1997] 2 FLR 828.

53 It was seen that the status, rights and protection afforded to the foetus vary within the different jurisdictions in the USA.

54 *Unborn Victims of Violence Act of 2004* (Public Law 108-212) USA.

rights but are, they equal rights? Where the interests of the women and foetus are symbiotic this is not problematic. Where they are not there is potential for undermining women's autonomy.

The granting of personhood to the foetus is regarded as detrimental to women's autonomy for several reasons. First, there has been inconsistency about how to define viability. It was seen in the examination of the *foetal personhood approach* in the USA that although the foetus could be regarded as having personhood at some time prior to birth there was no precision or agreement as to the time at which this occurs. It could be at conception or at viability or at some other stage.

The legal recognition of foetal rights may result in women being made liable for criminal offences.[55] The earlier the foetus is given protection the earlier women who either have an abortion or refuse medical treatment might be potentially prosecuted. It would follow that abortion would be re-criminalised. Failing to undergo treatment necessary for the health of the foetus might be labelled child abuse. Where the woman refuses a caesarean and the foetus dies the woman might attract liability of unlawful homicide.[56] This may appear to be an overstatement of the concerns if it were not for the many cases in the USA where this has occurred.[57]

Second, granting foetal personhood ignores the physical reality of pregnancy where the foetus from the time of conception to time of birth is within the body of the woman and totally dependent upon her. It severely impinges upon the bodily integrity of the women who may be regarded as a foetal container. Further it diverts attention from the conflict between the pregnant woman and those who would interfere with her project of becoming a person.

Three, there are no mechanisms in place which allow for the exercise of foetal rights or whether the rights of the foetus ought to be subordinate to the rights of the woman who

55 See eg *Bei Bei Shuai v Indiana*, 966 NE 2d 619, 622 (Ind C App.2012) where a woman faced charges of murder of her foetus because of an attempted suicide.

56 Lynn Paltrow and Jeane Flavin, 'Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health.' (2013) 38 (2) *Journal Of Health Politics, Policy & Law* 299, 335.

57 Lynn Paltrow, 'Roe v Wade and the New Jane Crow: Reproductive Rights in the Age of Mass Incarceration.' (2013) 103 (1) *American Journal of Public Health 17*-21.

has legal personhood. The foetus is unable to act independently and is totally dependent on the woman. It is clear that the woman's autonomy should prevail because she is a competent legal person and has an ability to make decisions. To allow anyone other than the pregnant woman to make decisions for herself and her foetus once again promotes the myth of conflict between the woman and the foetus.

### *E Autonomy and Extraneous Considerations*

The legal systems regulate whether an abortion will be lawful or unlawful. However, the laws as enacted and applied to render an abortion legal or illegal are not the only factors which determine whether women will or will not be able to have safe and timely access to lawful termination procedures. Chapter 4 identified and considered additional factors which have important implications for the exercise of women's autonomy. These were governmental policies, including funding; the governmental grant of a monopoly over abortion procedures to the medical profession; the medical professional's right to refuse to perform abortions; the overarching problem of the stigmatisation of abortion and the impact of anti-abortion protest on the ability to safely access premises where abortions are performed.

Although not the focus of the thesis it is apparent that the (in)ability to exercise complete autonomy whilst pregnant was further hindered by other characteristics. Such factors as being a woman: of low economic and social status; of colour; belonging to a minority group; belonging to a minority religion; or, belonging to a particular race, militated against being accorded equivalent autonomy.

The legal right to access a timely and safe abortion is only a first step in protecting women's autonomy to make reproductive choices. For women who decide to continue with their pregnancy their autonomy requires that they should determine the type of medical treatment they receive.

## IV CONCLUSION

This research has supported a conclusion that pregnant women are regarded under the law and its application as theoretically having full legal personhood and therefore entitled to equivalent treatment under the law. It follows that laws which identify women as a 'special class' of person impinge upon women's autonomy. The analysis indicates that the laws which regulate abortion still contain remnants of negative

attitudes towards women. These may be unspoken but clearly remain strongly held but frequently unspoken. Likewise, the manner in which the validity of a woman's consent to medical treatment is determined reveals an implicit distrust of women's decision-making abilities, particularly when they are pregnant

Acknowledgement of women as free and equivalent legal persons is a relatively recent development and remains a continuing endeavour which addresses questions of how real equality is best achieved in the future. What is of equal importance is that those advances which have been made, particularly in the legalisation of abortion, are not reversed by making the rights of the woman subordinate to those of the foetus.

