

## Locating lawful abortion on the spectrum of “proper medical treatment”

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### Introduction

As every undergraduate medical law student knows, when a patient is capable of giving her consent, the least touching *without* consent may amount to a tort and a crime.<sup>1</sup> But, as Lord Mustill remarked in *R v Brown*,<sup>2</sup> more invasive medical treatments (those intrusions which outwith the medical context might amount to assaults causing actual or grievous bodily harm, or maim) may be ‘well above any point at which consent could even arguably be regarded as furnishing a defence’.<sup>3</sup> According to his Lordship, where such treatments are concerned, it is not the existence of consent, but the fact that the intervention counts *as* proper medical treatment, which prevents criminal liability from attaching to those treatments. In these more invasive cases, as Margot Brazier and Sara Fovargue suggest, proper medical treatment works ‘magic’<sup>4</sup> and ‘transform[s] something wrong into something right’.<sup>5</sup>

Where abortion is concerned, the concept of proper medical treatment *never* works to transform wrongs into rights; that magic is worked instead by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). The practice of abortion, otherwise a statutory crime in England and Wales under sections 58 and 59 of the Offences Against the Person Act 1861 (and a common law crime in Scotland), is transformed, provided that certain conditions are met, into lawful medical treatment by section 1 of the 1967 Act as amended. Why consider the concept of proper medical treatment in this context at all, then? I suggest that there are at least two reasons to regard the concept as being relevant to abortion

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<sup>1</sup> See, e.g., *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 All ER 643, HL *per* Lord Scarman.

<sup>2</sup> [1994] 1 AC 212, HL.

<sup>3</sup> *Brown* (n 2) 266.

<sup>4</sup> M Brazier, S Fovargue, ‘Transforming wrong into right: What is “proper medical treatment”?’ in this collection, page XX

<sup>5</sup> Brazier and Fovargue (n 4) page XX

law, notwithstanding that the current lawfulness of abortion is not attributable to it. The first is that the concept of proper medical treatment is wider than just the medical exception. Whether an intrusion is minor enough that consent alone can render it non-criminal (as is the case with superficial examinations and treatments involving only minor touchings of the body), or is sufficiently severe to require the “magic” power of the medical exception, the idea of proper medical treatment is busy in the background. It defines the nature and contours of the practitioner-patient relationship, and sketches out the landscape of healthcare law.

The second reason why we need to be clear about whether, and to what extent, the practice of abortion conforms to the notion of proper medical treatment is that although the lawfulness of abortion does not *currently* depend upon such conformity, an emerging strand of pro-choice activism is focused on the demand that abortion be completely decriminalised.<sup>6</sup> It is unclear at the time of writing precisely how the fulfilment of that demand would be cashed out in terms of detailed law reform, but it is likely that the legislative apparatus that currently marks out the (admittedly somewhat byzantine) boundary between lawful and unlawful abortion would need to be repealed or amended, at least in part. Depending on how and to what extent the current legislative framework is disturbed, surgical abortion, like other invasive treatments, may come to depend for its lawfulness upon the transformative power of proper medical treatment. Medical abortion, as a less invasive form of treatment, may remain within the category of treatments for which consent alone is enough to remove criminality; if so, proper medical treatment would retain the same kind of background role in relation to *medical* abortion, post-decriminalisation, that (I will argue) it currently has in relation to *all* cases of abortion.

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<sup>6</sup> See, e.g., ‘Four good reasons for Britain to decriminalise abortion altogether’, *BPAS Reproductive Review: Issues in Abortion, Pregnancy, and Birth* (12 June 2014) <<http://www.reproductivereview.org/index.php/rr/article/1592/>> (accessed 1 December 2014); S Sheldon, ‘Why We Should Take Abortion out of the Criminal Law’, Centre for Law and Society seminar, University of Edinburgh, 6 November 2014.

## Understanding proper medical treatment

In their chapter, Brazier and Fovargue subject the concept of proper medical treatment to forensic analysis, exploring each of its component parts in order to build up a picture of what counts as proper medical treatment and why. They begin by noting what appear to be ‘two elements to the medical exception’ (over and above the presence of consent, where consent is possible), namely ‘the reasonableness of the activity under consideration’ and the fact that ‘that activity is in the public interest.’<sup>7</sup> Of these two, reasonableness seems to have a particularly fundamental role: ‘[t]he *reason* for the treatment (...) appears central to the medical exception.’<sup>8</sup> In highlighting reasonableness, Brazier and Fovargue join a tradition which was, arguably, begun by Denning LJ in *Bravery v Bravery*<sup>9</sup> when he implied that operations must be carried out with ‘just cause or excuse’,<sup>10</sup> and continued by Lord Lane CJ in *Attorney-General’s Reference (No. 6 of 1980)*,<sup>11</sup> who referred to the undesirability of bodily harm ‘for no good reason.’<sup>12</sup> From the initial insight that proper medical treatment is somehow connected with reasonableness of purpose, Brazier and Fovargue embark upon a detailed inquiry into the various factors that seem capable either of rendering a practice ‘proper’ in themselves, or at least of contributing to a determination of properness. From their analysis, several factors seem to emerge as having justificatory potential, notably that the activity is beneficial to (or has the potential to benefit) the patient,<sup>13</sup> that the activity is in the public interest (or ‘public good’),<sup>14</sup> that the activity is in accordance with the norms of the healthcare profession(s),<sup>15</sup> and that it is performed by ‘trusted’ healthcare professionals.<sup>16</sup>

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<sup>7</sup> Brazier and Fovargue (n 4) XX.

<sup>8</sup> Brazier and Fovargue (n 4) XX, emphasis in original.

<sup>9</sup> [1954] 1 WLR 1169 (CA).

<sup>10</sup> *Bravery* (n 9) 1179.

<sup>11</sup> [1981] 1 QB 715 (CA).

<sup>12</sup> *Attorney-General’s Reference* (n 11) 719.

<sup>13</sup> Brazier and Fovargue (n 4) XX.

<sup>14</sup> Brazier and Fovargue (n 4) XX.

<sup>15</sup> Brazier and Fovargue (n 4) XX.

<sup>16</sup> Brazier and Fovargue (n 4) XX.

The idea of “reasonableness” seems immanent in all of these; so that it has the air of an overarching or background element in the process of justification.

