The role of law in promoting reproductive autonomy: English and Chinese regulatory models of abortion

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Abstract

This thesis provides a normative exploration of abortion law in England and China from a feminist, ethical and comparative standpoint. It proceeds from the assumption that legal regulation of abortion should take account of the principle of respect for autonomy.

While I accept that the value of embryos and putative fathers' interests should be accorded recognition, I argue that legally women's autonomy should be given priority in abortion decisions. Following my discussion of traditional ethical accounts of the concept of 'autonomy', I argue that women's exercise of autonomy over abortion decisions is essential to satisfy their basic needs for health and for control over their lives. I expand upon the traditional account of the principle of respect for autonomy by employing a broadly liberal feminist approach. I argue that this approach to empowering women in abortion decisions is more constructive because it not only requires law makers to protect women's decision-making from controlling influences, but also advocates law's commitment to a female-friendly environment where medical and state support are accessible. While the concept of 'autonomy' is close to liberalism, I also draw upon the radical, global and multi-cultural schools of feminist thought. Following my investigation of the English and Chinese regulatory models of abortion, I argue that the main reason for women's lack of control over their autonomously held abortion decisions is that these two models have produced the power imbalance in the two key relationships: one between women who need abortion and health professionals and the other between female citizens and the state. I also suggest that the differences between the English and Chinese politico-legal systems do not rule out the possibility that their law makers can learn from each other's regulatory experiences. Thus, this comparative study provides a basis for drawing up proposals for the reform of the two models.

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Chapter 1

Introduction

1. Reflections on the 'Back-street' Abortion Market in and between England and China

In 2007, the *BBC News* highlighted the problem of selling abortifacient pills in several Chinese herbal shops located in the east of London.[1] A BBC undercover reporter posing as a woman seeking an abortion paid £100 for termination drugs in one of those shops and then found that these drugs were actually RU486, which have been legalised in England but can be only be lawfully used in hospitals and authorised private medical sector units. The staff of this shop claimed that the drugs had been ordered and delivered from China. In the same year, *Souyao*, a Chinese online news website, reported that UK-made pills were sold unlawfully in some shops on *Taobao*, which is the biggest Chinese one-stop online platform similar to *Ebay* and *Amazon*. While knowing that it was illegal to buy abortion drugs without a physician's prescription and surveillance, many anonymous users commented that it was a more convenient and cost-effective choice compared with legal medical abortion services. After ¥100 (about £10) was paid, pills were delivered to buyers nationwide. Some *Taobao* shops were also targeted at overseas buyers and delivered pills to customers worldwide.[2] Thus, there is a possibility that those unlawful tablets sold in the London shop were produced in the UK and then returned to the UK from one of the Chinese *Taobao* shops. These drugs could have travelled halfway around the

[1] BBC News (23 November 2007) 'Illegal Abortions Still Blight UK' available at http://news.bbc.co.uk/1/hi/health/7108026.stm (last accessed 23 April 2011)

[2] SouYao (4 July 2007) '*Taobao* Gongkai Jiaomai Liuchanyao' available at http://www.souyao.com.cn/html/9372/9373/10356.shtml (last accessed 23 April 2011)

world and finally returned to their place of production with an increase of ten times its original price.

This is not a thesis about the English or Chinese black market for abortion drugs *per se*, so I shall stop further exploring the sophisticated and subtle connections between the above two phenomena. However, even as two separate issues, their emergence raises the question of why, in these two jurisdictions where abortion has been legalised for nearly a half century, back-street termination still has its market and some women still have to resort to illegal means of abortion even though they know that it is less likely to be reliable. While it is agreed that unsafe back-street abortions mainly exist in areas where abortion laws are highly restrictive,[3] the above phenomena suggest that even in comparatively less restrictive jurisdictions, women's needs for safe termination services are not well satisfied and they may have to take a risk in seeking unreliable abortion providers. In 1967 and the late 1970s, England and China both legalised abortion. So far termination has been decriminalised in the regions of the world where 62 per cent of the global population lives.[4] It seems that the current tendency towards legalising abortion represents a success in feminism or a sign of winning the struggle for a woman's right to choose. Nevertheless, I argue that feminists should be more critical of the current legal position in England and China. Safe and accessible abortion services are not only essential to the satisfaction of women's needs for health, but also to gain control over life choices. Although today both English and Chinese women's chances to access legal abortions are considerably increased by comparison with those days when there was a complete ban, I doubt whether the

[3] Ina Warriner (2006) 'Unsafe abortion: an overview of priorities and need' in Ina K. Warriner and Iqbal H. Shad (eds.) *Preventing Unsafe Abortion and Its Consequences* (U.S.A: Guttmacher Institute) p.vi and Maja Kirilova Eriksson (2001) 'Abortion and Reproductive Health: Making International Law more Responsive to Women's Needs' in Kelly Askin and Dorean Koening (eds.) *Women and International Human Rights Law* (New York: Transnational Publisher) p.6

[4] Rebecca Cook and Bernard Dickens (1978) 'A Decade of International Change in Abortion Law: 1967-1977' 68(7) *American Journal of Public Health* 637-644 p.638

existing regulatory model of abortion can meet women's basic needs for health and for control over their daily lives.

Raymond has reminded feminists to be wary of 'reproductive liberalism'. It superficially looks like a female-friendly concept by comparison with reproductive conservatism, but in fact could do little to ensure gender justice. This is because 'reproductive liberalism' may provide women with 'a supposed liberty that requires women to give up more freedom' and 'a right to privacy that is more accurately a right to private privilege for men (and some women)'.[5] With this observation and the above discussion of the back-street abortion market in mind, the existing English and Chinese regulatory models of abortion deserve an in-depth analysis. Why do some women still resort to back-street providers under a regulatory model that has legalised abortion? Was the conditional decriminalisation of abortion achieved at the expense of women's decision-making in England and China? If so, why are women not granted the ultimate right to make abortion decisions? Are there any factors that are not female-friendly behind the English and Chinese law-making on abortion? If so, what are they? And what are the reasons why the English and Chinese models of the regulation of abortion cannot meet women's needs for health and for control over their lives? These questions in relation to both the abortion 'law in the books' and access to termination services in practice inform objectives for this thesis that are outlined below.

2. A Global Context of Abortion

By engaging with questions such as those listed above, this thesis conducts a critical and comparative study of the English and Chinese models of the regulation of abortion. In general, I

[5] Janice Raymond (1993) *Women as Wombs* (USA: Spinifex Press) p.77

attempt to achieve three goals in this thesis. Before discussing these objectives, I will give a brief introduction to a global context of abortion provision and regulation.

At the end of the twentieth century, two international conferences – the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing (FWCW) highlighted the pressing need for work in improving safe termination of unintended pregnancies and also raised people's awareness of women's needs for reproductive health. Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unwanted pregnancy done by persons who may lack the necessary skills or conducted in an environment that lacks the minimal medical standards, or both.[6] According to a WHO report issued in 2001, it is estimated that worldwide around 53 million abortions are performed every year; about two out of five abortion procedures are unsafe and between 100,000 and 200,000 women die of unsafe abortion.[7] Therefore, the 1994 ICPD and the 1995 FWCW considered unsafe abortion as a major public health concern and emphasised that legal and safe termination of unwanted pregnancy is one of women's basic needs.

While the reasons for and causes of back-street abortions are various, according to research on unsafe terminations from different disciplines, many scholars believe that legally restrictive domestic abortion law is to blame. For example, Warriner notes:

> Broadly speaking, where there is no legal restriction, abortion services are likely to be safe. In these settings, the abortion is performed in a regulated medical setting and the providers are properly trained. In contrast,

[6] The World Health Organisation (2003) 'Technical and Policy Guidance for Health System' available at http://whqlibdoc.who.int/publications/2003/9241590343.pdf (last accessed 06 February 2012)
[7] The World Health Organisation (2001) 'Women's Health: Western Pacific Region' available at http://www.wpro.who.int/internet/files/pub/360/141.pdf (last accessed 27 April 2011)

where abortion laws are highly restrictive, women turn to clandestine providers with a high risk of incurring a serious or life-threatening complication.[8]

Eriksson has also commented that because of the tendency in the international community to recognise the negative effects of unsafe terminations on women's health, the necessity for decriminalising abortion has been gradually accepted by national law makers.[9] While I agree that high maternal morbidity caused by women resorting to unsafe terminations is a justification for legalising and promoting abortion services, it is not and should not be the only one. According to the above mentioned WHO reports and many international human rights scholars' arguments for a liberal abortion law, the most acceptable reason for legalising abortion is that a restrictive law will force women to resort to back-street providers and lead to high maternal mortality and morbidity.[10] As discussed earlier in this chapter, access to safe abortion services is not only essential for satisfying women's needs for health, but also for meeting their needs for control over their everyday lives. Focusing the importance of safe termination of pregnancy only on health-related issues or medical elements could lead to ignoring the fact that it is part of women's basic needs for control over their everyday lives. However, satisfying women's needs for health and for control in the context of abortion is not an either/or situation. In chapter 2 of this thesis, I will examine how both of these needs can be achieved by law regulating abortion in accordance with the principle of respect for autonomy.

[8] Ina Warriner (2006) p.2 and also Rebecca Cook and Bernard Dickens (1999) 'International Developments in Abortion Law from 1988 to 1998' 89(4) *American Journal of Public Health* 579-586 and (2003) 'Human rights dynamics of abortion law reform' 25(1) *Human rights quarterly* 1-59

[9] Kirilova Maja (2001) 'Abortion and Reproductive Health: Making International Law more Responsive to Women's Needs' in Kelly Askin and Dorean Koening *Women and International Human Rights Law* (New York: Transnational Publisher) p.49

[10] Ina Warriner (2006) and Rebecca Cook and Bernard Dickens (2003)

3. Objectives

Let's return to the three broad goals of this doctoral study. The first is to examine three issues in the context of abortion: the principle of respect for autonomy, feminism and law. The investigation of these three issues conducted in this thesis also aims to address three questions: first, how to properly understand the principle of respect for autonomy in abortion decisions and its importance to women; second, what role law ought to play in regulating abortion services in accordance with this understanding; and third, how to introduce and translate the principle of respect for autonomy into the English and Chinese abortion regulatory systems.

My second objective is to assess the extent to which women's autonomy is restricted under the English and Chinese models of the regulation of abortion and to explore the possible reasons for law's lack of respect for autonomy. This helps the reader to understand why these two models fail to treat women who need abortion as autonomous decision makers and how this failure has negative effects on women, particularly those who are socioeconomically disadvantaged. Moreover, scrutinising the causes of abortion law's lack of respect for women's autonomy in abortion decisions is helpful in exploring the nature of the regulation of the issues in relation to women's reproduction.

My third purpose is to suggest feasible proposals for the reform of English and Chinese abortion laws by contrasting their regulatory models of abortion. Thus, a comparative study of the English and Chinese models of the regulation of abortion is provided, which assesses their merits and shortcomings in the way in which women's decision-making concerning reproduction is treated. This comparative study is also targeted at examining the power imbalance in two key relationships: the first is between women who need abortion and health professionals and the second is between female citizens of reproductive age and the state.

4. Parameters and Analytical Approaches

This thesis is built on ethico-legal, feminist legal, and comparative legal analyses of primary and secondary sources. The former sources mainly include primary and secondary legislation, cases, and governments' political documents, reports and statistics relating to abortion in England and China. The regulation of abortion in Northern Ireland and in two special administrative regions in China (Hong Kong and Macau) are not included because the current English and Chinese laws of abortion do not extend to these regions. While the law of abortion in England applies to Scotland and Wales, this thesis focuses on abortion law and practice in England and the use of the terminology of 'English' and 'England' is also for convenience. The secondary sources in this work include relevant international books, articles, reports, surveys, conference papers and internet resources.

4.1. A Feminist Legal Analytical Approach

Feminist scholars from different theoretical standpoints, such as liberal, radical, post-modern, multicultural, global and third-wave may have very different views on the same issue. As Tong has observed, the diversity of modern feminist thinking means that feminism is not 'a monolithic ideology' and 'all feminists do not think alike'.[11] At the beginning of my doctoral project, I struggled to find out which school of feminist thought is most helpful in developing a critical legal study of the English and Chinese laws of abortion. Given that the extent to which feminism is accepted and women's consciousness of reproductive rights is raised is different in England

[11] Rosemarie Tong (1997) Feminist Approaches to Bioethics: Theoretical Reflections and Practical Applications (USA: Westview Press) p.129 and (2009) *Feminist Thought: A more Comprehensive Introduction* (U.S.A: Westview Press) p.1

and China,[12] a single school of feminist thought is not enough to analyse the problems with access to abortion services in these two different jurisdictions. Furthermore, because of different legal and political contexts, reproductive autonomy in abortion decisions can have different meanings for English and Chinese women. For example, as will be discussed in chapters 3 and 4, in England law's embrace of the medicalisation of abortion means that pregnant women may experience more difficulties in acting on their desires to end their pregnancies compared with acting on their desires for childbirth.[13] In China, due to the close connection between the state's policy-making on population figures and its law-making on abortion, the promotion of autonomy in abortion decisions includes protecting women's right to refuse involuntary termination of pregnancy 'by order'.[14] Thus, it is problematic to restrict the feminist approach used in this thesis to a particular school of feminist thought. In addition, as Tong has argued, it is theoretically impossible to categorise today's feminist theories.[15] She comments:

> Any attempt to categorize feminist thought will serve only to invite criticism from a variety of feminist thinkers, each of whom will have good reason either to amend or reject the proposed categorization as limited or wrongheaded.[16]

Apart from categorising feminist thought, defining feminism itself, particularly in the academic arena is not an easy task. The diversity of feminist thinking means that feminist scholars are not likely to accept a single explanation of the value and purposes of feminist studies. While a detailed analysis of feminism could easily grow into a book, I accept that in brief, feminism can

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[12] Dorotby Ko and Wang Zheng (2007) *Translating Feminisms in China* (Oxford: Blackwell) p.11 and Jing Bao Nie (2004) 'Feminist Bioethics and the Language of Human Rights in the Chinese Context' in Rosemarie Tong Anne Donchin and Susan Dodds (eds) *Linking Visions* (Oxford: Rowman & Littlefifield Publishers) p.74

[13] See chapters 3 and 4 and also Sally Sheldon (1997) *Beyond Control: Medical Power and Abortion Law* (London: Pluto); Michael Thomson (1998) *Reproducing Narrative* (Aldershot: Ashgate) and Ellie Lee (2003) *Abortion, Motherhood and Mental Health* (London: Aldine de Gruyter)

[14] See chapter 4 and also Jingbao Nie (2005) *Behind the Silence* (Oxford: Rowman & Littlefield Publishers) p.51

[15] Rosemarie Tong (2007) 'Feminist Thought in Transition: Never a Dull Moment' 44(1) *The Social Science Journal* 23-39 p.23

[16] Ibid.

be considered as the study of or the struggle for 'the liberation of women from the oppressive circumstances of patriarchal cultures'.[17] This definition provides an overview of some basic characterisations of feminism, though modern feminist work is not restricted to females anymore. Feminism also involves studying men, transgendered persons, animals and human embryos.[18] Since this thesis discusses the regulation of abortion, the main concern of my doctoral study is women.

While the feminist legal analytical method in this thesis is not restricted to a particular feminist theory, liberal feminism provides the theoretical base for this study. This is because, as will be shown in chapter 2, the principle of respect for autonomy is closely linked to liberalism.[19] The values that are derived from this principle, such as liberty, freedom, equality and self-determination, are helpful in offering solid grounds for feminist fights for reproductive rights.[20] Nonetheless, the liberal feminist approach adopted in this thesis not only advocates law's protection of women's independence in abortion decisions, but also suggests that law should recognise and respect their interdependence in accessing abortion services. In chapter 2 I will scrutinise how women's exercise of autonomy over reproductive decisions can be enhanced by reconstructing their relationships with health professionals and the state. Furthermore, as will be indicated in chapter 4, the liberal feminist approach will be particularly productive in the Chinese

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[17] John Christman (1995) 'Feminist and Autonomy' in Bushnell, Dana (ed) *"Nagging" Questions*, (USA and England: Rowman & Littlefield Publishers) p.17

[18] Paul Smith (1987) 'Men in Feminism: Men and Feminist Theory' in Alice Jardine and Paul Smith (eds) *Men in Feminism* (New York: Routledge) pp.33-40;
Andrew Sharp (2000) 'Transgender Jurisprudence and the Spectre of Homosexuality' 14(March) *The Australian Feminist Law Journal* 23-37 and Marie Fox (2009) 'Legislating Interspecies Embryos' in Stephen Smith and Ronan Deazley (eds) *Transformation/Transgression: The Legal, Medical And Cultural Regulation Of The Body* (Aldershot: Ashgate)

[19] See chapter 2 and also Gerald Dworkin (1988) *The theory and practice of autonomy* (Cambridge: Cambridge university press) pp.12-13and Onora O'Neill (2002) *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press) p.29

[20] Frankfurt Harry (1971) 'Freedom of the Will and the Concept of a Person' 68(I) *The Journal of Philosophy* 5-28 and Onora O'Neill (2002) pp.49-50

context because it is helpful in raising women's awareness of procreative freedom and exploring many 'unnamed'[21] problems caused by law's infringement of their reproductive rights.

However, other schools of feminist thinking are also adopted in this thesis. For instance, in chapter 5 I will be critical of law's usefulness in enforcing gender equality. This discussion is also reliant on radical feminist thought, which focuses on the issues of power, gender relations and social construction.[22] Furthermore, because this thesis involves abortion law in two different legal, political and cultural contexts, the feminist analysis in this study includes global and multicultural feminist thought. According to global feminist thinking, gender equality should be achieved at a global level. As Bunch notes:

> The oppression of women in one part of the world was often affected by what happen(ed) in another, and that no woman could be free until the conditions of oppression of women were eliminated everywhere.[23]

Nonetheless, a global level of gender equality is not a goal that can be achieved in the near future. My analysis of law's lack of respect for women's autonomy in England and China suggests that even pursuing gender equality at a single jurisdictional level is not an easy short-term task. Nevertheless, with this goal in mind, feminists in different nations should share their experience of engaging with their domestic laws.[24] To facilitate their experience-sharing, multicultural feminist thought is required in order to dispel misunderstandings and to create alliances among women from different cultural backgrounds.[25] As Bottomley, Gibson and Meteyard have argued,

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[21] JingBao Nie (2004) 'Feminist Bioethics and the Language of Human Rights in the Chinese Context' in Rosemarie Tong Anne Donchin and Susan Dodds (eds) *Linking Visions* (Oxford: Rowman & Littlefifield Publishers) p.80

[22] Ngaire Naffine (1990) *Law and the Sexes: Explorations in Feminist Jurisprudence* (London: Allen & Unwin); Virginia Held (1993) *Feminist Morality* (London: The University of Chicago Press) and Nicola Lacey (1998) *Feminist Essays in Legal and Society Theory* (Oxford: Hart Publishing)

[23] Charlotte Bunch (1993) 'Prospects for Global Feminism' in Alison Jaggar and Paula Rothenberg (eds) *Feminist Frameworks* (New York: McGraw-Hill) p.249

[24] Anne Bottomley, Susie Gibson and Belinda Meteyard (1987) 'Dworkin: Which Dworkin? Taking Feminism Seriously' 14(1) *Journal of Law and Society* 47-60 p.49

[25] Rosemarie Tong (2007) pp.30-31

developing feminist legal studies should welcome the work of 'non-white' feminists from 'less advantaged backgrounds' and compare their work with the work of white academic feminists from the 'position of relative privilege'.[26]

In general, the feminist analysis offered in this thesis is committed to developing the literature on feminist legal studies. Specifically, it aims to scrutinise how women's reproductive decision-making is restricted under the English and Chinese regulatory models of abortion and to explore the underlying causes of English and Chinese laws' lack of respect for autonomy. Law reflects society, makes normative statements and rewords certain choices but stigmatises others.[27] By discussing the law makers' attitudes towards women's abortion decisions in England and China, I will closely examine the frameworks within which the English and Chinese regulatory models work and seek possible proposals for law reform. A final point that deserves a brief mention is that while this thesis advocates the diversity of feminist thinking, not all feminists support the concept of autonomy or the principle of respect for autonomy. As will be discussed in chapter 2, both concepts are criticised by some feminist scholars.[28] In chapter 2, I will respond to these critiques and also scrutinise how the feminist analytical method adopted in this thesis can offer a better approach to understanding the principle of promoting autonomy in the context of abortion.

[26] Anne Bottomley, Susie Gibson and Belinda Meteyard (1987) p.59

[27] Ruth Fletcher, Marie Fox and Julie McCandless (2008) 'Legal Embodiment: Analysing the Body of healthcare Law' 16(3) *Medical Law Review* 321-345 p.344

[28] Anne Donchin (2001) 'Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethics Principles' 26(4) *Journal of Medical and Philosophy* 365-386 p.371 Robin West (1992) 'The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory' in Mary Joe Frug (ed.) *Women and the Law* (Westbury: The Foundation Press) p.823

4.2. An Ethical Analytical Approach

As abortion is still one of the most controversial topics today, the moral debates provoked by abortion are seemingly endless.[29] An abortion involves using medical or surgical means of terminating an established pregnancy. Apart from women's autonomy, the interests of embryos/foetuses and putative fathers are the other most frequently mentioned issues in the debates on abortion.[30] Whilst the ethical approach adopted in this thesis mainly deals with women's autonomy in abortion decisions, the interests of embryos/foetuses and putative fathers will also be discussed in chapter 2. This subsection explains the role of the ethical analysis in this study.

