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A guerrilla strategy for a pro-life England

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ABSTRACT

Access to safe and legal abortion is integral to women’s sovereignty over their own bodies. In this paper I examine current anti-abortion strategising in England. I suggest that the range of anti-abortion activities can be understood as part of a broader ‘Guerrilla Strategy’ to restrict access to abortion care. Such an approach focuses on capitalising on the marginalisation of abortion services and areas of legal ambiguity to make abortion care ‘uncomfortable’ to both access and deliver. Guerrilla strategies rely for success on the marginalisation of abortion care (both physically and ideologically) from mainstream medical practice and flourish within a legal framework that relies on physicians as gatekeepers. The paper ends with a consideration of how we might respond to these anti-abortion strategies; in particular paying attention to the ways we can embrace and encourage provision of services to women through supporting and improving the conditions of the important professional bodies needed to deliver these services.

KEYWORDS abortion law; abortion services; anti-abortion guerrilla strategies; pro-life

1. Introduction

To Vera Houghton and the late Alan Guttmacher, who, on opposite sides of the Atlantic and in different ways, have changed the attitudes of society and professional groups towards the difficult problem of abortion.1

The above is the dedication in the book Abortion written by Malcolm Potts, Peter Diggory and John Peel. Both Potts and Diggory were members of the Abortion Law Reform Association (ALRA) and were heavily involved in the law reform process that led to the Abortion Act 1967. The book was published 10 years after the legislation was passed.2 In this paper I will consider the extent to which societal and professional attitudes have evolved following

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1Malcolm Potts, Peter Diggory and John Peel, Abortion (Cambridge University Press, 1977).
the enactment of the Abortion Act, and will argue that while much has changed in the last 50 years, there remains some level of ambivalence on the part of the ‘medical establishment’ and society generally to abortion provision and indeed abortion providers. Women in England still have less than total control of their bodies in pregnancy and the access to abortion they do enjoy may reduce and not increase.

Drawing on the work of sociologist Everett Hughes, Lisa Harris has described abortion as an example of society’s ‘dirty work’ and provided an account of the ways in which abortion providers are both stigmatised and marginalised in their work.3 I move from this theoretical grounding to highlight and detail ‘guerrilla’ anti-abortion strategies in England; these strategies rely for much of their success on a marginalised (both physically and ideologically) abortion service. I describe these strategies as guerrilla, a term which both reflects their nature and also acknowledges the publication by Mark Crutcher Firestorm: A Guerrilla Strategy for a Pro-Life America.4 Much recent anti-abortion lobbying and protesting in England has a transnational element – the strategies of anti-abortion campaigners mirrors those used by groups in the United States (US) and it has been suggested that those leading the attacks have worked in conjunction with US counterparts.5 In this paper I detail how such strategies capitalise on a ‘marginalised’ abortion service.

The paper starts by providing the context that explains why abortion provision in England is vulnerable to guerrilla strategies. I provide a brief history of the abortion law reform process in England and how this has shaped the provision of abortion care.6 In examining the law reform process I detail how abortion was treated with great ambivalence by the very medical establishment that sought control of it; in particular the Royal College of Obstetricians and Gynaecologists (RCOG) worried that provision of abortion care would lead to reputational taint.7 Carol Joffe’s study, Doctors of Conscience, describes the experiences of doctors who provided abortions in the US

6For a general discussion of the interplay between the medical profession and the abortion law reform process see John Keown, Abortion, Doctors and the Law (Cambridge University Press, 1988); Sally Sheldon, Beyond Control: Medical Power and Abortion Control (Pluto Press, 1997); Angus McLaren, Reproductive Rituals: The Perception of Fertility in Britain from the Sixteenth Century to the Nineteenth Century (Law Book Co, 1984); Michael Thomson, Reproducing Narrative: Gender, Reproduction and Law (Dartmouth, 1998).
prior to the decision in Roe v Wade.8 She emphasises the suspicion they faced from their medical establishment peers and suggests that:

[I]t is the experiences of these doctors, whose careers so often reflect the price they paid for their commitment to abortion provision, that tells us the most about the difficult history and uncertain place that abortion services have had within the larger medical establishment.9

Although not quite as extreme as the situations recounted in Joffe’s interviews, it is clear that a similar attitude existed in England.10 I theorise abortion as an example of the medical profession’s ‘dirty work’.11 This view of abortion care that makes provision of services particularly vulnerable to the kinds of anti-abortion lobbying I mention later in the paper. Moving on from this theoretical framing I detail the emergence of the ‘standalone’ abortion clinic post the Abortion Act 1967 and detail our continued reliance on independent sector clinics to this day. Medical control of abortion care has often been a target for criticism and understood as a mechanism through which women’s bodily autonomy is restricted.12

However, it is also widely accepted that in practice the ‘medicalised’ model of abortion regulation adopted in England has, up until this point, allowed for quite liberal access to care.13 Doctors have in fact been reasonably permissive gatekeepers to abortion services.14 In England although most abortions are funded through the National Health Service (NHS) many are carried out outside of NHS hospitals. The independent sector emerged in the 1960s and 1970s to facilitate access to abortion services outside of the NHS and to circumvent the attitudes of a conservative medical establishment (particularly hospital consultants).15 This sector has been key to the liberal model of service provision but also means that abortion services exist at the margins of mainstream medical practice. While the standalone clinic model has much to offer, as evidenced by the growth of such services, it is important to embrace abortion care within mainstream medical practice and provide stronger support from within the medical establishment for the staff who provide these services.16

8Carol Joffe, Doctors of Conscience: The Struggle to Provide Abortion before and after “Roe v Wade” (Beacon Press, 1995).
9Ibid xii.
10I rely on first person accounts of involvement in abortion law reform (n 2).
11See Harris (n 3).
14See Sheldon, Beyond Control (n 6) 2.
The response of the RCOG to the 2012 ‘Abortion Investigation’ carried out by The Daily Telegraph highlighted the ambivalence with which that body treats this constituent group of its membership. This ‘investigation’, which I will provide further detail on later in the paper, consisted of a series of ‘stings’ involving an undercover journalist secretly filming consultations with doctors about abortion which purported to show examples of practice outside of the law.17

The latter half of the paper starts by detailing what I mean by ‘guerrilla’ anti-abortion strategies. Much of my analysis is based on literature that has emerged in the context of the US ‘abortion wars’.18 The focus of my paper will be England, although much of what I say applies in the United Kingdom (UK) generally. There are many differences between England and the US, which means that a direct comparison of the minutiae of anti-abortion strategies is not possible. However, there are general trends and themes in the nature of anti-abortion strategising in the US, which are illuminating when considering recent activities in England. Published in 1992, when the US ‘abortion wars’ moved from ‘Mayhem to Murder’,19 Crutcher’s Firestorm sets out a strategy for restricting access to abortion service when fundamental law reform seems unlikely.20 Crutcher’s approach differs from other sections of the anti-abortion lobby in that he advocates for working within the confines of the law and capitalising on the ambivalent cultural and legal status of provision of abortion care.21

The central premise of Firestorm is that while it is unlikely that Roe v Wade22 will be overturned, it is possible to make access to abortion difficult and uncomfortable. Specifically, it aims to encourage an army of individuals to take steps that stigmatise and marginalise abortion and abortion providers and provides a toolkit for how people who wish to restrict access to abortion services can act. I move from a general overview of the literature outlining anti-abortion strategising to describe four instances that I believe can be categorised as guerrilla strategies in England. First, ‘on street harassment’ outside of abortion clinics; described by David Cohen and Krysten Connor as ‘general clinic protest’.23 Next I provide an overview of The Daily Telegraph stings and

