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INTERPRETING THE DISABILITY GROUND OF THE ABORTION ACT

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I. INTRODUCTION

"NOT only would it be a bold and brave judge ... who would seek to interfere with the discretion of doctors acting under the Abortion Act 1967, but I think he would really be a foolish judge who would try to do any such thing, unless, possibly, where there is clear bad faith and an obvious attempt to perpetrate a criminal offence." So said Sir George Baker P. in *Paton* v. *B.P.A.S.*[1] and his view has been repeated at apposite judicial moments in subsequent cases.[2] Recently, however, a legal attempt was indeed made to question the discretion of doctors in *Jepson* v. *The Chief Constable of West Mercia Police Constabulary*.[3] Reverend Joanna Jepson asked the West Mercia Police to investigate doctors who had authorised an abortion for bilateral cleft lip and palate at 28 weeks under the disability ground of the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). Abortion is legal under that section if two doctors have formed an opinion in good faith 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".[4] When the police decided not to pursue a prosecution, the claimant succeeded in obtaining permission to proceed with a claim for judicial review of that decision. However, the hearing was then suspended pending a renewed police investigation. In due course the Crown Prosecution Service (CPS) announced that, following an extensive review of evidence of various kinds, it would not prosecute the doctors in the

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[1] [1979] Q.B. 276, 282.

[2] *E.g. C* v. *S* [1988] Q.B. 135, 153.

[3] [2003] EWHC 3318.

[4] The relevant part of s. 1(1) of the Abortion Act 1967 as amended by the HFE Act 1990 reads: "Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith ... (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".

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case and, in turn, Reverend Jepson stated that she would seek legal advice as to whether to continue with her claim for judicial review.[5] Given the constraints of such an action, coupled with the CPS's view that the doctors formed a "good faith" judgment about the abortion in question (which again underlines the words of Sir George Baker P. in *Paton*), it seems unlikely that Reverend Jepson will be advised further to pursue her claim. Either way, it is appropriate to consider the central questions the case raises. The obvious ones concern the terms of the disability ground of the Abortion Act, in particular the meanings of "substantial risk" and "serious handicap". The underlying questions concern the balance between the moral and legal interests of the foetus and its mother (or parents).

Since Parliament entrusted the operation of the Abortion Act to doctors, a position which has been strongly criticised over the years,[6] judges have been very reluctant, as witnessed by Sir George Baker P.'s statement, to interfere with the operation of the Act. It is not surprising, then, that (apart from *Jepson*) there has been only one direct judicial challenge to the good faith of doctors in the operation of the Act.[7] Judicial deference to medical opinion is common in medical law. The particular problem with such deference in this context is that abortion is primarily a moral, rather than a medical matter. This is so notwithstanding that, in the case of selective abortion, assessments as to the impairments

[5] For accounts of these developments, see *e.g.* "Cleft Lip Abortion to be Investigated", *The Guardian*, 17 April 2004; "Curate Postpones Cleft Palate Late Abortion Action", *The Daily Telegraph*, 9 May 2004; and a CPS Press Release of 16 March 2005, entitled "CPS Decides Not to Prosecute Doctors following Complaint by Rev. Joanna Jepson", which reads, in part: "The Chief Crown Prosecutor for West Mercia CPS, Jim England, said: 'This complaint has been investigated most thoroughly by the police and the CPS has considered a great deal of evidence before reaching its decision ... The issue is whether the two doctors who had authorised the termination were of the opinion, formed in good faith, that there was a substantial risk that if the child were born it would suffer from such physical and mental abnormalities as to be seriously handicapped. I consider that both doctors concluded that there was a substantial risk of abnormalities that would amount to the child being seriously handicapped. The evidence shows that these two doctors did form this opinion and formed it in good faith. In these circumstances I decided there was insufficient evidence for a realistic prospect of conviction and that there should be no charges against either of the doctors.' Mr. England said the evidence considered by the CPS included medical records; guidance from the Royal College of Obstetricians and Gynaecologists; evidence from a number of professionals involved in the care, counselling and treatment in this case, and interviews of the two doctors. Opinions were also obtained from independent medical experts. 'We took all these matters into account when reaching our decision that there was no offence.'" For Rev. Jepson's reaction, see C. Dyer, "Doctor who Performed Late Abortion Will Not be Prosecuted" (2005) 330 B.M.J. 668.

[6] See *e.g.* S. Sheldon, "Who is the Mother to Make the Judgment?: The Construction of Woman in English Abortion Law", (1993) 1 Fem. Leg. Stud. 3; S. Sheldon, "The Law of Abortion and the Politics of Medicalisation", in J. Bridgman and S. Millns (eds.), *Law and Body Politics: Regulating the Female Body* (Aldershot 1995) 105; E. Jackson, "Abortion, Autonomy and Prenatal Diagnosis" (2000) 9(4) Social and Legal Studies 467.

[7] *R* v. *Smith* (1974) 58 Cr. App. R. 106, in which a doctor was convicted for lack of good faith in authorising an abortion under s. 1(1)(a) of the Act.

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that a born child would have require a certain but sharply contested degree of medical input.[8]

Despite the dearth of directly relevant jurisprudence, there are in fact several sources which give indications as to how the disability ground of the Act might be interpreted, if it were to come under judicial scrutiny. The first, of somewhat limited assistance, is Hansard. The second is the Royal College of Obstetrician's and Gynaecologists' (RCOG) guidelines on the interpretation of this section of the Act. The third, perhaps surprisingly, is in fact in existing case law, notably the wrongful birth cases. The fourth, more obviously, is the case law on abortion under the European Convention on Human Rights. Some ethical argument is also required to link these pieces together.

II. Exploring the Meanings of the Terms

A. "Substantial Risk"

The issue of the degree of risk does not appear to have been of great concern in the Parliamentary debates surrounding the amendments to the Abortion Act. Turning immediately to the RCOG guidelines on abortion, these have no legal status. However, as with General Medical Council guidelines on issues such as confidentiality,[9] they would likely be treated with a good degree of judicial respect. To define "substantial risk", the RCOG guidelines resort, initially, to dictionary definitions.[10] To assess the risk in any given case where a positive diagnosis is not possible, the risk must be seen as substantial by "informed persons with no personal involvement in the pregnancy and its outcome".[11] This suggests that the doctors who must make this assessment are not to be guided by the woman's (or her partner's) perception of the risk. The guidelines identify relevant factors as the information diagnostic tests have revealed and the outcome for the foetus during pregnancy, when a child and when an adult, as gleaned from published studies.[12] Thus, the guidelines only refer to a woman's perceptions of risk in the negative sense by apparently ruling out a subjective risk assessment.

There is, however, an alternative section of the Abortion Act that may implicitly be used for selective abortion and, in effect,

[8] On medical assessments of disability in this context, see *e.g.* T. Shakespeare, "'Losing the Plot?' Medical and Activist Discourses of Contemporary Genetics and Disability" (1999) 21:5 Sociology of Health and Illness 669, 678.
[9] GMC, "Confidentiality: Protecting and Providing Information", April 2004.
[10] RCOG, *Termination of Pregnancy for Foetal Abnormality in England, Wales and Scotland* (January 1996) para. 3.2.1.
[11] *Ibid.*
[12] *Ibid.*

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allows weight to be given to a woman's concerns. Section 1(1)(a) of the Act permits abortion where two doctors are of a good faith opinion "that the pregnancy has not exceeded twenty-four weeks 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". (This section was not available as regards the abortion in the *Jepson* case because the pregnancy had gone beyond 24 weeks.) The RCOG guidelines state that "where a woman feels strongly that she is unable to accept a probability of risk or a degree of handicap that her medical practitioners consider less than substantial or serious ... the practitioners may decide that abortion has become necessary to protect her mental health".[13] So, where the pregnancy has not exceeded 24 weeks, this section provides a means of sidestepping the requirement that two practitioners consider the risk to be substantial or the condition serious. Juxtaposed against the use of the disability ground itself, there is an element of a subjective assessment under the "social ground" provided, of course, that two doctors judge there is a risk to the woman's mental or physical health (or that of any of her children). This is in contrast to, if not an objective, then at least a more impersonal assessment of the degree of risk under the disability ground of the Act. Although the RCOG guidelines make clear that under the disability section of the Act the degree of risk is to be assessed impersonally, it would be premature to conclude that some kind of impersonal or objective assessment is either required or possible regarding the criterion of seriousness.