In chapter 2, I will discuss the moral principle of respect for autonomy that is the theoretical basis of this thesis. First, I will examine the traditional accounts of the concept of 'autonomy' in order to answer the question of why it is essential for being regarded as a competent human being.[31] Second, I will address the question of why women should have their abortion decision-making treated with respect. While mainstream ethical accounts can help in understanding the concept of autonomy, I argue that these traditional approaches should be treated more critically. Being able to act on autonomously held desires is 'not just a status, but a skill, one that must be developed and maintained'.[32] As will be argued in chapter 2, the mainstream methods of respecting autonomy that focus on reducing controlling influences imposed by other parties on women's decision-making are not productive in the context of abortion because women may

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[29] Margaret Brazier and Emma Cave (2011) *Medicine, Patients and the Law* (London: Penguin Books) p.387 and Mason, JK and GT Laurie(2011) *Mason and McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press) p.313

[30] For an example of discussing putative fathers' say and the status of embryos/foetuses in abortion decisions, see Marie Fox (1998) 'Abortion Decision-making – Take Men's Needs Seriously' in Ellie Lee (ed) *Abortion Law and Politics Today* (London: Macmillan) and Margaret Brazier (1988) 'Embryos' "Rights": Abortion and Research' in Michael Freeman (ed) *Medicine, Ethics and the Law* (London: Stevens & Sons) respectively.

[31] For a discussion of the traditional approaches to the concept of autonomy, see chapter 2 of this thesis and Gerald Dworkin (1988)

[32] Christopher Meyers (2004) 'Cruel Choices: Autonomy and Critical Care Decision-making' 18(2) *Bioethics* 104-119 p.104

need support from health professionals and states in order to have greater control over abortion choices. Third, as has been discussed above, in chapter 2 I will suggest a more defensible approach to understanding women's autonomy in abortion decisions and the role that law should play in promoting women's abortion decision-making. Moreover, I will examine how this account of respecting autonomy can be translated into the English and Chinese jurisdictions.

Furthermore, the ethical analysis offered in this thesis includes consideration of the interests of embryos/foetuses and putative fathers. As will be discussed in chapter 2, in the context of abortion women's decision-making does not always conflict with the interests of their partners and embryos/foetuses. For example, when a woman is deciding whether to continue her pregnancy, she is likely to take account of the opinion of her husband or partner and whether the putative child will have good care. Nevertheless, I argue that legally women's right to abortion should be given priority over the protection of embryonic/foetal interests and men's desire to be a father. The 'not-proven' nature of embryos/foetuses cannot require law to enforce any belief about their moral status.[33] Thus, abortion law should ensure that the provision of abortions is brought into line with the principle of respect for autonomy. As McLean has argued, liberal law which 'permits people to do *x* forces no one to do it, but permits those who wish to, to undertake *x*'.[34] In addition, the ethical approach used in this thesis will be also applied to analysing moral controversy caused by the current English and Chinese regulation of late abortions, non-medical sex-selective abortions, abortions on the grounds of foetal abnormality and post-IVF abortions.

[33] Margaret Brazier and Emma Cave (2011) p.395
[34] Sheila McLean (1990) 'Abortion Law: Is Consensual Reform Possible?' 17(1) *Journal of Law and Society* p.110

4.3. A Comparative Legal Analytical Approach

Another method adopted in this thesis is a comparative legal analytical one. In contrast to, for instance, criminal or civil law, which are subjects with a core content, comparative law should be viewed as a method of studying different jurisdictions.[35] Comparing and contrasting one's own home jurisdiction with another one or several can help a person to develop a deeper insight into her home regulation of an issue and also broaden her knowledge of other means of governing the same or similar issues.[36] As Peters and Schwenke have observed, comparative legal studies can offer critical responses to one's home jurisdiction, because:

> They help to create a critical intellectual distance from one's legal system, forcing us into sympathetic yet critical knowledge of law in another context, disrupting our settled understandings, and provoking new judgments.[37]

Because the value of comparative methodology used in this thesis will be discussed in more detail in chapter 5, in this section I only briefly explain the value of conducting a comparative study of the English and Chinese regulatory models of abortion and the outcomes that will be produced in this thesis.

Instead of contrasting specific English and Chinese rules and cases relating to abortion, I focus the comparative analysis on two different models of the regulation of abortion. As will be discussed in chapters 3 and 4, these two models work within the frameworks of 'doctor knows best' and 'state knows best' respectively. I will also explore the changes made by the English and Chinese governments to the regulation of abortion in the era of criminalisation and in the era of decriminalisation. While I draw two different models of abortion law in chapters 3 and 4 – the

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[35] Peter Cruz (2001) *Comparative Healthcare Law* (London and Sydney: Cavendish Publishing Limited)
[36] Ann Peters and Heiner Schwenke (2000) 'Comparative Law Beyond Post-Modernism' 49(4) *International and comparative law quarterly* 800-834 p.831
[37] Ibid.

medical-centred model and the state-centred model, I do not view them as two totally different regulatory methods. From the discussion offered in chapters 3, 4 and 5, it can be seen that under both models, abortion is subject to the changes made by law makers and is legally provided by the medical profession. Furthermore, in both systems, there is a connection between the population policy and the regulation of abortion; there are medical restrictions on the performance of termination. Moreover, as will be analysed in chapter 2, by the lens of gender, the two regulatory models are both motivated by the desire to assert the assumption of womanhood and to maintain the existing social relations. In addition, as will be argued in chapter 5, under the two models, women who need abortion services are not treated as autonomous decision makers. Thus, the comparative analysis of the two models helps the reader to understand how similarly and differently abortion is regulated and women's decision-making is treated in the English and Chinese jurisdictions. By comparing women's relationship with health professionals under the English model and their relationship with the state under the Chinese model, I will scrutinise why women are not given the power to exercise autonomy over abortion decisions under these two regulatory models.

The fact that the English and Chinese legal and political systems are very different does not rule out a comparative study of their regulatory models of abortion. As a method of studying law, comparative legal research should not be limited to those jurisdictions that have very similar political and legal systems. As has been discussed earlier, promoting feminist legal studies requires examining regulatory experiences and situations in different legal contexts.[38] Furthermore, Menski has stressed the importance of researching Asian and African legal systems in order to avoid legal imperialism in the literature on comparative law and the promotion of

[38] Anne Bottomley, Susie Gibson and Belinda Meteyard (1987) p.59

legal pluralism under Western-led globalisation conditions.[39] The comparative legal analytical approach adopted in this thesis is committed to developing the literature on both feminist legal and cross-jurisdictional studies.

As has been discussed in section 1.2 of this chapter, one of my objectives is to examine what lessons English and Chinese law makers can learn from each other's experience of having a different method of regulating abortion. This task requires taking their localised cultural and historical contexts seriously. The importance of being sensitive to contextual particularities is emphasised by many legal comparatists. For example, Zwegert and Kötz have claimed that a comparison of legal systems should include their background information, such as historical development and cultural identities.[40] As Fox and Murphy have suggested, reforms that are not tailor-made to suit local situations are likely to be counter-productive.[41] The comparative analytical approach adopted in this study will take the English and Chinese contextual differences into account. For example, in chapter 5, by examining the characteristics of the Chinese family planning context, I will approach the question of why in practice the Chinese law of abortion is less respectful of women's autonomy in comparison with the English law of abortion, despite the 'law in the books' looks less restrictive. In addition, in chapters 4 and 5, I will discuss how feminism is accepted differently and women's awareness of human rights and reproductive liberty is developed differently in England and China. As will be discussed in chapter 5, the comparative approach offered in this thesis also helps national legal scholars to broaden their insights into the influences of abortion law on women's procreative health and everyday lives. As Lee has observed, examining more than one case has the potential to offer

[39] Werner Menski (2006) *Comparative Law in Global Context: the Legal Systems of Asia and Africa* (Second Edition) (Cambridge: the Cambridge University Press)
[40] Konrad Zweigert and Hein Kötz (1992) (Second Edition) *Introduction to Comparative Law* (Oxford: Clarendon Press) p.10
[41] Marie Fox and Therese Murphy (1992) 'Irish Abortion: Seeking Refuse in a Jurisprudence of Doubt and Delegation' 19(4) *Journal of Law and Society* 454-466

useful perspectives on the causes of the phenomenon studied and its possible limits and effects on women.[42] Moreover, because of 'a recent trend towards the "globalisation" of health policy and law',[43] there is an increasing need for comparative research in health care law.

The above three legal analytical approaches are not separately applied in this thesis. In chapters 3, 4 and 5, I will show that these three methods interact with and complement each other. For instance, the limits to using the comparative approach as 'an operator of critique'[44] can be reduced by adopting the feminist legal method. Furthermore, the comparative method will be used to facilitate an in-depth analysis of the cultural and historical differences between the English and Chinese contexts. This analysis is helpful in exploring the underlying reasons for law's lack of respect for autonomy under the English and Chinese regulatory models. Additionally, the ethico-legal analytical method can offer a theoretical base for the feminist and comparative studies of these two models.

5. Thesis Structure

The remainder of this thesis is set out as follows: in chapter 2, I discuss the principle of respect for autonomy in the context of abortion and its importance to women's health and everyday lives. First, the mainstream accounts of the concept of autonomy are examined in order to help the reader understand the meaning of autonomy and its value to personhood. Second, I approach the question of why women should have their abortion decision-making treated with respect. Third, a discussion of what role law should play in promoting women's autonomy in abortion decisions

[42] Ellie Lee (2003) *Abortion, Motherhood and Mental Health* (New York: Aldine de Gruyter) p.12
[43] Keith Syrett (2011) 'Introduction: On the Value of Lesson-Drawing in Comparative Health Law and Policy' 11(1) *Medical Law International* 45-51 p.45
[44] Ann Peters and Heiner Schwenke (2000) p.831

is provided. Finally, I assess the possibility of translating this principle into the Chinese jurisdiction.

In chapter 3, I scrutinise the English model of the regulation of abortion in order to address the question of how women who need abortion are treated by law and in practice. I discuss the statutes and cases relating to abortion in the era of criminalisation and in the era of medicalisation respectively. By analysing the regulation of abortion in these two eras, I examine whether abortion law reform in 1967 granted women any right to make abortion decisions and how the reformed law is different from the law before 1967 in the way in which women's reproductive decision-making is treated. Furthermore, I discuss how a medical-centred regulatory model of abortion was established by law makers to place closer control over women's fertility and how law's embrace of the medicalisation of abortion produced the power imbalance between women who need abortion and health professionals. I end the chapter with a suggestion that the role of the English law of abortion should be reframed according to the discussion of the principle of respect for autonomy offered in chapter 2.

In chapter 4, I analyse the Chinese state-centred model of the regulation of abortion. First, the Chinese legal and health care systems are introduced in order to offer the reader some background information. Second, I discuss how the state-centred model of abortion regulation was established by successive governments and how women's reproductive autonomy was treated under this model. To do so, I examine the influence of the state's different population policies on legislation on abortion. Third, by analysing how abortion is used by successive governments as a tool to facilitate their implementation of population policies, I suggest that the state-centred model serves to subject women's reproductive decision-making to the state's population strategies.

In chapter 5, I attempt to address two questions: first, what comparative lessons English and Chinese law makers can learn from contrasting the English and Chinese models of the regulation of abortion and second, how the current English and Chinese laws of abortion should change according to the principle of respect for autonomy. To address the first question, I assess the strengths and weaknesses of the English and Chinese laws of abortion with regard to how they treat women's procreative autonomy. Then I suggest proposals for reforming the two models and scrutinise how these proposals can bring the provision of abortions in England and China into line with the principle of respect for autonomy. Nevertheless, I am also critical of the suggested law reforms and highlight their limits.

The concluding chapter (chapter 6) is a brief summary of my research findings. It also points out some limitations of this study and makes some suggestions for my further research.

Chapter 2

In Defence of Reproductive Autonomy in Abortion Decisions

'Reproductive choices have such a major impact on a person's life – on one's identity, one's body, and one's sense of meaning...'.[1]

Introduction

The concept of autonomy is a difficult and complex one in philosophical writing. As Friedman has observed, this term generates ongoing debates and so far there has been no agreement on how it can be best understood.[2] It is also a crucial one in contemporary health care, because it is related to many significant liberal values, such as independence, authenticity, self-determination and non-intervention.[3] Respecting autonomy has been translated into a right for patients to accept or refuse health care treatment according to their own preferences. O'Neil has claimed that 'insofar as patients are protected by informed consent procedures that are scrupulously used, they will be protected against coercive or deceptive medical treatment'.[4] However, law's embrace of women's reproductive autonomy remains ambiguous and inconsistent. While law regulating procreative issues may claim to be gender-neutral and objective,[5] it often fails to 'accord due protection to women's autonomy, or provides it less protection than is accorded to that of men'.[6] For example, as the discussions offered in chapter 3 and chapter 4 will indicate, the law of abortion in England adopts the paternalist principle 'doctor knows best' rather than

[1]John Robertson (1995) 'Liberalism and the Limits of Procreative Liberty: A Response to My Critics' vol.52 *Washington and Lee Law* 233-251 p.235
[2]Marilyn Friedman (2003) *Autonomy, Gender, Politics* (Oxford: Oxford University Press) p.1
[3] Onora O'Neill (2002) *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press) and Jean McHale and Marie Fox (2007) *Health Care Law: Text and Materials* (London: Sweet & Maxwell)
[4] Onora O'Neill (2002) p.49
[5] Janice Raymond (1993) *Women As Wombs* (Melbourne: Spinifex Press) p.142
[6] Sally Sheldon and Michael Thomson (1998) *Feminist Perspectives on Health Care Law* (London: Gavendish) p.10

granting women who need abortion any substantial rights. Abortion services are provided within the Chinese regulatory framework by the central government as a compulsory means to implement its population control policy.

The first aim of this chapter is to explore the concept of autonomy in terms of the hierarchical account in order to examine how this concept is traditionally understood in moral philosophy and why it is treated as essential to people's heath and exercise of control over their lives. Secondly, this chapter plans to stress the importance of respecting autonomy in the context of abortion. It also suggests how law's lack of respect for women's self-determination in abortion decisions increases maternal morbidity and mortality relating to unsafe abortion methods. Thirdly, an analysis of the relationship between the theory of feminism and the values in autonomy is offered in this chapter in order to examine how feminism could be used as an analytic method to discuss how women's autonomy in abortion decisions can be enhanced. Recently some feminists have shown a resistance to the adoption of autonomy in campaigns for reproductive freedom; according to these critics, valuing autonomy is to embrace an exclusively male character.[7] This chapter critically responds to this argument and suggests that feminism and the idea of autonomy are not inconsistent and they are able to strategically work together in an exploration of oppressive situations against women and to draw effective solutions to promote the interests and welfare of women in the area of reproductive health care. Additionally, this chapter also tries to be critical of the argument that the concept of autonomy is not appropriate for Chinese society where Confucian family-centred traditions are valued, because it is derived from Western culture.[8] However, this chapter argues that contextualising the principle of respect for autonomy

[7] Robin West (1992) 'The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory' in Mary Joe Frug (ed) *Women and the Law* (Westbury: The Foundation Press) and Anne Donchin (2001) 'Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethics Principles' 26(4) *Journal of Medical and Philosophy* 365-386

[8] Michael Cheng-tek Tai and Tsung-po Tsai (2003) 'Who Makes the Decision? Patient's Autonomy vs. Paternalism in a Confucian Society' 44(5) *Croatian Medical Journal* 558-561

is essential for importing it to the Chinese legal context. The fourth task is to scrutinise what role law ought to play in regulating abortion according to the discussion of the principle of respect for autonomy. Finally, because human embryos/foetuses and putative fathers are often directly affected by termination decisions made by women, the last section discusses these relevant interests at stake in order to address the question of whether these interests will post a challenge to the translation of the principle of respect for autonomy into the legislation on abortion.

1. Traditional Analytical Approaches to the Concept of Autonomy

The term 'autonomy', derived from the Greek word 'autonomia', literally means 'self-rule' or 'self-governance'. According to the *Longman Dictionary of Contemporary English*, it is the freedom of governing or controlling oneself or the ability or the opportunity to make decisions without external coercion.[9] Its synonyms, such as self-determination, self-governance and independence, can provide the reader with a general understanding of an autonomous person, namely one who is able to govern herself and make free choices without external coercion. The concept of autonomy was first used as a basis by regimes to claim the right to deal with their own affairs without the control of a conquering power. Since the nineteenth century, it has been extended to refer to the psychological trait of individuals by many Western scholars such as Dworkin,[10] Frankfurt[11] and Haworth.[12] They have made early successful attempts to apply the theory of autonomy to personhood from different philosophical perspectives.[13] For example, Raz has argued that to be autonomous a person must have 'minimum rationality, the ability to

[9] Linglex Dictionary and Corpus Advisory Committee (2005) *Longman Dictionary of Contemporary English* (London: Pearson) p.86
[10] Gerald Dworkin (1988) *The theory and practice of autonomy* (Cambridge: Cambridge University Press) pp.12-13
[11] Harry Frankfurt (1971) 'Freedom of the Will and the Concept of a Person' 68(1) *The Journal of Philosophy* 5-28; (1998) *The Importance of What We Care About* (Cambridge: Cambridge University Press) and (1999) *Necessity, Volition, and Love* (Cambridge: Cambridge University Press)
[12] Laurence Haworth (1991) 'Dworkin on Autonomy' 20 (2) *Ethics* 129-139
[13] James Stacey Taylor (2009) *Practical Autonomy and Bioethics* (London: Routledge) p.19

comprehend the means required to realize his goals, the mental faculties necessary to plan actions...'.[14] Compared with Raz's 'rationality/ability' method of defining personal autonomy, its meaning is broader in accordance with Dworkin's extensive taxonomy which links it to the concepts 'liberty', 'self-rule', 'sovereignty', 'freedom of the will', 'dignity', 'integrity', 'individuality', 'independence', 'responsibility' and 'self-knowledge'. More specifically, Dworkin has viewed the concept of autonomy as identified with qualities of self-assertion 'with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one's own interests...'.[15] This section does not aim to examine every single approach to the concept of autonomy. While there are different means of understanding it, the concept of autonomy has its 'connotative contours'[16] which can be found in different definitions. Taylor has observed that as a property of persons, the term of personal autonomy indicates:

> Persons are held to be able to direct themselves in ways that are not open to other agents. They are able to reflect on their inclinations, desires, and values to determine if they wish to be moved by them or not.[17]

According to Taylor's explanation, to be autonomous a person should meet two conditions – firstly, she has to be able to form her preferences after thinking about her wants critically. Suppose at lunchtime, a person has two conflicting desires: to eat a big beef cheese burger or to follow her doctor's advice on eating a healthy diet (say, a green salad). (The meaning of desires in this chapter is not limited to its ordinary definition in contemporary English[18] and it is extended to include wants, aspirations, purposes, goals, intentions, volitions, conations and preferences[19]). To be autonomous, she should have the capacity to compare these two wants and

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[14] Joseph Raz (1986) *The Morality of Freedom* (Oxford: Clarendon Press: Oxford) p.373
[15] Gerald Dworkin (1988) p.15
[16] James Stacey Taylor (2009) p.2
[17] Ibid.
[18] For example, see Longman Dictionary of Contemporary English (2005) 'a strong hope or wish'
[19] Wright Neely (1974) 'Freedom and Desire' 83(1) *The Philosophical Review* 32-54 p.33 and Stephen Wilkinson (2003) *Bodies For Sale: Ethics and Exploitation in the Human Body* (London: Routledge) p.121

reflect on the advantages and disadvantages of each choice for her. She may prefer to eat the beef burger because of the good taste or to choose a green salad because of her doctor's suggestion that her weight problem should be treated by controlling her diet. No matter which one she finally chooses to eat, her decision is the result of careful deliberation. Secondly, an autonomous person should be able to make decisions according to her own preferences. If she likes to stick to her diet, she should manage to repudiate the desire for the burger and choose to eat the green salad. In brief, she should have the capacity to reject and identify with her desires. This approach defines 'autonomy' as a capacity to reflectively rank various desires (namely people's hierarchical desires). It is often named as 'the hierarchal analysis', which has been developed by Gerald Dworkin, Harry Frankfurt, Laurence Haworth, Keith Lehrer[20] and Michael Bratman.[21]

Although their methods of explaining the concept of autonomy are not identical, the core feature shared by these authors is that autonomy can be defined in accordance with the hierarchy of desires. More specifically, human beings have various basic wants, for example, to eat, to sleep, to drink. Having these desires means people are able to exert control over how they want things to be', but it does not necessarily reflect their preferences. As Lehrer has argued, having low-order (also, low-level/first-order/first-level) desires does not ensure that people are the authors of their preferences.[22] For example, a desire to eat can be owned by a competent adult, a very young child, an infant, even animals. According to 'the hierarchal analysis', to be autonomous people must have the capacity to form second-order or high-level desires. Second-order desires are defined as the preferences concerning first-order desires.[23] In other words, they are the desires to (or not to) want to do something. Having high-order desires indicates being capable of identifying with and repudiating first-order preferences. Second-order desires are not only wants

[20] Keith Lehrer (1997) 'Freedom, Preference and Autonomy' 1(1) *The Journal of Ethics* 3-25
[21] Michael Bratman (2003) 'Autonomy and Hierarchy' 20(2) *Social Philosophy & Policy* 156-436
[22] Keith Lehrer (1997) p.10
[23] Laurence Haworth (1988) p.131 and Harry Frankfurt (1998) p.21

and desires for something, but the desires (not) to want the desires for something. In other words, they are the desires concerning first-order wants. While high-level desires, to some extent, depend on the strength of first-order desires, forming high-order preferences requires much more than having basic ones. To have high-order wants, people should be able to critically organise and structure their basic wants. Generally, only humans who can rationally reason are thought of as capable of forming high-level desires. Thus, having high-order preferences distinguishes autonomous people from non-autonomous ones (nevertheless, as will be discussed below, it is not a sufficient condition of being autonomous). As Frankfurt has observed, if a creature does not have the capacity to form second-order desires, it is not a person, but a 'wanton' because it has no second-order volitions.[24]