18See for example Carol Joffe, Dispatches from the Abortion Wars: The Costs of Fanaticism to Doctors, Patients, and the Rest of the US (Beacon Press, 2009).
20Crutcher (n 4).
21ibid.
subsequent concerns around (a) pre-signing of HSA1 forms; and (b) sex selective abortions. 24 Finally, I detail recent fallout of the Telegraph sting; primarily the attempts to prosecute some of the doctors involved. 25 These latter examples are what Cohen and Krysten categorise as ‘targeted harassment of abortion providers’. 26

The paper concludes with a consideration of how we might respond to ‘Guerrilla Strategies’ and how we might support providers and improve the legal framework within which they operate. I suggest four ways in which the structural weaknesses that allow guerrilla strategies to flourish can be addressed. The first two are processes of law reform – we need to address what Emily Jackson has called the ‘extraordinary treatment’ of abortion in law. 27 The latter two responses relate directly to workforce management and service delivery – improving the professional support offered to providers and mainstreaming of abortion care.

2. Abortion provision in context

Two factors create ‘structural weaknesses’ in the current framework for provision of abortion services and so give rise to conditions within which guerrilla strategies flourish. First, there is the marginalisation of abortion services from mainstream medical practice. This marginalisation is explicable in the context of the history of the relationship between the law reform process and the medical establishment. Second, there is the current legal framework for

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26 See Cohen and Connor (n 23) 6.

27 Emily Jackson, Regulating Reproduction: Law, Technology and Autonomy (Hart, 2001) 111.
regulation of abortion provision in England. The current regulatory framework places doctors as ‘gatekeepers’ to abortion services; they play a key role in the accessibility of abortion services and have much discretion in interpreting the law.28

The Abortion Act 1967 states abortion will only be lawful where ‘two registered medical practitioners are of the opinion, formed in good faith’ that a woman is entitled to an abortion.29 As detailed later in the paper those who are involved in the day-to-day running of abortion services (e.g. nursing staff, clinic managers) and in particular doctors are often targeted as a strategy for reducing access to services.30 Relatedly, the general legal framework for regulating this medical service has been described as a wholesale example of Targeted Regulation of Abortion Providers (TRAP).31 TRAP has been one of the most successful mechanisms for restricting access to abortion services in the US.32 Although motivations for the current regulatory framework cannot be framed with the same purpose it is clear that a consequence of over-regulation of abortion care is that it makes providing such care burdensome and can often create obstacles to accessing care.

2.1 Abortion law reform: control and ambivalence

The relationship between abortion law reform and the medical profession is well documented.33 Many works have highlighted how abortion law reform was intimately linked with advancing the medical establishment’s social and economic goals. However, it is also clear that this did not mean that the establishment wished to facilitate access to a liberal abortion service.34 Rather, medical establishment attitudes were largely conservative, regarding abortion provision and motivated to a large extent by professional self-interest. What is less documented is how the disjuncture between the medical establishment and the reality of abortion provision in the lead-up to the Abortion Act has had long term consequences for models of abortion provision in England.35

29Abortion Act 1967, s 1(1).
30Baird-Windle and Bader (n 19) 89.
33See (n 6).
34McGuinness and Thomson (n 7).
35Ibid.
Post the Act it is clear that there was lack of preparedness within the NHS. Many of those involved in the law reform process set their sights on provision of abortion services and the English standalone clinic was born in the form of pregnancy advisory services (PAS).36

The advent of the Abortion Act did not bring with it significant liberalisation in the attitudes of many within the medical profession. The attitudes of the medical establishment, and in particular the RCOG, remained conservative and their engagement in the reform process was largely to ensure that they could retain control over the abortion decision-making process.37 In this regard, Aleck Bourne epitomises the establishment attitude to abortion provision. Bourne had originally been supportive of the efforts of the ALRA and the importance of clarifying the range of cases when abortion could be legally performed.38 However, he later staunchly rejected progressive arguments on access to abortion and was a founding member of the Society for Protection of the Unborn Child (SPUC).39 SPUC was established in the lead up to the Abortion Act to campaign against any liberalisation of abortion law.40 Bourne’s attitude reflects the broader establishment attitude. Abortion could only be considered appropriate medical practice in a limited range of cases related to paternalistic concerns for health rather than broader consideration of a woman’s bodily integrity and it should be the doctor who retains ultimate control of the decision-making process.41 It is clear looking back on the debates within medical journals at the time that the RCOG was reticent about the need for law reform and lacked any real understanding of how legal changes would impact on their day-to-day working practices, as captured in the following statement:

[A]ll in all we did not expect a great change in practice from that obtaining before the Act … How wrong we were. I am afraid that we did not allow for the attitude of, firstly, the general public, and, secondly, the general practitioners.42

Specifically the RCOG did not think that the Act would lead to an increase in the number of abortions. It is evident that those involved in the reform process believed that the Act could be liberally interpreted, and it was around the time that the Act was being debated that the creation of independent sector abortion service was considered. The creation of the independent

36Potts et al (n 1).
37McGuinness and Thomson (n 7).
40ibid.
41See for example the comments on ‘objective criteria’ for abortion contained in ‘Summary of Memorandum by RMPA’ (2 July 1966) British Medical Journal 44. It is worth noting that the RMPA were liberal in comparison with other sections of the medical establishment such as the RCOG.
sector is an important consequence of the reform process – the RCOG had gained primary control of a service that it was not supportive of.43

In considering post-Act abortion provision, it was very important to many of those involved in the law reform process that abortion services should largely be provided within the NHS.44 This is consistent with the social justice foundations of the movement – it was considered important that all women could access abortion services; that it should not be confined to the wealthy.45 There was also some concern that the ‘private’ sector was exploiting vulnerable women.46 However, it became evident during the reform process that the NHS would likely be unable to meet abortion care needs for two key reasons, both related to the influence and power of the medical establishment, specifically the RCOG. First, there were a number of conservative NHS hospital consultants who made it clear that they would block access to services.47 This meant that there were pockets of the country, such as Birmingham, where women would not be able to access services in NHS hospitals.48 Second, and again a consequence of the influence of the RCOG, it was clear that the NHS was not prepared. As mentioned above, the medical establishment, and in particular the RCOG, did not believe that the Abortion Act 1967 would lead to an increase in the number of requests for abortions.49 Therefore, there was no budgetary allowance provided to extend NHS services:

The [Abortion] Act was not backed up by any specific allocation of money for facilities or staff within the NHS, and the service provided has varied from district to district, depending on the attitudes of the consultants concerned.50

Those involved in the law reform movement thus began to think of methods for ensuring post-Act provision:

While the Abortion Act was being discussed, individual members of the Abortion Law Reform Association, and a few other concerned individuals, foresaw that the National Health Service (NHS) would be unable to meet the potential national needs, and began planning to set up charitable bodies to help women seeking abortions.51