To a significant extent, Brazier and Fovargue’s analysis reflects (although it does not replicate) Penney Lewis’s evaluation of the medical exception in her seminal paper.<sup>17</sup> The factors they identify as relevant to assessments of properness largely map on to Lewis’s discussion of public policy justifications. Lewis argues that the medical exception operates only where two conditions are met: consent (where that is possible), and the existence of a public policy justification. She distinguishes between ‘patient-focused’, ‘public-focused’ and ‘professionally focused’ public policy justifications,<sup>18</sup> and the main factors identified by Brazier and Fovargue seem broadly to mirror these categories.<sup>19</sup>

Since Lewis is concerned with the line between criminality and non-criminality, it is unsurprising that her discussion focuses exclusively on tracing that boundary. Brazier and Fovargue’s examination of proper treatment likewise concentrates on what might be required, over and above consent, in order to prevent actions from attracting criminal liability. They focus on the medical exception and do not explicitly distinguish this from proper medical treatment; nevertheless, the two terms are not synonymous. Whereas the medical exception has a limited role insofar as it applies only to those interventions which are intrusive enough to amount to serious offences against the person, the concept of proper medical treatment as described by Brazier and Fovargue encompasses *all* lawful medical treatment, and not only those treatments which involve the kind of significant intrusions authorised by the medical exception. The medical exception performs a specific function (the exclusion of criminal liability) and, in so doing, it ushers new and controversial practices into the fold of proper medical treatment. Thus, we begin to build a picture of the relationship between the two

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<sup>17</sup> P Lewis, ‘The Medical Exception’ (2012) 65 *Current Legal Problems* 355-376.

<sup>18</sup> Lewis (n 17) 357-364.

<sup>19</sup> Brazier and Fovargue (n 4) XX.

ideas, in which the medical exception appears to serve to police and extend the *boundaries* of the wider and more general category of proper medical treatment.

### **The spectrum of proper medical treatment: paradigm, clear and liminal**

If one feature of the existing literature is that it has not yet begun to tease out the distinction between the medical exception on the one hand and the wider concept of proper medical treatment on the other, another is that little attention seems to have been paid so far to gradations of properness *within* the landscape of the lawful. Because so much attention has been trained on the medical exception, it is the line between the lawful and the unlawful which has drawn the academic eye. But further distinctions are possible. In the context of a recent discussion of conscience rights,<sup>20</sup> Sara Fovargue and I have argued that within the category of ‘proper medical treatment’, a given treatment can be either ‘clearly proper’ or ‘liminally proper’:

A treatment may occupy liminal status because, despite being lawful, it is ‘morally controversial and contentious’. Practices which involve the ending of human life, such as abortion, IVF, and withholding or withdrawing treatment from unconscious patients or severely disabled newborns may be liminally ‘proper’ for this reason; assisted dying will be too, if it becomes lawful to provide it within the healthcare context (...) A treatment may also have liminal status if it is extremely risky or experimental, or if it is more concerned with the satisfaction of preferences than with healing or treating disease.<sup>21</sup>

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<sup>20</sup> S Fovargue, M Neal, “‘In good conscience’”: Conscience-based exemptions and proper medical treatment’ (2015) 23 *Medical Law Review* (forthcoming).

<sup>21</sup> Fovargue and Neal (n 20).

We distinguished between clear and liminal cases of proper medical treatment in order to identify liminal treatment as the zone within which conscience-based exemptions can be appropriate. The existence of a conscience clause may be a clue that the status of the treatment in question *is* liminal; hence, the existence of conscience-based exemptions in relation to (non-emergency) abortion<sup>22</sup> and the activities governed by the Human Fertilisation and Embryology Act 1990,<sup>23</sup> and the conscience clauses in Bills aimed at decriminalising assisted suicide.<sup>24</sup> Indeed, the existence of a permitting statute (whether or not it contains a conscience clause) may be a clue in itself, since the need for clear statutory authority may indicate that a practice exists at the margins of what could otherwise be accepted as “proper”. Practices currently permitted by statute include living organ donation,<sup>25</sup> abortion, and embryo research, and the legalisation of assisted suicide seems also to be regarded as a matter for the legislature.<sup>26</sup>

The distinction between clear and liminal proper treatment is, in a sense, the subject-matter of the present volume, and many of the chapters herein can be read as mapping out areas of liminality *within* the category of proper medical treatment, as much as charting the border between the proper and the improper.<sup>27</sup> In the passage quoted above, Fovargue and I focused on specific contexts and examples where treatments might be regarded as liminal as a (non-exhaustive) way of describing the realm of liminality. But another approach to

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<sup>22</sup> Section 4(1) of the Abortion Act 1967 provides that ‘no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection’.

<sup>23</sup> Section 38(1) of the 1990 Act provides that ‘No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so.’

<sup>24</sup> Provision for conscience was included in the various Assisted Dying for the Terminally Ill Bills tabled by Lord Joffe, and there is a conscience clause in the Assisted Dying Bill (the ‘Falconer Bill’) currently before the House of Lords. The version of the Assisted Suicide (Scotland) Bill currently before the Scottish Parliament does not include a conscience provision because although health (including assisted dying) is devolved, regulation of the professions is reserved to Westminster.

<sup>25</sup> Under the Human Tissue Act 2004 and the Human Tissue (Scotland) Act 2006.

<sup>26</sup> *R (Nicklinson) v Ministry of Justice* [2014] UKSC 38.

<sup>27</sup> D Griffiths, A Mullock, ‘The medical exception and cosmetic surgery: Culpable doctors and harmful enhancement?’; R Huxtable, ‘Death on demand: Proper medical treatment?’; C Kitzinger, J Kitzinger, ‘Family perspectives on proper medical treatment for people in prolonged vegetative and minimally conscious states?’; J Laing, ‘Doctors orders?: Appropriate medical treatment in mental health law?’.

describing the distinction between clearly and liminally proper treatments might be to identify what the features of a “paradigm case” of proper medical treatment are, and to regard a treatment as “proper” in a stronger or weaker sense depending on how closely it models that paradigm.