'Wantons', according to Frankfurt's explanation, are not only those non-human beings, but could be any humans who do not have the ability to be concerned about their preferences. Thus, 'wantons' can be infants or even adults with very serious mental handicaps. They do not act on those desires which on reflection they have decided to endorse, but are driven solely by basic desires. For example, suppose both a wanton and an autonomous person have two different choices at the same time but can only choose one of them (say to drink a glass of red wine or to drink a cup of coffee). The wanton will choose to drink one of them randomly but not compare or form a preference concerning both. On the contrary, the autonomous person will be able to reflectively compare the two wants and reflectively form her preference. The ability to have high-level desires regarding relevant first-order desires is a necessary condition of autonomy. Dworkin commented:

[24] Harry Frankfurt (1971) p.16

> Putting the various pieces together, autonomy is conceived of as a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values.[25]

Although the capacity to form second-order desires is a necessary condition of being autonomous, it is not sufficient alone. Besides shaping second-level desires, autonomous people should also be able to accept or attempt to change their basic desires in the light of their high-level preferences. For example, heroin addicts may have two conflicting first-order desires: wanting heroin and wanting to stop the addiction to heroin. They may prefer the desire to give up their addiction, since it is not difficult for them to gain relevant information about the fact that using heroin is harmful and also costly. Therefore, they will prefer to be driven by the desire not to keep being addicted to heroin. This means that they have the capacity to critically reflect on their first-order desires and also form a second-order preference concerning their basic wants. Nonetheless, like most drug addicts, they could fail to stop their heroin addiction. While the desire for heroin is not the one by which they want to be driven, in practice they are eventually moved by it. Thus, the capacity to form high-level desires is not sufficient to define the capacity to be autonomous. The addicts' first-order desire for heroin is inconsistent with and unresponsive to their second-order preference that wants not to have the addictive desire. They are unwilling to be addicted, but are not able to repudiate the desire for heroin. As Haworth has claimed, a person could not be autonomous if she only has the capacity to raise the question of whether she will identify with or reject the reasons for which she acts. She has to be able to act on those preferences by which she wants to be moved.[26] Based on Haworth's understanding of autonomy, those unwilling addicts are not autonomous because they fail to reject their addictive desire and make their high-level motivation effective. Given that there is another kind of heroin addicts who

[25] Gerald Dworkin (1988) p.20
[26] Laurence Haworth (1991) p.132

are satisfied with their addictive desires and willing to be addicted to heroin, these willing addicts have much more inner liberty than those unwilling addicts, according to Haworth's explanation. Although a willing addict theoretically could have the first-order desire which is consistent with her high-level preference, she does not exercise actual governance over her addictive desire in practice. The reason why the desire for heroin is not a free one is not that it is viewed as irrational in our society, but that being addicted to something is a kind of controlling influence which limits people's capacity to deliberate. Wilkinson notes:

> What matters (for autonomy) isn't so much the nature of the object of desire as the relationship between the desirer and the desire – in particular, is the desire immune to elimination by reflection?[27]

According to his comment, the reason why an addictive desire is not autonomous is that addiction makes elimination of the desire through deliberation impossible. Therefore, both unwilling and willing addicts are not able to exercise their addictive desires autonomously because addiction is unlikely to be repudiated. Nevertheless, this does not mean that addicts are not autonomous at all. For example, they can still freely make other decisions, such as to eat or to sleep. When attempting to address the question of whether a person has the capacity to exercise autonomy over a desire, people should first know whether the desire is autonomously held by this person: in other words, whether this desire is eliminable by this person's deliberation.

The cases of heroin addicts may not be convincing because addictive desires can be regarded as 'unusual' or 'abnormal'. Let's use a common and normal desire as an example. The desire to return a book to the library can be held more or less autonomously by different people in different situations. For example, a person plans to go to the library tomorrow morning in order

[27] Setephen Wilkinson (2003) *Bodies For Sale: Ethics and Exploitation in the Human Body Trade* (London: Routledge) p.122

to return a book which is expected to be returned next week, but finally she changes this plan because she decides to meet a friend instead. In this case, the library desire is autonomously held by this person since the desire is vulnerable to elimination by her reflection. Nonetheless the library desire can also be non-autonomous if it is held by a person 'afflicted by some kind of irrational, maybe even pathological, library-compulsion'. [28] Immunity to elimination by deliberation is not an all or nothing issue, but a matter of degree. This means that desires can be more or less autonomously held.

Furthermore, the extent to which a desire is susceptible to rejection by reflection also depends on 'social forces' and individual 'will-power'.[29] The influence of social forces over individuals and the degree of people's will-power are different, so a desire can be easily eliminable for a person in one environment, but difficult in another one or in another condition and a person may be able to reject a certain desire after deliberation, but cannot do so to another. For example, *China Sina News* reported that a mother voluntarily cut off one of her hands in order to more effectively beg for money to save her daughter who had leukaemia.[30] Although it seems that this mother decided to harm herself because she has no alternative way to get money for her daughter's treatment, her want for self-harm is quite autonomous. If her situation changed, for example, her daughter died or she becomes able to afford her daughter's leukaemia treatment, her desire to cut off her hand can be given up. Nevertheless, the desire for self-harm can be non-autonomously held by another person, such as one suffering from body dysmorphic disorder. Given that a person affected by a severe psychological anxiety disorder may be excessively preoccupied by a perceived defect in her physical features, such as lacking hands, this person may still have the desire to cut off her hands, but this self-harm desire is less eliminable for her compared with that for the mother. In

[28] Ibid.
[29] Ibid.
[30] Sina Online News (02 August 2005) 'Muqin Duanshou Qitao Chouqian' available at www.gd.news.sina.com.cn/guangzhou (last accessed: 02 February 2010)

the mother's voluntary case, the underlying desire driving her to cut off her hand is not to satisfy her need to change physical appearance, but to save the life of her daughter.

The fact that a person may be unable to freely hold a certain desire or this particular desire in a certain moment (or in a certain condition) does not mean that she is not able to autonomously act on some other desires or the same desire in some other circumstance. As Beauchamp and Childress have argued, even autonomous people can fail to govern themselves in their choices due to temporary constraints imposed by 'illness or depression, or because of ignorance, coercion, or conditions that restrict options'[31]; on the contrary, some people who are not considered as autonomous generally may still be able to make some free choices. For instance, although some mentally handicapped patients have been declared legally incompetent, they may be able to act on some autonomous desires, such as starting preferences for dressing, meeting the people they like and accepting medical treatment. Thus, to act on autonomous wants, people, particularly those who are in some difficult circumstances, may need external assistance and support. While being autonomous is determined by one's inner capacity to critically deal with her wants, having this capacity does not mean that a person is always able to effectively exert her preferences. External elements, such as other persons' coercive and cooperative influences, also have considerable effects on her exercise of autonomy. Since human beings are in 'the matrix formed by complex social life and interpersonal relationships',[32] our free actions cannot happen without social cooperation and support. This fact involves a crucial principle – respect for autonomy – which is examined in the following section.

[31] Tom Beauchamp and James Childress (1994) *Principles of Biomedical Ethic* (Oxford: Oxford University Press) p.121
[32] Emily Jackson (2001) *Regulating Reproduction* (Oxford: Hart Publishing) p.7

2. The Principle of Respect for Autonomy

The above discussion of the mainstream analytical approach to the term of autonomy has stressed the importance of autonomy to human beings. Having some degree of autonomy means that one can reflectively develop and form preferences and act on higher-order plans of action 'which take as their self-critical object one's life and the way it is lived'.[33] Having the internal capability to reflect on her wants suggests that a person has her own way to author and lead her life, which is independent from other agents' external forces and controlling influence. Thus, one's exercise of autonomous choice is 'essential to being a person' as it makes her different from non-human beings, such as animals'.[34] Furthermore, to be treated as an autonomous human, one should be thought of as an independent and rational agent capable of making responsible and rational decisions. Young has claimed that autonomy should also be regarded as a 'presupposition of moral agency and hence of responsibility, dignity, and self-esteem'.[35]

Nonetheless, since a desire cannot be completely freely held, having autonomy is not a matter of all or nothing. Therefore, most people, including many very young children and not very seriously mentally handicapped adults, to some degree, have the capacity to exercise some choices. Their autonomy should also be treated with respect. Being respected as an autonomous decision-maker, according to Beauchamp and James, is different from being autonomous which, as has been discussed in the previous section, is a personal psychological characteristic based on the internal capacity to reflectively structure preferences. Having autonomy treated with seriousness can be defined as a moral obligation in a normative sense. Depending on their definition of the principle of respect for autonomy, people have an ethical duty to treat other autonomous beings with respect. More specifically, this moral obligation means that one should

[33] David Richards (1971) *A Theory of Reasons for Action* (Oxford: Clarendon Press) p.66
[34] Harry Frankfurt (1971) p.10
[35] Robert Young (1989) 'Autonomy and the "Inner Self"' in John Christman (ed) *The Inner Citadel: Essays on Individual Autonomy* (New York and Oxford: Oxford University Press) p.77

acknowledge that all other persons have the right to 'hold views, to make choice, and to take actions based on personal values and beliefs'.[36] The duty to treat other people's autonomy with respect involves a respectful attitude and also respectful action. According to Beauchamp and Childress, respectful actions require more than obligations of non-intervention in the affairs of persons, because they also includes obligations to 'maintain capacities for autonomous choices in others...' and enable persons to act autonomously.[37] Accordingly, 'respect for autonomy' involves two kinds of moral obligations – the negative one and the positive one. The former requires that a person should treat others as responsible and independent moral agents and not infringe their right to exert autonomy over meaningful choices. A person should be able to pursue a good life which is not subjected to others' controlling constraints, so she is able to form her own volition rather than being treated ad others' means.[38] Thus, people have a negative ethical duty not to violently impose coercive influences over others' decision-making. Moreover, this means that people have a right to lead a life which is independent from any others' controlling intervention. In this way, this negative ethical duty can also be thought of as 'a stalwart right of authority to control one's personal destiny',[39] so a competent person has the right to decide on what her own good is and live a selected lifestyle.

The principle of respect for autonomy, in terms of the positive obligation, indicates that a person may need to offer relevant assistance and support to others, so they are able to effectively exert actual governance over free choices. As has been argued earlier in this chapter, as being in the matrix formed by various social relationships and networks, people's ability to act on their autonomously held desires requires support and assistance from others. This ability is

[36] Tom Beauchamp and James Childress (1994) p.125
[37] Ibid.
[38] Nicolette Priaulx (2007) *The Harm Paradox: Tort Law and The Unwanted Child in an Era of Choice* (London: Routledge) and (2008) 'Rethinking Progenitive Conflict: Why Reproductive Autonomy Matters' 16(2) *Medical Law Review* 169-200
[39] Tom Beauchamp and James Childress (1994) p.126

significantly reliant on one's 'actual governance' rather than just one's internal capacity for governance.[40] One's actual governance can be reduced or increased depending on how much social support and cooperation is available. Given that a person wants to have some sleep, the extent to which she can effectively exercise actual governance over this desire may depend on how much respect she could gain from her family or other persons in her house. For example, her children's cooperation to turn down the TV is helpful in providing a quiet environment. In the meantime, the fact that people may own a positive obligation to promote others' autonomy suggests that human beings, to some degree, have a right to obtain support from others in order to act on their freely held desires.

As has been mentioned in the introduction, the 'respect for autonomy' principle is particularly important in the field of health care. To demonstrate its importance, I review two important relationships in medical practice – the one between medical professionals and their patients and the one between states and their citizens. Since chapters 3 and 4 provide a detailed analysis of these two relationships in the context of the English and Chinese regulation of abortion, in this section I only briefly present the influences which may be imposed on medical treatment seekers' decision-making in these two relationships.

Firstly, the paternalist relationship between medical professionals and patients, as McLean has observed, has 'a long and remarkably robust history in medicine'.[41] Compared with 'the Hippocratic oath' – the previous dominant principle in bioethics – paternalism prioritises patients' welfare and best interests. However, in the paternalist doctor/patient relationship, the welfare or best interests of patients was dependent on what doctors believed to be good for their patients. Thus, the right to make decisions and choose relevant treatment was left in the hands of doctors.

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[40] Ibid.
[41] Sheila McLean (2010) *Autonomy, Consent and the Law* (Oxford: Routledge-Cavendish) p.9

Because doctors were thought to be uniquely qualified to define what was in patients' best interests, 'the dominant, and indeed the accepted, model of the clinical relationship for most of medicine's history' was paternalism.[42] As a consequence, the principle 'doctor knows best' was absorbed into health care practice. The penetration of this principle has considerably prevented medical professionals from paying attention to their patients' experiences and discouraged them from creating 'genuine communication'[43] with them. As a result, when patients' preferences are not consistent with their doctors', paternalism assumes that the latter's professional knowledge represents the former's welfare and best interests and can override patients' personal convictions.

Secondly, disrespect for patients' autonomy does not only exist in the paternalist physician/patient relationship, but also in the patriarchal state/citizen relationship. In health care practice, states may also exert their controlling interference over patients' decision-making by means of domestic law-making. As will be discussed in chapter 4, the Chinese party state expresses its interest in regulating the population through legislating to value or constrain female citizens' reproductive choices in the name of the protection of individual health and the collective welfare. Furthermore, the paternalist doctor-patient and the patriarchal state-citizen relationships can be interactive. Mclean has clearly observed that national legislation has 'a history of deference to the medical profession that has often worked to prioritise the concept of professional beneficence'.[44] Accordingly, the state's policy/law-making can entrench medical power and enhance medical control over individual patient autonomy. In the meantime, medical science can be used by the state as a tool to facilitate the implementation of its law and policy. For example, around the beginning of the 1950s, to stimulate population growth and carry out its pro-nationalist policy, the Chinese government encouraged women to continue their unwanted

[42] Edmund Pellegrino and David Thomasma (1087) 'The Conflict Between Autonomy and Beneficence in Medical Ethics: Proposal for a Resolution' 3(23) *Journal of Contemporary Health Law and Policy* 23-46 p.25
[43] Harvey Teff (1994) *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (Oxford: Clarendon Press) pp.69-70
[44] Sheila McLean (2010) p.87

pregnancies by widely publicising the medical statement that abortion is permanently detrimental to maternal health.

The emergence of the 'respect for autonomy' principle has fundamentally challenged power imbalance in the above two relationships. It can be seen from the analysis offered in the last section of this chapter that being treated as autonomous is inconsistent with the argument that a person's welfare and best interest should be determined by any others without considering her definition of good even if they have certain skills and knowledge. The principle of respect for autonomy involves a commitment to patients' own moral agency and indicates that individuals should be regarded as ends in themselves. This strongly defends patients against medical and state controlling intervention. As has been discussed above, the principle of respect for autonomy, in the negative form, means that human beings' reflective formation of their preferences should be independent from controlling influences exerted by other agents. It could be translated into a patients' right to refuse unwanted medical services even if they are viewed as life-saving treatment by their doctors. Thus, patients can be protected by the right to informed consent from being enforced to receive unwanted heath care treatment. The fully paternalistic model assumes that doctors, as 'assessors of happiness',[45] always make rational and responsible decisions for their patients. Patients in this relationship are often not well informed and treated as dependent from their doctors.

Nevertheless, in a relationship established according to the principle of respect for autonomy, patients' vulnerability to medical professionals' abuse of power will be effectively avoided. Medical professionals' obligation to promote patients' autonomy, in the negative sense, is not to obstruct patients' access to relevant information or impose their beliefs and values on their

[45] Jean McHale and Marie Fox (2007) *Health Care Law: Text and Materials* (London: Sweet & Maxwell) p.125

patients. In other words, patients are able to express their sense of self by forming their own perspective on relevant medical services. For example, a pro-life GP should not exert her moral belief over her patients who request abortion services. However, as will be discussed in chapter 3, in practice, there is no lack of cases in which anti-abortion doctors did not provide women who need abortion with competent advice.[46] Moreover, the translation of the principle of respect for autonomy into health care law, in terms of the negative form, can protect patients from the state's coercive interference in their decision-making. Since the decision about whether or not to access medical treatment is essential to patients' health and social flourishing, any state involvement in prohibiting citizens' access to selected medical services may be unnecessary and even violent in some cases, such as reproductive treatment, unless there were proper reasons for doing so.[47]

Nonetheless, the negative explanation of the promotion of autonomy can be too narrow to stress patients' needs for support to enhance their actual governance over medical decisions. In terms of its positive definition, patients not only have the right to refuse medical treatment, but also the right to access a medical service and gain relevant assistance. The latter requires a cooperative and supportive patient-doctor and a state-citizens relationship rather than just non-interference in patients' decision-making. Competent advice and adequate information offered by medical professionals can facilitate patients' exercise of autonomy over medical choices and promote their capacity to give informed consent. As McLean has argued, medical professionals' sharing of information and provision of medical advice can effectively enhance patients' ability to act autonomously, so they are able to act in 'an autonomous manner based, but not solely dependent, on that information'.[48]

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[46] For a further discussion and for a detailed discussion of 'uncooperative doctors' in England, see chapter 3
[47] Stephen Wilkinson (2010) *Choosing Tomorrow's Children: the Ethics of Selective Reproduction* (Oxford: Clarendon Press) p.12
[48] Sheila McLean (2010) p.10

Accordingly, in order to 'give consent validly',[49] a patient should be given medical information about her treatment and also understand it. While there is no universally accepted answer to the question of how much information the patient needs to know in order to give her consent validly, at least she has to understand relevant benefits or harmful side effects which could be caused to her by taking this treatment. In this way, she may know those factors 'which one would reasonably expect to affect' her.[50] Consequently, medical professionals are obligated to help their patient obtain and understand basic information about her treatment in accordance with the principle of respect for autonomy in the positive form. In general, doctors have easier and more unrestricted access to information and knowledge about patients' health problems and medical treatment compared with patients because of the professionalisation of medical services[51] and the availability of relevant techniques. Thus patients may need doctors' professional support and cooperation in order to give informed consent. Although doctors should not be their patients' moral arbiters or sharers of patients' decision-making, as skilled technicians they are able to facilitate patients' formation of a good outlook on medical treatment by sharing their medical information and knowledge.[52] Thus, I argue that the positive obligation of promoting autonomy does not only require that physicians keep their own beliefs away from their patients' decision-making, but also, and more importantly, needs their cooperation and support in enhancing patients' choices. As Pellegrino has observed, the principle of respect for autonomy may lead to an 'often-neglected duty' which is to 'help restore that autonomy or help establish it when it is

[49] For the definition of 'valid consent', see Stephen Wilkinson (2003) pp.75-77
Wilkinson has claimed that valid consent in the context of medical ethics is normally called 'informed consent'. There is a distinction between 'valid consent' and 'consensual': the former should be defined in moral sense but the latter in psychological and social sense.
[50] Ibid.
[51] John Keown (1988) *Abortion, Doctors and the Law* (Cambridge: Cambridge University Press)
[52] Tom Beauchamp and James Childress (1994) p.126

absent'.[53] Due to patients' lack of proper information and resources, medical professionals' assistance is important to increase patients' actual governance over accessing medical services.

However, while doctors are able to provide cooperation and support, they are not capable of judging what treatment patients desire to have. Thus, the ultimate decisional authority should be left in the hands of patients. What was wrong with the paternalistic ideology in medicine was not that doctors did not really know what was beneficial for patients; on the contrary, they often do 'at least in a clinical sense ... know what is best and that expertise carries with it greater responsibility', but that there was a mixing of greater responsibility with 'the notion of greater authority over a patient's choices and preferences about life and death'.[54] In this way, I suggest that the doctor-patient relationship built in the light of the principle of respect for autonomy can enhance patients' self-determination and also facilitate medical professionals' promotion of patients' beneficence possible. Moreover, a doctor-patient relationship that is built in the principle of respect for autonomy can improve the protection of other moral norms in medical practice. As Gillon has clearly observed, among four common moral norms, namely the principle of respect for autonomy, the principle of non-maleficence, the principle of beneficence and the principle of justice,[55] the principle of respect for autonomy should be 'first among equals'.[56] He has given three reasons why autonomy is a necessary component of aspects of the other three. Firstly, autonomy, as the ability and tendency to make decisions according to the way one wishes to lead one's life makes any sort of morality possible. Secondly, beneficence and non-

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[53] Edmund Pellegrino and David Thomasma (987) p.45

[54] Kelley Maureen (2005) 'Limits on Patient responsibility' 30(2) *Journal of medicine and philosophy* 189-206 p.197

[55] The principle of respect for autonomy, the principle of non-maleficence, the principle of beneficence and the principle of justice are claimed by many moral philosophers, such as Herissone-Kelly's, Beauchamp and Childress to be 'prima facie common moral norms' and 'common morality'.

For detailed information about the 'Four Principle' Account, see Matti Hayry and Tuija Tkala (eds) (2003) *Scratching the Surface of Bioethics* (Amsterdam: Rodopi) pp.65-76 and Tom Beauchamp and James Childress (1994) p.101

[56] Raanan Gillon (1985) 'Autonomy and the Principle of respect for Autonomy' 290(6484) *British Medical Journal* 1806-1807 and (2003) 'Ethics needs principles – four can encompass the rest – and respect for autonomy should be "first among equals"' 29(5) *Journal of medical ethics* 307-312

maleficence to other autonomous human beings involves respect for autonomy of those humans. Thirdly, respect for autonomy pays an important role in securing justice, because satisfying people's needs involves respect for their autonomous views. It includes:

> Autonomous rejection of offers to meet their needs; and more importantly, because providing for people's needs requires resources, including other people's resources.[57]

Obviously, not all moral scholars agree that these four principles represent common morality. For example, Charles Erin has argued that 'the four principles approach' has never purported to provide 'a decision mechanism' or a coherent moral theory, so he has noted that 'there is no rule that there must be four principles'.[58] In this chapter, I do not aim to convince the reader of 'the four principles approach' (though many citations in this section are from those scholars in favour of the four principles approach), because whether or not the principle of non-maleficence, the principle of beneficence, the principle of justice and the principle of respect for autonomy are the only four common moral norms is not an issue closely related to the key argument in this thesis. However, based on the reasons given by Gillon, I argue that to some degree a medical model grounded in the principle of respect for autonomy can also promote other morality, such as beneficence, justice and veracity.