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44See e.g. David Paintin in ‘Pioneers of Change’ (n 2) 35.
45Alice Jenkins advocated for this in her publication Law for the Rich (Gollancz, 1961) which many of the reformers mention in their recollections in ‘Pioneers of Change’ and ‘The Seminar’ (n 2).
46See David Paintin in ‘Pioneers of Change’ (n 2) 35.
48Lafitte (n 43).
49Lewis (n 42) 241.
51Potts et al (n 1) 299.
The independent sector emerges from these charitable bodies. The ‘independent sector’ can be distinguished from the existing ‘private sector’ because of the charitable aims of the organisations involved. In particular a key aim of these services was to ensure that women could access abortion services for as low a cost as possible.52 The Birmingham Pregnancy Advisory Service (now the British Pregnancy Advisory Service or BPAS) was one such organisation. It was created to meet the needs of women in the Birmingham area to circumvent the conservative practices of Hugh McLaren, a senior NHS consultant and a staunch opponent of abortion.53 McLaren blocked the appointment of any doctors who were supportive of abortion within the region. BPAS opened their doors on the day the Abortion Act came into force.54

This provides the historical and political background for how abortion services came to exist physically, in terms of the standalone clinic, and ideologically, in terms of medical establishment failure to fully embrace the service, at the margins of mainstream medical practice. Such a story is not unusual. In his comparative analysis of abortion provision Drew Halfmann identifies three different models for abortion care, each of which evidences the relationship between abortion and mainstream medical practice and as such the position of abortion within society.55 Halfmann summarises the relationship between the medical establishment and the State in the reform process in England as ‘not only one of closeness, but of interdependence’, which consequently allowed the RCOG to make the not-so-veiled threat that Parliament should assure that doctors would cooperate with the new law before changing it.56 A key concern of the medical establishment and professional bodies in the law reform process was to defend clinical discretion and maintain clinical control of the abortion decision-making process. Nothing in the Act should give rise to situations in which women could demand a termination.

Beyond this gap between establishment perception of the need for abortion care and the reality, it is also important to consider the distrust and suspicion of abortion and those who provided abortions prior to the Abortion Act 1967, both from the medical establishment and society generally. There were also dominant societal discourses about the illegitimacy of backstreet abortions and ‘abortionists’.57

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52 ibid.
53 Lafitte (n 43) 7.
It was clear that the RCOG was concerned that liberal provision of abortions would negatively impact on the reputation of their professional body. Harris has suggested that abortion is an example of society’s ‘dirty work’. This is a concept that was developed by sociologist Everett Hughes to describe work that is ‘physically, socially or morally’ tainted. By this he means that ‘it may be “dirty work” in that it in some way goes counter to the more heroic of our moral conceptions’ or it may be ‘physically disgusting’ or a ‘symbol of degradation’. ‘Dirty work’ occupies a very particular place in society – society is reliant on such work but in some senses repulsed by it. It is clear from the accounts of those involved in the abortion law reform process that there was often suspicion from the medical establishment of physicians who openly provided abortions prior to the Abortion Act. This point is clearly made in the following quote from Malcolm Potts explaining how he came to be involved with the ALRA:

When I was at University College Hospital … my obstetric professor was a remarkable man called Will Nixon, who played an important role in many things to do with abortion and family planning. He was called ‘the abortionist of Gower Street’ by his conservative peers, because he would do literally two or three abortions a year … As I was coming to an end of PhD work at Cambridge I was made a fellow of Sidney Sussex College, which gave me a very respectable address. So I was put on the executive committee of ALRA as the only physician. I was young, I was strongly motivated, I was a tolerably good scientist. There were people like Peter Diggory who were much more experienced consultants. But if they stood up on television and said we should change the abortion law, the opposition would say, ‘Ah yes, you are only saying that because you want to make money.’

This highlights the suspicion described above of those involved in abortion provision. Similarly there was a fear that involvement would give rise to a negative reputation within the profession as evidenced in the following quote from David Paintin about his experiences of providing abortions in the early 1960s:

The medical establishment’s interpretation of the abortion law in those days was unnecessarily cautious. Our work attracted adverse comments from our senior gynaecological colleagues at the Samaritan Hospital. They feared that their respectable and well-known unit would get ‘that sort’ of reputation.

Every profession has its form of ‘dirty work’ and there is evidence in the attitudes described above that abortion provision could be suggested to occupy this space within the professional body of the RCOG. As Everett states:

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59 See Harris (n 3).
61 See Potts in ‘Pioneers of Change’ (n 2) 39–40.
62 See Paintin in ‘Pioneers of Change’ (n 2) 34.
In professional, as in other lines of work, there grows up both inside and outside some conception of what the essential work of the occupation is or should be. In any occupation, people perform a variety of tasks, some of them approaching more closely the ideal or symbolic work of the profession than others. Some tasks are considered nuisances and impositions, or even dirty work – physically, socially or morally beneath the dignity of the profession.63

The Abortion Act 1967 resulted in the RCOG being left with primary control for a service that it clearly treated with some level of disdain. They were concerned about women threatening clinical autonomy and suspicious of those within the profession who were willing to provide this care. This ambivalence continued after the enactment of the Abortion Act 1967 as evidence in the following statement in the Report of the Lane Committee:

[F]orecasts were made of … a lowering of the status of the Speciality of Obstetrics and Gynaecology, as well as of the numbers and quality of those who would enter it.64

This provides the historical context for the ideological marginalisation of abortion within the established professional body, the RCOG.

The independent sector has continued to be crucial to abortion provision in the UK and a key feature of this service, as already noted, is the creation of the standalone abortion clinic. This is something that distinguishes models of service provision across the UK. Such clinics are common in England and Wales but not so in Scotland where abortion is generally provided in NHS hospitals.65 While this model of provision has many benefits it undoubtedly creates concerns that have been acknowledged by many as it maintains abortion at the margins of medical treatment:

In spite of the generally excellent record of clinics, the estrangement of mainstream health providers from the provision of abortion is of concern. It hinders better integration of health services and makes the development of adequate referral and informational resources for abortion more difficult. By isolating some abortion providers, it decreases opportunities for the professional interaction vital for continuing education and professional self-regulation … 66

It is clear that many of those clinicians who were involved in the establishment of the clinics imagined them to be temporary:

Hodgson’s vision for the mainstreaming of abortion services into U.S. medical institutions has not been realised, save for occasional exceptions, and this

63See Hughes (n 60) 121–2.
66Lindheim as quoted in Hodgson and Ward (n 15) 527.
failure on the part of medicine in general – and the field of obstetrics and gynecology in particular – is Hodgson’s greatest disappointment.67

In England there has been a clear increase in the reliance on the standalone clinic. Immediately following the implementation of the Act just over 60% of abortions were provided by the NHS. However, this figure began to increase from the 1970s onwards. This move towards increased independent sector provision was accelerated by changes to NHS contracting of services which Halfmann summarises as follows:

In 1981, NHS regional health authorities began contracting for clinic abortions through ‘agency agreements’ with charitable providers such as the British Pregnancy Advisory Service. … These ‘NHS agency’ abortions were no more than 5 percent of all abortions for the next ten years. But in 1992, these abortions rose about 20 percent per year for the next five years, and 10 percent per year for the next ten years.68

This creation of the ‘internal market’ meant that if doctors blocked procedures being performed in ‘their’ hospitals, then commissioners could just buy them from elsewhere. According to the most recent abortion statistics for England and Wales: ‘98% of abortions were funded by the NHS. Of these, two thirds (67%) took place in the independent sector under NHS contract, up from 64% in 2013.’69 It is interesting to note that the Lane Committee report in 1974 rejected a move towards increased reliance on standalone clinics for similar reasons to those expressed by Joffe above: ‘there is the probability of stigma attaching to such a unit, both to the patients and the staff looking after them.’70 There is also a further potential consequence - deskilling of NHS doctors which is problematic as the independent sector needs to be able to refer women into the NHS in rare cases where there are complications or for complex cases where comorbidities mean appropriate care cannot be provided outside of a hospital setting.