In *Bravery* Denning LJ described ‘ordinary’ surgery as being ‘done for the sake of a man’s health, with his consent.’<sup>28</sup> Borrowing this formulation and adapting it slightly, I propose that we regard the *paradigm case* of proper medical treatment as being “treatment carried out with the consent of the patient and for the patient’s therapeutic benefit.” The first element of this formulation, consent, is indicated by the centrality of the principle of autonomy in contemporary healthcare law and the resulting requirement that where consent is possible, it *must* be obtained on pain of criminal and civil sanction. The second element, therapeutic benefit,<sup>29</sup> is indicated by the widespread perception that one of the central purposes of healthcare is to provide health-related benefit to patients (only a minority of practices permitted in the healthcare context have *no* potential therapeutic benefit for the patient), and the resulting mainstream characterisation of the relationship between the healthcare professional and patient as a therapeutic relationship. The British Medical Association characterises the doctor-patient relationship as a ‘therapeutic relationship’,<sup>30</sup> and the encounter between doctor and patient as a ‘therapeutic encounter’.<sup>31</sup> It contrasts the ‘usual model of a therapeutic partnership’<sup>32</sup> and the ‘normal therapeutic role’<sup>33</sup> of the doctor with other situations where doctors act in a dual capacity (doctors who work in prisons, for example, have duties to their employers as well as to their patients), or where there is no

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<sup>28</sup> *Bravery* (n 9) 1180.

<sup>29</sup> I adopt the phrase “therapeutic benefit” from Brazier and Fovargue because it reflects the idea of a “therapeutic relationship” and captures the sense in which “benefit” in the context of healthcare law and ethics goes wider than narrow *clinical* benefit, but not so wide as to encompass the mere satisfaction of patients’ personal preferences.

<sup>30</sup> *BMA Medical Ethics Today: The BMA's Handbook of Ethics and Law* (Wiley, 2012), 27, 208, 702.

<sup>31</sup> BMA (n 30) 6.

<sup>32</sup> BMA (n 30) 649.

<sup>33</sup> BMA (n 30) 690.

therapeutic aspect to the relationship at all (where a doctor completes a report for an insurance company as an independent assessor, for example).<sup>34</sup>

Space does not permit a discussion of the “ends of medicine debate” here, except to note that while there is disagreement among scholars regarding what the proper ends of medicine are, plausible suggestions invariably seem to cite beneficence/best interests.<sup>35</sup> This is clearly so where the physician patient relationship is regarded, in the traditional way, explicitly as a ‘healing relationship’.<sup>36</sup> However, a set of revised goals identified by an international panel of experts which set out specifically to challenge traditional views of the goals of medicine and identify new goals more reflective of the realities of modern medicine seems to rely just as heavily on notions of beneficence/best interests.<sup>37</sup> The “new” goals are (i) the prevention of disease and injury and promotion and maintenance of health, (ii) the relief of pain and suffering caused by maladies, (iii) the care and cure of those with a malady, and the care of those who cannot be cured, and (iv) the avoidance of premature death and the pursuit of a peaceful death.<sup>38</sup> Each of these seems obviously to be focused on producing benefit for patients. While Mark Wicclair regards the traditional claim that medicine is oriented toward ‘healing’ as overly-essentialist, he concludes nevertheless that ‘it is plausible to maintain that healing is associated with the concept of medicine (or any credible conception of it), and it is arguable that an individual who is not committed to that end fails to qualify as a physician, let alone a virtuous one’.<sup>39</sup>

Clearly, there are healthcare interventions which do not model the paradigm case outlined above, but which are, nevertheless, well-accepted. Treatment without consent is

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<sup>34</sup> BMA (n 30) 27-28.

<sup>35</sup> See also L Frith, ‘What do we mean by “proper” medical treatment?’ in this collection.

<sup>36</sup> ED Pellegrino, ‘Toward a Reconstruction of Medical Morality’ (2006) 6 *The American Journal of Bioethics* 651, 67.

<sup>37</sup> An International Project of the Hastings Center, ‘The goals of medicine: Setting new priorities’ (1996) 25 *Hastings Center Report* S1.

<sup>38</sup> Hastings Center, ‘Specifying the goals of medicine’ (n 37) S10-S14.

<sup>39</sup> M Wicclair, ‘Is conscientious objection incompatible with a physician’s professional obligations?’ (2008) 29 *Theoretical Medicine and Bioethics* 171, 174.



possible where a patient lacks the capacity to consent, either temporarily (in which case any proposed intervention must be justified on grounds of necessity) or permanently (in which case any proposed intervention must satisfy a “best interests” test). However, I suggest that the *paradigm case* of proper treatment is one where consent is present; the justification for intervention in other cases, although still patient-centred, takes an “alternative” form. The “therapeutic benefit” element can also be absent in certain cases without this meaning that the intervention is impermissible. Cases of living organ donation are an example. The bodily intrusion involved in retrieving an organ from a living donor is significant, and it is not performed for the direct therapeutic benefit of the patient being intruded upon. Arguably, the retrieval of the organ provides a psychological or emotional benefit for the donor; this argument is perhaps strongest where the recipient of the organ is a loved one of the donor, but may also be present where the donation is impersonally altruistic. Usually, however, the permissibility of such interventions is discussed in terms of “public interest” or “public good” justifications, perhaps implying that the benefit to the donor is regarded as being too weak, or too indirect, to provide a convincing justification in itself. That the permissibility of living organ donation is established by statute in the UK may hint at the ‘exceptional’ nature of this kind of intervention. The need for a statute to put its lawfulness beyond doubt is surely connected to the lack of a therapeutic benefit to the donor and could be regarded as implying that, in the absence of clear statutory authorisation, the lack of such a benefit would render the practice questionable, and locate it at (or possibly beyond) the periphery of proper medical treatment.

The two key elements of the paradigm case, consent and therapeutic benefit, have different roles in determining the properness of treatment. Consent operates in an “all or nothing” way. If it is possible, it must be present, and if it is present and the intervention is also clearly therapeutic, what we have is a paradigm case of proper medical treatment. If the

capacity to consent is absent, then providing that the relevant patient-centred test is met (necessity or best interests, depending on the patient's condition), and providing that the intervention is clearly therapeutic, the absence of consent does not preclude proper medical treatment. Although we are not dealing in such circumstances with a paradigm case, the properness of the treatment is not in doubt. This is because treatment in cases where patients cannot consent is both necessary and desirable, and also because the portion of the overall justification which consent represents in the paradigm case can be satisfied by necessity or best interests in other cases. Therapeutic treatment without consent which is justified by necessity in the case of an unconscious patient, or in the best interests of a patient who lacks capacity on a longer term basis, is thus "clearly" proper; albeit not paradigmatic.