Another point deserves a brief mention in this section, which is that 'respect for autonomy' should be regarded as a right but not a duty for patients.[59] When a patient is vulnerable to illness, injuries or any other unexpected health problems, she may want her doctor to make a decision for her. In this circumstance, the doctor's active participation in the patient's decision-making is not to infringe the patient's right to self-determination, but to fulfil the commitment to fostering

[57] Raanan Gillon (2003) pp.310-311
[58] Charles Erin (2003) 'Who Need "the Four Principles"' in Matti Hayry and Tuija Tkala (eds) *Scratching the Surface of Bioethics* (Amsterdam: Rodopi) p.82
[59] JK Mason (2006) *Law and Medical Ethics* (Oxford: Oxford University Press) pp.8-10

it. Thus, it indicates that the doctor-patient relationship based on the principle of respect for autonomy is not a sterile, static and monolithic one; on the contrary, various methods of developing active and effective communications and information sharing between physicians and patients should be encouraged.

Furthermore, according to 'respect for autonomy' in terms of the positive explanation, a patient's actual governance over accessing medical services also depends on whether she is able to obtain relevant support from the state. Therefore, she does not only have the right to decide on her treatment freely from the state's coercive involvement, but she is also entitled to obtain support from the state, such as to access financial assistance. As Pellegrino and Thomasma have suggested, the government should protect those rights based on ethical principles which will bring about the proper ends to a good human life.[60] The importance of 'respect for autonomy' to patients' physical and social development discussed above suggests that people's right to autonomy in health care practice should be promoted by the state.

3. Reproductive Autonomy in Abortion Decisions

Respecting autonomy in the context of reproduction is particularly important to people's health and everyday lives. For John Roberson, reproduction fulfils 'cultural norms and individual goals about a good or fulfilled life' and should be considered as 'the most important thing a person does with his or her life'.[61] In this way, reproductive autonomy involves making intimate decisions about a person's body and life, such as whether and when to have a child. Thus, limiting a person's procreative freedom could lead to the violation of her 'psychological and

[60] Edmund Pellegrino and David Thomasma (1981) *A Philosophical Basis of Medical Practice* (Oxford: Oxford University Press) p.171

[61] John Robertson (1983) 'Procreative Liberty and the Control of Conception, Pregnancy, and Children' 69(3) *Virginia Law Review* 405-463 p.408

social identity'.[62] Since making procreative decisions is a significant way for a person to author and lead her life and she is affected most directly by the consequences of these decisions, she is best placed to make her procreative plans.

The significance of treating procreative autonomy seriously is also emphasised by Emily Jackson, who has argued that lack of respect for one's reproductive autonomy undermines her ability to control the most intimate sphere of her life. Whether to reproduce or not is 'among the most momentous choices'[63] that a person will make and will have a profound impact upon the course of one's life. Since reproduction happens inside female bodies and procreative duties are mainly undertaken by women in the current gender system, the effects of restricting procreative freedom on women are particularly harmful and detrimental. Whether or not to reproduce changes a woman's physical state for at least nine months. Even after giving birth, it takes time for her body to return to its pre-pregnancy state. Therefore, giving birth is rightly termed 'labour', because 'it is hard work, often painful and sometimes dangerous'.[64] More importantly, once the woman's pregnancy ends in the birth of a baby, many changes in the rest of her life may then start. For example, the woman will have a day-to-day responsibility to care for and support this child until she becomes mature enough to take care of herself. Even after the child grows up, the connections between them will to some extent continue to influence the woman's life. Thus, infringing women 's right to exert autonomy over reproductive choices will lead to serious physical and psychological harm. As Robertson has observed, reproduction should be willing and desired, otherwise it 'imposes great physical burdens on women, and social and psychological burdens on both men and women'.[65]

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[62] John Robertson (1994) *Children of Choice: Freedom and the New Reproductive Technologies* (West Sussex: Princeton University Press) p.24

[63] Emily Jackson (2001) *Regulating Reproduction* (Oxford: Hart Publishing) p.7

[64] Emily Jackson (2008) 'Degendering Reproduction?' 16(3) *Medical Law Review* 346-368

[65] John Robertson (2003) 'Procreative Liberty in the Era of Genomics' 29(2003) *American Journal of Law & Medicine* 229-487 p.450

For a long time (especially before sex was able to be separated from reproduction), women had very little control over procreative biology and living their selected lifestyle. Even after procreative medicine and techniques were considerably developed, women's procreative autonomy has not been given adequate respect. Women have been socialised into 'reproductive behaviour' and somehow their roles have been closely linked to maternity in the current gender relations. As Virginia Held has observed, the term 'reproduction' itself is misleading, 'for it already assimilates human childbirth to the reproduction of animals',[66] which is regarded as a completely natural process. The close connection between women, reproduction and nature has been constructed and can be found in various communities and cultures. This connection, according to Ortner, is not due to 'a given of nature', since she is not any closer to nature than man, but 'a construct of culture'.[67] Ortner's observation has explained well why women often find it more difficult to refuse procreation compared with their male peers.

While modern procreative medicine and techniques have made avoiding and managing procreation possible, women's access to reproductive services has not been enhanced sufficiently; in other words, they have not been granted the ultimate decisional authority on their procreative choices. While the ideal of respect for patient autonomy has been at the very centre of medical ethics and practice since the second half of the twentieth century, women's right to refuse unwanted treatment and access desired medical services in the context of reproduction has not been secured.[68] As O'Neil has noticed, reproductive coercion is not rare in modern history, for example, during the twentieth century, forced sterilisation, often with eugenic aims, happened in many countries.[69]

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[66]Virginia Held (1993) *Feminist Morality* (London: The University of Chicago Press) pp.125-27
[67] Sherry Ortner (1972) 'Is Female To Male as Nature to Culture?' 1(2) *Feminist Studies* 5-31 p.28
[68] Mary Donnelly (2010) *Healthcare Decision-making and the Law* (Cambridge: Cambridge University Press) p.269
[69] Onora O'Neill (2002) p.50

Furthermore, women's right to have procreative autonomy treated with positive support has not been paid enough importance by medical staff as well as governments. The unavailability of relevant assistance may also lead to women's lack of actual governance over their reproductive decision-making. According to Jackson and Sclater, the promotion of autonomy may not only involve an absence of state-controlling interference, but also 'the positive provision of resources to enable some to have a meaningful set of options'.[70] As has been suggested above, when the physician-patient and state-patients relationships are constructed according to the principle of respect for autonomy, patients' access to non-directive information and competent advice will be greatly facilitated. Given that women can only exert control over meaningful reproductive choices in a friendly and supportive environment 'respectful of self-determination',[71] the provision of reproductive services should be based on the principle of respect for autonomy.

To further explore the principle of respect for autonomy, the following section aims to use the provision of abortion as an analytic site to examine its meaning and value to women. Additionally, it applies feminism, as a theoretical base, to discuss how to use this principle to enhance access to abortion services.

3.1. The Principle 'Respect for Autonomy' in Abortion Decisions

Nowadays, termination of pregnancy is not and does not need to be highly technological. Various methods of discontinuing gestation have been around a long time. For example, in

[70] Emily Jackson and Shelley Day Sclater (2009) 'Autonomy and Private Life' in Shelley Day Sclater, Fatemeh Ebtehaj, Emily Jackson and Martin Richards (eds) *Regulating Auotnomy: Sex, Reproduction and Family* (Oxford: Hart Publishing) p.2

[71] Laura Riley and Ann Furedi (2009) 'Autonomy and the UK's Law on Abortion: Current Problems and Future Prospects' in Shelley Day Sclater, Fatemeh Ebtehaj, Emily Jackson and Martin Richards (eds) *Regulating Auotnomy: Sex, Reproduction and Family* (Oxford: Hart Publishing) p.241

addition to lawful and unlawful surgical abortions performed by doctors and abortionists in nineteenth-century England,[72] the history of induced abortion by using certain traditional herbs to miscarry is not short.[73] Additionally, a number of ingredients commonly used in traditional Chinese medicine were known for their abortifacient properties, such as aromatic stimulants, croton fruit, morning glory seed and Peking spurge.... References to the use of these herbs appear in Chinese medical books written more than 2,000 years B.C.[74] Their market proved to be good.[75] People's desire to plan their births indicates that human reproduction is much more than a purely natural process and it is different from that of non-autonomous beings which may be mainly driven by their first-order wants. For autonomous persons, reproduction is not just to create another human, but also to construct new relationships, to take responsibilities and to author their lives according to reflective high-level desires. Therefore, managing reproduction safely and freely is one of humans' basic needs for health and control over their lives.

The emergence of modern medical and surgical abortion as a safe method of avoiding unplanned or unwanted procreation has tremendously enhanced women's reproductive choices and well-being. Savulescu and Hendrick have claimed that the availability of safe termination makes human procreation more manageable: it should be regarded as one of the breakthroughs in the development of reproductive technologies.[76] Based on the importance of safe termination to women's health and everyday lives, many human rights scholars, such as Eriksson and Fathalla, have argued for the liberalisation of abortion regulation. Eriksson has suggested that access to

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[72] Malcolm Potts, Peter Dggory and John Peel (1977) *Abortion* (Cambridge: Cambridge University Press)
[73] Qiufang Lü and Mingying Gai (2004) *Handbook of Obstetrics and Gynaecolog* (Beijing: China Xiehe Medical University Press) pp.341-347
[74] Susan Rigdon (1996) 'Abortion Law and Practice in China: An Overview with Comparisons to the United States' 42(4) *Social Science & Medicine* 543-560 p.547
[75] For a discussion of the abortion market in England and China, see chapters 3 and 4.
[76] Tony Hope, Julian Savulescu and Judith Hendrick (2003) *Medical Ethics and Law: The Core Curriculum* (Edinburgh: Churchill Levingstone) p.115 The other two are that the emergence of various means of assisting conception and prenatal visible technique.

safe abortion services is 'an emerging human right in international law',[77] since it is a prerequisite for gender equality. I follow Eriksson by suggesting that protecting women against physical and mental injuries caused by unsafe termination requires removing the restrictions on the provision of abortion services. The necessity of removing the ban on abortion can be proved by Warriner's observation of the relationship between law and 'back-street' abortions, which indicates:

> Broadly speaking, where there is no legal restriction, abortion services are likely to be safe. In these settings, the abortion is performed in a regulated medical setting and the providers are properly trained. In contrast, where abortion laws are highly restrictive, women turn to clandestine providers with a high risk of incurring a serious or life-threatening complication.[78]

Accordingly, in order to promote women's health and enhance their exercise of control over life choices, there is an urgent need to remove the legal limits on women's decision-making, making abortion services safe and accessible and giving legal protection to abortion-seeking women's right to obtain adequate support. Today, termination treatment, especially medical and early surgical abortion, has proved to be very safe and has become one of the most commonly performed operations in many regions of the world.[79] However, a WHO report issued in 2003 has suggested that worldwide around 53 million abortions are performed every year, but about two out of five abortion procedures are unsafe and between 100,000 and 200,000 women die of these unsafe abortions.[80] Additionally, as will be discussed in chapters 3 and 4, although abortion has been legalised in England and China, unsafe and illegal terminations are not eradicated in the

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[77] Maja Kirilova Eriksson (2001) 'Abortion and Reproductive Health: Making International Law more Responsive to Women's Needs' in Kelly Askin and Dorean Koening (eds) *Women and International Human Rights Law* (New York: Transnational Publisher) p.55

[78] Ina Warriner (2006) 'Unsafe abortion: an overview of priorities and need' in Ina Warriner and Iqbal Shad (eds) *Preventing Unsafe Abortion and Its Consequences* (New York: Guttmacher Institute) p.2

[79] World Health Organisation (2003) 'Safe Abortion: Technical and Policy Guidance for Health System' available at http://whqlibdoc.who.int/publications/2003/9241590343.pdf (last accessed: 17 May 2011)

[80] Ibid.

two jurisdictions; women who find it difficult to access legal and safe abortion services will still resort to 'back-street' services.

The decision about whether or not to continue gestation significantly affects a woman's physical state and also her life, so law should respect her exercise of autonomy over this decision in both negative and positive senses. The removal of the legal limits on abortion only decreases the possibility that a woman's right to self-determination is infringed by controlling intervention from others. Thus, it only protects her negative right to request termination services, but not a positive one to gain medical cooperation and state support. According to the positive right derived from the principle of respect for autonomy, medical staff and governments should take an active role in supplying cooperation and assistance to women who need abortion services, particularly those from socioeconomically disadvantaged backgrounds. While 'respect for autonomy' should not be treated as an absolute right to access some very expensive medical treatments which are funded by scarce resources, financial support for abortion-seeking women should be maximally available, because an abortion is obviously not one of those treatments and it will 'always'[81] cost much less than a woman's pregnancy and delivery. As Jackson has observed, refusal to support women in abortion decisions could not be justified on ground of cost, since continuing gestation and giving birth need more public resources and medical support than abortion. She notes:

> Even if we completely disregard any expense incurred after the child's birth, carrying the average pregnancy to term will cost a health authority approximately seven times as much as the average abortion.[82]

[81] Emily Jackson (2002) 'Abortion: Patient Autonomy or Medical Paternalism?' in Ellie Lee (ed) *Abortion: Whose Right?* (Oxford: Hodder & Stoughton) p.6
[82] Ibid.

Moreover, in a woman's clinical interest, abortion services, even those performed in the third trimester of gestation, are often less risky than carrying a pregnancy to term and giving birth.[83] Nonetheless, as the analysis offered in chapters 3 and 4 will indicate, although abortion has been legalised for around a half century in England and China, the right to make abortion decisions has not been left in the hands of women who request abortions services. Firstly, the failure of abortion law to endorse autonomy leads to social injustice and oppression against women and also against some men, particularly those from socioeconomically disadvantaged backgrounds. Since law has not given adequate protection to women's right to self-determination in abortion decisions, termination and reproduction could be coercive and undesirable. For example, it will be seen from the discussion in chapter 4 that there are a large number of abortions performed against women's and their husbands' free will in China in the name of the welfare of the nation or the good of the collective. According to a survey conducted by Nie, 80 per cent of the 624,000 abortions in Guangdong province were performed 'by order', and one-third were in the sixth month of pregnancy or later.[84] The analysis provided in chapter 3 will suggest that because law's motivation is the desire to limit the number of terminations by entrenching doctors' power over the provision of abortion, women have to bear the strain and stress caused by abortion-service delays or may even carry an unwanted pregnancy to full term.

Secondly, law's lack of respect for autonomy can increase the demand for back-street abortion. As will be discussed in chapters 3 and 4, before abortion was legalised in 1967 and the end of the 1970s in England and China respectively, the criminalisation of abortion forced many poor and low social status women to seek unlawful and unsafe terminating means.[85] At the same time, the

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[83] Ellie Lee (2003) 'Tensions in the Regulation of Abortion in Britain' 30(4) *Journal of Law and Society* 532-553 and (2007) 'The 1967 Abortion Act: Four Reasons to Fight for Choice' available in http://www.prochoiceforum.org.uk/ocrabortlaw12.php (last accessed: 17 May 2011)

[84] Jing-Bao Nie (1999) 'The Problem of Coerced Abortion on China and Related Ethics Issues' 8(4) *Cambridge Quarterly of Healthcare Ethics* 463-479 p.465

[85] Penny Haslam (23 November 2007) BBC News 'Illegal Abortions Still Blight UK' available at http://news.bbc.co.uk/1/hi/health/7108026.stm (last accessed: 17 May 2011)

right to use safe abortion services supplied by trained medical professionals to avoid unwanted procreation became a privilege of women from advantaged backgrounds. Even today after abortion has been conditionally decriminalised, women who cannot afford a private service in England have to bear the pressure caused by their doctors' unsympathetic attitudes towards unwanted gestation. In the meantime, an abortion could be coercive in China if the woman is not able to afford fines imposed by the local family planning department for having unpermitted gestation.[86] As has been discussed, to exert autonomy over abortion decisions, in addition to being independent from controlling influences imposed by any third party, women may require positive support from abortion providers and the state. For example, women who cannot afford a private abortion need public funding for a safe service. Nevertheless, as will be suggested in chapters 3 and 4, the current laws of abortion in England and China fail to secure women's access to positive medical and state support. Moreover, even their right to autonomy, in terms of the negative meaning, is not given effective protection.

Given that the above problems can be caused by abortion law's lack of respect for women's autonomy, section 4 will provide a normative analysis of what role law should take in regulating abortion services according to the discussion of the principle of respect for autonomy offered above. Before this analysis, the final part of this section will scrutinise how feminism is helpful in achieving the task of reframing the role of law. Furthermore, this part will address the questions of how feminism could be used as a critical legal study approach to exploring the underlying reasons behind the infringement of women's right to abortion and how it could be adopted as a strategy for improving their powerlessness in abortion decision-making.

[86] For a discussion of coerced abortions in China, see chapter 4

3.2. Feminism and the Principle of Respect for Autonomy in the Context of Abortion

The investigation of the relationship between the two concepts – 'feminism' and 'autonomy' – in the context of abortion provided in this subsection helps the reader understand how to strategically use feminism as a tool to explore the legal obstacles to women's exercise of autonomy over reproductive decisions. 'Feminism' is not a concept that is any easier to define than 'autonomy'. In brief, it can be characterised as 'the study of, and struggle for, the liberation of women from the oppressive circumstances of patriarchal cultures'.[87] As has been demonstrated in chapter 1, as a critical legal analytical approach, 'feminism', through the prism of gender, explores oppressive circumstances against women in the existing regulatory system and scrutinises how to eliminate oppression and injustice against women. More specifically, according to Bartlett and Kennedy, a feminist approach involves three processes – asking woman-related questions, feminist practical reasoning and consciousness-raising.[88] The principle of respect for autonomy, as has been analysed earlier in this chapter, first, emphasises the importance of freedom, liberty, self-determination, authenticity and independence from controlling coercion and second, and values a supportive and cooperative environment which enhances people's actual governance of their life choices. Thus, it seems to me that the values and ideas derived from the concepts 'feminism' and 'autonomy' should not be inconsistent because they both flag the elimination of coercive and oppressive influences and they both facilitate people's decision-making and actual control over their lives.

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[87] John Christman (1995) 'Feminist and Autonomy' in Dana Bushnell (ed) *'Naggin' Questions* (London: Rowman & Littlefield) p.17

[88] Katharine Bartlett and Rosanne Kennedy (1991) (eds) *Feminist Legal Theory: Reading in Law and Gender* (Boulder: Westview Press) p.370

However, their relationship has become rather a complex and complicated one, because the concept 'personal autonomy' has recently provoked some feminist criticisms.[89] The values developed from the concept 'autonomy', in the eyes of these critics, stem from the images of privileged males in human society, for example, self-interest and independence. Therefore, promoting 'autonomy' is to advocate an asocial, gendered, abstract conception of individuals and devalue female experiences, such as interdependence, connection, care and cooperation.[90] Some feminists have claimed that advocating 'autonomy' means embracing an exclusively male idea which is 'inextricably connected with notions such as individuality, separation, and self-reliance'.[91] Based on these criticisms, the 'respect for autonomy' principle is unsuitable and improper for analysing and solving woman-related problems. For instance, Ann Donchin has argued that the traditional values derived from the concept of autonomy ignore women's experiences in pregnancy. She notes:

> The tendency to construct the fetus as an isolated, separate individual aptly illustrates the tenacity of the conception of individuality that abstracts from all individual particularities. The proclivity to perceive pregnant women as 'fetal containers' only incidentally conjoined with their 'contents' is a corollary of this construction of the fetus as a separate individual that just happens to be occupying space within the body of the childbearing woman.[92]

This suggests that a pregnant woman and the foetus are viewed as two different independent persons according to the theory of autonomy, so advocating for autonomy in the context of abortion means denying the connection between the woman and the foetus and the dependence of the latter on the former. This argument is shared by Robin West, who has claimed that valuing personal autonomy in abortion decision-making turns a blind eye to the fact that:

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[89] For a feminist criticism of the term 'personal autonomy', see Catharine Mackinnon and Natalie Stoljar (2000) (eds) *Relational Autonomy* (Oxford: Oxford University Press)
[90] Anne Donchin (2001) p.370
[91] John Christman (1995) p.17
[92] Anne Donchin (2001) p.371

> The experience of being human, for women, differentially from men, includes the counter-autonomous experience of a shared physical identity between woman and fetus, as well as the counter-autonomous experience of the emotional and psychological bond between mother and infant.[93]

I would agree that the intimacy between a pregnant woman and the embryo/foetus is unique. Nonetheless, this special connection cannot rule out the possibility of applying the 'respect for autonomy' principle to dealing with problems with regard to abortion. Treating a pregnant woman as autonomous does not mean that she and the embryo/foetus inside her should be regarded as two separate and independent persons. On the contrary, based on the analysis of the hierarchical account offered earlier in this chapter, since embryos/foetuses lack the capacity to deliberate, reflect on, reason and rank desires, they are not able to exercise autonomy. The above critics' understanding of the theory of autonomy are both grounded on an ill-considered assumption that acknowledging a pregnant woman's autonomy means granting an equal degree of autonomy and independent moral status to the embryo or foetus. It is true that the bond between a pregnant woman and her foetus is a uniquely intimate one, which is obviously distinguished from that of two independent persons. The uniqueness of such a bond, as Jackson has suggested, does not 'necessarily render the concept of autonomy redundant or meaningless'; on the contrary, it should alert people to 'the intrinsic interest of the pregnant woman in defining for herself the scope of her relationship with the fetus that is living inside her body'.[94] Thus, stressing the maternal-embryonic/foetal intimacy suggests that the pregnant woman's autonomy in abortion decisions should be respected adequately. According to the hierarchal account, a person's autonomy is mainly influenced by her capacity to reflectively form desires, regardless of the fact of whether or not she is pregnant. Therefore, people should respect pregnant woman's autonomy by letting her exert her own agency on reproductive decision-making. For feminists

[93] Robin West (1992) p.823
[94] Emily Jackson (2001) p.3

who support the promotion of legal and safe abortion services, the principle of respect for autonomy can provide a theoretical base where they are able to struggle for women's procreative self-determination. In the meantime, feminism, as a critical legal method, also plays a crucial role in reforming abortion law in the light of promoting women's autonomy. It can help reformists explore underlying causes of oppression and injustice against women who need abortion under the current regulatory model and find possible alternatives.