2.2 The regulatory framework

In addition to structural weaknesses within models of abortion provision there are also vulnerabilities within the current legal framework. First, the current legal framework retains abortion within the sphere of criminal law. It has been recognised in various human rights organisations that the positioning of abortion within the criminal law, and the potential for serious

67 Joffe, Doctors of Conscience (n 8) 24.
68 Halfmann, Doctors and Demonstrators (n 55) 122.
criminal sanction (sentence of up to 14 years in prison) has a significant potential to have a ‘chilling effect’ on clinical practice. This is something that Crutcher recognises in advocating for increased litigation, including criminal prosecutions where possible. Recently abortion providers across the US received a ‘care package’ in the post consisting of plastic handcuffs, details of a news report about an abortion provider who had been arrested (the provider had been engaged in criminal activity not related to his clinical practice), and a note asking ‘Could you be next?’ Later I detail the protracted attempts in England to prosecute the doctors involved in the Telegraph sex-selective abortion sting. It is clear that the aim here is to make doctors uncomfortable in their practice. It also emphasises a link between abortion and criminal activities and behaviour.

Second, abortion care is arguably over-regulated. Ann Furedi, chief executive of BPAS, described the regulatory framework as a wholesale example of ‘TRAP’ regulation. TRAP laws are laws and regulations that have a restrictive aim rather than being aimed at the safety of the pregnant woman or the abortion procedure. A defining feature is that although they use the rhetoric of ‘patient protection’, their reach extends far beyond this so as to have an obstructive effect – they are ‘laws or policies that regulate abortion providers and go beyond what is necessary to ensure patient’s safety’. Strategically such laws have risen in popularity since the early 1990s when anti-abortion campaigners identified their use as part of an incremental strategy to restrict access to abortion services. The strategic aim was that, through the successful implementation of TRAP laws, there would be ‘an America where abortion may indeed be perfectly legal, but no one can get one’. The ideological motivations for over-regulation of abortion care in England departs from that identified in the US in that they are examples of historical legacy rather than being aimed at hindering access. However, it could still be argued that they are overly burdensome on both those providing and accessing abortion care. Key examples in England include the requirement that two doctors sign a HSA1 form and the Department of Health’s Required Standing Operating Procedures (RSOPs) with which all clinics must comply.

71See e.g. A, B and C v Ireland 25579/05 [2010] ECHR 2032; Amnesty Reports of Ireland and Northern Ireland – she is not a criminal.
72Crutcher (n 4).
74Furedi (n 31).
76‘Targeted Regulation of Abortion Providers’ (n 75).
In this section I have detailed the politics of abortion law reform, the legacy of which provides the context for why abortion services are to some extent marginalised from mainstream healthcare provision in England and Wales. We must be cognisant of the complicated history of abortion law reform and the ambivalence with which the medical establishment treated this service that it strived to control. It is my argument that the current legal framework and models of provision create an environment within which guerrilla strategies flourish. It is to these strategies I now turn.

3. Guerrilla strategies: an introduction

In the late 1980s and early 1990s, US-based anti-abortion activists produced books and manuals detailing strategies for reducing or eliminating abortion. These ‘books’ concrete, hands-on approach reflect[ed] years of experience and aim[ed] to turn neophyte protestors into seasoned professionals. The anti-abortion strategies outlined in these books are as wide-ranging as the politics of the movement itself, including what have been described as acts of domestic terrorism, bombing and murder, nuisance and on-street harassment outside clinics. There is also an extensive academic literature documenting and theorising these works and activities. These activities provide a useful background against which to consider anti-abortion strategising in England. Notwithstanding the political and cultural differences between these countries, there are certain themes evident in the strategies adopted. However, I want to be clear at this point that I am not suggesting that anti-abortion activists are homogenous in nature; to the contrary they are diverse in terms of both aims and strategies. My purposes in this paper is to highlight how some of these activities fit together.

I focus on how strategies involve ‘targeted’ harassment of abortion providers. This targeting is based on the view that the personnel involved in the day-to-day running of abortion services, and in particular doctors, constitute the ‘weakest link’ in the context of provision of abortion. The approach is

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79 Baird-Windle and Bader (n 19) 87.
82 For example, strategies of mass telephone calling as detailed in Scheidler (n 76) ch 91.
83 Ibid ch 3.
84 See e.g. Baird-Windle and Bader (n 19); Alesha Doan, Opposition and Intimidation: Wars and Strategies of Political Harassment (University of Michigan Press, 2007); Cohen and Connor (n 22); Joffe, Dispatches from the Abortion Wars (n 18).
85 See Baird-Windle and Bader (n 19) 89.
summarised well in the following quote from Kevin Sherlock’s *Abortion Busters Manual*: 

If it becomes too much hassle to run an abortion mill, then fewer people will do it and the numbers of abortions will drop. We might not be able to cut off the enemy’s head yet, but we can certainly start making him bleed from a number of wounds.86

This quote also illustrates well two features of the ‘guerrilla’ nature of much of the strategising involved. Like guerrilla warfare, the anti-abortion strategies involve ‘secretiveness, treachery, and surprise’ and ‘the impression … that he [the enemy] is surrounded’.87 Furthermore, they often rely on ‘pincer movements’; chipping away at the edges of abortion provision. Guerrilla approaches are usually aimed at oppressive State structures or power and flourish when wholesale law reform seems unlikely. For example, some have suggested that the election of Bill Clinton acted as a catalyst for anti-abortion violence in the early 1990s in the US as he rolled back many of the anti-Roe laws of the Reagan era.88

In this article I focus on the techniques outlined in *Firestorm* for several reasons.89 First, Crutcher advocates working within the existing legal framework in order to push for abortion law reform. Although at times the tone seems sympathetic to those who are moved to violence he suggests that pro-life violence is something ‘which could instantly and completely take it [the pro-life movement] out of the game’. To date the anti-abortion lobby in England has used non-violent means; indeed Abort67 (one of the main anti-abortion protest organisations in the UK) states on their webpage that they will ‘take legal action against any individual or organisation who defames either Abort67, BR or CBR UK in relation to violence’.90 Second, that *Firestorm* resonates with the activities of organisations like Abort67 is probably unsurprising given that Crutcher explicitly endorses the clinic harassment strategies of the Center for Bioethical Reform (CBR).91 The UK arm of this organisation is explicitly linked to Abort67. It has also been suggested that CBR is linked to another of England’s main protest groups – *40 days for Life*.92

A key feature of *Firestorm* is dissatisfaction with anti-abortion strategies aimed at winning the moral war against abortion. Crutcher thinks that the

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86 ibid as quoted in Baird-Windle and Bader.
88 See e.g. Kushner (n 78) 40; Baird-Windle & Bader (n 19) ch 6.
89 Crutcher (n 4).
anti-abortion lobby is unlikely to be successful in what he describes as its ‘Plan A’ – to make abortion illegal. Firestorm provides a framework for the anti-abortion lobby’s ‘Plan B’:

Obviously, every single one of the problems we face today are directly related to the process of trying to make abortion illegal. But let’s remember that the pro-life movement’s goal is not to outlaw abortion, but to stop it. Outlawing it is simply the vehicle we’ve always chosen to do that.