B. "Serious Handicap"

The House of Commons debates on the amendments to the 1967 Act do not tell us what "serious handicap" should mean. But they do give some indication as to what it was thought the term would not mean. In particular, there was a debate of sorts as to whether abortions might be performed for reasons of cleft lip. One speaker suggested that the idea that abortions could be conducted for such reasons was "scaremongering".[14] Regardless of whether or not this was so, the flavor of the debate suggests that such conditions would not have been viewed as serious in the requisite sense. By contrast,

[13] RCOG, *Termination of Pregnancy*, para. 3.4. The guidelines go on to note the World Health Organisation's definition of health as "... a state of physical, mental and social wellbeing and not merely an absence of disease or infirmity". The RCOG guidelines continue: "In determining whether there is a risk to mental health in a particular pregnancy the medical practitioners have to identify factors in the woman's life and personality that would threaten her mental health if the pregnancy were to continue: they do not have to certify that she has a mental illness."

[14] Mr. Frank Doran, *Hansard*, 21 June 1990, vol. 174, col. 1187.

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there is some indication that conditions such as spina bifida, hydrocephalus and cystic fibrosis would have been.[15] With reference to a proposed amendment that the type of disability should have to be recorded following a termination under this section of the Act, Kenneth Clarke said:

> There is some point to the amendment. It would finally answer one way or the other the continual claim that abortion is carried out for a hare lip or other such condition. I share the doubts of those who say that that does not take place.[16]

We know about the abortion in the *Jepson* case because the Department of Health gathers and records a great deal of statistical information about abortions carried out each year.[17] As regards the seriousness of the condition in that case we saw earlier that, in the light of a range of evidence, the CPS decided that the relevant doctors had formed a good faith judgment on this issue.

Turning to the RCOG guidelines, if an "abnormality" is untreatable and would lead to the death of the child once born, termination is permissible. Apart from this, a judgment has to be made as to "whether the abnormality would be likely to result in 'serious handicap' ".[18] The guidelines cite World Health Organisation definitions of disability, suggesting that "[a] person is only likely to be regarded as seriously handicapped if they need the support described in the WHO Points 3 and 4". Point 3 refers to the need for a "helping [human] hand" and point 4 to "dependent performance", which denotes the need for someone else to assist "most of the time".[19] Other factors which may be relevant to what should be "cautious" judgments are:

> ... the probability of effective treatment, either *in utero* or after birth; the probable degree of self-awareness and of ability to communicate with others; the suffering that would be experienced; the extent to which the actions essential for health that normal individuals perform unaided would have to be provided by others.[20]

Amongst these, I shall discuss the ideas of treatment, dependence on others and suffering.

[15] *Ibid.* Miss Ann Widdecombe, col. 1190.
[16] *Ibid.* col. 1201.
[17] Available at http://www.publications.doh.gov.uk/public/sb0323.htm.
[18] RCOG, *Termination of Pregnancy*, para. 3.3.1
[19] *Ibid.* Point 3: "Assisted performance. Includes the need for a helping hand (*ie:* the individual can perform the activity or sustain the behaviour, whether augmented by aids or not, only with some assistance from another person." Point 4: "Dependent performance. Includes complete dependence on the presence of another person (*i.e:* the individual can perform the activity or sustain the behaviour, but only when someone is with him most of the time)."
[20] *Ibid.* para. 3.3.

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1. The Idea of Remediability

The claimant in *Jepson* sought declarations (*inter alia*) "that 'seriously handicapped' in section 1(1)(d) of the Abortion Act 1967 has to be understood by reference to the remediability of the condition". She or her counsel may well have read the RCOG guidelines in point which cite the notion of "treatment". However, the most likely reason for the claimant's apparently single-minded focus on the idea of remediability was that she herself was born with problems with her jaw, for which she had a number of successful corrective operations during childhood.

Although the idea of remediability may be thought to have a certain solidity to it, the meaning of the term in this context may not in fact be clear-cut. The term could refer to a medical cure or correction, as Reverend Jepson apparently obtained by means of her successful operations. Alternatively, it could imply correction or alleviation to a significant degree by means of social support. This point relates to a distinction between medical and social concepts of disability.

Views of disability have been dominated by a medical conception of what it is to be disabled. John Harris is a proponent of this model, although he prefers to call this a "harmed condition" model. Harris defines disability as a "physical or mental condition which we have a strong [rational] preference not to be in", a "harmed condition".[21] The alternative "social model", as defended for instance by Tom Shakespeare, distinguishes between impairment, as a medical condition of the body, and disability, as social prejudice and discrimination.[22] On this latter approach, whether an impairment leads to a disability will depend on the nature of the social environment the individual inhabits. On the medical model, then, disability is situated within the individual and on the social model, it is social in nature. There are two points to note about this distinction here.

First, in referring to "treatment", the RCOG guidelines do not envisage the idea of a remedy through social support. Indeed, social support in the sense of aid from others is only negatively incorporated into the guidelines in the form of the last factor cited above, namely "the extent to which the actions essential for health that normal individuals perform unaided would have to be provided by others". The implication is that the likelihood of a

[21] J. Harris, "Is There a Coherent Social Conception of Disability?" (2000) 26 J.M.E. 95, 97, citing S. Reindal's interpretation of Harris in the former's, "Disability, Gene Therapy and Eugenics—a Challenge to John Harris", (2000) 26 J.M.E. 89.

[22] T. Shakespeare, "Choices and Rights: Eugenics, Genetics and Disability Equality", (1998) 13/5 Disability and Society 665, 665 (citing M. Oliver, *The Politics of Disablement* (Basingstoke 1990)).

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considerable degree of dependence would further support the idea of a termination.

Secondly, the distinction between medical and social models of disability has implications for the *Jepson* claimant's assertion that "serious" must be understood in terms of the remediability of the condition. If "remediable" only refers to "medical cure or correction", then "serious" effectively has a very wide meaning, automatically incorporating a large number of conditions, such as Down's syndrome or cystic fibrosis, which are not medically curable or correctable (although some of the health problems associated with Down's syndrome, such as heart conditions, may be). Of course, if "remediable" can include "alleviation", then "serious" becomes narrower in scope, since the health problems inherent, for instance, in cystic fibrosis can be alleviated to some degree. But there is an important and less obvious possible meaning of "remediable"—"alleviation through social support". If this is a permissible meaning, the definition of "serious" is considerably narrower in scope. This is because many conditions are alleviated by social support. Notably, the RCOG guidelines have recently been criticised as relying on a "potentially discriminatory" conception of disability in the context of preimplantation genetic diagnosis (PGD). The Human Fertilisation and Embryology Authority's and Human Genetics Commission's report on PGD recommended that the extent of social support available should be one of the relevant factors in decisions regarding PGD.[23] In the light of these developments the idea of remediability through social support could become, if not a positive, then at least a less negative factor in the assessment processes inherent in selective abortion. This would require some redrafting of the existing RCOG guidelines on point.