As has been discussed earlier, since abortion has been legalised in the English and Chinese jurisdictions, people tend to believe that 'if women need to terminate pregnancy then the law allows them to do so',[95] so there is no need to reform law. This is only half right. While the decriminalisation of abortion means that it can be lawfully performed in England and China, access to safe and legal services are not readily available to all women, particularly those who are socioeconomically disadvantaged. As will be analysed in chapters 3 and 4, since women's autonomy in the context of abortion has not been enhanced, some women have to turn to 'back-street' providers or even carry unwanted gestation to full term. The limits on women's exercise of control over their reproductive choices have also increased gender inequalities between women and men. As Willis has claimed, if women can have the same degree of autonomy as men have, they should have the power to decide whether or not to continue their pregnancies.[96]

To find underlying reasons why the existing English and Chinese regulation of abortion fails to respect women's exercise of autonomy over reproductive decision-making, one process of the feminist legal analytical means – asking woman-related questions – is required. I adopt this approach to raising three woman questions relating to abortion in order to explore the importance of respecting women's autonomy in reproductive decisions and the causes of law's failure to

[95] Ellie Lee (ed) (1998) *Abortion Law and Politics Today* (London: MacMillan Press) p.xi
[96] Ellen Willis (1990) 'Putting Women Back into the Abortion Debate' in Marlene Gerber Fried (ed) *From Abortion to Reproductive Freedom: Transforming a Movement* (Boston: South End Press) p.132

promote it. Why do women need safe abortions? Why should the ultimate authority to make abortion decisions be granted to individual women? And why do women often find it difficult to exert their agency over making reproductive decisions? Answers to the first two questions have been discussed in the previous subsections – women need safe reproductive services to satisfy their needs for health and also actual governance of their life choices. As will be discussed in chapters 3 and 4, the reasons for women accessing abortion are often beyond their control in practice, for example, contraception may fail or even be inaccessible to some women, and sex could be involuntary and even violent sometimes.[97] There are broad social elements with regard to unwanted reproduction and reasons for using termination services, which are often complex and cannot be summarised.

Furthermore, as Welin has observed, if human beings are in the era of 'reproductive ectogenesis', which is defined by her as a new human procreative time when a whole embryonic/foetal development is completely outside of the woman's body, termination may not be a method of managing reproduction specific to women and they may be able to deal with unwanted or unplanned gestation in a position which is similar to that of men.[98] Nonetheless, the fact is that human beings are still in a traditional procreative era when it is 'extremely unlikely' that the reproductive process will ever be 'comprehensively degendered'.[99] Thus, so long as people opt for the traditional reproductive process, procreative duties, particularly physical ones, are mainly taken by women and undesirable reproduction has much more detrimental effects on women compared with their partners. A pregnant woman is the one whose mental and physical status is most profoundly influenced by the decision (not) to continue gestation, so she should be best

[97] Yingjie Xu (2006) 'Shaonv yiwai huaiyun jiezhu zhongxin zhounian huigu' (A review on the young girls' accident pregnancy aid centre) available at http://news.xinhuanet.com/focus/2006-02/05/content_4112197_3.htm (last accessed: 17 May 2011) A survey conducted by the teenage pregnancy aid centre in Nanjing in 2005 shows that two main reasons for young girl seeking abortion are lack of contraceptive knowledge and involuntary sex.
[98] Stellan Welin (2004) 'Reproductive Ectogenesis: The Third Era of human Reproduction and some Moral Consequences' 10(4) *Science and Engineering Ethics* 615-626
[99] Emily Jackson (2008) p.368

placed to judge whether she has the ability to cope with physical and psychological strains produced by the decision. In this way, the pregnant woman rather than anybody else should be granted the ultimate power in abortion decisions by law.

To address the third question – why there are still obstacles to accessing abortion in the English and Chinese jurisdictions, though it is legalised – feminism is a particularly useful critical analytical approach. The investigation of this issue requires feminist criticisms of law's objectivity, rationality and neutrality. Some feminist scholars, such as Smart,[100] Naffine[101] and Lacey[102] have posted challenges to the concepts law has employed to represent itself as an objective, rational and neutral institution. For instance, Nafine has claimed that law should not be regarded 'as a neutral and dispassionate institution' which deals with disputes and organises social relations justly; law in fact is not 'the coherent, logical, internally consistent and rational body of doctrine it professes to be'.[103] This view is shared by Smart, who has noted that law does not live up to its rhetoric of consistency, rationality and fairness and it can be 'profoundly sexist', and can be 'seen to assist in the reproduction of the dominant patriarchal social order'.[104] As chapter 5 will provide a discussion of the limitations of law and the proposals for law reform made in this thesis, this section does not further explore this issue. With reference to feminist critiques of the use of law as an ideal solution, the reasons behind oppression and injustice against women under the existing English and Chinese regulatory models of abortion can be found. Three 'phrases', summarised by Naffine, is helpful in providing some answers – first, 'the male monopoly' which has been systematically supported by a male-controlled law in the public sphere, second, 'the male culture of law' which means that men have fashioned a legal system in

[100] Carol Smart (1989) *Feminism and the Power of Law* (London: Routledge) and (1994) *Law, Feminism and Sexuality: Essays in Feminism* (London: Sage Publications) p.79
[101] Ngaire Naffine (1990) *Law and the Sexes: Explorations in Feminist Jurisprudence* (London: Allen&Unwin) p.11
[102] Nicola Lacey (1998) *Unspeakable Subjects: Feminist Essays in Legal and Social Theory* (Oxford: Hart Publishing) p.4
[103] Ngaire Naffine (1990) p.12
[104] Carol Smart (1994) p.85

their own image, and third, 'legal rhetoric and the patriarchal social order' which indicates that the law-making process is often male-dominated and biased.[105] According to these three 'phrases', law is conceived through male eyes, represents male perspectives and stems from the male experience. Based on Naffine's three 'phrases', I argue that abortion law's lack for respect for women's autonomy in England and China is due to the fact that it has embraced the compulsory cultural assumption about the normal role of woman as mother,[106] so it does not treat woman who need abortion as a responsible and rational decision maker.

To scrutinise the English and Chinese abortion laws' acceptance of the assumption about the social role of women as maternal, I first use two recent events in England and China to present women's normal role as having been closely related to their reproductive biology; second, I offer a discussion of the question of how this fact leads to law's failure to promote women's procreative autonomy. The first event is that some British doctors have claimed that they are 'a step closer to carrying out the first ever successful womb transplant',[107] which is considered as advanced technology to offer 'miserable'[108] women who were born without a womb or whose womb has been destroyed the great chance to bear their own child. However, doctors have not clearly explained why female infertility is a disease and why women without a womb need to be helped by medical science. The other event is a Chinese documentary, 'Women for Sale'.[109] It revolves around two women at the grassroots of Hong Kong society, struggling to survive and haunted by demons in their respective pasts. One of the women, who is from mainland China, tries to become a Hong Kong citizen and claim housing benefit by marrying a local man and giving birth to a baby for him. She views herself to be of higher status than the sex worker who

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[105] Ngaire Naffine (1990) pp.4-7
[106] Judith Butler (2007) *Gender Trouble* (London: Routledge Classics) p.123
[107] BBC News (22 October 2009) 'Giving Birth to Womb Transplants' available at http://news.bbc.co.uk/1/hi/health/8319149.stm (last accessed: 17 May 2011)
[108] Ibid.
[109] It was produced in 2008. Its Chinese name is *Wobumaishen, Womaizigong* (literally, I do not sell my body, I sell my womb)

lives in the same apartment building. The film demonstrates that there is no difference between the womb seller and the street walker, because both sell their bodies – the former sells her womb and the latter sells sex. Most of the interviewees in the film show a lot of sympathy for the sex worker but are angered by the womb seller because the latter gains much more than she deserves just by doing the work equivalent to prostitution. Nevertheless, the hard work of bearing the baby and the uncertain future in which the child will be raised are rarely mentioned in the film or by the interviewees. These two events are not directly related to abortion. However, they both indicate that women's values, to a large degree, are still determined by their reproductive biology. As Janice Raymond has observed, the existing gender structure tends to reduce the woman to a womb and therefore infertility is medicalised. There is a principle assumed by reproductive technologists that women are always willing to suffer any pain, invasive procedure or medical violence in order to become pregnant.[110] Therefore, invasive procreative medical intervention on women's bodies often appears to be therapeutic and is justified by helping them to become a normal woman. Whilst women's values are closely connected to their reproductive biology, reproduction is often devalued as unpaid domestic work in our society. It is constructed as women's contribution to others – their husbands, the community and the state, so women's own interests in procreative decisions are often ignored. Women are expected to lead a self-sacrificing life in order to effectively take reproductive responsibility for others.[111] This not only involves procreation, but also requires that women subject their own preferences to others' needs and reproduce according to others' interests. As the analysis provided in chapters 3 and 4 will demonstrate, women can be required (not) to be procreative for the welfare of their existing family or children and for the state's interests and the collective good. Raymond notes:

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[110] Janice Raymond (1993) pp.79-80

[111] Reva Siegel (1992) 'Reasoning from the Body; A Historical perspective on Abortion Regulation and Questions of Equal Protection' 44(2) *Stanford Law Review* 261-381 p.297

> It is women who bear the burden of their own and their male partners' infertility in the so-called First World, and their own and their male partners' fertility in the so-called Third World.[112]

Although the existence of a womb does show 'the existence of basic biological differences between men and women in the context of reproduction'[113], it does not adequately explain why women's destiny is thought of as more related to reproduction than men's in society. According to Butler's observation, the mechanism for 'the compulsory cultural construction of the female body as a maternal body' has imposed an obligation on women to reproduce.[114] The womb has been constructed as something representing the images of a woman: a self-sacrificing woman who is able to effectively take maternal responsibility. Accordingly, what has historically confined women to the reproductive arena is not their wombs, but the construction of womanhood as motherhood. Butler has claimed that women are expected to have 'maternal instincts', which is 'a culturally constructed desire which is interpreted through a naturalistic vocabulary'.[115] This expectation of female reproductive biology has received many feminist criticisms.[116] For example, Fineman has commented that women's social role has been construed as that of maternity, so they are required to fulfil the domestic responsibility for their husband and children. As a consequence, women who choose not to bear and rear children may be thought of as 'non-traditional, even unnatural'.[117] Therefore, what society expects women to have is not a womb, but what a womb embodies – the maternal instinct. However, from the second event, it could be seen that while women are required by society to contribute their reproductive biology to others, their procreative work is not considered as productive. According

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[112] Janice Raymond (1993) p.2
[113] Sally Sheldon (2007) 'Reproductive Choice: Men's Freedom and Women's Responsibility?' in John Spencer and Autje Bois-Pedain (eds) *Freedom and Responsibility in Reproductive Choice* (Oxford: Hart Publishing)
[114] Judith Butler (2007) p.123
[115] Ibid.
[116] Ellie Lee and Emily Jackson (2002) 'The Pregnant Body' in Martian Evans and Ellie Lee (eds) *Real Bodies* (Hampshire: Palgrave); Michael Thomson (1998) *Reproducing Narrative* (Aldershot: Ashgate Publishing Limited); Nicola Naffine (1990); Rosemarie Tong (1997) *Feminist Approaches to Bioethics: Theoretical Reflections and Practical Applications* (Boulder: Westview Press) and McLean Sheila (2010) *Autonomy, Consent and the Law* (Oxford: Routledge-Cavendish)
[117] Martha Albertson Fineman (2004) *The Autonomy Myth: A Theory of Dependency* (London: The New Press) p.41

to Butler, effective reproduction is defined by the process of socialisation as a thing which woman should do and is motivated by their natural desire. Thus, as the analysis offered in chapters 3 and 4 will suggest, women's own preferences in reproductive decision-making are not treated with respect by law makers. This can lead to the fact that women, particularly those from less advantaged backgrounds, become increasingly vulnerable to undesirable medical and state intervention. For example, as will be discussed in chapter 3, under the English regulatory model, although pregnancy and childbirth are clinically more dangerous than having an abortion, a woman's request for an abortion must be vetted by doctors. A pregnant woman who has decided to have an abortion is rarely described as a patient who needs medical support; instead she is treated as an irrational woman 'whose potentially illegal act can be legitimized by the beneficent exercise of medical discretion'.[118] As Clark has clearly observed, mothers have no right with respect to abortion, but 'doctors have rights and medical staffs have rights' in English law.[119]

Another issue which deserves a special mention is that although reproductive liberty in the context of abortion appears to be a right to access termination services in most English feminists' work cited in this chapter, 'respect for autonomy' in this thesis also includes a right to refuse unwanted termination. Law's promotion of this right, derived from the principle of respect for autonomy, requires that terminations 'by order' in the Chinese family planning context shall be eradicated. As the analysis in chapter 4 will show, according to the Chinese national population control programme, women, in particular those who cannot afford the financial punishment for breaking the birth control policy, may be forced to undergo an abortion. While English and Chinese women may experience different difficulties in exerting their autonomy over the decision (not) to continue their pregnancy, the underlying cause is similar – both the English and the Chinese regulatory models have been built on the assumption about the normal role of

[118] Emily Jackson (2000) 'Abortion, Autonomy and Prenatal Diagnosis' 9(4) *Social & Legal Studies* 467-494 p.478
[119] Elizabeth Clark (1989) 'Self-Ownership and the Political Theory of Elizabeth Cady Stanton' vol.21 *Cinnecticut Law Review* 905-941 p.935

women as maternal. Under the two models, women are required by law to play the 'good mother' role. The difference is that this task in China involves obeying the state's population policy – women were required not to take any contraception or access abortion in the period when the government advocated for the 'pro-nationalist' policy, but to terminate 'unauthorised'[120] births when the government implements the population control programme.

As a consequence of law's embrace of the construction of womanhood as maternal, women are not provided with an environment where their procreative preferences are recognised and supported. This suggests that to protect women's interest and welfare in the context of abortion, a new regulatory model should be established according to the discussion of the principle of respect for autonomy offered in section 2 of this chapter.

4. Law's Role in Promoting Autonomy in Abortion Decisions

As has been suggested earlier in this chapter, nowadays, law is still passed and enacted in accordance with male-dominated norms in order to maintain the existing gendered power structure, so feminists should be aware of the limitations of using law to enhance women's reproductive decision-making. Raymond has claimed that while modern legislation is claimed to pursue procreative liberty and gender-neutral reproductive rights, its promotion of gender-neutral rights 'obscures the real privilege and dominance of men.'[121] For example, from the discussions offered in chapters 3 and 4, it can be seen that the current means adopted by English and Chinese law makers of decriminalising abortion have entrenched medical and state control over women's life choices rather than endowing them with any substantial right to make decisions. Nevertheless, challenges to the current regulation of abortion and reform proposals are still

[120] For the analysis of the births that are 'unauthorised' in the Chinese family planning context, see chapter 4.
[121] Janice Raymond (1993) pp.79-80

posed and made in this thesis, because law, as 'a system of knowledge which can define and disqualify of truth and discourse'[122], should not be left stable and can be changed. Alternative perspectives and views can be formulated by feminists' engagement with law, so that they may challenge the authorised truth and discourse accepted by law which in fact are against women's well-being.[123]

4.1. Contextualisation of the Principle of Respect for Autonomy

Before examining the extent to which law ought to promote procreative autonomy in the context of abortion, this section first looks at the voices of some scholars from Confucian communities, who oppose the adoption of the theory of respecting autonomy in Confucian jurisdictions. For instance, Michael Cheng-tek Tai and Tsung-po Tsai have argued that in some Asian countries and areas dominated by Confucianism, such as mainland China, Hong Kong, Taiwan and Singapore, people prefer to use family-orientated ethical values rather than autonomy-orientated ones in their decision-making concerning medical treatment. They have claimed that when a patient is going to make an important medical choice, she will feel more confident and comfortable by discussing it with her family members and getting support from them.[124] Tai and Tsai comment:

> Obviously, an individual autonomy in medical decision-making is missing in Taiwan society. This finding is not surprising, as in a Confucian society, father deserves the right to make decisions on behalf of his family

[122] Ngaire Naffine (1990)
[123] Carol Smart (1989) *Feminism and the Power of Law* (London: Routledge)
[124] Michael Cheng-tek Tai and Tsung-po Tsai (2003) and Ruiping Fan and Julia Tao (2004) 'Consent to Medical Treatment: the Complex Interplay of Patients, Families, and Physicians' 29(2) *Journal of Medical and Philosophy* 139-148

members. As the head, he is also responsible to bring happiness and well-being to the people under his care ... Strictly speaking, the patient's autonomy is violated ...[125]

It seems to me that this opinion is not a well-considered one. First, it is unreasonable to assume that the ideas stemming from the concept of autonomy encourage people to isolate themselves from networks of relationships or make asocial decisions without considering any others. As has been discussed in sections 1 and 2, autonomous persons are able to form their preferences by comparing and reflecting on basic desires. Distinct from other non-human beings, competent humans are capable of being socialised into making decisions and acting on their freely held high-level desires. To be autonomous, people do not need to isolate others from their decision-making. On the contrary, supportive external influences and constructive networks often increase people's actual governance of making meaningful choices.

Second, quite clearly, the fact that a father often plays a role as the head of his family in Chinese Confucian culture does not necessarily suggest that a person always subjects her convictions to those of her father or other senior family members. The fact that a patient's family members, especially the male elder, may actively participate in her medical decision-making does not mean that her autonomy is not respected sufficiently by the positive and cooperative effects of her family members. As has been suggested above, external influences do not always have negative or detrimental effects on people's exercise of decision-making autonomy. On the contrary, the availability of support and cooperation from others, especially from close ones, can significantly promote one's self-determination. In this way, a patient's exercise of autonomy over medical choices is not limited by taking perspectives and suggestions from family members or friends into account.

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[125] Michael Cheng-tek Tai and Tsung-po Tsai (2003) and Ruiping Fan and Julia Tao (2004) 'Consent to Medical Treatment: the Complex Interplay of Patients, Families, and Physicians' 29(2) *Journal of Medical and Philosophy* 139-148

Additionally, as I have argued in section 2, the right translated from the principle 'respect for autonomy' should not be regarded as an obligation for people to make decisions alone. Even in Western countries, there may be some patients who want their families, friends or doctors to make medical decisions on their behalf. Therefore, it is important to distinguish a person who voluntarily makes medical decisions through learning from other persons' experiences from one who is enforced to obey other people's agency.

Last but not least, according to the hierarchical account of autonomy, competent persons, regardless of race, religion, or sex should be free to reflectively structure aspirations and form their own convictions. Obviously, people who are from Confucian or Western societies should all be granted the right to have their agency treated with seriousness. Thus, I cannot agree with the argument that the principle of respect for autonomy cannot work in the Chinese medical and legal contexts due to the so-called conflicts between this principle and Confucian traditions. Nonetheless, applying this principle to examining and solving problems in the Chinese jurisdiction are not an easy task. This not only involves simply translating 'respect for autonomy' into the Chinese characters 'zizhi/zizhu' or giving a definition in Chinese, but also, and more importantly, requires that it can be contextualised in the Chinese legal system and accepted by Chinese people, particularly women, whose rights consciousness has historically proved to be weak compared with their English sisters.[126]

In chapter 5 I will provide a discussion of the relationship between values developed from Confucianism and the theory of autonomy, which suggests that Confucian traditions are not essentially inconsistent with the values derived from the concept of autonomy. In this section I

[126] For the reasons for arguing that women's awareness of reproductive rights is comparatively weak in China, see chapters 4 and 5.

only briefly discuss why the introduction of autonomy-based ideas into the Chinese legal system will effectively raise people's awareness about reproductive liberty. According to Nie, though the language of rights has not been spoken as frequently as the language of responsibilities, relationships and duties in the Chinese regulatory system and public discourses, it does not mean that Chinese people do not need procreative rights or that 'Chinese women do not feel violated and wronged when, for example, their foetuses are coercively taken from their wombs'.[127] On the contrary, Chinese women's comparatively weak awareness of procreative rights and law's lack of respect for their reproductive liberty suggest that contextualising the principle of respect for autonomy and implanting it into the Chinese legal system can considerably improve this situation. At least, it will help women whose pregnancy is forced to be terminated 'label their as yet nameless problem, to express their sense of reproductive loss and possibility'.[128] For example, why is the family planning duty mainly undertaken by woman in practice?[129] Why do most abortions subsequent to prenatal sex diagnosis result in the elimination of female foetuses?[130] And why is the rate of repeated induced abortions so high among unmarried young women?[131] Ge, a Chinese feminist activist, has expressed how Western right-based language and feminist

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[127] JingBao Nie (2004) 'Feminist Bioethics and the Language of Human Rights in the Chinese Context' in Rosemarie Tong, Anne Donchin and Susan Dodds (eds) *Linking Visions* (Oxford: Rowman & Littlefifield Publishers) p.76

[128] Ibid. p.80

[129] From a survey conducted by the national Family Planning Commission, only about 11% married couples chose male sterilisation although it is a simpler and safer operation compared to female sterilisation and two most main contraceptive measures are female sterilisation and intra-uterine device (IUD), which were adopted by about 79% couples between 1985 and 1994. For more information, see chapter 4 and Elina Hemminki, Zhuochun Wu, Guiying Cao and Kirsi Viisainen (2005) 'Illegal births and legal abortions—the case of China' 2(5) *Reproductive Health* 1-8

[130] According to a recent survey by the national family planning research institute, during the population aged between 0 and 26, there are 34.02 million men more than women; the ratio of males to females at birth was 120.56 (the number of males/that of females*100) in 2008, which is the highest in the world. Without factitious factors, the natural sex ratio at birth should be 103-107 (the number of males/that of females*100). For more information, see Shaofeng Guo (27 November 2009) *China News* available at http://www.chinanews.com.cn/gn/news/2009/11-27/1986759.shtml (last accessed: 17 May 2011)

[131] According to a survey conducted by the National Research Institute for Family Planning, of 4547 unmarried young women seeking termination at abortion clinics in Beijing, Changsha, and Dalian from January to September 2000, 33.0% reported having had more than one previous induced abortion.
Yi Cheng, Xuan Gao, Ying Li, Sun Li, An Qu and Bing Kang (2004) 'Repeat induced Abortions and Contraceptive Practices among Unmarried Young Women seeking An Abortion in China' 87(2) *International Journal of Gynecology and Obstetrics* 199-202

thoughts helped her clearly view the underlying cause of a problem which for a long time she could not identify: why did her parents treat her brothers better than they treated her? She notes:

> I came to acquire words and concepts such as gender discrimination, gender stereotype, gender role and gendered structure. I began to put things in perspective, a gendered perspective. I was amazed at the effectiveness and forcefulness of these English words in describing and deconstructing Chinese women's secondary position in families and societies.[132]

4.2. A Regulatory Model of Abortion Grounded in the Principle of Respect for Autonomy

The analysis offered earlier in this chapter suggests that whether a woman is pregnant or not does not affect her capacity to exert autonomy over decision-making, so law should respect pregnant women's reproductive autonomy. Nevertheless, a difficult question is what role law should undertake in order to foster women's autonomy in the context of abortion. Addressing this question not only involves dealing with serious moral considerations (for example, the status of unborn life), but also requires making a realistic and reasonable reform target rather than a simple slogan. I will return to the former point in section 5. This part focuses on examining the latter – the extent to which a national abortion legislative model ought to support women's decision-making.