Plan B aims at using legal, non-violent, means to increase the psychological and financial costs associated with providing and accessing abortion services. It outlines a strategy of ‘guerrilla’ legislation and litigation in association with targeted anti-abortion lobbying. Carol Mason has summarised this approach as intended ‘to sabotage and harass, on an irregular and arbitrary basis, those seeking or providing abortions’.

Crutcher thinks that once the pro-life lobby moves beyond strategies aimed at making abortion illegal there are two alternative foci: make abortion (i) ‘unwanted or unthinkable’; or (ii) ‘unavailable’. It is the second alternative that he suggests holds the most opportunities for the anti-abortion lobby:

Today, we have opportunities before us which, if properly exploited, could result in an America where abortion may indeed be perfectly legal, but no one can get one. The political importance of that is that in such an environment the forces still fighting to keep abortion legal would be much smaller, and far easier to deal with, than the ones we face now. In other words, if we make abortion unavailable, it will then be a lot easier to make illegal.

In order to maximally exploit this possibility Crutcher suggests a number of lobbying strategies, numbered G1 to G5, for which the following is a summary:

1. Personnel: Reduce the number of clinicians willing to provide terminations
2. Increase litigation against providers
3. Increase legislation (where possible framed in the language of maternal concern)
4. Make provision burdensome
5. Capitalise on the fact of, and encourage, key abortion services being marginalised or excluded from mainstream medical care

Given the differences in the nature and structure of the healthcare system in England from the US, some of the specific activities that Crutcher
suggests are not relevant (for example civil litigation against providers). However, the evolution of abortion services in both jurisdictions shares common features which mean that many of the strategies that Crutcher advocates could be, and indeed are, being used in England.97 For example, when considering legislative efforts to prohibit certain kinds of abortion (e.g. sex selective terminations) there is a clear rhetoric abortion in these instances should be ‘unwanted or unthinkable’. All of the strategies outlined by Crutcher thrive when abortion care is treated with societal ambivalence and is marginalised (both ideologically and physically) from mainstream medical practice. This makes it easier to create an environment where doctors and other healthcare practitioners (HCPs) are unwilling to provide such services.98

4. Guerrilla strategies in England

In this section I outline some of the key recent anti-abortion strategies in England. In keeping with G1–G5 above, the lobbying is clearly aimed at making access to abortion care burdensome. The target of the strategies are often doctors or clinic staff. The ‘ethicality’ of doctors is being called into question, and it is suggested they are no longer fit to act as ‘gate-keepers’ to abortion services, the role historically designated to them by English law.99

4.1 General clinic protest: on-street harassment

There are several organisations that protest outside abortion clinics in England, including Abort67 and 40 Days for Life.100 Such protests aim at making access to abortion care difficult and have been increasing in number and intensity in recent years.101 The impact of these activities is wide-ranging. There is an expressive dimension to the harassment; it gives lobbyists a public platform to state their dissatisfaction with, and disgust of, abortion. This expression is oral, aural and visual. Protests also provide an opportunity to ‘change the mind of women entering the clinic so they do not obtain an abortion, to “bear witness” to what they believe is mass slaughter, and to participate in the national movement to end abortion’.102

97For a comparative account of abortion provision in the UK and US, see Halfmann, Doctors and Demonstrators (n 55).
98Doctors who provide abortion services face stigma in many different contexts: see Lisa Harris et al, ‘Physicians, Abortion Provision and the Legitimacy Paradox’ (2013) 87 Contraception 1.
100http://abort67.co.uk; www.goodcounselnet.co.uk/40-Days-for-Life.html (both accessed 29 June 2015).
102Cohen and Krysten (n 23) 6.
The impact of protests on perceptions of care and provision in England is currently unknown. A US study published in 2013 found that protesting made the experience more distressing at the time of treatment but did not affect women’s perception of their decision to terminate a week later.103 What is clear is that the protests turn clinic staff and abortion-seeking women into ‘non-governmental political actors’ in a way which they almost certainly will not have intended or desired. It makes the decision to provide and access abortion care a political decision, subject to burdens beyond those ordinarily associated with medical treatment. Concern over the impact of ‘on street harassment’ has led to BPAS, one of the largest independent sector abortion providers in England, calling for ‘buffer zones’ around clinics.104 Such a response mirrors the US Freedom of Access to Clinics Entrances Act (FACE).105 Alesha Doan suggests that in order to fully appreciate the implications of these protests we need to understand the wider context within which it occurs; it is to this I now turn.106

4.2 Abortionists are not to be trusted! Stigmatisation of providers: consent and pre-signing

The next two examples of guerrilla strategies play on the idea that abortion providers are in some senses untrustworthy. During the legislative passage of the Health and Social Care Bill (now the Health and Social Care Act 2012), Conservative MP Nadine Dorries attempted to introduce a clause that would require that local authorities and clinical commissioning groups must provide ‘independent’ counselling for all women who wished to have an abortion.107 ‘Independent’ here was defined as meaning counselling from a ‘private body that does not itself refer, provide or have any financial interest in providing for the termination of pregnancies’ or from a statutory body. During the debates she suggested that abortion providers could not be trusted to provide women with impartial advice. Capitalising on the increasingly ‘privatised’ – perhaps better read as marginalised – nature of provision of abortion care, she stated:

BPAS and other organisations would say that they do not have to meet targets and that they have no financial concerns. However, BPAS has advertised for business development managers, whose primary function is to increase its

106Doan (n 84) 3.
market share – those are its own words in the advert. If an organisation advertises that it wants to increase the number of abortions, can we trust it to provide vulnerable women who walk through the door with the counselling that they need? On pensions mis-selling, this place has separated by law the people who provide and sell pensions from the people who advise on pensions.108

‘Independent’ counselling and ‘crisis’ pregnancy agencies are notorious in other jurisdictions where they have been opened by anti-abortion organisations to dissuade women from having an abortion.109 It has been suggested that Dorries was acting in conjunction with transnational anti-abortion lobbying agencies when she proposed the amendment.110 Although not specifically part of the guerrilla strategy, these agencies are mentioned as a complementary strand of anti-abortion activities in Firestorm. Dorries’ intervention does fit with a strategy that Crutcher advocates which is to make access to abortion more burdensome. The unexpected way the amendment was introduced is an example of guerrilla legislation.111 Furthermore, Dorries’ proposal follows Crutcher’s suggestion that legislation be couched in the language of maternal concern.