If consent is possible, but is not obtained, then any intervention on the patient is *improper*. The absence of consent cannot, therefore, be what locates an intervention within the liminal zone of proper medical treatment. If consent is absent because of the patient lacks capacity, then providing that the appropriate alternative mechanism for justification is satisfied, treatment (if clearly therapeutic) is clearly proper. On the other hand, if consent is absent because the consent of a patient with capacity has not been given for a particular intervention, this is not liminal but *improper*. Liminal proper medical treatment is still lawful, and, indeed, still proper. It occurs at the margins or peripheries of what is proper. By contrast, any treatment of a patient with capacity *without* her consent stands completely outside of the realm of what is proper. As such, the consent element of the paradigm can never be the basis for a determination of liminality.

What *could* point to 'liminally proper treatment', then? Determinations regarding whether an intervention is clearly or only liminally proper will focus on the *therapeutic value* or potential of the intervention (the second element of the paradigm case). If it can be shown (or if a strong consensus emerges) that a whole practice, or a particular intervention, is

positively *harmful* – either exclusively harmful or so harmful that any supposed countervailing benefit(s) cannot render it therapeutic on balance – then whether it is liminally proper or improper will depend on the circumstances. Notwithstanding the practitioner’s ethical duty to ‘do no harm’ (non-maleficence), living organ donation, which represents a net harm to the donor, can be lawful. For a harmful intervention to be liminally proper, consent must be present, and so must a strong public interest justification. Statutory authorisation may also be necessary, as discussed above, and it is present in the case of living organ donation. Even with all of this in place, I suggest that a harmful intervention can only ever be *liminally* proper at best (never clearly or paradigmatically proper). Harmful interventions where consent and/or public interest are *absent* cannot even be liminally proper. Whole practices that fall into this category might include female genital mutilation, extreme or multiple cosmetic procedures, and (perhaps less clearly) the amputation of healthy limbs as treatment for body integrity disorder. Individual interventions that belong in this category might include burdensome interventions upon dying patients: the resuscitation of a patient who is terminally ill and close to death, for example, or the aggressive treatment of an infection in a dying patient with antibiotics which cause unpleasant side effects. Insofar as such interventions cause suffering which is not outweighed by any meaningful gain in comfort or enhanced life expectancy, they too may be outside the boundaries of proper treatment.

In other cases therapeutic benefit is speculative or uncertain, but the intention in providing the treatment is clearly to *try* to benefit the patient. The provision of a risky or experimental new cancer treatment might be one example. Alternatively, although therapeutic potential for the patient is absent, there may be an overwhelming public interest in permitting the practice which may be sufficient to compensate for the absence of the therapeutic element. Penney Lewis discusses what she terms ‘new or controversial medical procedures’, such as ‘cosmetic surgery; circumcision and genital mutilation; contraceptive

sterilization; organ donation; non-therapeutic research; gender reassignment surgery; and amputation for body integrity disorder'.<sup>40</sup> These practices exist at the boundaries of proper medical treatment, and Lewis has explored how the medical exception might operate to bring them within it. My claim here is that the potential for recognising them as proper will depend on the extent to which *either* the therapeutic element can be made out, *or* its absence can be compensated by overwhelming public interest.

Much more could be said about all of this, and, in particular, about which categories particular practices and interventions belong in. Is living organ donation “positively harmful” to the donor, or just “not therapeutic”, for example? Different commentators will come to different conclusions about this and similar questions, but I want to sidestep such questions for the moment, since it is not necessary for present purposes to resolve the content of each of the categories which is entailed by my analysis so far. It will be necessary, however, before I can proceed to apply that analysis in the content of abortion, to summarise my argument and to sketch the (necessarily basic) typology of proper medical treatment that emerges from it.

### **A basic typology of proper medical treatment**

The essence of my argument so far has been threefold. First, proper medical treatment is wider than the medical exception. Second, as Sara Fovargue and I have argued elsewhere, within the category of proper medical treatment we can distinguish between ‘paradigm’, ‘clear’ and ‘liminal’ cases of proper treatment. Finally, developing the second point, I want to understand proper medical treatment as a spectrum. At one end of this spectrum are paradigm cases of proper treatment, treatment (i) where consent is both possible and clearly present, *and* (ii) which has clear therapeutic benefit for the patient being intervened upon. Further along the spectrum, there are cases where interventions ‘clearly’ constitute proper treatment

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<sup>40</sup> Lewis (n 17) 355.

because (i) they are justified, not by consent (because consent is impossible), but by some other patient-centred test such as necessity or best interests, *and* (ii) there is clear therapeutic benefit to the patients concerned. Further along still, interventions which are consensual may be proper notwithstanding that their potential for therapeutic benefit is either contested or non-existent, providing *either* that the intervention is not a clear harm which is not outweighed by (potential for) benefit (risky/experimental cancer treatment, for example), *or* that there are public interest considerations which weigh in favour of allowing the intervention to take place (if we construe live organ donation as a net harm to the donor, we may decide nonetheless, as UK law has done, that it ought to be permitted as a public good). This is the liminal zone of proper medical treatment; still proper but less *clearly* proper than the first two categories of treatment. If therapeutic potential is absent or contested, a treatment is either liminally proper or even improper, depending on the circumstances; but it is liminally proper *at best*.

Perhaps the most controversial category of liminal treatment is treatment where the patient lacks capacity and a procedure with no therapeutic value is performed. Infant male circumcision might be one example of this. Academic opinion is divided regarding whether this practice ought to be permitted; Margot Brazier has taken the view that '[a]lthough medical opinion may not necessarily regard [infant circumcision] as positively beneficial, it is in no way medically harmful if properly performed.'<sup>41</sup> Michael Thomson and Marie Fox, on the other hand, have criticised 'continued professional willingness to tolerate the non-therapeutic, non-consensual excision of healthy tissue.'<sup>42</sup> Another example is the non-therapeutic sterilisation of a patient who lacks capacity. This is permissible if it is authorised by a court; on the other hand, *therapeutic* sterilisation of a patient without capacity - for

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<sup>41</sup> M Brazier, *Medicine, Patients and the Law* (Penguin, 1992) 350.