A person's autonomy in terms of the hierarchical account is dependent on her inner capacity to reflect on various desires. Although the hierarchical tradition stresses individual independence from external coercion, the formation of personal briefs and preferences relies on various social influences and networks of relationships. Thus, one's exercise of autonomy over decisions should also be relational and interdependent rather than asocial and isolated. Jackson notes:

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[132] Cecilia Milwertz (2003) cited by JingBao Nie (2004) p.75

> Human beings are not self-constituting subjects, with a set of pre-social desires, but neither do they entirely lack the capacity for agency and self-direction, otherwise it would be impossible to account for the different choices made by similarly situated people.[133]

Oshana has also argued that social contexts should be considered when we value personal autonomy.[134] Therefore, we should view autonomous choice as a form of independence and also a form of interdependence. The relationship between the values of independence and interdependence in personal autonomy can be harmonious though they appear to be inconsistent. Modern culture has been dominated by dualism which tends to construct two opposite parts in everything, such as body and mind, self and other, femininity and masculinity and independence/interdependence.[135] Dualism may mislead people into believing that there is an inconsistency between 'independence' and 'interdependence'. Nonetheless, 'independence' itself is relational because it is 'independence from something or other'.[136]

With reference to the harmonious relationship between these two concepts, I suggest that to promote procreative autonomy in the context of abortion, legal protection should focus on two individual capacities – being independent and being interdependent – by removing coercive influences and enhancing a supportive environment. More specifically, to promote women's ability to act on autonomously held high-level desires in abortion decisions, law should first protect their exercise of control of procreative choices free from controlling intervention or oppressive situations. It should be defined as a right for women to give informed consent before accessing abortion services and defend them from the 'medical-centred' and 'state-centred'[137]

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[133] Emily Jackson (2001) p.7
[134] Marin Oshana (2006) *Personal Autonomy in Society* (London: Ashgate)
[135] Onora O'Neill (2002) p.28
[136] Ibid.
[137] For a discussion of medical-centred and state-centred control, see chapters 3 and 4.

interference imposed by the existing English and Chinese models of the regulation of abortion. In addition, arguing for the right to autonomy in this chapter is not to value the decision (not) to reproduce or stress an absolute right (not) to have an abortion, but is to value a right to express one's own sense of the good. Therefore, law ought not to advocate for or depreciate the decisions (not) to continue gestation or support certain abortion-seeking women but limit others. As will be indicated in chapters 3 and 4, because of the influence of the compulsory cultural assumption about women's normal role, the existing English and Chinese jurisdictions have restricted female decisional authority by forming the different regulatory images between women who need abortion and their doctors and between female citizens and their state. As a consequence, women, particularly those from socioeconomically disadvantaged backgrounds, may not be able to decide reproductive decisions according to their own free will, but are subjected to what is constructed as 'rational' or 'glorious'[138] by medical professionals or the state.

Moreover, law's commitment to facilitating individual autonomy means that it ought to stress one's interdependence by ensuring that a supportive environment where cooperative and constructive networks of relationships can be established. First, this requires that law makers can appreciate abortion-seeking women's powerless situations caused by their lack of equal and supportive relationships with their doctors and the state. For example, as will be discussed in chapters 3 and 4, contraceptive duties are mainly undertaken by women, and a large number of women have no access to the free national contraceptive scheme in China; doctors' unsympathetic attitude towards unwanted gestation may drive some women to travel for terminating treatment or pay for a private service in England. Second, to achieve the aim of improving the situation in which women lack actual government over their reproductive decision-making, a regulatory model grounded in the principle of respect for autonomy should

[138] For an analysis of 'rational woman' and 'glorious mother', see chapters 3 and 4.

be also targeted at redressing the power imbalance in the paternalist relationships between women who need abortion and their doctors in England and in the patriarchal relationship between female citizens and the party state in China.[139]

5. Other Interests at Stake and Moral Consideration in Abortion Decisions

While abortion is a family planning service specific to women, there are other parties affected by any decision to abort. The two parties who are very directly involved in a woman's abortion decision are the foetus and the putative father. This section provides a discussion of the embryonic/foetal interests and the putative father's rights in seeking to address the question of whether law's promotion of reproductive autonomy can be overridden by protecting the interests of embryos/foetuses and putative fathers.

5.1. Human Embryos/Foetuses

An issue which is not usually and should not be omitted from ethico-legal debates relating to abortion is the status of the human embryo/foetus. Abortion means termination of pregnancy and it unavoidably leads to the destruction of embryos or foetuses. Some scholars have argued against translating the principle of respect for autonomy into the regulation of abortion on grounds of protection of the unborn human life. For instance, John Finnis notes:

> Every attempt to harm an innocent human person violates the principles of non-maleficence and justice, and is always wrong. Every procedure adopted with the intention of killing an unborn child, or of terminating its

[139] For a discussion of these two relationships, see chapters 3 and 4.

development, is an attempt to harm, even if it is adopted only as a means to some beneficent end (purpose) and even if it is carried out with every great reluctance and regret.[140]

There is a great amount of philosophical literature on the moral status of the foetus, which mainly focuses on the point at which personhood may be attributed to the foetus.[141] Some people, such as Finnis, believe that embryos/foetuses have a full personhood at a very early stage of pregnancy, such as the moment of conception. Others argue that a foetus should be treated as a person at a certain point of the gestation, so before that point they are just something more than a collection of cells but less than a full person. There are also some people who hold that embryos/foetuses do not have personhood until birth.[142] To avoid reinventing the wheel, this section does not examine various views on the moral status of human embryos/foetuses.

The views on the status of embryos and foetuses vary significantly from person to person. Autonomous agents can form their own judgements according to their own beliefs, values and convictions.[143] People's beliefs and goals vary according to different contexts they are in, so their understandings about the moral status of embryos/foetuses are not identical. For example, two (not the only two) very different traditional perspectives on embryonic/foetal development were developed in English and Chinese culture. The two views had affected people's perspectives on embryonic/foetal moral status and even national abortion legislation. The stages of foetal development were defined as different steps on a ladder in English culture and the foetus becomes a person at a certain step of foetal growth when the innocent soul made by God

[140] John Finnis (1973) 'The Rights and Wrongs of Abortion' 2(2) *Philosophy and Public Affairs* 117-145 p.141
[141] For example, John Finnis (1973), Marshall Cohen, Thomas Naggel and Thomas Scanlon (1974) (eds) *The Rights and Wrongs of Abortion* (Princeton: Princeton University Press) and Rosemarie Tong (1995) *Feminist Approaches to Bioethics* (USA: Westview Press)
[142] For a discussion of different views on the status of human embryos/foetus, see Rosemarie Tong (2009) *Feminist Thought* (Boulder: Westview Press) pp.77-80 and Margaret Brazier and Emma Cave (2011) *Medicine, Patients and the Law* (London: Penguin Books) pp.393-396
[143] Daniel Little (1991) *Varieties of Social Explanation: An Introduction to the Philosophy of Social Science* (Oxford: Westview Press)

enters its body.[144] In early English abortion regulation, 'quickening' is a point to distinguish criminal abortion from non-criminal ones. As Potts, Diggory and Peel have observed, the British legal tradition itself is an amalgam of the tradition of the Roman legal system and the influence of Christianity. They noted:

> Canon law followed the same pattern and St Augustine drew a distinction between the 'embryo informatus' and 'formatus', similarly English common law made a distinction between early and late abortion, drawing the dividing line at quickening.[145]

Comparatively speaking, self-abortion provoked much less criticism in Chinese traditional society. According to the traditional medical theory of foetal development in China, there was no sharp upper limit which is similar to the English ideas of animation or viability, because the whole process of foetal development was regarded as horizontal. *Wuzang Lun* (literally, the discussion on five organs), one of the earliest and most influential Chinese medical works on foetal growth, showed that the different stages of foetal development were defined in terms of the ten-month lunar cycle of pregnancy:

> 1st month: the incipient embryo; 2nd month: the incipient fat; 3rd month: the incipient fetus; 4th month: the water Essence (shuijing) activates the formation of blood and blood-vessels; 5th month: the fire Essence (huojing) activates the formation of blood and blood-vessels; 6th month: the Essence (jing) activates the formation of sinews; 7th month: the Wood Essence activates the formation of bones; 8th month: the Earth Essence activates the formation of skin; 9th month: the Stone Essence activates the formation of hair; 10th month: the organs, joints, body, and spirits (sheng) are formed.[146]

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[144] Bernard Hung-kay Luk (1977) 'Abortion in Chinese Law' 25(2) *The American Journal of Comparative Law* 372-392

[145] Malcolm Potts, Peter Dggory and John Peel (1977) *Abortion* (Cambridge: Cambridge University Press) p.277

[146] Jingbao Nie (2005) *Behind the Silence: Chinese Voices on Abortion* (Oxford: Rowman & Littlefield Publishers) p.83

Accordingly, during the foetal growth period, the embryo/foetus gradually obtains the elements which are necessary for it to form a humanoid body. For example, its bones are supplied in the seventh month by the evolutive phase of Wood Essence and its skin is formed in the eighth month by the evolutive phase of Earth Essence. Thus only after all these stages can the foetus be treated as a fully developed person and the birth is the symbol of completing foetal development.[147] In accordance with this understanding of foetal growth, a foetus was regarded as a part of the pregnant woman's body and the pregnant woman was thought of as the supplier who provided the foetus with those key elements to develop its humanoid shape. Consequently, there was a distinction between self-abortion and infanticide in Chinese ancient criminal law – the former was not regulated and the latter was a crime.[148]

The analysis above does not try to make judgements about which theory can better address the question of what the moral status of the foetus is and which kind of regulation is more reasonable. As has been stated above, there is no universal answer to the questions of what the moral status of embryos/foetuses is and after which point in the gestation embryos/foetuses can obtain full personhood. While embryos or foetuses do have the possibility of becoming a fully formed person, the embryonic/foetal potentiality does not mean that the embryo/foetus automatically has the ability to become a fully developed person. As McLean has claimed, a foetus neither possesses nor is self-evidently able to claim to be a bearer of rights and any respect due to the embryo/foetus 'stems not from its own characteristics, but rather from our interest in showing it respect'.[149] Therefore, while theoretically it may be possible to plug a 24-week-old foetus into life support apparatuses, this does not mean that women should be forced to continue their unwanted procreation and take 'primary responsibility for supporting – in every sense – a child

[147] Charlotte Furth (1987) 'Concepts of Pregnancy, Childbirth and Infancy in Ch'ing Dynasty China' 46(1) *The Journal of Asian Studies* 7-35
[148] David Mungello (2008) *Drowning Girls in China: Female Infanticide since 1650* (Lanham: Rowman & Littlefield Publishers) p.5 and p.127
[149] Sheila McLean (2010) pp.128-154

through to adulthood'.[150] While I believe that an embryo/foetus should be accorded respect, when its claims to rights conflict with the claims of the mother 'whose status is beyond doubt',[151] the claims of the embryo/foetus should be subordinated to the mother who is obviously a legal person.

As will be discussed in chapters 3 and 4, both the current English and Chinese regulatory systems value a certain belief about the moral status of embryos/foetuses but depreciate some others. Permissive law should protect people's freedom to form their own judgement on their reproductive choices, rather than force them to make some certain choices. As Sheila McLean has noted, a law which permits people to do *x* forces no one to do it, but permits those who wish to, to undertake *x*.[152] Based on McLean's argument, I suggest that a regulatory model of abortion grounded in the principle of respect for autonomy is less problematic and more equal than the existing English medical-centred and Chinese state-centred ones which drive any woman who (does not) believes that foetal life can (not) be damaged (not) to do so.

5.2. Putative Fathers

The question of how to deal with putative fathers'/pregnant women's sexual partners' interests in abortion decisions is a difficult one for feminists. On the one hand, feminists have welcomed the demand that men should take more responsibility and play a greater role in contraception and parenting. On the other hand, because of this demand, it is not easy to dismiss arguments for men's interests in abortion decision-making. I agree that in order to encourage men to participate actively in reproductive and parenting activities, their interests in abortion decisions should also

[150] Maureen McNeil (1991) 'Putting the Alton Bill in Context' in Sarah Franklin, Celia Lury and Jackie Stacey (eds) *Off-Centre: Feminism and Culture Studies* (London: Harper Collins Academic) p.156
[151] Margaret Brazier and Emma Cave (2011) p.395
[152] Sheila McLean (1990) 'Abortion Law: Is Consensual Reform Possible?' 17(1) *Journal of Law and Society* 106-123 p.110

be taken seriously.[153] However, I intend to draw two conclusions in this part: first, the pregnant woman's and her sexual partner's interests in the abortion decision should not always be treated as conflicting and second, legally men's interest in abortion decisions should not be given priority over pregnant women's decision-making authority.

First, pregnant women's and their sexual partners' interests in abortion decision-making are not always in conflict; on the contrary, they are often consistent. As has been discussed, the promotion of one's autonomy in reproductive decisions is dependent on social support and constructive relationships. In practice, it is likely that a woman will take her partner's suggestions and her relationship with her partner into account in abortion or other reproductive decisions. For example, as Lee, Clements, Ingham and Stone have observed, the end of the relationship with the putative father is an important reason why pregnant women have an abortion in the UK.[154] Similarly, a Chinese online survey conducted in 2009 shows that 90 per cent of female participants took the relationship with their partner/husband as a significant element when they considered whether to continue an unplanned pregnancy.[155]

Second, undeniably in some cases there is a conflict between pregnant women's and putative fathers' interests in abortion decisions, for instance, *Paton v Thustees of the British Pregnancy Advisory Service and Another*[156] and *Shihua v Cuixinfeng*[157]. In the former case, an English husband sought an injunction to restrain the British Pregnancy Advisory Service from proceeding with termination for his wife and in the latter a Chinese husband sued his wife for

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[153] Marie Fox (1998) 'Abortion Decision-making – Take Men's Needs Seriously' in Ellie Lee (ed) *Abortion Law and Politics Today* (London: Macmillan Press Ltd)
[154] Ellie Lee, Steve Clements, Roger Ingham and Nicole Stone (2002) *A Matter of Choice?* (York: the Joseph Rowntree Foundation)
[155] Nürenjie (07 July 2009) '*Dang Danshen Muqin*' (literally being a single mother) available at http://www.nverjie.com (last accessed: 22 August 2010)
[156] [1978] 2 All E.R. 978
[157] (2003) *fangcheng* civil(1) no.17

mental injury because she had an abortion without his consent. Although the husbands' claims in both cases were eventually dismissed in the courts, two questions are raised – whether, and if so to what extent, men's say in abortion decisions should be reflected and protected by law.

Reproduction happens inside women's bodies and physically reproductive responsibility is mainly undertaken by women. As Jackson has observed, carrying a pregnancy to full term changes the woman's physical state for at least nine months; the process of giving birth is often hard, painful and sometimes dangerous labour.[158] Unwanted reproduction therefore imposes greater physical and perhaps also more mental burdens on women compared with men.[159] Men's desire for fatherhood should not be at the expense of women's bodily integrity and reproductive health. Similarly, when a man does not want to become a father, his decision to adopt contraception should be respected even if his partner wants to have a child biologically related to him. As has been suggested above, women's and men's interests are often consistent and interdependent rather than conflicting and separated. As Fox has observed, in practice men can be encouraged through counselling to be involved with abortion decision-making, so that consensus between partners may be established.[160] Nevertheless, when there is a conflict between the pregnant woman's and her partner's interests, the woman's reproductive autonomy that is essential to satisfy her basic needs for health and for control over her life should be given more importance than the man's desire to become a father in law.

[158] Emily Jackson (2008) p.350
[159] John Robertson (2003)
[160] Marie Fox (1998)

Conclusion

The first four sections in this chapter have attempted to answer three questions: 'What does the term "autonomy" mean according to the hierarchal account?; why does reproductive autonomy matter in the context of abortion?; how can promotion of reproductive autonomy in abortion decisions be understood from feminist perspectives?; and what role ought abortion law to play in fostering procreative autonomy?' The final section has examined other interests in abortion decisions.

In response to the first question, section 1 has focused on 'the hierarchical analysis', which defines autonomy as people's inner capacity to critically rank various desires. More specifically, it is the capacity to indentify with or repudiate their basic wants in terms of their higher-order convictions and preferences. Because of its significance to personhood, dignity and integrity, competent persons should have the right to be treated as autonomous agents. This right can be viewed in negative and positive ways. The former involves no controlling influence on people's decision-making and the latter requires that proper support is available for enhancing the exercise of free decisions. The analysis offered in section 2 has examined the importance of the principle of respect for autonomy in contemporary medical ethics and practice. This principle claims that patients should be allowed to decide whether or not to accept health care treatment according to their own conception of good. It therefore challenges the paternalist idea of 'doctor knows best' and the state's authority to shape the good life for individual citizens. However, in the field of procreative health care, women's decision-making is often ignored and even violated. To argue for importing the principle of respect for autonomy to the national regulation of abortion, section 3 has stressed the importance of willing reproduction to women's basic needs for health and for control over their lives. High maternal morbidity and mortality are caused by the unavailability of safe termination in the jurisdictions where strict restrictions are imposed on

the provision of abortion services. Furthermore, this section has conducted a feminist investigation of the possible legal obstacles in England and China to women's exerting autonomy over meaningful procreative choices. Feminist legal analytical methods are helpful in investigating different forms of sex oppression and injustice which decrease women's actual control over their reproductive biology and lives. This section has also aimed to ease the tension between the concepts 'feminism' and 'autonomy' by arguing that traditional values, such as self-determination and independence relating to the concept 'autonomy' do not necessarily 'embrace an exclusively male ideal'.[161] On the contrary, they could both be understood from a female-friendly perspective. Additionally, it has been claimed that some feminist criticisms of the theory about autonomy are based on a narrow and problematic definition of autonomy – a right to make asocial and isolated choice. Section 4 has examined the role a model of the regulation of abortion should play according to the principle of respect for autonomy. The examination has suggested that law makers should remove unnecessary limits on the access to abortion and, more importantly, secure the availability of positive cooperation and support in order to redress the power imbalance produced in the paternalist patient/doctor and citizens/state relationships. The final section has discussed the interest of the embryo/foetus and the putative father, who will be directly affected by the pregnant woman's abortion decision. On the one hand, human embryos/foetuses deserve some respect because of their potentiality to become fully formed persons, and putative fathers' say in abortion decisions should be taken seriously in seeking to encourage equally sharing reproductive responsibilities and rights. On the other hand, this section has argued that they cannot override women's abortion decision-making that is essential to meet their needs for health and for control over lives. Thus, legally pregnant women's reproductive autonomy should be given priority.

[161] John Christman (1995) p.17

Law's respect for procreative autonomy not only stresses decision makers' independence, but also their interdependence. Women's exercise of meaningful procreative choice is dependent on an environment where their convictions are allowed to freely develop and are treated with seriousness. Thus national law makers should be sensitive to abortion-seeking women's powerlessness caused by oppressive communications with others. As has been indicated in chapter 1 of this thesis, chapters 3 and 4 will undertake the task of exploring the controlling influences imposed by health professionals and the state on women's reproductive autonomy under the existing English and Chinese regulatory models of abortion.