This is not to say that the possibility of social support necessarily rules out extensive dependence on others as a factor of some relevance in selective abortion. As the debate on models of disability has progressed, for instance, John Harris has accepted that there may be "social dimensions" to physical and mental conditions which disadvantage the individual[24] and Tom Shakespeare has acknowledged that some impairments can result in significant problems in themselves.[25] The implication is that some conditions will be disabling despite all possible support:

[23] HFEA and HGC, *Outcome of the Public Consultation on Preimplantation Genetic Diagnosis*, 18 June 2001, Rec. 15. The concern about discrimination, however, is not analysed either in this document or in the minutes of background meetings prior to the publication of this document.

[24] Harris, "Is There a Coherent Social Conception of Disability?", 95.

[25] Shakespeare, "Choices and Rights", 670.

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> Most physical and some mental disabilities can be overcome with social support and changes in the physical environment. Some mental and neurologic disabilities, however, require lifetime care and overwhelm parents' lives. Such disabilities may never be overcome even with massive economic and social support.[26]

In this light, extensive dependence on others for crucial needs could continue legitimately to be a factor in selective abortion, though perhaps a less pronounced, or more reflective, one. Because some combination of the two models of disability is preferable to reliance on either one, I continue to refer both to "impairments" and "disabilities".

2. Suffering—Whose Interests?

Some, mostly very rare, conditions from which a child might suffer would give rise to a very great degree of suffering. Tay-Sachs is the obvious example:

> The classical form of Tay-Sachs disease (TSD) is a fatal genetic disorder in children that causes progressive destruction of the central nervous system ... By about two years of age, most children experience recurrent seizures and diminishing mental function. The infant gradually regresses, losing skills one by one, and is eventually unable to crawl, turn over, sit, or reach out. Other symptoms include increasing loss of coordination, progressive inability to swallow and breathing difficulties. Eventually, the child becomes blind, mentally retarded, paralysed, and non-responsive to his or her environment. To date, there is no cure or effective treatment for TSD.[27]

In this extreme and rare case, it is not in the interests of a foetus who would develop Tay-Sachs as a born child to be born.[28] Abortion is therefore morally and legally legitimate on the basis of the suffering of the prospective child (although, notoriously, there are problems in comparing a disabled existence with non-existence);[29] further, some

[26] D. Wertz and J. Fletcher, "A Critique of Some Feminist Challenges to Prenatal Diagnosis", 175, as cited in B. Steinbock, "Disability, Prenatal Testing and Selective Abortion", in E. Parens and A. Asch (eds.), *Prenatal Testing and Disability Rights* (Washington, DC 2000) 108, 115.

[27] National Tay-Sachs and Allied Diseases Association, Inc. http://www.ntsad.org/pages/t-sachs.htm.

[28] Someone with strongly "pro-life" views would disagree.

[29] For legal reference to the difficulties of doing so, see *McKay* v. *Essex A.H.A.* [1982] Q.B. 1168. For philosophical discussion, see *e.g.* J. Feinberg, "Wrongful Life and the Counterfactual Element in Harming", in J. Feinberg, *Freedom and Fulfillment: Philosophical Essays* (Princeton 1992) 6; A. Buchanan, D. Brock, N. Daniels, D. Wikler, *From Chance to Choice: Genetics and Justice* (Cambridge 2000) 224 *ff.*

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might argue that abortion is morally required.[30] Other cases are more complex.

Recent work with people with impairments shows that we should be careful not to make assumptions about a child's suffering and cautious about the relevance of the language of suffering.[31] For instance, Prescilla Alderson undertook a series of interviews with adults who have one of a number of different conditions: cystic fibrosis, sickle cell anaemia, thalassaemia, Down's syndrome and spina bifida. She sought their views about their lives and about prenatal screening practices and found that the interviewees felt they suffered more from social stigma than from their actual physical condition. This relates to the distinction between medical and social models of disability discussed earlier. A recurring theme was of "adaptation, ingenuity and a resilience that grows through accepting and surmounting difficulties".[32] The lesson here is that we should not presume a connection between disability and suffering.[33]

Does this mean that abortion in such cases is not morally or legally justified? This depends on whose interests are legitimately at stake in selective abortion.

3. A Woman's or Couple's Moral Interests

People can decide whether to reproduce. If they decide to have a child, arguably some broad degree of control over the nature of the child which will be born should be entailed.[34] The desire to abort for reasons related to serious foetal impairment, however this is defined, may be justified because such reasons may seriously invoke the parents' reproductive autonomy interests and thereby determine whether or not they reproduce. There is considerable support for this position, including from the perspective of disability interests.[35] To hold this view is not to deny the positive aspects of raising a disabled or seriously ill child or to express a view as to the net

[30] For the view that abortion may be morally required, see J. Glover, *Causing Death and Saving Lives* (Harmondsworth 1977) 146.

[31] P. Alderson,"Prenatal Counselling and Images of Disability", in D. Dickenson (ed.), *Ethical Issues in Maternal-Foetal Medicine* (Cambridge 2002) 195, 201.

[32] *Ibid.* 208.

[33] The point has been well made by S. Edwards, in "Prevention of Disability on Grounds of Suffering" (2001) 27 J.M.E. 380.

[34] The classic statement of this view is likely found in J. Robertson, "Genetic Selection of Offspring Characteristics" (1996) 76 Boston U. Law Rev. 421, 445.

[35] See *e.g.* Buchanan *et al.*, *From Chance to Choice*; J. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* (Princeton 1994), and n. 34 above; B. Steinbock, "Disability, Prenatal Testing and Selective Abortion", 108, 118, 119; J. Botkin, "Line Drawing: Developing Professional Standards for Prenatal Diagnostic Services", in Parens and Asch (eds.), *Prenatal Testing and Disability Rights*, 288 and "Foetal Privacy and Confidentiality" (1995) 25(5) Hastings Center Report, 32. From a disability interests' perspective, see *e.g.* Shakespeare, "Choices and Rights", 672.

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balance of positive and negative experiences which might result.[36] It is simply to maintain that parents are entitled to form a view, which should be appropriately informed,[37] as to the broad kind of reproductive experience they wish to have.

Now, an important feature of the interviews discussed above is that the individuals had impairments the seriousness of which is very much a matter of debate.[38] Whilst conditions such as Tay-Sachs are very rare, those such as cystic fibrosis, spina bifida and Down's syndrome are much more common and the subject of the most routine screening practices. The difficulty here is that beyond the extremes of conditions such as Tay-Sachs, it is very difficult to define "serious". This has been acknowledged in the literature, such as in an extensive study undertaken by the Hastings Center.[39] It has also been acknowledged in England by the Human Genetics Commission in relation to PGD: "It has proved impossible to define what 'serious' should mean in this context. We have listed some factors that should be taken into account when considering seriousness, but perhaps the most important is that this technique should not be used for the purposes of trait selection or in a manner which could give rise to eugenic outcomes."[40] The central difficulty with the definition of serious is that clinicians, genetic counsellors, prospective parents and those with impairments (who may thereby have an insight into the interests of the foetus) may all have different views as to seriousness. So would the child who would be born unless aborted. The question, in effect, is "serious for whom?".[41]

[36] See Botkin, "Line Drawing", 300–01 for a discussion of the possible kinds of impact on parents.