<sup>42</sup> M Fox, M Thomson, 'A covenant with the status quo? Male circumcision and the new BMA guidance to doctors' (2005) 31 *Journal of Medical Ethics* 463.

example, to deal with a medical condition such as excessive menstruation or cancer - does not require such authorisation.<sup>43</sup>

When we pass the liminal area of the spectrum, we reach the realm of *improper* activity which includes non-consensual treatment of patients with capacity, treatment of patients who lack capacity which is not in their best interests, and activity carried out by non-qualified persons.<sup>44</sup>

The largest category is likely to be that containing paradigm cases of proper medical treatment, where consent and therapeutic benefit are both clearly established. The next largest category is probably ‘clearly proper’ treatment, where therapeutic benefit is not contested, but consent is substituted by another patient-centred justification. The liminal zone of proper treatment where therapeutic benefit is absent or contested will be a smaller category, followed by ‘improper activity’. As we travel along the spectrum from the paradigm case to the improper, therapeutic benefit tends to decrease. The only exception to that general trend is that at the ‘improper’ end of the spectrum, interventions will be improper regardless of clear therapeutic benefit if they are performed in the absence of a patient-centred justification (which must be consent in the case of a patient with capacity).

### **Abortion and proper medical treatment**

What light, if any, can the foregoing analysis of proper medical treatment shed on the status of abortion? I claimed in the introductory section of this chapter that it is useful to consider abortion in light of the emerging discussion about proper medical treatment for two reasons. First, because pro-choice activists have recently put the decriminalisation of the practice of abortion on the political agenda; decriminalisation would be likely to involve the removal of any *statutory* justification for the practice, so that surgical abortion would fall to be justified

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<sup>43</sup> J Herring, *Medical Law and Ethics* (5<sup>th</sup> edn, Oxford University Press, 2014) 281.

<sup>44</sup> Note that interventions performed negligently, or performed where consent is insufficiently informed, occupy a sub-category of *proper* treatment, albeit that they are not “properly” carried out.

in the same way as any other intrusive intervention. Second, because the concept of proper medical treatment is wider than just the medical exception. It is, I have claimed, a graduated concept, so that all treatment can be located somewhere on the spectrum of the proper. The issues at stake in lawful abortion have, of course, been considered thoroughly from a range of angles, but the lens of proper medical treatment offers yet another perspective from which to consider the practice.

One key measure in determining where practices ought to be located along the spectrum will be their potential therapeutic value; in other words, the extent to which we regard a practice as capable of serving patients' best interests, or offering them benefit. In the context of abortion, the state of modern medical science is such that '[lawful] abortion is almost always safer than (...) a full term birth'.<sup>45</sup> One recent US study found that '[t]he risk of death associated with childbirth is approximately 14 times higher than that with abortion', and that 'the overall morbidity associated with childbirth exceeds that with abortion'.<sup>46</sup> The implication of this is that in almost all cases, performing a safe, lawful abortion prevents a greater risk to maternal health, and on this basis it could be argued that where abortion is performed non-negligently and lawfully, it is *always* clearly therapeutic. Providing that clear consent is also present, then, on this view all safe and lawful abortion would always fall within the *paradigm* zone of proper medical treatment. Alternatively, recalling the passage above in which Fovargue and I discuss the factors that might render a practice liminal, it could be concluded that lawful abortion will always fall within the *liminal* zone of proper medical treatment, because it always involves the destruction of human life. Abortion always ends the life of an individual human entity, *regardless* of the reason for performing it. This is

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<sup>45</sup> A Furedi, 'Abortion is safe, and it should be as available as easily as contraception: the time has come to decriminalise it altogether' *The Independent* (London, 21 October 2014) <<http://www.independent.co.uk/voices/comment/abortion-is-safe-and-it-should-be-as-available-as-easily-as-contraception-9808803.html>> (accessed 1 December 2014).

<sup>46</sup> See, e.g., EG Raymond, DA Grimes, 'The comparative safety of legal induced abortion and childbirth in the United States' (2012) 119 *Obstetrics & Gynecology* 215, 215.

so even where it is performed in an emergency to save the life of the pregnant woman. We could choose to regard abortion as always liminal for this reason.

A discussion of abortion and proper medical treatment could end in either of these ways, and some may decide that it should. Others may be unsatisfied with an account which fails to take account of the diversity of abortion, however, and may consider that the fact that abortion is almost always safer than carrying a pregnancy to term fails to get to the heart of what is under discussion here. When we speak of an intervention being “therapeutic”, it could be argued that there is, implicit in this description, the idea of a link between the therapeutic *purpose* and the therapeutic *benefit*.<sup>47</sup> In other words, the intervention is performed *in order to produce* (or in the hope of producing) the contemplated benefit, and it is the potential for *that* benefit that contributes to the justification of the intervention (although, as I have noted already, some manner of patient-centred justification – consent, best interests, or necessity – must also be present). Abortion is permitted by the law in Scotland, England and Wales on any one or more of the following grounds:<sup>48</sup>

- A. that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated;<sup>49</sup>
- B. that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;<sup>50</sup>

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<sup>47</sup> See, e.g., S Fovargue, *Xenotransplantation and Risk: Regulating a Developing Biotechnology* (Cambridge University Press, 2012) 63.

<sup>48</sup> The convention of lettering the statutory grounds A-G is used by the Department of Health in England and Wales and the equivalent reporting body in Scotland when reporting the abortion statistics annually. See, e.g., Department of Health (DH), *Abortion Statistics, England and Wales: 2012* (DH, 2014). Schedule 1 of the Abortion Regulations 1991 No.499 uses the letters A-E, and Schedule 1 of the Abortion (Scotland) Regulations 1991 No. 460 (S41) uses A-G. Grounds A-E inclusive must be certified by two registered medical practitioners, whereas Grounds F and G (the emergency grounds) require certification only by a single practitioner.

<sup>49</sup> Abortion Act 1967, s 1(1)(c).

<sup>50</sup> Abortion Act 1967, s 1(1)(b).