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*Stenberg v Carhart,* 530 US 914 (2000)

*Thornburgh v American College of Obstetricians and Gynecologists*, 476 US 747 (1986)

*Union Pacific Railway Co v Botsford* 141 US 250 (1891)

*Whitner v South Carolina*, 523 US 1145 (1998).

*Whitner v State*, 492 SE 2d 777 (SC Sup Ct, 1997)

*Whole Woman's Health v Cole*, 790 F 3d 563 (5th Cir, 2015).

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*Younquist v Stallman,* 125 Ill 2d276, 126 Ill Dec 60, 531 NE 2d 355

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# LEGISLATION

## Australia


*Abortion Law Reform Act 2008* (Vic)

*Abortion Law Reform Act 2008* (Vic)

*Australia Commonwealth Franchise Act* 1902 (Cth

*Charter of Human Rights and Responsibilities Act 2006* (Vic)

Clause Notes Reproductive Health (Access to Terminations) Bill 2013 (Tas),

*Coroners Act 2003* (SA)

*Crimes (Abolition of the Offence of Abortion) Act 2002* (ACT)

*Crimes Act 1900* (ACT)

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*Crimes Act 1949* (Vic)

*Crimes Consolidation Act 1935* (SA).

*Criminal Code (Cth)*

*Criminal Code (Medical Treatment) Amendment Act 2009* (Qld)

*Criminal Code* (NT)

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*Criminal Code* 1899 (Qld)

*Criminal Code 1913* (WA)

*Criminal Code Act 1899 (Qld)*

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*Electoral Act 1893 (57 Vic 1893 No 18)*

*Guardianship and Administration Act 1986* (Vic)

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*Health (Patient Privacy) Bill 2015 (ACT) Mr Rattenbury, Presentation Speech to Legislative Assembly 17th September 2015*

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*Health and Wellbeing Act 2008* (Vic)

*Health Insurance (General Medical Services Table) Regulations 2017* (Cth).

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*Legislation Act 2001* (ACT)

*Married Women's Property Act 1883* (Tas); *Married Women's Property Act 1883-4* (SA)

*Married Women's Property Act 1884* (Vic); *Married Women's Property Act 1892* (WA);

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*Mental Health Act* (Qld)

*Mental Health Act 2014* (Vic)s70 (2)

*Mental Health Act 2014*(Vic)

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*National Health Act 1953*

*National Health Act 1953* (Cth)

*Penalties and Sentences Act 1992* (Qld)

*Penalty Units and Other Penalties Act 1987* (Tas)

*Protection of Personal and Property Rights Act 1988* (NZ)

*Public Health and Wellbeing Act 2008* (Vic).

*Reproductive Health (Access to Terminations) Act 2013* (Tas)

*Sentencing Act 1991* (Vic)

*Summary offences Act 1988* (NSW)

*Summary Offences Act 2005* (Qld)

Summary Offences Amendment (Safe Access to Reproductive Health Clinics) Bill 2017 (NSW)

*Termination of Pregnancy Reform Act 2017* (NT)

*Therapeutic Goods Administration Act 1989* (Cth)

## Canada

*Access to Abortion Services Act* (Bill 482)

*Canada Health Act 1984*

*Canada Health Act*, RSC 1985, c C-6

*Canadian Charter of Rights and Freedoms*, 1982,§ 1;

Charter of Human Rights in Canada, Convention on Political Rights in Canada

*Criminal Code of Canada*

*Criminal Code*, RSC 1906, c 146

*Criminal Code*, RSC 1927, c 36,

*Criminal Code*, RSC 1970, c C-34

*Criminal Code*, SC 1953–1954, c 51

*Criminal Code*, SC 55 & 56 Vict, c 29

## Ireland

*Constitution of Ireland* (Ire)

*Constitution of the Irish Free State (Saorstát Ireann) Act, 1922*, Art 9.