[37] See C. Williams, P. Alderson and B. Farsides, "'Drawing the Line' in Prenatal Screening and Testing: Health Practitioners' Discussions", (2002) 4(1) Health, Risk and Society 61, 73, for discussion of the value of this. For observations as to the inadequacies of current counselling services, see Shakespeare, "Losing the Plot", 676. He also observes, at 685, that "[d]ecisions about screening should be based on good information: rather than evaluating screening programmes in terms of those who undergo tests and terminations, programmes should be evaluated in terms of the proportion of people who were empowered to make an informed choice". For consideration of the information provided in relation to Down's syndrome, see C. Williams, P. Alderson and B. Farsides, "What Constitutes 'Balanced Information in the Practitioners' Portrayals of Down's Syndrome?", (2002) 18 Midwifery 230. For a detailed discussion of the ways in which information-giving in this context should be developed, see B. Bowles Biesecker and L. Hamby, "What Difference the Disability Community Arguments Should Make for the Delivery of Prenatal Genetic Information", in Parens and Asch (eds.), *Prenatal Testing and Disability Rights*, 340.

[38] For one view of such conditions, see A. Asch, "Can Aborting 'Imperfect' Children be Immoral?", from A. Asch, "Real Moral Dilemmas", Christianity and Crisis, 46(10) 237. Reprinted in J. Arras and B. Steinbock, *Ethical Issues in Modern Medicine*, 5th edn. (New York 1998), 384, 386: "Down's syndrome, spina bifida, cystic fibrosis, or muscular dystrophy cause degrees of impairment ranging from mild to severe, the degree indeterminable at the time of prenatal diagnosis ...."

[39] The essays resulting from this study are collected in Parens and Asch (eds.), *Prenatal Testing and Disability Rights*.

[40] HGC, *Response to the Human Fertilisation and Embryology Authority on the Consultation on Preimplantation Genetic Diagnosis*, para.6.

[41] Botkin, "Line Drawing", 300, likewise notes this.

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If being born in any given case is compatible with having a good or reasonable quality of life, then we cannot say that it is not in the foetus's interests to be born. (At sentience, it is arguable that the foetus develops interests in its own right.[42] Before then, reference to the "foetus's interests" can loosely be understood as being those of the child it will become.) This will be the case for many conditions for which we currently routinely screen. In such cases, however, parents may still have an interest in being able to choose to accept or avoid certain experiences which the birth of a given child might entail: there might be significant mental impairment or serious health problems requiring, for instance, repeated hospitalisation, perhaps with major operative procedures of uncertain success. In such cases parental and foetal interests are potentially in conflict, since it is in the foetus's interests to be born.

If parents do have an interest in choosing whether to continue or terminate a pregnancy where the foetus is at risk of being born seriously impaired, their views as to the seriousness of its impairment will have moral legitimacy, within reason. The last point is an important caveat. This is because we do have a reasonably sure sense of the notion of seriousness at the extremes—for instance Tay-Sachs versus the webbing of two toes[43] or a susceptibility to moderate obesity. As suggested above, the problematic area is the large one of "mid-spectrum" conditions in between.[44]

Even if there is reasonable disagreement about the severity of certain conditions, a legal decision still has to be made under the Abortion Act as to whether the criterion of seriousness is satisfied. Can the law be interpreted to mean that "serious" includes all those conditions about which there is such disagreement and, in particular, can it take prospective parents' views on this issue into account?

[42] On the link between interests and sentience, see B. Steinbock, *Life Before Birth* (New York: 1992) 24, n. 24. On the notion of interests, see J. Feinberg, *Harm to Others* (New York 1984) 34: "In general, a person has a stake in X ... when he stands to gain or lose depending on the nature or condition of X."

[43] "Webbing (syndactyly) refers to the union of two or more fingers or toes, which usually only involves a skin connection between the two, but may rarely also include fusion of bones in the affected digits. Webbing may extend partially up between the digits, frequently just to the first joint, or may extend the entire length of the digits. Polysyndactyly describes both webbing and the presence of an extra number of fingers or toes." MedLine Plus Health Information, http://www.nlm.nih.gov/medlineplus/ency/article/003289.htm#Alternative%20Names. Note, however, that a minor anomaly may be an indication of a more serious anomaly as, for instance, Down's syndrome may be a relatively common cause: *ibid.* A possible concern that "that's not all that's wrong with [the] baby ..." was noted by a midwife quoted in C. Williams *et al.*, "'Drawing the Line' in Prenatal Screening and Testing", 68.

[44] D. Wertz, "Drawing Lines: Notes for Policymakers", in Parens and Asch (eds.), *Prenatal Testing and Disability Rights*, 261, 263 ff discusses the difference of views amongst practitioners as to what is serious.

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4. A Woman's or Couple's Legal Interests

The claimant in *Jepson* contended that a key error of law surrounding the abortion in that case was "that the medical practitioners who signed the certificate ... took into account the views of the parents involved" and "that ... in relation to the decision in question, the parents' views, as a matter of law, could have no weight".[45] Certainly the Act states that two doctors must be "of the opinion, formed in good faith" that the impairment is serious. Whether two doctors can decide in good faith that the condition is serious and mean, in so doing, "serious for this woman or couple" is a crucial question. Doctors could decide that a woman's or couple's views as to seriousness are relevant to their opinion of whether the condition of seriousness is satisfied if they consider that the purpose of the disability section of the Act, at least in some cases, is to protect parents by giving them choice.

Several commentators have made just this claim, suggesting that where the foetus would have a reasonable quality of life as a born child, it is in fact the woman's or parents' interests which underlie this section of the Abortion Act. Glanville Williams laid the ground for this argument some time ago[46] and the basis of this section has recently been reconsidered by Sally Sheldon and Stephen Wilkinson.[47] They argue that, because very few foetuses aborted under this ground would have lives of little or no quality if born, most abortions under this section cannot be seen as protecting the foetus from such a life. Rather, in most cases in which this section is invoked, the real concern is with the woman's or parents' interests. This is a moral argument as to the legal interpretation of this section of the Act.

The legal objection to this argument, originally explored by Derek Morgan,[48] is that a "parental interests" interpretation of section 1(1)(d) of the Act would essentially repeat section 1(1)(a) of the Act, making section 1(1)(d) redundant. Sheldon and Wilkinson observe that, from an ethical viewpoint, it may simply be that there is more than one justification for this section. From the viewpoint of statutory interpretation, however, they suggest that "there are some grounds for questioning" whether Parliament can have intended that section 1(1)(d) should protect parents' interests.

[45] [2003] EWHC 3318, para. [12].
[46] G. Williams, *Textbook of Criminal Law*, 1st edn. (London 1978), 256.
[47] S. Sheldon and S. Wilkinson, "Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law?", (2001) 9 Med. Law Rev. 85.
[48] D. Morgan, "Abortion: the Unexamined Ground" [1990] Crim. L.R. 687 692.

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Of course, section 1(1)(d) can never be entirely redundant in that, unlike section 1(1)(a), it allows terminations up until birth. Apart from this point and more fundamentally, it may be that as a society we have not necessarily been honest about whose interests the disability section of the Act is capable of protecting: it is to some degree taboo to say that parents have an interest in choosing to accept or avoid the birth of an impaired child and those debating the Act in Parliament may well have sensed this. By contrast, in related legal contexts we have apparently found it easier, at least in this country,[49] to accept the legitimacy of parental interests in selective abortion. The cases on wrongful birth demonstrate this and are a further source as to the interpretation of this section of the Abortion Act.