The amendment was ultimately defeated, but it is noteworthy as a clever strategic move designed to undermine the trustworthiness of abortion providers, focused on the fact that the majority of services are delivered through independent sector providers and outside of the ‘trusted’ NHS system. The ‘maternal turn’ in Dorries’ language also makes it difficult to argue against such a proposal, especially from a woman-centred perspective. Informed consent requirements that are justified as being in the interest of pregnant women have been a successful way of restricting access to abortion services in the US.112 They have been used to mandate amongst other things that doctors read out particular scripts to the pregnant woman prior to performing the procedure, the introduction of waiting periods between the request for a procedure and its performance and the requirement that women see a sonogram or hear the foetal heartbeat.113

Subsequent to this there have a series of attacks on the ability of doctors to act as gate-keepers to abortion care. At the start of 2012, The Daily Telegraph, a UK newspaper, published the findings of its ‘Abortion Investigation’; a series of sting operations undertaken at clinics across England.114 Undercover reporters went into clinics to request abortions for ‘reasons of gender

[109] Lee (n 13).
[111] Crutcher (n 4).
[113] Ibid.
[114] See above (n 24).
This was something that the paper felt was ‘clearly illegal’. Andrew Lansley, then Secretary of State for Health, condemned the practice of sex selective abortion and endorsed *The Telegraph*’s views that such abortions were outside the scope of legal abortions as provided in the 1967 Act. He ordered the Care Quality Commission (CQC) to conduct unannounced inspections on abortion clinics across the country. This was a bold request; the CQC was (and continues to be) over-burdened. The planned work of the regulator, and thus patient care, would be adversely affected, as highlighted by the CQC’s Chair, Dame Joan Williams.

I will return to attempts to restrict abortions for particular reasons (e.g. on the basis of the sex of the foetus) in the next section, but here focus on the fallout from the CQC inspections. A further media furore followed (again led by *The Telegraph*) over the ‘pre-signing’ of HSA1 forms, again something that was condemned as illegal. In England, Scotland and Wales, the doctor taking overall charge of the abortion must ensure that (usually) a HSA1 (Certificate A in Scotland) is completed. This form certifies that two doctors have formed an opinion in good faith that ‘at least one and the same ground’ in s 1(1) has been met. The guidance states that:

Certifying doctors are expected to have enough evidence of the woman’s circumstances to justify that they were able to form a good faith opinion that the ground for the termination exists.

At the time, there was no further guidance on what evidence the doctors must have in their possession or that they are required to meet with the woman face-to-face. However, when the initial reports emerged *The Telegraph* ran with headlines suggesting that ‘pre-signing’ of forms was something that was ‘clearly’ outside the scope of the law. For reasons of space I cannot explain here why this is not necessarily the case. Suffice to say that the law is unclear. Subsequent to the sting, however, ‘best practice’ guidelines have been issued in order to curb the practice. Although these are only

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115 Abortion Investigation: Available on Demand’ (n 24).
116 ‘Abortion Investigation: Health Secretary Andrew Lansley to Report Clinics’ (n 24).
119 In an emergency a HSA2 form is completed (Certificate B in Scotland).
121 ibid.
guidelines, this serves to highlight how strategies are working to create an increasingly conservative environment for abortion care. It also goes against the trend of allowing for clinical discretion in this area, instead pushing for increasingly detailed guidance to proscribe certain practices.

4.3 Guerrilla legislation: sex selective abortion

I now return to the issue of sex selective abortions and attempts to restrict access to abortion services by targeting specific reasons for having an abortion – this making certain kinds of abortion ‘unwanted and unthinkable’. As detailed above, The Telegraph published details of a sting operation running with the headline: ‘Abortion investigation: Available on demand – an abortion if it’s a boy you wanted’. This was one of several stories the paper published detailing how undercover reporters had stated during consultations that they wanted to have an abortion for reasons of foetal sex. During early 2012, sex selective abortion was also a live issue in the US, culminating in a House of Representatives vote on an anti-choice bill entitled the Prenatal Nondiscrimination Act (PRENDA). The purported aim of the Act was to ‘To prohibit discrimination against the unborn on the basis of sex or race, and for other purposes’. However, the Act had a primarily anti-choice intent.

An important question here is what precipitated this proposed legislation? It is again part of a strategy aimed at restricting access to abortion, using incremental methods that are likely to garner public support – most people disagree with sex discrimination! Claims of widespread discriminatory practices were bolstered through the distribution of video evidence of undercover anti-choice lobbyists purporting to ask for an abortion for reasons of foetal sex. The US Bill was ultimately defeated, but the strategy remains

124See (n 24).
125See (n 24).
live, as evidenced by Senator David Vitter’s (Republican Senator for Louisiana) attempt in 2013 to insert an anti-choice amendment into the Employment Non-Discrimination Act.\textsuperscript{131}

Aiming to restrict certain reasons for having an abortion is a well-discussed anti-abortion strategy. For example in 2008 Steven Calabresi argued:

The key to eroding Roe v. Wade, then, is to pass a number of state or federal laws that restrict abortion rights in ways approved of by at least fifty percent of the public in national public opinion polls.\textsuperscript{132}

This is an example of an area where there is potential for ‘salami tactics’ – where a range of legislative proposals reduce access to abortion in slices.\textsuperscript{133} In 2014, as a response to the ‘sex selection scandal’, Fiona Bruce MP (Conservative Party) attempted to introduce legislation to ban sex selective abortions. Bruce, who has a long history of anti-abortion advocacy, used the 10-minute rule procedure to introduce her proposed amendment.\textsuperscript{134} To make the case for the need to change the law, Bruce described three scenarios when women are coerced (either directly or indirectly) into having a termination. All of the scenarios implicitly draw on concern for women to make the case for having a termination. Sheldon summarises the misplaced focus of Bruce’s amendment as follows:

In sum, the structural sexism that leads to the practice of sex selective abortion is deplorable, a fortiori, when it manifests itself in violence and coercion. However … there are strong practical reasons for being wary of seeking a response to these problems within the criminal law. A specific prohibition on sex selection is likely to be unworkable in practice and could not fail to be highly intrusive. Either screening out the very small number of cases where a termination might be sought for this reason would involve close questioning of all woman (not least given Bruce’s concern with women persuaded to lie about their motivation) or, alternatively, it might potentially lead to a kind of racial profiling, with enhanced suspicion and scrutiny of women from particular ethnic communities.\textsuperscript{135}

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Bruce was ultimately unsuccessful, but it is worth noting that at first reading she received widespread support. A consequence of Bruce’s Bill is section 84 of the Serious Crime Act 2015, sub-section 1 of which states:

The Secretary of State shall arrange for an assessment to be made of the evidence of termination of pregnancy on the grounds of the sex of the foetus in England, Wales and Scotland.

At the time of writing it is unclear what the impact of this section will be but it serves as an example of the random and arbitrary ways in which guerrilla legislation can emerge.

4.4 Targeted harassment of abortion providers: criminal prosecution

The final example of guerrilla strategies that I want to mention was also a fallout of The Telegraph sting operations. Subsequent to the CQC investigation of clinics there was an investigation by the General Medical Council (GMC) and the Crown Prosecution Service (CPS). This fits with G2 – increasing litigation against doctors. This was not the first attempt to prosecute doctors. In 2003, Reverend Joanna Jepson successfully sought leave to apply for judicial review of the decision by West Mercia Police (WMP) not to prosecute the doctors involved in a late gestation abortion for reasons of foetal anomaly. Again, the basis of Jepson’s complaint was that the clinicians’ actions were outside the remit of the Abortion Act. Jepson, in the first instance, complained to the Commissioner of the Metropolitan Police, who stated that the case fell within the jurisdiction of the WMP. Following an investigation, the WMP decided there was no cause for prosecution and that the two clinicians had made their decision in good faith, the threshold contained in the Abortion Act. Following Jepson’s complaint, the investigation was reopened by the CPS. Again the decision was not to prosecute.