Chapter 3

The Law of Abortion in England

Introduction

In chapter 2, I have discussed the importance of promoting autonomy in abortion decisions to satisfy women's basic needs for health and for the exercise of control over their lives. Law's commitment to autonomy suggests that it should effectively protect women's decision-making from other agents' controlling influence and enhance their access to state and medical support. Building on the analysis offered in chapter 2, this chapter provides a critical discussion of the English model of abortion regulation in order to examine how its lack of respect for women's autonomy contravenes social justice and increases inequality against women, particularly those from socioeconomically disadvantaged backgrounds. Restricting access to abortion, as a health care procedure that only women need, is a form of social injustice because it does not allow women to have procreative freedom as their male peers do. Moreover, as will be discussed in this chapter, legal limits on abortion make the exercise of control over reproductive choices even more difficult for women from a comparatively low social class who cannot afford to or do not have the knowledge to circumvent these restrictions. Therefore, restricting the provision of termination services can increase social class inequality against women from socioeconomically disadvantaged backgrounds.

The existing regulatory model of abortion in England is composed of statutes and case laws which were brought into force before and after the legalisation of abortion in 1967. Many

scholars, such as Cook, Dickens,[1] Rahman[2] and Latham[3] have viewed the enactment of the Abortion Act 1967 (the 1967 Act) as a landmark in the English history of abortion legislation because it is the first time that law had liberalised abortion in some special circumstances. For example, Latham has claimed that the enactment of the 1967 Act symbolises the shift in abortion from 'criminalisation' to 'liberalisation'.[4] In order to analyse changes in English abortion law and draw a clear comparison with Chinese abortion law in different eras, in this chapter I also adopt the 1967 abortion law reform as a boundary line to distinguish law in the era of criminalisation from that in the era of medicalisation. However, instead of seeing it as a sign of liberalising abortion, the discussion provided in this chapter attempts to critically respond to the post-1967 regulation of termination by scrutinising how it fails to prevent the medical profession from exercising coercive influences on women's procreative decisions. Additionally, while the distinction will be drawn between laws in the two different eras, I argue that there is no fundamental difference between them in the way in which they treat women's decision-making. They have been both targeted at entrenching the medical monopoly on the provision of abortion at the expense of women's autonomy. Consequently, as will be suggested later in this chapter, under the English regulatory model, the performance of abortion has become restricted to the medical profession. However, women's needs for controlling fertility have been marginalised. Moreover, through the lens of gender, my analysis of the English medical-centred model of abortion regulation offered in this chapter will suggest that the medical profession's control over performance of abortion serves to maintain the compulsory assumption of womanhood which has been discussed in chapter 2.

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[1] Rebecca Cook and Bernard Dickens (1978) 'A Decade of International Change in Abortion Law: 1967-1977' 68(7) American Journal of Public Health 637-644; (1999) 'International Developments in Abortion Law from 1988 to 1998' 89(4) American Journal of Public Health 579-586

[2] Anika Rahman, Laura Katzive and Stanley Henshaw (1998) 'A Global Review on Induced Abortion, 1985-1997' 24(2) Internal Family Planning Perspectives 56-64

[3] Melanie Latham (2002) *Regulating reproduction: A century of conflict in Britain and France* (Manchester: Manchester University Press)

[4] Melanie Latham (2002) p.87

In section 1 of this chapter, I will explore the English statute and common law relating to abortion in the era of criminalisation, which means the period from the second half of the nineteenth century to 1968 when the Abortion Act came into force. It can be seen from the analysis provided in this section that the emerging medical intervention shifted abortion from a comparatively unregulated issue to a crime which might only be lawfully committed by 'medical men' in the nineteenth century. Furthermore, abortion law-making in the century before 1967 demonstrates how doctors had gained the ultimate decisional authority in women's abortion decisions. Meanwhile, pregnant women had been construed as figures who needed to be deterred by severe punishment from damaging the embryo/foetus inside their bodies. Consequently, pregnant women's life experiences and preferences had become irrelevant to abortion decision-making. In addition, this chapter examines the provision of abortion services in practice in order to illustrate that the regulatory model in the era of criminalisation did not serve to stop women from seeking abortions, but forced them to resort to 'back-street' services which were often unsafe and performed in unhygienic conditions. I suggest that abortion legislation and judicial decisions in the era of criminalisation have largely underpinned the principle 'doctor knows best' based on which the regulatory model in the era of medicalisation has been established. Therefore, while the focus of this chapter is abortion law in the era of medicalisation, the discussion of the law of abortion in the era of criminalisation offered in section 1 not only serves as a historical description to explain how abortion was regulated in the past, but also provides background information which is essential to a deep insight into the regulatory model in the era of medicalisation. The investigation of the regulatory model of abortion in the era of medicalisation, by which I mean the period from 1967 to the present, is mainly undertaken in sections 2 and 3. I shall emphasise that the frameworks within which law works in both eras are not fundamentally distinct from each other. As suggested later in this chapter, if the nineteenth century is the time

when medical involvement in the legislation on abortion emerged, the twentieth century is the period when legislators' leading strategy to govern abortion has changed to medicalisation. An analysis is also provided to explore the reasons why legislators and judges adopt a positive attitude towards medical control and a negative one to women's autonomy. I refer this back to the discussion of the nature of law and the compulsory gendered assumption of womanhood offered in chapter 2.

Through exploring the following four issues, I argue that the medical monopoly has been entrenched since 1967 and it has led to the fact that women have lost control in abortion decisions. This is partly due to the creation of the four statutory grounds in the 1967 Act, the adoption of the upper limit, law's construction of abortion as a medical decision and problems caused by the regulatory model in practice. The analysis offered in sections 2 and 3 suggests that centralising medical power and disrespecting women's decisional autonomy are two interrelated and simultaneous processes, since 'the more abortion becomes seen as a medical decision, the more difficult it becomes to see this decision as one which fundamentally belongs to women rather than to doctors'.[5] In the meantime, I argue that law's lack of respect for abortion-seeking women's autonomy and entrenchment of the medical monopoly have unavoidably produced power imbalance in the women/doctors relationship and subjected the former to the latter's moral scrutiny.

The discussion provided in this chapter first aims to achieve a thorough understanding of the English-style liberalisation of abortion by scrutinising whether and how the modern regulation of abortion works within the framework 'respect for autonomy'. Second, this chapter will lay the

[5] Sally Sheldon (1997) *Beyond Control: Medical Power and Abortion Law* (London: Pluto) p.157

groundwork for the comparative study with the Chinese law, which will be undertaken in chapter 5.

1. Abortion Law and Practice in the Era of Criminalisation

This section examines how abortion was regulated in the era of criminalisation. More specifically, it provides an analysis of two statutes and a case relating to abortion: the Offences Against the Person Act 1861 (the 1861 Act) which is regarded as comprising 'fundamental' rules governing termination in the English jurisdiction,[6] the Infant Life Preservation Act 1929 (the 1929 Act) and *R v Bourne*[7] (*Bourne*) which was used to regulate abortion before 1967. In addition, this section explores possible causes of the huge number of 'back-street' terminations in practice. The discussion of the criminalisation of abortion in law and practice will achieve three goals. First, it helps the reader understand how health professionals' involvement changed the English model of the regulation of abortion before 1967. As has been discussed in the introduction to this chapter, while abortion law in the era of criminalisation and that in the era of medicalisation will be discussed separately in this chapter, the connection between them is a close one. Their relationship will be further scrutinised in section 2 of this chapter. I suggest that an investigation of the regulation of abortion before the enactment of the 1967 Act helps the reader have a thorough understanding of the medical-centred model of abortion regulation. Second, based on the analysis of the provision of abortion services in practice and the possible detrimental effects of criminalising abortion on women, I argue that establishing an autonomy-based regulatory model requires completely decriminalising termination. While the task of drawing possible proposals to reconstruct the current model according to the principle of respect for autonomy is undertaken in chapter 5, this section makes an early attempt by suggesting that

[6] See Jonathan Montgomery (2003) *Health Care Law* (Oxford: OUP)
[7] [1939] 1 KB 687

an initial and crucial step in reforming the existing regulatory model of abortion is to challenge law's construction of women who request abortion as criminals. Third, the discussion of the English regulation of termination provided in this section is helpful in producing a clear and logical comparative study with the Chinese law and policy of abortion in the Maoist era which will be examined in chapter 4. The analyses offered in this section and in section 2 of chapter 4 can help the reader understand how the medical-orientated and state-orientated controlling intervention began to effect change in the regulation of abortion in England and China.

1.1. Medical Intervention and Abortion Law in the Era of Criminalisation

The regulation of abortion did not become part of criminal law in England until the beginning of the nineteenth century.[8] Although medical knowledge about terminations was very limited and surgical abortions were not available before the nineteenth century, similar to many other societies there was no lack of alternative measures in England such as various abortifacient drugs. Malcolm Potts et al. have observed that abortifacient drugs were sold by pharmacists and druggists in the UK and these qualified or unqualified suppliers had a 'perfect market'.[9] Termination of a pregnancy was treated as a 'common law misdemeanour' only if it were procured after 'quickening'[10]. This was defined as the moment when pregnant women can feel the foetus moving and also the time when human life begins, namely four months after conception.

While modern and safe termination methods have been introduced and adopted in England since the nineteenth century, women became less free to access abortion because the law governing termination has formed part of the criminal law. The rest of this section discusses how the

[8] Malcolm Potts, Peter Dggory and John Peel (1977) *Abortion* (Cambridge: Cambridge University Press) p.278
[9] Ibid (1977) p.257
[10] Angus McLaren (1984) *Reproductive Rituals* (London: Methuen) p.122

nineteenth-century medical men used their knowledge as power to affect the English abortion regulatory model. There are three main changes. Firstly, abortion, which was unregulated before the nineteenth century, has been governed by criminal law. Secondly, because of medical intervention, law has defined abortion as a procedure controlled by health professionals. Thirdly, changes in abortion regulation made by successive governments are motivated by their desire to protect medical direction on termination.

1.1.1. The Legislation on Abortion in the Era of Criminalisation

A key step in the process of criminalisation of abortion in the early nineteenth century was that the medical profession challenged the legitimacy of the adoption of 'quickening' as a criterion to distinguish criminal and non-criminal abortions. As has been explained above, 'quickening' depends on women's subjective feeling. Thus, medical professionals have claimed that 'quickening' was not a 'scientific basis' because they could neither observe nor define it.[11] Moreover, new medical evidence was adopted by the nineteenth-century doctors to reject the use of 'quickening' as the sign of human life starting, and they argued that an embryo/foetus made the transition to personhood much earlier than at quickening. To justify their opposition to abortion and obtain the public's support, doctors publicised their concern for foetal life. As Keown has commented, 'medical men' in the nineteenth century invoked their scientific knowledge to prove that termination at any stage of pregnancy is indistinguishable from 'infanticide and called for severe punishment' in order to construct abortion as a crime.[12]

Sections 58 and 59 of the 1861 Act, which continue to apply to abortion today, state:

[11] John Keown (1988) *Abortion, Doctors and the Law* (Cambridge: Cambridge University Press) p.23
[12] Ibid. p.38

> Section 58 Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall *unlawfully* use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be liable... to be kept in penal servitude for life...
>
> Section 59 Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be *unlawfully* used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of an offence, and being convicted thereof shall be liable...to be kept in penal servitude...[13]

These two sections do not mention the difference between termination of pregnancy before and after 'quickening'. Accordingly, abortion at any stage of pregnancy on any grounds was treated as a criminal offence and 'quickening' was completely removed. Sections 58 and 59 suggest that there were two types of people who may be guilty of the offence: a pregnant woman who self-induces her own abortion and any third-party who procures the miscarriage of a woman. Comparatively speaking, the penalty for the prior, namely a woman who had a self-abortion, was more severe. The maximum sentence was life imprisonment, but for those who procured a miscarriage in another person, it was up to five years. Even if a woman mistakenly believed that she was pregnant and tried to terminate a non-existent pregnancy, she might be prosecuted for conspiring to procure an abortion.[14]

On the one hand, the 1861 Act overrode 'traditional reliance on women's immediate experience of foetal movement' as a significant stage of development and treated women as 'criminal for

[13] Offences Against the Person Act 1861. Words omitted were repealed by the Statute Law Revision Act 1892 and the Statute Law Revision (No. 2) Act 1893.
[14] See the case in the Queen v Whitchurch and others, (1890) LR 24 QBD 420.

any interference in their own pregnancy'.[15] Consequently, women's life experiences in gestation were marginalised and their agency was also denied. On the other hand, abortions performed by medical professionals were still labelled as 'lawful'. In sections 58 and 59, the word 'unlawfully' in italics implies that an abortion could be carried out lawfully even if it may have caused foetal death. Given that nineteenth-century doctors did perform so-called therapeutic abortions without being prosecuted, it is likely that nineteenth-century legislators intentionally left a defence to them when they damaged embryos/foetuses in the processes of performing therapeutic terminations.[16] Furthermore, from the analysis of *Bourne* provided below, it can be seen that the right to define 'therapeutic termination' was left in the hands of doctors. In accordance with *Bourne*, doctors were able to perform this therapeutic surgery according to their individual standards even if it resulted in foetal death.

After the early twentieth century, therapeutic abortions were often performed by doctors when they believed that pregnant women could die if they continued the gestation, 'particularly in the case of women with tuberculosis'.[17] Against this background, a second statute relating to abortion: the Infant Life Preservation Act of 1929 (the 1929 Act), was passed by parliament in 1929. Sections 1(1) and 1(2) of the 1929 Act require:

> (1) Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life.
>
> Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

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[15] Barbara Brooks (1988) *Abortion in England 1900-1967* (London: Croom Helm) p.26
[16] Emily Jackson (2006) *Medical Law* (Oxford: Oxford University Press) p.596
[17] Malcolm Potts, Peter Diggory and John Peel (1977) p.282

(2) For the purposes of this Act, evidence that the woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be *prima facie* proof that she was at that time pregnant with a child capable of being born alive.

Compared to the 1861 Act, the major change is that the 1929 Act confirms the legitimacy of therapeutic termination provided by medical professionals and states that the defence can be claimed when termination is performed in their 'good faith' to save the woman's life. Thus, enacting the 1929 Act was mainly motivated by the desire to prevent medical professionals from being prosecuted for performing termination. Moreover, the adoption of 'good faith' implies that abortion can only be lawfully carried out by doctors. While early surgical abortion had become relatively safe since the 1900s, abortions conducted by lay persons, including pregnant women themselves, were still criminalised no matter whether they were carried out in 'good faith'.[18] The 1929 Act conveys a message to the public that the provision of termination services must be restricted to doctors only. As analysed above, around the late nineteenth century, terminations on strictly therapeutic grounds were accepted and commonly practised by doctors. Consequently, they needed a new piece of legislation which could guarantee them a legal defence, because the term 'unlawfully' in the 1861 Act does not clearly state that doctors are entitled to decide when an abortion could be performed lawfully.

As discussed earlier in this chapter, in order to enhance their discretion on abortion, the nineteenth-century English doctors first attacked the concept of quickening and claimed to be better qualified than to determine how far women's pregnancies had progressed. By doing so, they aimed to ensure that patients could not be entrusted with legal decision-making.[19] Thus, according to the 1861 Act, any attempt by a woman to end her pregnancy is criminalised and

[18] Barbara Brooks (1988) p.30
[19] Angus McLaren (1984) p.139

harshly punished. Furthermore, by asserting their monopoly on abortion, medical professionals also sought to repress 'irregular practitioners'[20] and to define themselves as the only legitimate abortion provider. As will be suggested in section 1.3 of this chapter, the nineteenth-century medical men's activities relating to abortion not only served to facilitate their exercise of control over performance of termination services, but also led to the criminalisation of abortion. My analysis of the 1929 Act has shown that while enactment of this act partially decriminalised abortion, women were not granted any right to decide whether to end their pregnancy. From the analysis in the rest of this chapter, it will be seen that in the twentieth century, the medical profession played a crucial role in decriminalising terminations in certain circumstances. By doing so, the twentieth-century doctors monopolised the process of abortion.

1.1.2. The Judicial Decision in Bourne[21]

In *Bourne*, Aleck Bourne, a gynaecologist, 'deliberately'[22] challenged the 1861 Act and the 1929 Act by performing an abortion for a 14-year-old girl who became pregnant after being raped by a group of soldiers. Mr Bourne was a gynaecologist with a good reputation at St. Mary's Hospital in London. He carried out the abortion with the girl's mother's written approval and without charging any fee and then was charged under section 58 of the 1861 Act with unlawfully procuring the girl's miscarriage. His defence was that the words 'for the purpose of preserving the life of the mother' should be understood in a 'reasonable' way. In his opinion, the effect of carrying the pregnancy to term would make this girl 'a physical or mental wreck', so performing the abortion in question was not unlawful. A specialist in medical psychology as a witness for Bourne gave evidence that it was likely that the girl would become a mental wreck if she continued the pregnancy and gave birth. Eventually he was acquitted of causing the foetal death,

[20] Ibid, p.137
[21] John Keown (1988) p.78
[22] Bernard Dickens (1966) *Abortion and the Law* (Bristol: MacGibbon & Kee) p.38

because the jury believed that he performed the abortion in 'good faith' on the grounds of preserving the life of the mother in order to prevent the pregnant girl from severe mental injuries. Case law in the form of the summings-up in *Bourne* governed the provision of legal abortion until 1967 in England and Wales.[23]

The discussion of *Bourne* offered in this subsection does not aim to give a sweeping statement about the morality of the abortion in question. As suggested in chapter 2, how people think about termination of pregnancy is significantly dependent on their cultural backgrounds, briefs and values. The examination of *Bourne* is motivated by my desires to demonstrate changes in the common law regulating abortion which were caused by medical involvement and to examine why judges supported law's centralisation of medical knowledge. As discussed earlier in this section, the therapeutic grounds of 'preserving the life of the mother' in the 1929 Act only include life-saving terminating operations. Therefore, technically, the abortion service provided by Bourne was not based on the grounds because, as he claimed, it mainly aimed to avoid physical and mental damage to the girl caused by unwanted gestation and fertility rather than to save her life. Nonetheless, the judge did not stick to the original meaning of the grounds, but adopted Bourne's 'reasonable' explanation of 'preserving the life of the mother'. Consequently, the judge expanded the scope of defences available for doctors who performed terminations in life-saving situations to those in health-threatening ones. The meaning of preserving the life of the mother was broadened from saving pregnant women from instant death to protecting them from physical or mental harm in order to protect doctors' 'good practice'. As Judge Macnaughten noted:

> If the doctor is of the opinion, on *reasonable grounds* and with *adequate knowledge*, that the probable consequences of the continuance of the pregnancy will be to make the woman a physical or mental wreck,

[23] [1939] 1 KB 687

> the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that *honest belief*, operates, is operating for the purpose of preserving the life of the woman...Take a *reasonable* view of the words 'for the preservation of the life of the mother'. I do not think that it is contended that those words mean merely for the preservation of the life of the mother from instant death...[24]

Through expanding the meaning of 'preserving the life of the mother', the court entrenched doctors' power over the decision about whether women could have an abortion. Furthermore, from the italic words in the following extract, it can be seen that the court considered abortion as a medical-centred procedure by drawing a sharp distinction between abortions performed by a 'callous and greedy back-street abortionist' and those performed by 'the altruistic medical practitioners'.[25] Macnaughten condemned abortionists for performing profitable surgery, but appreciated the significance of the therapeutic abortions carried out by doctors. He commented:

> In that other case a woman *without any medical skill or medical qualifications* did what is alleged against Mr. Bourne here; she *unlawfully* used an instrument for the purpose of procuring the miscarriage of a pregnant girl; she did it *for money*; £2 was her fee...she came from a distance to a place in London to perform the operation. She used her instrument, and within an interval of time measured not by minutes but by seconds, the victim of her malpractice was dead on the floor...The case here is very different. A man of the *highest skill, openly,* in one of our *great hospitals*, performs the operation. Whether it was legal or illegal you will have to determine, but he performs the operation as an *act of charity*, without fee or reward, and unquestionably believing that he was doing the right thing, and that he ought, in the performance of his duty as a member of *a profession devoted to the alleviation of human suffering*, to do it...[26]

Nonetheless, the judge turned a blind eye to the fact that the criminalisation of termination could not eliminate women's desire for ending unwa nted gestation and drove a huge number of working class women to resort to 'back-street' providers. The discussion of abortion in practice

[24] Ibid. pp.689-690
[25] Sally Sheldon (1997) p.80
[26] [1939] 1 KB 687 p.690

offered in the following section will suggest that abortion law in the era of criminalisation acutely violated women's basic needs for health and for control over their lives and also caused social injustice against women who are socioeconomically disadvantaged. The judicial decision in *Bourne* indicates that the protection of the medical monopoly on abortion services in common law was even more obvious and stronger than that in the 1929 Act. According to the 1929 Act, an abortion can be performed lawfully by a doctor when he thinks that it is necessary to save the pregnant woman's life. Nevertheless, the Act does not define the medical profession as the only authority to provide terminations. In fact, neither the concept 'good faith', adopted in the 1929 Act, nor the word 'unlawfully', used in the 1861 Act, clearly draw a line between abortions carried out by doctors and those by 'lay persons', such as abortionists. *Bourne* served the purpose of restricting the performance of abortions to qualified medical men only. The judges' attitude towards abortion in *Bourne* demonstrates the traditional judicial respect for and deference to medical professionals.[27] The cooperation between the legal and the medical professions can be also seen in the legislation on abortion after 1967 in which the role of doctor is defined as a 'parallel judge'[28] who asserts 'appropriate sexual/gender behaviour'[29] in the provision of abortion services.