III. Related Case Law

A. Wrongful Birth Cases

The idea of compensating parents for the lost opportunity to abort a disabled foetus has been legally recognised for some time. The recognition of the wrongful birth claim progressed in response to scientific and legal developments in a way intended to enhance the deliberative quality of the abortion decision.[50] Wrongful birth cases correspond (indirectly) to the terms of the Abortion Act.[51] In *Rance* v. *Mid-Downs Health Authority*,[52] for example, one of the doctors was concerned that the couple might have had access to an abortion on the grounds of section 1(1)(d), it therefore being the relevant doctors' duty to inform them of information relating to a serious disability. Similarly in *Rand* v. *East Dorset Health Authority*, Newman J. refers to the "legal right accorded to parents by the 1967 Act as relevant to the ambit of the duty of care assumed by those having responsibility in connection with childbirth".[53]

[49] By comparison, see in particular the US cases which reject the wrongful birth action, *e.g. Schloss* v. *Miriam Hosp.*, No. C.A. 98–2076, 1999 WL 41875, at 4 (R.I. Super. Ct. Jan.11, 1999): "These cases are not about birth, or wrongfulness, or negligence, or common law. They are about abortion." See also *Dansby* v. *Thomas Jefferson University Hospital*, 623 A.2d 816 (Pa. Super. 1993) 821, *per* Wieand J.: "The protection of foetal life has been recognised to be an important state interest. The legislature's expressed concern is to prevent lawsuits leading to eugenic abortions of deformed or unwanted children."

[50] In the United States, the catalyst for these cases was the leading abortion decision in *Roe* v. *Wade* (1973) 35 L.Ed.2d 147.

[51] See R. Scott, "Prenatal Screening, Autonomy and Reasons: The Relationship between the Law of Abortion and Wrongful Birth", (2003) 11 Med. L. Rev. 265.

[52] [1991] 1 Q.B. 587. The case concerned a failure to diagnose spina bifida and the legality of an abortion under the unamended Abortion Act 1967, in which the foetal disability ground of the Act was subject to time limits.

[53] (2000) 56 B.M.L.R. 39, 48, my emphasis. This point is made in conjunction with a discussion of damages. Newman J. also observes: "The existence of the Act is sufficient to introduce into the relationship between the health authority responsible for a pregnancy and the parents, a

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Given that the scope of the wrongful birth action is effectively delineated by the terms of section 1(1)(d) of the Abortion Act there has been no doubt that a wrongful birth action cannot succeed unless, amongst other factors, a woman was not informed of a substantial risk of a serious handicap. But there has sometimes been doubt as to whether the condition of seriousness of disability is itself fulfilled. This is illustrated by the case of *Rand*, which concerned the lost opportunity to abort a child with Down's syndrome. Newman J. noted that "[t]here is an issue as to whether [the child in question] should be described as 'seriously disabled' ", observing that "she is regarded as one of the most able and intelligent children among those who suffer from Down's Syndrome".[54] In due course he concluded that it was appropriate to describe her as "seriously disabled".[55] The issue of seriousness was also addressed in *Parkinson* v. *St James and Seacroft University Hospital N.H.S. Trust*, which concerned a negligent sterilisation and the subsequent birth of a child with "severe learning difficulties". In this case, Brooke L.J. observed:

> What constitutes a significant disability for this purpose will have to be decided by judges, if necessary, on a case by case basis. The expression would certainly stretch to include disabilities of the mind (including severe behavioural disabilities) as well as physical disabilities. It would not include minor defects or inconveniences, such as are the lot of many children who do not suffer from significant disabilities.[56]

In his allusion to a spectrum of seriousness, Brooke L.J.'s language shifts from "disability" to "defect or inconvenience". One of the judicial concerns in this area is that there should be a meaningful distinction between the disabled and the non-disabled child, as evidenced in the judgment of Hale L.J. in the same case.[57] Developments in wrongful conception case law serve to reinforce

duty to take reasonable steps to ensure the parents can exercise their choice under the Act": *ibid.*, 50.

[54] *Ibid.*, 40.

[55] *Ibid.*, 45. He added: "[T]he quality of her life, her ability, her personality and her potential have incalculable value." In part, the evidence was: "Where everyday life skills are concerned K is likely to be a very competent young woman with Down's Syndrome, to be capable of living with some degree of independence, and even of being employed at a simple level ... She is however very unlikely ever to be able to live entirely independently; to marry, or to bring up children. She will need care and supervision for the rest of her life." (*Ibid.*, 43).

[56] [2002] Q.B. at 266, 383. The reference to "severe learning difficulties" is at 271.

[57] *Ibid.*, at 293: "[H]ow disabled does the child have to be for the parents to be able to make a claim? The answer is that the law has for some time distinguished between the ordinary needs of ordinary children and the special needs of a disabled child." She goes on to refer to statutory criteria. Note also Lord Steyn in *MacFarlane* v. *Tayside Health Board*, [2000] 2 A.C. 59, 84, who observed: "[C]ounsel for the Health Board was inclined to concede that in the case of an unwanted child who was born seriously disabled the rule may have to be different. There may be force in this concession but it does not arise in the present appeal and it ought to await decision where the focus is on such cases."

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this point. The idea—embodied in the House of Lords' judgment in *McFarlane* v. *Tayside Health Board*[58]—that the birth of a healthy child can never be an injury sounding in economic loss is some indication of the possible offence to legal policy of compensating for the missed opportunity to abort for aspects of a foetus's condition which are not in some reasonable sense "serious".

Whilst Brooke L.J.'s gloss on seriousness gives some sense of the meaning of "serious" under the disability ground of the Act, he also makes plain that cases will have to be decided on a case-by-case basis. In cases of difficulty, then, judges in wrongful birth cases will have themselves to address whether legitimate weight can be given to a woman's or couple's views on this matter. It may be helpful at this juncture to reflect further on the purpose of the wrongful birth action and for what it supposedly compensates.

As noted earlier, the purpose of such actions is to protect prospective parents' interests in being able to avail themselves of the opportunity to abort. If compensation were awarded solely for the extra costs of raising a disabled child—which have a very real monetary value—the cases would be unlikely to give much indication as to whether doctors can take a woman's (or couple's) views on seriousness into account in deciding that the grounds for section 1(1)(d) are made out. However, the courts are prepared to award damages for the impact on parents of raising a disabled child. In *Rand*, Newman J. states:

> It is obvious that *the birth of a disabled child will dramatically affect the quality of life of both parents and it is to be inferred that a reason why they would have terminated the pregnancy was to avoid such a loss of amenity in their lives*. As the law stands they cannot recover for any distress which causes no injury, but the loss of amenity caused by being required to expend time caring for a disabled child is a real and physical consequence. I have no doubt that it has sometimes led to exhaustion. In my judgment the law can recognise a claim for a continuing loss of amenity where a breach of duty has caused physical consequences giving rise to the loss of amenity.[59]

Newman J. notes that the idea of damages for "loss of amenity" in parents' lives was accepted by Brooke J. in the earlier wrongful birth case of *Allen* v. *Bloomsbury Health Authority*.[60] He also supports this head of damage with reference to the notion of a legally protected autonomy interest advocated by Lord Millett in

[58] [2000] 2 A.C. 59.
[59] (2000) 56 B.M.L.R. 39, 57, my emphasis.
[60] [1993] 1 All E.R. 651.

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the wrongful conception case of *McFarlane*.[61] Lord Millett observes of the parents in that case: "They have suffered both injury and loss. They have lost the freedom to limit the size of their family. They have been denied an important aspect of their personal autonomy." (It should be noted that the courts, appropriately, do not treat a woman's refusal to undergo an abortion as breaking the chain of causation.) Although not taken up by any of the other judges in *MacFarlane* itself, Lord Millett's approach was approved by the majority of the House of Lords in *Rees* v. *Darlington Memorial NHS Trust*,[62] which concerned whether a disabled mother could recover damages (for the extra costs of child-raising associated with her disability) for the birth of a healthy child following a negligently performed sterilisation. Although the majority decided that such recovery would be inconsistent with the principles of *MacFarlane*, it approved the award of a "conventional" sum in recognition of the "legal wrong" done to her. Lord Bingham, whose wording was approved by Lord Millett, described the loss as follows: "[A] parent ... has been denied ... the opportunity to live her life in the way that she wished and planned."[63]

Returning to the wrongful birth case law itself, the existing cases do not clearly indicate that parents' views are relevant as to the seriousness of a child's disability. However, since damages are recognised for the *impact* on parents of raising a disabled child (beyond, that is, the financial costs of so doing) described, in negligence terms, as consequential loss of amenity and supported with reference to the protection due to autonomy interests in surrounding case law, there is at least an *opening* to consider that parents' views on seriousness should carry some weight, at least in cases which are the subject of reasonable disagreement.