In the more recent example related to The Daily Telegraph stings on sex selection, the behaviour of two doctors, Prabhan Sivaraman and Palaniappan Rajmohan, was singled out for investigation. Following their investigation, the


137 Serious Crime Act 2015, s 84(1).


139 ibid.

CPS concluded ‘that it would not be in the public interest to prosecute’. The GMC investigation has been more protracted. The investigation into Dr Sivaraman’s practice was closed in April 2015 – over three years after the story unfolded. At the time of writing the investigation into Dr Rajmohan is ongoing and the GMC website indicates that his practice is still restricted, including not being able to authorise abortions or work outside of the NHS. It has been reported that he will face a public hearing later this year (2015). Additionally, subsequent to the decision of the CPS not to prosecute, an anti-abortion activist, Aisling Hubert, launched a private prosecution against the two doctors. Hubert’s attempt failed. This all serves to emphasise the severe consequences that litigation against abortion providers can have. Such litigation aims to strike fear into providers, pushing to decrease the number of doctors willing to provide services or ensure that those who do provide are more conservative in how they interpret the law – whether this has been a success remains to be seen.

5. Strategies for ensuring abortion services

In what follows I provide three suggestions of how we can respond to and reduce the efficacy of guerrilla strategies.

5.1 Professional reform

First, work needs to be done to better support those clinical staff who currently provide abortion services. As mentioned above, there is a clear historical legacy of ideological marginalisation of abortion within the established professional body, the RCOG. That this is continuing is evidenced by a 2008 statement on the website: ‘Nobody enjoys performing abortions’ which may be true but in the absence of any empirical evidence to attest to this it reads more like a rhetorical example of a continuing ambivalence.

143I checked the registration status of Dr Palaniappan Rajmohan (Registration Number 4701989) on the GMC website, www.gmc-uk.org (accessed 19 June 2015).
towards the procedure. Similarly the lack of support provided by professional organisations to clinical staff in the wake of the recent attacks outlined above was startling. Although BPAS was keen to defend the activities of staff in their clinics, they were largely a lone voice in defending abortion providers. Further, as is evident from the discussion of Dorries above, BPAS has been tainted as an ‘interested party’.

It would have been good to see more engagement with the mainstream professional organisations such as the General Medical Council (GMC) and the RCOG. In response to *The Daily Telegraph* sting the GMC, who regulate doctors, issued a press release that incorrectly stated the law, citing the Human Fertilisation and Embryology Act 2008, a piece of legislation that has nothing to do with abortion, as evidence of the statutory prohibition of sex selective abortion. Subsequently the RCOG issued a statement which reproduced the errors contained in the GMC response. It is also surprising that so little was done to publicise the findings of the CQC investigation into abortion care; this report found care on the whole to be very good to excellent and where instances of poor practice were evidenced (e.g. pre-signing of HSA1 forms) the report was at pains to say that this had not impacted on patients’ clinical care. Finally, notwithstanding that abortion is the most commonly performed surgical procedure on women, abortion has not been a compulsory part of the specialist obstetrics and gynaecology curriculum in England. It is currently accepted that over-reliance on the independent sector can have a negative impact on training and education:

Increasingly the independent sector is providing abortion care. In 2009, 94% of abortions were funded by the NHS; of these, over half (60%) took place in the independent sector under NHS contract. This has been identified as a significant issue for clinical training and mentorship of clinicians undertaking abortions, particularly at later gestations. The independent sector has neither the resources nor the responsibility to provide training, and as the amount of abortions performed in the independent sector increases, the opportunities for training in NHS facilities decrease.

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152 Ibid.
One way to address this is to create a new, cross-sector, professional ‘body’ to represent the interests of concerns of clinical staff who provide abortion care in England and Wales. Such a grouping already exists in Scotland, Network of Scottish Abortion Care Providers (NSACP). There is a potential danger that the creation of such a body makes providers more publicly identifiable and so could lead to increased levels of harassment. However, such an organisation would provide a much-needed space for cross-sector support and engagement for all abortion providers rather than this work being left to independent sector representatives who can be charged as self-interested. In order to reduce the potential for further marginalisation such a body could be supported within the broader remits of the RCOG and the Faculty of Sexual and Reproductive Health (FSRH). The role of professional organisations has long been recognised as an important source of professional advancement. Such an organisation could also work to improve morale; something that is necessary to the continued provision of abortion services:

Predictably, interaction with other providers is a major source of support and affirmation and helps sustain this group’s commitment to abortion practice … Contrasting the colleagueship that typifies NAF meetings with the coldness that he experiences from many in his local medical community … Daniel Fieldstone too drew a contrast between the camaraderie he experienced at NAF and the lukewarm support given many abortion providers at the most relevant mainstream organisation, the American College of Obstetricians and Gynaecologists.

A professional association has the potential to further enhance a cohesive abortion service; something that is important if we keep in mind the earlier point that the independent sector does not have the capacity to meet the entirety of service needs in this area.

5.2 Law reform

Second, it is clear that law reform is long overdue. The current framing of abortion in law is a medicalised model, reliant on ‘therapeutic’ indications. This framing can be traced back to the case of R v Bourne, the starting point for what Andrew Grubb has described as process of medicalisation of a crime. This positioning of abortion within the criminal law framework

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154 Joffe, Doctors of Conscience (n 8) 176.
155 Andrew Francis summarises this point as follows: ‘the importance of a well-organized professional association which provides leadership and structure to the claims of the wider profession is clear; not simply as signifying the traits of the profession, but as a key way in which professionalization occurs – a fulcrum of professional advancement’ Francis (n 152) 16 [references omitted].
156 [1938] 3 All ER 61.
can be traced back to legislative efforts in the eighteenth century and it is increasingly becoming clear that it is not fit for purpose in the twenty-first century.\(^{158}\) Sheldon has recently highlighted not just the outmoded framework in the Abortion Act 1967 but the lack of Parliamentary consideration of the inclusion of abortion within the Offences Against the Person Act 1861 (OAPA).\(^{159}\) Sheldon questions the purpose of the criminal law in this arena. If doctors act criminally, for example operating without consent, they can be prosecuted under the general criminal framework without recourse to ss 58 and 59 of the OAPA 1861. Similarly, if a doctor behaves negligently there is existing law to deal with this. So what purpose exactly does the Abortion Act 1967 serve? That this medical procedure continues to be regulated using the criminal law exceptionalises and stigmatises abortion care.\(^{160}\) So a major achievement in the area of law reform to ensure access to abortion services would be to decriminalise the procedure. Abortion has been successfully decriminalised in Canada following the litigation involving Henry Morgentaler in the 1970s.\(^{161}\) More recently the Australian state of Victoria also decriminalised it.\(^{162}\) In England, a campaign was also launched in 2014 calling for similar decriminalisation here.\(^{163}\)

Whether campaigns for decriminalisation will be successful remains to be seen. It is interesting to note that the Law Commission has decided not to consider sections 58 and 59 in its forthcoming review of the Offences Against the Person Act 1861.\(^{164}\) There are steps short of decriminalisation that could go some way to address current shortfalls in the legal framework – an obvious improvement would be to reduce the number of signatures from two doctors to one. In 2007 the House of Commons Science and Technology Committee supported this, stating that it would like to ‘see the requirement for two doctors’ signatures removed’.\(^{165}\) In response to the House of Commons Science and Technology Committee several amendments were tabled in 2008 as part of the review of the Human Fertilisation and

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\(^{159}\) Ibid.