*Criminal Law Amendment Act 1935* (Ire)

*Eighth Amendment to the Constitution of Ireland Act 1983 (Ire)*

*Protection of Life During Pregnancy Act 2013* (Ire)

*Regulation of Information (Services Outside the State for Termination of Pregnancies) Act 1995* (Ire)

*Regulation of Information (Services Outside the State for Termination of Pregnancies) Act, 1995* (Ire)

*Thirty-sixth Amendment of the Constitution Act 2018 (E*re)

## New Zealand

*Accident Compensation Act 2001* (NZ)

*Bill of Rights Act 1990* (NZ)

*Code of Health & Disability Services Consumers' Rights* (NZ)

*Contraception, Sterilisation, and Abortion Act 1977* (NZ)

*Crimes Act 1961* (NZ)

*Health Practitioners Competence Assurance Act 2003* (NZ)

*Hospitals Amendment Act 1975* (NZ)

*Legislative Council Abolition Act 1950 (No 3)* (NZ);

*New Zealand Bill of Rights Act* 1990 (*NZBORA*)

*Statutes Amendment Act* 1941 (5 Geo VI no 26) (NZ)

*Women's Parliamentary Rights Act 1919* (10 Geo V 1919 No 16) (NZ)

## United Kingdom

*Abortion Act 1967* (UK) c 87

*An Act Respecting Offences against the Person*, 1869, c 20 (UK)

*Births and Deaths Registration Act 1953* (UK)

*British North America Act 1867*, 30 & 31 Vict, c 3

*Commonwealth of Australia Constitution Act 1900* (UK).

*Congenital Disabilities (Civil Liability) Act 1976* (UK)

*Constitution Act 1867 (Imp)*, 30 & 31 Vict, c 3, s 91(27) ('*Constitution Act 1867*').

*Constitution Act 1867*, 30 & 31 Vict Ch 3 (UK)

*Crimes Amendment Act 1977* (NZ)

*Criminal Injuries Compensation Act 1995* (UK) c 53

*Criminal Justice Act (Northern Ireland) 1945* (UK) c 15

*Equal Franchise Act 1928* (UK)

*Health and Social Care Act 2012* (UK)

*Human Fertilisation Act and Embryology Act 1990 (UK) c 37*

*Human Rights Act 1998* (UK)

*Infant Life (Preservation) Act 1929,* 19 & 20 Geo 5, c 34.

*Ireland Act 1949*, 12, 13 & 14 Geo 6

*Irish Free State (Agreement) Act 1922*, 12 & 13 Geo 5, c 4

*Life Peerages Act 1958*

*Lord Ellenborough's Act 1803, 43 Geo 3, c 58 (aka Malicious Shooting Act of 1803* (UK)

*Married Women's Property Acts* and the *Matrimonial Causes Act* 1857

*National Health Service Act 2006* (UK)

*Northern Ireland (Executive Formation etc) Act 2019* (UK)

*Northern Ireland Act 1998* (UK) c 47

*Offences Against the Persons Act 1861(UK)*

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*Parliament (Qualification of Women) Act 1918*

*Parliament (Qualification of Women) Act 1918* (UK)

*Peerage Act 1963* (UK)

*Representation of the People Act 1918*

*Representation of the People Act 1918* (UK)

*Sex Disqualification (Removal) Act 1919*.

*Stabbing Act of 1803* (UK), and the *Miscarriage of Women Act of 1803* (UK))

**United States of America**

*Fetal Assault Law 2014*, SB 1391 (amended Tennessee's Fetal Homicide Law Tenn Code Ann §§ 39-13-107, 39-13-214 (2014))

*Freedom of Access to Clinic Entrances Act of 1994,* 18 USCA § 248 (1994)

La Rev Stat Ann §§ 9:121, 9:123 (1999).

Neb Rev Stat § 28-328(1) (Supp 1999)

NYC Admin Code § 8-107(22)' (NYC Commission on Human Rights, 2016)

*Patient Protection and Affordable Care Act* (USA) (*Affordable Care Act*)

*Religious Freedom Restoration Act*

SC Code Ann § 20-7-50 (currently § 63-7-20)

*Texas Health and Safety Code* (1999).

*Unborn Victims of Violence Act of 2004*, 18 USC § 1841; 10 USC § 919a (2004).

Wis Stat § 48.133 (2013).

# Abbreviations

| | |
|---|---|
| LGBT | Lesbian Gay Bi-sexual Transgender |
| ACOG | American College of Gynaecologists |
| PSPO | Public Spaces Protection Order |
| GCN | Good Counsel Network |
| CEDAW | Convention on the Elimination of Discrimination Against Women (Committee) |
| FFA | Fatal Foetal Abnormality |
| ICCPR | International Convention on Civil and Political Rights |
| TRAP | Targeted Regulation of Abortion Providers |
| FACE | *Freedom of Access to Clinic Entrances Act of 1994* |
| AMA (Aus) | Australian Medical Association |
| AMA (USA) | American Medical Association |
| VLRC | Law Reform Commission of Victoria |