Against the relevance of parental views, however, consider the following statement by Newman J. in *Rand*:

> I have concluded that there is a difference between the choice available to parents to limit their family on the grounds of size alone, and the choice available by virtue of the Abortion Act 1967 to terminate a pregnancy on *medical grounds*. The existence of the Act is sufficient to introduce into the relationship between the health authority responsible for a pregnancy and the parents, a duty to take reasonable steps to ensure the parents can exercise their choice under the Act. The lawful and proper operation of the Abortion Act anticipates

[61] [2000] 2 A.C. 59, 114.
[62] [2004] 1 A.C. 309.
[63] *Ibid.*, 317.

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> and requires the opinions of medical experts to be available and *is firmly placed in the area of medical expertise*.[64]

In strict legal terms, Newman J. correctly emphasises that the operation of the Act is in the hands of doctors, in the sense that doctors must in good faith judge that the defence to what would otherwise be a crime is made out.[65] Yet, since he holds that the lawful operation of the Act "is firmly placed in the area of medical expertise", at the same time he is effectively declaring that the justification for the decision selectively to terminate is a medical one. In the light of the work that has successfully been done on questioning, though not overturning, the medical model of disability, this is somewhat unfortunate, if unsurprising. Additionally, this kind of statement fails to capture the intrinsically moral nature of the decision to terminate any pregnancy, including one on the grounds of foetal disability. Judges in future cases on wrongful birth would do well to take on board some of the criticisms of the exclusive role of doctors in evaluating disability.[66] These are criticisms implicitly recognised by bodies responsible for formulating legal guidelines in the parallel context of PGD, such as the Human Genetics Commission, whose views on the impossibility of defining seriousness I noted earlier. Judges could acknowledge these difficulties in their reflections on the meaning of "serious handicap", including as they affect doctors themselves in their job of operating under the Abortion Act. In so doing, given that the purpose of the wrongful birth action is to give a woman choice about whether to accept or continue a pregnancy in which the foetus is at substantial risk of being seriously impaired, judges could decide that her views (and those of her partner) can legitimately be relevant, within reason, to the meaning of "serious handicap" under the disability ground of the Act.

Indeed, this would be in line with the recognition, albeit limited, of the relevance of parents' views to testing and selection decisions in PGD. This technique is licensed on the "precautionary principle" of consistency with the disability ground of the Abortion Act and is lawful "where there is a significant risk of a serious genetic condition being present in the embryo".[67] At the same time Recommendation 13 of the *Outcome of the Public Consultation on Preimplantation Genetic Diagnosis*, concerning the shape of future guidance on the use of PGD, states: "The guidance should indicate

[64] (2000) 56 B.M.L.R. 39, 48, my emphasis.
[65] Offences Against the Person Act 1861, ss. 58 and 59.
[66] See *e.g.* Shakespeare, "Losing the Plot".
[67] HFEA and HGC, *Outcome of the Public Consultation on Preimplantation Genetic Diagnosis*, Rec. 11.

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that the perception of the level of risk by the people seeking treatment is an important factor in the decision-making process." Further, Recommendation 14 states "that the seriousness of a condition should be a matter for discussion between the people seeking treatment and the clinical team".[68] Given the starting point of the broad consistency of the criteria for PGD with those for selective abortion, it would seem that views about risk and seriousness in decisions about PGD may entail a rather delicate interplay of prospective parents' and clinicians' perceptions. The same interplay could (and perhaps does) occur in the context of selective abortion.

Lastly on the wrongful birth cases, it should be noted that causation will limit the scope of a possible action from a woman's (or couple's) point of view. The test of causation will be whether she would have aborted if she had been correctly advised of the foetus's health or condition. This is tested by a combination of subjective and objective factors.[69] In this sense, since the cases turn, in part at least, on what the woman (or couple) would have chosen to do when informed that the foetus was disabled, this is a further indication that autonomy interests are recognised, albeit to a limited degree.

B. Cases under the European Convention on Human Rights (ECHR)

The *Jepson* claimant sought declarations, *inter alia*, "that the foetus at 24 weeks gestation and greater has a right to life pursuant to Article 2 of the European Convention on Human Rights, which is only subject to the competing Article 2 right of the mother" and "that section 1(1)(d) of the Abortion Act is incompatible with Articles 2, 3, 8 and 14 of the European Convention on Human Rights".[70] Since the case did not proceed, we do not know what arguments the claimant was planning to make, but aspects of ECHR case law can be discussed here. This is relevant to the issue

[68] The recommendation goes on to state that "information provided to those seeking treatment ... should include genetic and clinical information about the specific condition; its likely impact on those affected and their families; information about treatment and social support available; and the testimony of families and individuals about the full range of experiences of living with the condition". Curiously, a somewhat puzzling variation of the point in Rec.14 can be found in the Summary of the responses to the Consultation Document which at one point observes that "80% *agreed* that the seriousness of a genetic condition should be a matter of *clinical judgment* based on general guidance". HFEA/HGC, *Analysis of the Responses to the Joint HFEA/AGCT Consultation on PGD*, para. 56(iv), my emphases.

[69] *Smith* v. *Barking, Havering and Brentwood H.A.* (1994) 5 Med. L.R. 285. Fears of fraud are often expressed in conjunction with hostility to the wrongful birth action. See *e.g.* K. Wilcoxon, "Statutory Remedies For Judicial Torts: The Need for Wrongful Birth Legislation" (2001) 69 U. of Cincinnati Law Rev. 1023, 1040. For a critique of the requirements of causation in the US context and suggestions for reform, see S. Ryan, "Wrongful Birth: False Representations of Women's Reproductive Lives" (1994) 78 Minnesota Law Rev. 857, 907.

[70] [2003] EWHC 3318, para. [8].

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ultimately underlying the meaning of the terms within the disability ground of the Abortion Act, namely the balance of legal interests between a pregnant woman and the foetus.

As regards article 8,[71] in *Brüggemann and Scheuten* v. *Germany* (1978),[72] the European Commission on Human Rights decided that although the decision to abort invokes a woman's private life, some regulation of pregnancy is consistent with respect for private life, since pregnancy "cannot be said to pertain uniquely to the sphere of private life".[73] Thus, abortion regulation does not need to be justified under Article 8(2). The reasoning of the dissenting Mr. Fawcett is sometimes preferred.[74] He held that "'private life' ... must in my view cover pregnancy, its commencement and termination: indeed it would be hard to envisage more essentially private elements".[75] Despite this, he held a certain degree of regulation of abortion to be justified under Article 8(2). On either reasoning the implication of *Brüggemann* is that the English Abortion Act is compatible with Article 8. But is Article 8 as applied to abortion compatible with the foetus's interests?