Embryology Act but these were ultimately unsuccessful or not discussed. The most recent guidance from the Department of Health is arguably skewed by the desire to keep a lid on the ‘pre-signing scandal’ towards reaffirming bureaucracy in this area regardless of how it impacts on clinical care.

5.3 Clinical reform

Third, there are changes to clinical practice that could also help respond to some of the guerrilla strategies identified in this paper and more generally maintain liberal access to abortion services. Deliberately accelerating the process of demedicalisation would accord with World Health Organization (WHO) guidelines that advocate that: ‘Abortion services should be provided at the lowest appropriate level of the health care system.’ Efforts to do this can be seen in the recent case of British Pregnancy Advisory Service v Secretary of State for Health. In this case BPAS sought a declaration that it would be in accordance with the Abortion Act for women to self-administer misoprostol at home. BPAS was unsuccessful. However, this represents a clear attempt to reduce the level of medical control over abortion care. It should be stressed that the results of this demedicalisation process may not have the purely positive effects that some hope for. As Halfmann notes:

The demedicalisation of abortion also had mixed results. It promoted less hierarchical provider–client interactions but also increased providers’ susceptibility to protest and harassment because they were isolated from legitimating biomedical institutions.

The tension between demedicalisation and support for abortion services is a tension that has long existed between those medical professionals who provide care and feminist advocates for women’s rights to bodily integrity. Harris links this tension with doctors’ responses to the designation of their practice as ‘dirty work’:

The feminist health activist seeks to make abortion: ‘a woman-centred service, with a limited ‘technical’ role for the physicians. However, the abortion-providing physician, in part as a response to the long history of stigmatisation of

170Halfmann, ‘Recognizing Medicalization’ (n 16).
171Joffe et al (n 16).
abortion as ‘dirty work’, desires to further medicalise and professionalise abortion services.\textsuperscript{172}

In conjunction with demedicalisation then it is perhaps time that abortion services were mainstreamed into general medical practice. In submitting their evidence to the Lane Committee, the Royal College of General Practitioners suggested that in the not too distant future it was possible that abortion care would be provided as part of general practice:

the need for hospital care in the future may be entirely eliminated if new medical methods of abortion such as prostaglandins and drugs of this type become available. If this were to happen we anticipate that such drugs would not be available directly to the public and would therefore be obtained through a general practitioner’s prescription.\textsuperscript{173}

Yet this has not happened. I do not suggest that the entirety of abortion care could or should be offered within the general health service (i.e. hospitals and GP surgeries). There are many and varied reasons women access services from standalone clinics when there are hospital-based services geographically closer.\textsuperscript{174} However, there seem to be good reasons for offering women more choice about where and how they can receive abortion care. And with increased rates of early medical abortions the need for specialist facilities is declining for the majority of women. Such mainstreaming makes guerrilla strategies more difficult, as anti-abortion advocate Joseph Scheidler states: ‘[i]t is more difficult to picket a hospital than to picket an abortion clinic. It is nearly impossible to counsel outside of a hospital.’\textsuperscript{175}

6. Conclusion

Historically there has been a tension in the relationship between those who provide abortions and the medical establishment – two professional bodies which overlap but are in tension. In this paper I have highlighted the marginalised provision of the service and the potential negative consequences to women seeking abortion. Nothing I have said in this paper is intended to cast a negative light on the quality of the care offered by the independent sector or abortion providers more generally. Rather I am concerned that continued societal and professional ambivalence regarding abortion creates conditions within which anti-abortion gains are likely.

\textsuperscript{172} Harris (n 3).
\textsuperscript{174} Christabelle Sethna and Marion Doull, ‘Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada’ (2013) 38 Women’s Studies International Forum 55.
\textsuperscript{175} Scheidler (n 78) 348.
Hughes’ analysis of ‘dirty work’ is instructive in two ways. First, it highlights the implicit pact that exists between society and those who carry out society’s ‘dirty work’. Second, he highlights the necessity of ‘dirty work’ and society’s reliance on it. As applied to abortion provision we should be wary of the ‘crisis of silence’ which surrounds such work.\(^{176}\)

Providers’ silence can be understood as a habitual, adaptive response to overt and subtle threat, as well as to the daily experience of performing one version of society’s dirty work. Abortion workers are not seen and not heard.

One mechanism to address this uncomfortable state of affairs is the creation of a body that represents the interests of abortion workers, another area of abortion provision that has hitherto been too reliant on the independent sector to fulfil this function.

My route into the analysis and reflection central to this paper was the increase in anti-abortion lobbying in England in the last few years and in particular the way in which this lobbying is increasingly directly targeted at doctors/abortion providers. Drawing on a key anti-abortion publication from the early 1990s, I have examined the success of attempts to restrict access to abortion when wholesale law reform is not possible. Arguably the increase in anti-abortion lobbying has been influenced by successive governments’ refusal to undertake a revision of the law in this area – most obviously during the debates on the Human Fertilisation and Embryology Act 1990 (when only time limits were discussed) and the subsequent revisions to the Act in 2008 (where debate of the Abortion Act 1967 was excluded altogether).

In researching this issue, it is striking how little we know about current experiences of abortion providers in this country; this is something which is also evidenced in other jurisdictions:

\[\text{[C]ompared to other medical professionals, they [abortion providers] are a group about which we know virtually nothing. Almost no research has been done on the experiences of abortion providers. Very few narratives exist ... \}

\[\text{[A]bortion providers fear that if they reflect openly on their experiences, they risk being perceived as disloyal to the feminist movement and pro-choice politics. Talking about abortion is ‘dangertalk’ ...}\(^{177}\)

At the same time as there being an absence of clinicians’ voices there is in fact much ‘abortion talk’. It is increasingly recognised that those who regard abortion as a integral to women’s bodily and reproductive autonomy must work to combat abortion stigma in its many forms.\(^{178}\) There are now several projects


\(^{177}\)ibid.

\(^{178}\)See e.g. Rebecca Cook, ‘Stigmatized Meanings of Criminal Abortion Law’ in Rebecca Cook et al (eds), Abortion in Transnational Perspective (University of Pennsylvania Press, 2014) ch 16.
and spaces that encourage women to share their experiences of having an abortion. Spaces to discuss women’s personal experiences of abortion provision are important. We need to create similar spaces for providers to discuss their experiences of providing this care. This is especially important because anti-choice lobbyists continually impugn the trustworthiness of abortion providers. It is clear that the marginalised position of abortion services within mainstream medical practice can be utilised in order to increase the chances that anti-abortion strategising will be successful and fewer doctors will be prepared to provide abortion care.

The emergence of the independent sector, and with it the standalone abortion clinic, provided women with an opportunity to circumvent obstructive NHS abortion practices. It also facilitated an enduring ambivalence within the medical establishment to abortion provision. It is clear that with the advent of the Abortion Act the medical establishment, and in particular the RCOG, found itself in control of a healthcare service it was neither prepared for, nor fully supportive of. The emergence of the independent sector provided a solution, but brought with it some disadvantages – specifically the potential for abortion services to appear less legitimate than other forms of medical care. I have suggested a number of strategies that may be used in conjunction with each other to provide support to abortion providers and thus ensure continued liberal access to abortion services. None of these strategies will be successful alone. But together they provide a clear response to some of the key features of the guerrilla strategies advocated by Crutcher.

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