- C. that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical and mental health of the pregnant woman;<sup>51</sup>
- D. that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical and mental health of any existing children of the family of the pregnant woman;<sup>52</sup>
- E. that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped;<sup>53</sup>
- F. that the termination is immediately necessary to save the life of the pregnant woman;<sup>54</sup> and
- G. that the termination is immediately necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman<sup>55</sup>

Officially, all terminations of pregnancy are performed on one or more of the above grounds. While it is not impossible that fear of childbirth or of the risks associated with carrying a pregnancy to full term may be the reason why some women seek to terminate their pregnancies, there is no way of estimating how many abortions, if any, are carried out for that reason. Given that childbirth and abortion are *both* very low-risk,<sup>56</sup> and that narratives about fear of childbirth do not seem to feature in explanations about why women require access to

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<sup>51</sup> Abortion Act 1967, s 1(1)(a).

<sup>52</sup> Abortion Act 1967, s 1(1)(a).

<sup>53</sup> Abortion Act 1967, s 1(1)(d).

<sup>54</sup> Abortion Act 1967, s 1(4).

<sup>55</sup> Abortion Act 1967, s 1(4).

<sup>56</sup> See, e.g., Raymond and Grimes (n 46) whose study ‘estimated mortality rates associated with live births and legal induced abortions in the United States in 1998–2005 by combining published data from several national data sets’ including ‘the Centers for Disease Control and Prevention’s Pregnancy Mortality Surveillance System, birth certificates, and Guttmacher Institute surveys’ and found that ‘[t]he pregnancy-associated mortality rate among women who delivered live neonates was 8.8 deaths per 100,000 live births’ and ‘[t]he mortality rate related to induced abortion was 0.6 deaths per 100,000 abortions’, 215.

safe, lawful abortion, it makes sense to assume that the vast majority of abortions are carried out for other reasons. In any case, if we accept the argument that ‘therapeutic’ implies a link between therapeutic *purpose* and therapeutic *benefit*, the fact that abortion always removes the greater (but still slight) risk to health associated with childbirth establishes the procedure’s therapeutic nature *only where it is carried out for this purpose*. In all other cases, whether abortion is therapeutic must be established and cannot simply be presumed.

Abortion will clearly satisfy the ‘therapeutic’ test where it is performed on one of the emergency grounds (F or G). The rubrics of Grounds A, B, and C also presuppose that where an abortion is performed, this is in order to avoid a risk to the pregnant woman’s life (Ground A), to prevent grave permanent physical or mental harm (Ground B), or otherwise to protect her physical or mental health (Ground C). Where abortion is performed in order to avoid risks like these, its therapeutic value seems straightforward. Whether such a risk is genuinely present in a given case is, of course, an empirical question, and, as such, whether abortion in a particular case is *in fact* therapeutic will depend on whether there is genuinely a reasonable perception of the relevant risk (that is, the risk specified in the statutory ground being utilised) on the part of the certifying practitioner(s). In this regard, there is a particular issue around the interpretation and use of ground C to allow practitioners to provide abortions which are not genuinely therapeutic in the medical sense (discussed below). Abortions provided only under grounds D and E are also explicitly *not therapeutic for the woman*. Ground D refers to the risk to the existing children of the pregnant woman’s family, and ground E to foetal abnormality. Where an abortion is performed to avoid risk to existing children or to terminate a pregnancy due to foetal abnormality, this cannot be construed as therapeutic for the pregnant woman herself, unless her own mental or physical health is jeopardised by these circumstances. If the latter is the case, the abortion will be justifiable not *only* under sections D or E, but also under one of the other grounds, and can be regarded as

therapeutic on *that* basis. Grounds D and E do not refer to the woman's health, and so do not by themselves set out any therapeutic basis for abortion.

Focusing on the straightforwardly therapeutic grounds A, B, F, and G for the moment, what proportion of all abortion is being represented as 'therapeutic' on one of these grounds? In Scotland, the numbers and percentages of abortions carried out under grounds A, B, F, and G are almost invariably suppressed 'due to the potential risk of disclosure'.<sup>57</sup> In other words, the numbers in these categories are so small that their publication may result in a reader being able to identify an individual from the statistics.<sup>58</sup> It is impossible to know with any certainty the numbers and/or percentages of abortions carried out in Scotland under grounds A, B, F, and G, not only because the direct data on those grounds is suppressed, but also because certifications of abortion may cite more than one statutory ground. It is thus not possible simply to calculate the total numbers/percentages of abortions performed under grounds C, D, and E and deduct that total from the overall total in order to arrive at the combined figure for grounds A, B, F, and G. Nevertheless, this method can tell us the combined percentage of abortions carried out under grounds A, B, F, and/or G *only* (that is, abortions which cite one or more of those grounds but do not also cite grounds C, D, and/or E). It reveals that the percentage of abortions carried out in 2012 and 2013 which cite *only* grounds A, B, F, and/or G is under 1% (because the combined percentages for grounds C, D, and E in those two years total 100%), and that the percentage of abortions carried out in 2010 and 2011 which cite *only* grounds A, B, F, and/or G was 0.1% at most in each of those years.

Because England and Wales has a much larger population than Scotland, the risk of identification is lower; accordingly, the figures for England and Wales are reported. The reported statistics for England and Wales reveal that in 2010 '[g]rounds A and B together

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<sup>57</sup> This is the form of words used in the published statistics.

<sup>58</sup> The reporting of abortion statistics for Scotland follows the guidance on disclosure of information in relation to 'sensitive topics' contained in the Information Services Division (ISD) Scotland's *Statistical Disclosure Control Protocol Version 2.3* (2012) <[http://www.isdscotland.org/About-ISD/Confidentiality/DISCLOSURE-PROTOCOL-VERSION-2-3\\_FULLVERSION.PDF](http://www.isdscotland.org/About-ISD/Confidentiality/DISCLOSURE-PROTOCOL-VERSION-2-3_FULLVERSION.PDF)> (accessed 1 December 2014).

accounted for *less than a quarter of one per cent* of abortions’,<sup>59</sup> and that in each of 2011, 2012, 2013 ‘[g]rounds A and B together accounted for *about a tenth of one per cent* of abortions’, that is approximately 0.1%.<sup>60</sup> In relation to grounds F and G, the most recently reported statistics note that ‘[a]bortions are rarely performed under grounds F or G. In the past 10 years, 4 such abortions have been performed, 1 in each of years 2006, 2011, 2012 and 2013’.<sup>61</sup>

The vast majority of lawful abortions in the UK are performed under ground C. In England and Wales, 98% of all abortions in 2011,<sup>62</sup> 97% of all abortions in 2012,<sup>63</sup> and 97% of all abortions in 2013<sup>64</sup> were carried out under it; almost always under its ‘risk to mental health’ aspect (99.96%,<sup>65</sup> 99.94%,<sup>66</sup> and 99.84%<sup>67</sup> of ground C abortions in 2011, 2012, and 2013, respectively). The picture in Scotland is similar; 94%,<sup>68</sup> 93%,<sup>69</sup> and 94.5%<sup>70</sup> of abortions were carried out under ground C in 2010, 2011, and 2012, respectively, with the

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<sup>59</sup> DH, *Abortion Statistics, England and Wales: 2010* (DH, 2011) 8, emphasis supplied: <[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215584/dh\\_127202.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215584/dh_127202.pdf)> (accessed 1 December 2014). Hereafter, e.g., DH, *ASEW: 2010*.