Cases such as *C* v. *S* and *Re F (in utero)*[76] establish that it has no legal status. Similarly, the Abortion Act implies that the foetus is not a legal person. How does this position square with Article 2 of the ECHR? The implications of a finding that the foetus of 24 or more weeks has a right to life under Article 2 (which could only be overridden where the pregnant woman's life was at risk) would be considerable. In addition to creating the need for a declaration of incompatibility under the Human Rights Act as regards the disability ground of the Abortion Act,[77] such a finding would have

[71] The first part of Article 8 of the Convention provides: "Everyone has the right to respect for his private and family life, his home and his correspondence". If an applicant can show an interference with this right, then, so far as Strasbourg jurisprudence is concerned, it falls to the state in question to try to justify this under Article 8(2): "There shall be no interference by a public authority with this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of crime and disorder, for the protection of morals, or for the protection of the rights and freedoms of others."

[72] (1981) 3 E.H.R.R. 244.

[73] *Ibid.*, para. [59].

[74] *E.g.* by L. Doswald-Beck, "The Meaning of the 'Right to Respect for Private Life' ", (1983) 4 H.R.L.J. 283, 291; D. Feldman, "Privacy-related Rights and their Social Value", in P. Birks (ed.) *Privacy and Loyalty* (Oxford 1997), 15.

[75] (1981) 3 E.H.R.R. 244, para. [1].

[76] Respectively [1987] 1 All E.R. 1230, in which a man sought to prevent his girlfriend having an abortion; and [1988] 2 All E.R. 193, in which the Court of Appeal decided that it could not make the foetus a ward of court in response to a local authority's concerns about the lifestyle and mental condition of its mother.

[77] Section 1(1)(b) would also be implicated.

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implications for surrounding case law, notably that dealing with "maternal-foetal conflict".[78]

The case which considered the application of Article 2 to the foetus under English law was *Paton* v. *U.K.*[79] Since it concerned an abortion in the early stages of pregnancy performed in order to protect a woman's interest in life and health, it left very open the extent to which Article 2 applies to the foetus.[80] Indeed, until recently it could only be said that, in the light of risks to the woman's physical or mental health, the early foetus has at best a limited right to life.[81] In 2004, the question of whether the foetus, including the late-term foetus, has a right to life under Article 2 was addressed by the European Court of Human Rights (ECtHR) in *Vo* v. *France*.[82] The case concerned a mistake as to names in a French hospital which resulted in a doctor attempting to remove an intra-uterine device from a woman who was in fact six months' pregnant. Some days later a scan revealed that her pregnancy could not continue and she had to have an abortion. The applicant, Mrs. Thi-Nho Vo, complained in relation to "the authorities' refusal to classify the taking of her unborn child's life as unintentional homicide" and "argued that the absence of criminal legislation to prevent and punish such an act breached Article 2".[83] Her argument was rejected in the ECtHR.

The court identified the novel issue before it as "whether, apart from cases where the mother has requested an abortion, harming a foetus should be treated as a criminal offence in the light of Article 2 of the Convention, with a view to protecting the foetus under that Article".[84] Following a review of prior case law, it observed that "the unborn child is not regarded as a 'person' directly protected by Article 2 of the Convention and that if the unborn do have a 'right' to 'life', it is implicitly limited by the mother's rights and interests".[85] Still, the Court noted that "the possibility that in certain circumstances safeguards may be extended to the unborn child" had not been dismissed.[86] Given that the interpretation of

[78] The cases in which a woman refuses a caesarean section are here in point. See *e.g. Re M.B. (Adult: Refusal of Medical Treatment)* (1997) 8 Med. L.R. 217.
[79] (1981) 3 E.H.R.R. 408. Article 2(1) states: "Everyone's right to life shall be protected by law."
[80] Of the decision F.G. Jacobs and R.C.A. White observe: "It is difficult to conclude other than that the Commission was anxious to sidestep a controversial case." *The European Convention on Human Rights*, 2nd edn. (Oxford 1996), 43. They also note, however, the lack of consensus amongst Member States of the Council of Europe on the moral and legal issues surrounding abortion.
[81] *R.H.* v. *Norway*, Appl. no. 17004/90 (1992) extended *Paton* to abortions for social rather than health reasons.
[82] Judgment of 8 July 2004, Appl. no. 53924/00.
[83] *Ibid.*, para. [46].
[84] *Ibid.*, para. [81].
[85] *Ibid.*, para. [80].
[86] *Ibid.* (citing *Brüggemann* (1981) 3 E.H.R.R. 244).

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Article 2 in relation to the foetus had till then taken account of the difference of approach at the national level, it held that the issue of the beginning of the right to life fell within the margin of appreciation.[87] The only point of agreement amongst states, the Court noted, is that the embryo or foetus is human. Despite this, it observed that since the foetus has the capacity to become a person and in some states is protected for instance by means of inheritance laws, it requires "protection in the name of human dignity, without making it a 'person' with the 'right to life' for the purposes of Article 2".[88] In the light of the above, the Court considered it "neither desirable, nor even possible ... to answer in the abstract the question whether the unborn child is a person for the purposes of Article 2 of the Convention".[89] Nor did it think it necessary to consider in the case at hand whether the ending of the foetus's life was within the scope of Article 2 because, even if Article 2 were applicable, it held that France had not failed to comply with requirements concerning the protection of life in the sphere of public health.[90] Accordingly, the implication of *Vo* v. *France* is that section 1(1)(d) of the Abortion Act remains compatible with Article 2 of the ECHR.

The remaining articles upon which Reverend Jepson sought declarations were Articles 3 and 14. A consideration of the foetus's claims in relation to Article 3, which states that "[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment" would require careful reflection. The issue under Article 3 would be whether abortion constitutes inhuman treatment, which has been defined as treatment which causes intense physical and mental suffering.[91] The possibility that the foetus feels pain would be relevant here and is pertinent to a consideration of the balance of interests under the disability ground of the Abortion Act since it allows abortions up until birth.

Vivette Glover and Nicholas Fisk have investigated the foetus's capacity to feel pain, noting that "[t]he foetus is currently treated as though it feels nothing, and is given no analgesia or anaesthesia

[87] In deciding this point, the Court noted both that the issue had not been decided in most of the Contracting States (including in France, which was currently debating the issue in other contexts) and that "there is no European consensus on the scientific and legal definition of the beginning of life". *Ibid.* para. [82].

[88] *Ibid.*, para. [84]. The relevant passage is a little unclear.

[89] *Ibid.*, para. [85].

[90] *Ibid.*, It rejected her argument that Article 2 required a criminal remedy, noting that "if the infringement of the right to life or to physical integrity is not caused intentionally, the positive obligation imposed by Article 2 to set up an effective judicial system does not necessarily require the provision of a criminal-law remedy in every case". *Ibid.* para. [90]. In this case, the applicant could have brought an action in negligence. *Ibid.* para. [91]. Further, that an administrative law action was statute-barred was considered reasonable, since the right of access to courts is not absolute: *ibid.*, para. [92].

[91] *Ireland* v. *United Kingdom* (1978) 2 E.H.R.R. 25, para. [167].

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for potentially painful interventions".[92] Pain in the foetus cannot be measured directly but, on the basis of the available anatomical and physiological evidence, it is "likely" that the foetus can feel pain from twenty six weeks, "possible" that it can feel pain from twenty weeks and is caused distress by interventions from fifteen or sixteen weeks. Glover and Fisk suggest that analgesia for the foetus might be considered from this time, although the "[a]dministration of safe and effective analgesia to the foetus, without adverse effects in the mother, is a considerable challenge".[93] They highlight the need for much more research in this area.[94]

Legally, if ever the application of Article 3 were to be considered in relation to the foetus, one objection may be that it cannot apply unless the foetus is considered a legal person and thus a rights-bearer, which could take us back to Article 2. Despite this, given that the majority in *Vo* emphasised the ways in which the foetus can and should be protected without granting it legal rights,[95] a concern about foetal pain could find legal expression, for instance through a legal requirement for analgesia for the foetus if this were to become possible without adverse effects on the woman.[96] This would be particularly relevant to late-term abortions under the disability ground of the Act.