<sup>60</sup> DH, *Abortion Statistics, England and Wales: 2011* (DH, 2012) 8 <[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213386/Commentary1.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213386/Commentary1.pdf)>; DH, *Abortion Statistics, England and Wales: 2012* (DH, 2013) 12 <[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/307650/Abortion\\_statistics\\_\\_England\\_and\\_Wales.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307650/Abortion_statistics__England_and_Wales.pdf)>; DH, *Abortion Statistics, England and Wales: 2013* (DH, 2014) 12, emphasis supplied <[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/319460/Abortion\\_Statistics\\_\\_England\\_and\\_Wales\\_2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics__England_and_Wales_2013.pdf)> (all accessed 1 December 2014).

<sup>61</sup> DH, *ASEW: 2013* (n 60) 12.

<sup>62</sup> DH, *ASEW: 2011* (n 60) 8.

<sup>63</sup> DH, *ASEW: 2012* (n 60) 12.

<sup>64</sup> DH, *ASEW: 2013* (n 60) 12.

<sup>65</sup> DH, *ASEW: 2011* (n 60) 8-9.

<sup>66</sup> DH, *ASEW: 2012* (n 60) 12.

<sup>67</sup> DH, *ASEW: 2013* (n 60) 12.

<sup>68</sup> ISD Scotland, *Abortion Statistics: Year ending 31 December 2010* (ISD Scotland/ National Statistics, 31 May 2011) 12 <<http://www.isdscotland.org/Health-Topics/Sexual-Health/Publications/2011-05-31/2011-05-31-Abortions-Report.pdf>> (accessed 1 December 2014).

<sup>69</sup> ISD Scotland, *Abortion Statistics: Year ending 31 December 2011* (ISD Scotland/ National Statistics, 29 May 2012) 13 <<http://www.isdscotland.org/Health-Topics/Sexual-Health/Publications/2012-05-29/2012-05-29-Abortions-Report-2011.pdf>> (accessed 1 December 2014).

<sup>70</sup> ISD Scotland, *Abortion Statistics: Year ending 31 December 2012* (ISD Scotland/ National Statistics, 28 May 2013) 13 <<http://www.isdscotland.org/Health-Topics/Sexual-Health/Publications/2013-05-28/2013-05-28-Abortions-Report.pdf>> (accessed 1 December 2014).

figure increasing to 98.6% in 2013.<sup>71</sup> Ground C is sometimes referred to as the ‘social ground’, because it is acknowledged to be interpreted liberally so as to effectively allow “abortion on demand”. Ann Furedi, Chief Executive of the British Pregnancy Advisory Service (BPAS), a private abortion provider, has claimed that ‘[w]e all know, if we are honest, that ground C is a kind of code for “it’s an unwanted pregnancy”’.<sup>72</sup> Furthermore:

at the moment (...) women have to pretend they will have a nervous breakdown if they continue the pregnancy, and doctors pretend to believe them. The current situation makes actors of both women and doctors; it would be far better if the law was explicit and if women were able to obtain an abortion because the pregnancy is unwanted.<sup>73</sup>

Furedi’s organisation is actively campaigning for the complete decriminalisation of abortion and the removal of the current statutory requirements, and for abortion to be treated by the law as a women’s rights issue, rather than as a criminal/medical matter.<sup>74</sup> In the context of that campaign, it makes strategic sense to acknowledge that the decision to terminate a pregnancy often has no “medical” basis, and that, except in cases where a woman’s health is genuinely at risk from the continuation of her pregnancy, abortion is more accurately regarded as a matter of personal choice with no ‘therapeutic’ imperative. Furedi highlights the pretence of women and their doctors around the mental health aspect of ground C in order to demonstrate that the 1967 Act fails to reflect modern social reality. Nowadays (the

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<sup>71</sup> ISD Scotland, *Abortion Statistics: Year ending 31 December 2013* (ISD Scotland/ National Statistics, 27 May 2014) 14 <<https://isdscotland.scot.nhs.uk/Health-Topics/Sexual-Health/Publications/2014-05-27/2014-05-27-Abortions2013-Report.pdf?14501589537>> (accessed 1 December 2014).

<sup>72</sup> A Furedi, ‘Are there too many abortions?’ (Winter 2008/9) *Special Edition 2 Abortion Review Special Edition: Abortion and Women’s Lives (Papers from the BPAS conference, London 25-26 June 2008)* 3 <[http://www.abortionreview.org/images/uploads/AR\\_SpecialEdition\\_2.pdf](http://www.abortionreview.org/images/uploads/AR_SpecialEdition_2.pdf)> (accessed 1 December 2014).

<sup>73</sup> Furedi (n 72) 3-4.

<sup>74</sup> *BPAS Reproductive Review* (n 6).

argument goes), abortion is ‘widely accepted as “part of life”’,<sup>75</sup> and understood as matter of personal choice, and a right. As such, the decision to terminate or continue with a pregnancy is properly a decision for the pregnant woman herself. If *she* decides that she needs an abortion, she should have access to it regardless of her reasons. It is highly undesirable that women and their doctors are forced to pretend that the reason for the termination is a ground C reason, and the law should change so that such pretence is no longer necessary.

It is not my concern here to approve or disapprove of this as a campaigning narrative; it is relevant to the present discussion, however, insofar as it implies that many ground C abortions may not be therapeutic in the sense envisaged by the 1967 Act. As Sally Sheldon has observed, ‘in the vast majority of cases (...) the request for abortion is not grounded primarily in medical factors’.<sup>76</sup> Claiming that a procedure is non-therapeutic (in the medical sense) is not the same as claiming that it is undertaken in a ‘frivolous or unconsidered’ manner.<sup>77</sup> Nevertheless, according to my analysis here, if a significant number of ground C terminations have no potential for therapeutic value (unless we take refuge in the “abortion is almost always safer than childbirth” formulation, which, I have argued, is of no assistance in this context), the status of these interventions as proper medical treatment must be liminal at best.

So far as ground C is concerned, each individual intervention would need to be judged on its merits; the above-quoted statements by Furedi and Sheldon certainly suggest that many ground C abortions may not be therapeutic, but the wording of the ground itself permits abortion *only* for therapeutic reasons. In contrast with this, any reference to therapeutic value *for the patient* is missing from the wordings of grounds D and E. Applying the basic typology of proper medical treatment that I set out in the first part of this chapter, where therapeutic

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<sup>75</sup> *BPAS Reproductive Review* (n 6).

<sup>76</sup> S Sheldon, ‘The Abortion Act’s paternalism belongs to the 1960s’ *The Guardian* (London, 22 March 2012) <<http://www.theguardian.com/law/2012/mar/22/abortion-act-needs-reform>> (accessed 1 December 2014).

<sup>77</sup> Sheldon (n 76).

value is absent (as it is on a literal reading of grounds D and E, and *de facto* in an unknown number of ground C cases), an intervention may still have the status of proper treatment if it is clearly in the public interest to permit it. I suggested earlier that living organ donation is an example of treatment which is proper *and* permitted despite lacking therapeutic benefit for the patient who is the subject of the intervention. In that case, the overriding public interest consideration could be framed as an interest in encouraging altruism, or in addressing the chronic shortfall in donor organs, or both. In the abortion context, public interest considerations would need to be framed carefully, particularly where ground E is concerned. Any public interest consideration would presumably need to be constructed so as to avoid creating norms that discriminate against people with disabilities, or devalue their lives. The most likely public interest justifications in the abortion context would be ones formulated in terms of child welfare (grounds D and E), or in terms of respecting autonomy and choice. It will be for others to identify and frame the relevant justifications. My purpose here is only to point out that public interest or public good type justifications will be necessary. If a sufficient public interest justification *can* be made out, then even a non-therapeutic abortion can be proper, just as living organ donation can; although, according to my typology, it will be liminally so.

In the absence of a compelling public interest justification, non-therapeutic interventions *cannot*, I argue, be proper medical treatment. What might the implications be of some abortions *not* qualifying as proper medical treatment? First, were existing laws governing abortion to be repealed, *surgical* abortions would require the benefit of the medical exception, not because abortion *per se* is criminal, but because surgical intrusions in general involve a greater level of intrusion than consent alone can mitigate. One consequence of my argument is that if the existing statutory justification were to be removed, surgical abortions could only benefit from the medical exception if they could be regarded as proper medical

treatment. Where abortion is clearly therapeutic, and the appropriate patient-centred justification is present, its status as proper medical treatment is unproblematic. If the patient-centred justification takes the form of *consent*, a paradigm case of proper medical treatment is constituted. If the patient is unconscious or lacks capacity, and the abortion is performed on grounds of necessity or best interests, it will, so long as it is therapeutic, be a clear case of proper medical treatment. A *non-therapeutic* intervention upon a patient who lacks capacity would be *improper*. Where there is no potential for therapeutic benefit, however, an intervention can only qualify as proper medical treatment if consent *and* an overriding public interest can be established, as in the case of living organ donation. Even then, the status of the treatment will be liminal at best.

My suggestion here, and I acknowledge that this will be controversial, is that abortions carried out *only* under grounds D and E, and those where ground C has been deployed in the way described by Furedi and Sheldon, can qualify as *liminally* proper treatment only if an overriding public interest justification can be identified. If no such justification can be made out, they cannot count as ‘proper medical treatment’ at all. The latter possibility might be viewed as an opportunity to demedicalise abortion, wresting control of the process away from doctors and the state, and giving it to women for the first time.<sup>78</sup> In addition it could offer a solution to the issue of conscientious objection.<sup>79</sup> But it also raises the possibility that if the existing statutory framework were to be removed, surgical abortions, lacking the benefit of the medical exception, would become vulnerable under the criminal law.

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<sup>78</sup> Sheldon (n 76).

<sup>79</sup> See, e.g., JK Mason, RA McCall Smith, GT Laurie, *Law and Medical Ethics* (6<sup>th</sup> edn, Butterworths, 2002), 175: ‘a logical case can be made, and a major ground for confrontation thereby removed, for delegating abortions which have no immediate therapeutic dimension to trained abortionists’.



## Conclusion

The medical exception demarcates the boundary between the proper and the improper. I have argued that on the “proper” side of that boundary there exists a spectrum of proper medical treatment, within which some treatments are more *clearly* proper than others. Furthermore, the *therapeutic value or potential* of treatments plays a key role in determining where we ought to locate them on that spectrum. Treatment that lacks therapeutic value *may* be “proper” if consent is clearly present *and* an overwhelming public interest justification exists (as in the case of living organ donation), but it can only ever be *liminally* proper. It is certainly not paradigmatic of proper treatment, since the paradigm case of such treatment involves *both* consent *and* a reasonable expectation of therapeutic value. It is also too far away from the paradigm case to count as “clearly” proper. Treatment without therapeutic value or potential is either liminally proper (at best) or improper, depending upon the other circumstances of the case.

Having rejected *both* the suggestion that all abortion is automatically therapeutic because birth is riskier, *and* the possibility that abortion can only ever be liminally proper at best because it always involves the destruction of human life, I have argued that whether abortion counts as “proper medical treatment” (and if so, how *clearly* proper it is) is something that can be determined only on a case-by-case basis. Nevertheless, proposals for decriminalising abortion completely ought to bear in mind that, at least so far as surgical interventions are concerned, the complete exclusion of the criminal law is impossible (given that *all* surgery depends upon a ‘medical exception’ to the criminal law), and interference with the current statutory framework may, in fact, leave the practice more, rather than less, vulnerable. Accordingly, law reform proposals should be cognisant of the need for a governing statute which provides explicit authorisation for abortion.