For Article 14 to apply requires that another convention right can be invoked on behalf of the foetus. If the foetus were deemed to have a right to life after 24 weeks, for instance, as sought by the claimant in *Jepson*, then an Article 14 argument could well be made out. Since the latter article is parasitic on the invocation of another right, however, the real issue would remain whether, under judicial scrutiny, the foetus is deemed to have another right. In the light of the recent ECtHR decision in *Vo* v. *France*, however, this is unlikely at least in relation to Article 2.

In short, a review by English judges of the compatibility of the disability ground of the Abortion Act with the provisions of the

[92] V. Glover and N.M. Fisk, "Foetal Pain: Implications for Research and Practice" (1999) 106 British J. of Obstet. and Gyn. 881, 884.

[93] *Ibid.*, 885.

[94] *Ibid.* "The physical system for nociception is present and functioning by 26 weeks and it seems likely that the foetus is capable of feeling pain from this stage. The first neurones to link the cortex with the rest of the brain are monoamine pathways, and reach the cortex from about 16 weeks gestation. Their activation could be associated with unpleasant conscious experience, even if not pain. Thalamic fibres first penetrate the subplate zone at about 17 weeks of gestation, and the cortex at 20 weeks. These anatomical and physiological considerations are important, not only because of immediate suffering, but also because of possible long term adverse effects of this early experience." (*Ibid.*) One of the questions the authors consider is the experience of the baby during birth, either by natural or surgical means, noting the levels of various hormones present following either means of birth and speculating that in the future analgesia might be administered immediately before or after instrumental deliveries: *ibid.*, 884.

[95] In text above at nn. 86 and 88.

[96] On abortion and foetal pain, see RCOG, *Termination of Pregnancy*, para. 5.3.

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ECHR would require judicial reflection on the balance of maternal and foetal interests in this context. The existence of the disability ground of the Abortion Act, prior case-law on cases of maternal-foetal conflict and abortion, including at the ECtHR level, coupled with the recent ECtHR decision in *Vo* v. *France* all indicate that a finding would be made in favour of compatibility, such that also the foetus of more than 24 weeks' gestation does not have a right to life. Thus, existing ECtHR case law cannot be used to prompt a shift in the English legal balance of interests as between a pregnant woman and her foetus, impaired or otherwise. The implications of this jurisprudence for the interpretation of the disability ground of the Abortion Act are in favour of the pregnant woman, rather than the foetus.

IV. Conclusions

It seems unlikely that the *Jepson* case will be taken any further and hence that the disability ground of the Abortion Act will receive direct judicial consideration in the near future. But we have a number of indications as to what its terms mean.

A brief study of Hansard revealed that there was concern at the time of the amendments to the Abortion Act that abortions on the ground of foetal impairment might be carried out for less than serious reasons. There was some indication that a cleft lip would not be considered serious but that conditions such as spina bifida, hydrocephalus and cystic fibrosis would be.

Aspects of the RCOG guidelines on selective abortion were questioned, particularly their apparent association with a purely medical model of disability under which use of the term "treatment" inevitably refers to medical treatment. Further, dependence on others was a purely negative factor which does not take account of the legitimacy, albeit limited, of the social model of disability. Although the latter positively emphasises the way in which support can be provided by society, the intrinsic limitations of some impairments were noted, including by those advocating the social model.

The wrongful birth cases were seen indirectly to correspond to the terms of the disability ground of the Act, with judges being concerned to emphasise a distinction between "significant disabilities" and "minor defects or inconveniences". There has yet to be clear judicial recognition of the moral nature of the decision selectively to abort and hence of the limited weight of doctors' views in providing the justification, at least morally, for such a decision. Legally, however, judicial recognition of this point would

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be complicated by the legal role of doctors in securing a defence to the crime that abortion would otherwise be. Despite this, it was seen that there is at least an opening for judges to give some weight, in cases which are the subject of reasonable disagreement, to the views of a pregnant woman (and her partner) on the seriousness of an impairment in a prospective child. This lies in the fact that in wrongful birth cases damages are sometimes awarded for "loss of amenity" to take account of the possible impact on parents of raising a disabled child. In *Rand* such damages were supported by reference to earlier wrongful birth case law and also by reference to the legitimacy of legally recognising and protecting parents' autonomy interests, as advocated by Lord Millett in *McFarlane*. Lord Millett's approach was further developed and applied by the House of Lords in *Rees* in the form of an award of "conventional" damages. Recognition of the potential relevance of parents' views on the issues of risk and seriousness in the recommendations governing the provision of PGD was also noted, as was the broad alignment of the legal criteria for PGD with those for selective abortion. The Human Genetics Commission's statement of the difficulties of defining "seriousness" in this context was also observed.

Ultimately, it is the idea of potentially unjustified foetal death that is deeply at stake in the *Jepson* case. In *Jepson* this has two related aspects—a concern about the reasons, in particular, for terminating a late-term foetus and a concern that certain conditions in a prospective child are inappropriately being viewed as serious.[97] (Of course, we have seen that the CPS, having reviewed a range of evidence, decided that a "good faith" judgment was made as regards the seriousness of the condition in *Jepson* itself.)

As regards the late-term foetus, the pressure for abortions after 24 weeks to be for particularly serious reasons is rightly strong. The RCOG guidelines on abortion after this time assert that this must be for particularly serious conditions: "As the protection due increases with embryonic development and foetal growth, reasons for termination, at no stage trivial, must be more pressing the longer pregnancy has progressed."[98] The guidelines thus endorse something of a gradualist approach to foetal moral status, which holds that the longer a pregnancy has been allowed to develop, the

[97] On the lack of a time-limit to s. 1(1)(d) of the Act, see *Hansard*, 21 June 1990, vol. 174, col. 1198, *e.g.* per Ms. Richardson: "Some handicaps are so severe that the foetus cannot survive. In a dramatic case, the brain or some other vital organ may be missing." She also observes: "There is no evidence that doctors have ever performed late abortions for trivial reasons."

[98] RCOG, *A Consideration of the Law and Ethics in relation to Late Termination of Pregnancy for Foetal Abnormality*, Report of the RCOG Ethics Committee (RCOG Press, March 1998) para. 7.4.

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greater must be the justification for in any way compromising it.[99] This approach is attractive in that it allows for an interplay of maternal and foetal interests. Of course, many foetal impairments—such as heart problems—are only detectable relatively late in pregnancy and thus could not be acted on, if desired, before.

As for our perceptions about the seriousness of an impairment a prospective child would have, there is a need for better information in prenatal screening practices, in particular that which includes the views of those who live with certain impairments or disabilities.[100] Consideration of such views will likely expose, though not necessarily expunge, presumptions about suffering. At the same time, it will lead to more open reflection about whose interests may be most at stake when we reflect on the legality of abortion in cases where a child would have an impairment the seriousness of which is a matter of reasonable disagreement. In such cases, I argued that doctors and judges should take parents' views on impairment into account. Although this aspect of the argument is a moral one as to the legitimate interpretation of the disability ground of the Abortion Act, the wrongful birth cases already provide a legal opening for the autonomy interests of prospective parents to receive greater protection. The irony is that many doctors probably already do recognise parents' interests in applying this section of the Act.[101] The law needs an opportunity to recognise that, within reason, this is correct.

[99] For further discussion, see R. Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Foetal Conflict* (Oxford 2002) ch. 1.
[100] See references in n. 37 above.
[101] Williams *et al.*, "'Drawing the Line' in Prenatal Screening and Testing", 66.

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