1.2. 'Back-street' Providers and Abortion in Practice Before 1967

According to the italic words in the above extract, abortion could not be lawfully performed by lay persons because their services were regarded as profitable, unprofessional and dangerous. In other words, they were considered as illegal providers who did not act in 'good faith'. As has

[27] Also see *Whitehouse v Jordan* [1980] 1 All ER 650 and *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 All ER 643

[28] Sally Sheldon (1997) p.86

[29] Michael Thomson (1998) 'Rewriting the Doctor: Medical Law, Literature and Feminist Strategy' in Sally Sheldon and Michael Thomson (eds) *Feminist Perspectives on Health Care Law* (London: Cavendish Publishing Limited) p.182

been discussed above, law's construction of abortions provided by lay persons served the purpose of restricting the provision of abortions to doctors only. Nonetheless, law's construction of back-street abortions in the judicial decision did not reflect their position in real life. According to Sheldon's observation, many 'back-street' abortionists were motivated more by 'compassion and a desire to help a woman in trouble than by any financial motive', but a great many medical practitioners might make a large sum of money from performing abortions.[30] Furthermore, Obeing's research on unlawful termination cases in England before 1967 shows that women admitted to a London hospital in 1960 due to the consequences of criminal abortion paid £5–£80, which was lower than the fee of those in private practice immediately after the 1967 reform even allowing for inflation; some even had the operation for nothing from sympathetic friends. Some illegal 'back-street' suppliers interviewed did not express any guilt and said that they made an initial attempt to help someone in desperate circumstances.[31] Similarly, according to Woodside's interview with 44 women serving sentences for criminal abortion in Holloway Prison in the 1960s, most of the interviewees were married mothers and some were grandmothers. They did not regard themselves as criminals and within their own community they had usually been hailed as public benefactors.[32] Although most did admit that they took money or gifts, financial gain was not their main motivation.[33]

Distinct from the greedy and callous image of illegal abortion suppliers created in the judicial decision in *Bourne*, in reality they could be the pregnant woman's husband, mother, grandmothers, friends or even herself. This may be the main reason why the so-called victims of criminal abortions did not want to accuse 'back-street' suppliers who performed the operation for

[30] Sally Sheldon (1997) pp.80-81
[31] Bernard Obeing (1967) *Five Hundred Consecutive Cases of Abortion* (Thesis submitted to the University of London for the Degree of Doctor of Philosophy) p.30
[32] Maya Woodside (1963) 'Attitudes of Women Abortionists' 11(2) *The Howard Journal of Criminal Justice* 1468-2311
[33] Ibid.

them. While terminations provided by qualified medical men were also available before 1967, women who could afford their services were normally middle class.[34] For working class women, seeking affordable 'back-street' terminations might be the only means of avoiding unwanted fertility. Thus, in practice, women often tended to appreciate what abortionists did for them by sending gifts or money voluntarily.[35]

The above discussion does not aim to justify 'back-street' abortions or suggest that maternal mortality caused by them should be ignored. On the contrary, I do think that unsafe termination means should be avoided and those 'bad old days of the back-street abortion'[36] should be over. However, the key point is that when legal and safe termination services are not provided into line with the principle for respect for autonomy, law's construction of abortionists as 'money-grasping butchers'[37] and criminalisation of terminations performed by them cannot effectively prevent women from seeking 'back-street' services even if they know that they are taking a risk. Through drawing a line between abortion services provided by medical professionals and lay persons and constructing different images for them, law misled the public into believing that abortions offered by lay persons should be blamed for high maternal mortality. Moreover, it covered up the fact that criminalising termination was the fundamental cause of the 'perfect market' of illegal terminations. As has been argued in chapter 2, a person's exercise of autonomy over reproductive decisions is essential for satisfying her basic needs for health and for control over life choices. Nevertheless, the ban on any basic family planning services, such as abortion,

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[34] Emily Jackson (2001) *Regulating Reproduction* (Oxford and Portland Oregon, Hart Publishing) pp.76-77

[35] It was difficult for the police to detect a legal illegal abortion unless it caused the woman's death. Thus, although there were a huge number of illegal abortions before 1967, the prosecutions under the 1861 Act were very rare. It was not only because those abortions were performed in secret, but also (and more importantly) the victims of those back-street abortions were not willing to accuse back-street abortionists. For more information, see Bernard Dickens (1966) p.87

[36] Ellie Lee (ed) (1998) *Abortion Law and Politics Today* (London: Macmillan Press) p.xi

[37] Malcolm Potts, Peter Diggory and John Peel (1977) p.269

cannot weaken people's desire to control their reproduction, but forces them to seek illegal and unsafe services. This can be confirmed by the 'back-street' termination statistics analysed below.

While it is impossible to accurately calculate how many illegal abortions were performed before 1967, the great market for abortifacient drugs and the increasing number of criminal abortions in the period from the 1940s to the 1960s suggests that the number could be considerable. According to Brookes, during the Second World War the number of crimes of procuring abortion known to the police increased four-fold, peaking at 694 in 1944; the number was likely to be an underestimate because the police wanted to reduce the number of recorded known crimes, so 'there was not too great a discrepancy between the figures for crimes known and crimes cleared up'.[38] Furthermore, the table 'British Abortion Statistics 1958-67' gives the reader a clear idea about the number of 'back-street' abortions in the last decade before the 1967 reform.

British Abortion Statistics 1958-67[39]

Year	Therapeutic abortions in NHS hospitals	Estimate of minimum no. of private therapeutic abortions	Estimate of criminal abortions
1958	1,570	12,000	100,000
1959	1,880	12,000	100,000
1960	2,040	12,000	100,000
1961	2,280	12,000	100,000
1962	2,830	14,000	100,000
1963	2,580	14,000	100,000+
1964	3,300	15,000	100,000+
1965	4,530	15,000	100,000+
1966	6,380	15,000	100,000+
1967	10,000	17,500	100,000+

Although the remarkably high number of 'back-street' terminations had made law makers grant women any greater autonomy. The discussion offered in the following section shows that law makers chose to severely limit women's reproductive decision-making and leave the final say in

[38] Barbara Brooks (1988) p.137
[39] The statistics were from Peter Diggory (1970) 'Experience with the new British Law' in Robert Hall (ed) *Abortion in a Changing World* (New York: Columbia University Press) p.144

the hands of medical professionals. The next section will also examine possible reasons why women's reproductive autonomy was not respected adequately and why medical control was entrenched in the legislation and judicial decisions relating to abortion by referring back to the analysis of the compulsory cultural assumption of womanhood as maternal in chapter 2.

1.3. Law's Construction of Women Who Need Abortion as Criminals

The above discussion of the 1861 Act, the 1929 Act and *Bourne* suggests that abortion has been defined as a crime since the beginning of the nineteenth century because of medical men's exercise of power and law's acceptance of their discretion. Abortion was comparatively unregulated before the nineteenth century when 'medical men' expressed a strong interest in controlling it. Similarly, the discussion of the development of Chinese abortion legislation in chapter 4 will show that termination was considered as a family-centred private decision until the Communist party state started to exert its direction over female citizens' (in)fertility. The analysis provided in the previous section demonstrates that law in the era of criminalisation constructed women of reproductive age as 'potential criminals', and the spirit of the 1861 Act, the 1929 Act and *Bourne* was that a legal deterrent should exist to prevent women from committing the offence of procuring a miscarriage. Consequently, both women's capacity and desire to exercise autonomy over terminating choices were treated as a threat to existing gender relations by the medical and legal professions, so strong opposition to abortion was aroused by medical professionals and severe punishment was imposed by law makers in order to deter women from accessing termination.

In accordance with the discussion offered in chapter 2, women were construed by law in the era of criminalisation as non-autonomous beings incapable of taking responsible and rational

decisions. Nevertheless, for the medical profession, adequate space was created by abortion law to exercise their discretion. From deliberately using the word 'unlawfully' in the 1861 Act, adding the defence of 'preserving the life of the mother' in the 1929 Act to expanding the therapeutic grounds in *Bourne*, law makers intentionally maintained the medical monopoly on the provision of abortion services. In the meantime, these changes also confirm the argument made in chapter 2 that law is not a logical, stable and neutral institution which always deals with disputes and manages social relations fairly and justly. Law in the era of criminalisation denied women agency and treated them as potential criminals. However, it defined doctors as figures of trustworthiness and responsibility. In addition to drawing a sharp distinction between abortionists and doctors, *Bourne* also created a line between the images of women who request abortion services and health professionals. Judge Macnaughten commented:

> A man of *the highest skill*, openly, in one of our *great hospitals*, performs the operation... Whether it was legal or illegal you will have to determine, but he performs the operation as an *act of charity*, without fee or reward, and unquestionably believing that he was doing the right thing, and that he ought, in the performance of his duty as a member of a profession devoted to *the alleviation of human suffering*...indeed, it is his duty – to perform this operation with a view to saving the life of the mother, and in such a case it is obvious that the sooner the operation is performed the better. The law is not that the doctor has got to wait until *the unfortunate woman* is in peril of immediate death and then at the last moment to snatch her from the jaws of death.[40]

The words in italics indicate that the images of Doctor Bourne and the young girl were construed in two ways which are opposite to each other. The figure of medical men is construed as highly skilled, humane and reputable. The judge deliberately described Doctor Bourne's good practice in detail and allowed him to bring his subjective judgement to abortion regulation. Nonetheless, the girl in question was rarely mentioned in the judge's summing-up. Her opinion on the

[40] [1938] 3 All ER 615

abortion decision appeared to be an irrelevant and insignificant part of the case. She was construed by the judge as 'unfortunate' but 'normal' and without 'feeble mind' or 'prostitute mind'.[41] Without considering the girl's voice, the judge assumed that the surgery performed by Bourne was in her best interest. In *Bourne*, the doctor's views were thought of by the judge as far more important than those of the girl and her parents. Thus, the judge's argument for the legitimacy of the abortion was based on the assumption that Bourne, rather than the girl, was a responsible and trustworthy decision maker.

In the era of criminalisation, medical and legal professionals claimed that abortion was banned because of their concern for embryos/foetuses and pregnant women's well-being. Keown has commented that 'the hazards of attempted abortion were continually stressed by medical and medico-legal authorities' in the nineteenth century in order to save embryos/foetuses and protect woman, 'pregnant or not, from potential danger'.[42] Nonetheless, I do not find arguments like this very convincing. First, I would not agree that law's construction of abortion-seeking women as criminals was targeted at protecting women from unsafe terminating means. The discussion of abortion in practice offered earlier in this section has indicated that law forced a huge number of working class women to seek 'back-street' suppliers and therefore caused the high maternal mortality rate. The regulation of abortion in the nineteenth century ruled out the possibility of defining termination of pregnancy according to women's life experiences. As has been discussed earlier in this section, the 1861 Act overrode the traditional definition of women's immediate experience of foetal movement as a meaningful stage of development and treated women as 'criminal for any interference in their own pregnancy'.[43] According to the 1929 Act, even if continuing a pregnancy would pose a potential and serious risk to women's health and life, they

[41] [1939] 1 KB 687 p.688 according to Mr Bourne, two types of women should not be allowed to terminate unwanted pregnancies: feeble-minded women and prostitute-mind women
[42] John Keown (1988) p.35
[43] Barbara Brooks (1988) *Abortion in England, 1900-1967* (London: Croom Helm) p.26

could not have an abortion unless doctors allowed them to do so. While *Bourne* extended the scope of therapeutic grounds, it did not change law's construction of women who need abortion as potential criminals, but only gave doctors the power to remit some women according to their 'professional judgements'.

Second, I find the protection for 'embryos/foetuses' argument ill-considered. Nothing in the 1861 Act, the 1929 Act or *Bourne* includes anything about the status of embryos/foetuses or recognises them as entities with any legal personhood. The 1929 Act only vaguely presumes that they have a capacity to be born alive at 28 weeks' gestation. Such a blurred interpretation first triggered endless debates in the coming law reforms and second left adequate room for medical professionals to exercise their authority on the morality of abortion decisions. If embryos/foetuses were taken into consideration by law makers, doctors would not be allowed to decide in which circumstances they could be damaged morally. While the termination performed by Bourne was not a traditional life-saving therapeutic operation and caused the death of the foetus, it was still considered as 'an act of charity' rather than killing. *Bourne* indicates that the extent to which an abortion could be 'therapeutic' enough and embryos/foetuses could be damaged legally should both be decided by doctors. Thus, it seems that behind the medical and legal professions' concern for embryonic/foetal life, what really worries them may be the challenge posed by the removal of legal limits on women's procreative autonomy to the assumption of womanhood as motherhood analysed in chapter 2.

The fear of medical and legal professionals is not that seeking termination could result in death of the embryo/foetus, but rather that it represents women's resistance to so-called maternal instincts. As has been discussed in chapter 2, maternal instincts are a culturally compulsory desire: women are required by society to lead a self-sacrificing life in order to become good

mothers. Seeking terminations, women challenge maternal instincts. Thomson has argued that the emergence of abortion and feminism were considered by medical and legal professionals in the nineteenth century as a sign of the development of women's rights and consciousness-raising, so they were thought of as a threat to existing gender relations built on the paradigmatic assumption of biological asymmetry between the sexes.[44] Therefore, both medical and legal men's objection to abortion can be viewed as a desire to stop women from bringing 'new avenues of experience and purpose beyond those provided by childbirth and child rearing'[45] into the current gender system. As Wilding has observed, the so-called 'elite professions – for example law and medicine'[46] worked together to maintain the existing social and economic system which considered them as privileged members and allowed them enjoy high social status. This can be seen from the discussion of how medical men distinguished their performance of termination from abortionists offered earlier in this chapter.

Law's construction of women who request abortion as criminals also shows that the state had an interest in controlling female reproductive bodies and enabling women to undertake the work 'that has traditionally defined their secondary social status'.[47] Since reproduction has been considered by the state as women's contribution to 'others',[48] such as their husbands, communities and state, seeking abortion can be treated as a means for women of refusing to make maternal contributions. Therefore, abortion law in the era of criminalisation was a result of the cooperation between medical professionals and law makers to suppress women's awareness-raising about reproductive freedom and to maintain the existing gender system.

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[44] Michael Thomson (1998) *Reproducing Narrative* (Aldershot: Ashgate Publishing Limited) pp.49-55
[45] Ibid. p.38
[46] Paul Wilding (1982) *Professional Power and Social Welfare* (London: Routledge) p.63
[47] Siegel Reva (1992) 'Reasoning from the Body; A Historical perspective on Abortion Regulation and Questions of Equal Protection' 44(2) *Stanford Law Review* 261-381 p.297
[48] Martha Albertson Fineman (2004) *The Autonomy Myth: A Theory of Dependency* (New York: The New Press) p.41

Based on the above analysis, I argue that to reform the current English abortion law in accordance with the principle of respect for autonomy, an initial and crucial step is to demedicalise and decriminalise abortion, namely, to challenge law's definition of abortion as a medical decision and its construction of women who need abortion as criminals. From the discussion of the regulation of abortion after 1967 offered in the following section, it can be seen that while the medical profession supported the partial decriminalisation of abortion in the twentieth century, this was motivated by their desire to affirm their knowledge and assert their power in abortion decisions. Thus, the conditional decriminalisation of abortion does not change the above definition and construction. Abortion is still treated as a crime unless it is approved and performed by health professionals. After the 1967 reform a medical-centred model of abortion regulation has been established and used to exert control over women's procreative decision-making. In the following section, I will discuss how the medical profession actively sought to monopolise abortion services in order to ensure 'appropriate gender behaviour'[49]. After examining the Chinese state-centred model of abortion legislation in chapter 4, in chapter 5 I will discuss how the Chinese experience of having a different regulatory model is helpful in providing some proposals to redefine abortion and reconstruct the image of women who need abortion under the English model.

2. Abortion Law in the Era of Medicalisation

As has been discussed in the introduction to this thesis, many legal scholars, such as Cook, Dickens and Cruz, have claimed that since the second half of the twentieth century there has been a tendency towards legalising and liberalising abortion.[50] It is true that during the second

[49] Michael Thomson (1998) p.54
[50] Rebecca Cook and Bernard Dickens (1978) 'A Decade of International Change in Abortion Law: 1967-1977' 68(7) American Journal of Public Health 637-644; (1999) 'International Developments in Abortion Law from 1988

half of the twentieth century abortion has been decriminalised in many regions of the world where 62 per cent of the global population lives.[51] For example, the regulation of termination has been less restrictive in England and China since 1967 and 1979 respectively. Seemingly 'back-street' abortions in the era of criminalisation are gone and there is no need to reform law, because the legalisation of abortion conveys a message that if women want a termination, they can have it. However, the analysis provided in this section suggests that feminists ought to be critical of the current regulation of abortion in England by scrutinising whether the so-called liberalisation of abortion can empower women to exert actual governance over abortion decisions.

In this section, I focus on the English medical-central model of the regulation of abortion after 1967. I argue that if the nineteenth century is the period when medical involvement in the legislation on abortion began, the twentieth century was the time when the main strategy to regulate abortion became medicalisation. I seek to achieve four goals in this section: first, to examine how abortion has been constructed and regulated under the current model of abortion law, second, to assess the effect of this model on women's procreative autonomy, third, to explore the significance of building an autonomy-based regulatory model and finally, to make an early attempt to raise the possibility of conducting a comparative study of the English and Chinese models of the regulation of abortion. The ground for substantial legal comparisons is laid out in this chapter and also in chapter 4.

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to 1998' 89(4) American Journal of Public Health 579-586; Anika Rahman, Laura Katzive, Stanley Henshaw (1998) 'A Global Review on Induced Abortion, 1985-1997' 24(2) Internal Family Planning Perspectives 56-64 and Peter Cruz (2001) Comparative Healthcare Law (London: Cavendish Publishing Limited)

[51] Peter Cruz (2001) p.413

2.1. Medicalising a Crime

The discussion offered in section 1 of this chapter suggests that medical involvement played a crucial role in shaping the criminal law of abortion and constructing the legal image of women who need abortion. The fact that abortion has been legalised since 1967 does not challenge the role of medical intervention in providing termination services. In this subsection, I first explain 'medicalisation' in the context of abortion and then give some background information about medicalising termination. According to Conrad, 'medicalisation' is a process by which 'non-medical problems become defined and treated as medical problems'.[52] Since the second half of the twentieth century, medical power has crept into the social scientific literature and led to 'medical social control or medical treatment'.[53] 'Medicalisation' normally consists of defining a non-medical problem in medical terms, using medical knowledge to explain this problem, adopting a medical framework to understand this problem or using medical intervention to solve it.[54] Conrad has argued that women are more vulnerable to the process of medicalising than men because women's reproductive issues, such as childbirth, infertility and abortion are a crucial part of the range of medicalisation. He notes:

> In any case, it is abundantly clear that women's natural life processes (especially concerning reproduction) are much more likely to be medicalised than men's and that gender is an important factor in understanding medicalisation.[55]

Built on Conrad's observation, a discussion of the post-1967 regulatory model will be provided in this section in order to explore the detrimental effects of law's medicalisation of abortion on women. Before 'medicalisation' crept into abortion, there was a decline in 'religious inhibition' around the beginning of the twentieth century, which was used by nineteenth-century legislators

[52] Peter Conrad (1992) 'Medicalization and Social Control' vol.18 *Annual Review of Sociology* 209-231 p.209
[53] Ibid. p.211
[54] Peter Conrad (2004) 'The Shifting Engines of Medicalization' 46(1) *Journal of Health and Social Behavior* 3-14
[55] Peter Conrad (1992) p.222

to facilitate the criminalisation of termination.[56] Therefore, twentieth-century law makers needed a new strategy to justify the imposition of legal limits over access to abortion. As Lee has observed, the twentieth century's cultural climate changed from religious to therapeutic, so 'health' above all else has become 'an unquestionable good' and our society has been increasingly reliant on experts.[57] As a result, medical knowledge has replaced 'religious inhibition' and become the main strategy adopted by subsequent governments to regulate the provision of abortion services. Abortion that was defined as a crime in the nineteenth century has been reconstructed as a medical decision which is regulated in the name of 'health'. In this way, women's reproductive health, as Thomson has claimed, has become inextricably linked to the health of 'others' – their children, husband, family and the state. A woman has become 'the figure whose health must be secure to enable her to carry out her responsibilities to others ... extending to the state'.[58] Consequently, medical professionals have become the only authority in abortion decisions. Their role in changing the regulation of abortion shows their desire for enhancing their professional monopoly.

2.2. Problems with Current Statutory Grounds and the Legal Time Limit

2.2.1. Four Abortion Grounds

According to some legal scholars, such as Cook, Dickens[59] and Rahman,[60] the enactment of the 1967 Act indicates that abortion has been liberalised in England. I would agree that after 1967 abortion law in England becomes relatively less restrictive by comparison with that in the era of criminalisation or the law in jurisdictions where termination is criminalised (for example, in

[56] Barbara Brookes (1988) p.54
[57] Ellie Lee (2003) *Abortion, Motherhood and Mental Health* (New York: Aldine de Gruyter) p.11
[58] Michael Thomson (1998) p.73
[59] Rebecca Cook and Bernard Dickens (1978)
[60] Anika Rahman, Laura Katzive and Stanley Henshaw (1998)

Ireland, Poland and Chile[61]). Nevertheless, as discussed below, instead of granting women decision-making autonomy, the 1967 reform has only created four highly problematic abortion grounds. This therefore suggests that abortion has only been conditionally decriminalised in England since 1967. While the 1861 Act has to be read together with the 1967 Act, sections 58 and 59 of the 1861 Act have not been repealed. The 1967 Act simply offers a defence against the offences defined in the 1861 Act. Moreover, an abortion is lawful only if it is approved by two doctors on the statutory grounds provided in section 1(1) of the 1967 Abortion Act. This means that doctors are still the only authority on abortion decisions. Section 1(1) of the 1967 Act, as amended in 1990 by section 37 of Human Fertilisation and Embryology Act 1990 (the 1990 Act), states:

> A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith—
>
> (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, *greater* than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
>
> (b) that the termination is *necessary* to prevent *grave permanent* injury to the physical or mental health of the pregnant woman; or
>
> (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, *greater* than if the pregnancy were terminated; or
>
> (d) that there is a *substantial* risk that if the child were born it would suffer from such physical or mental abnormalities as to be *seriously* handicapped.

Thus, there are four legal reasons for terminating a pregnancy: to save the pregnant woman's life; to avoid serious permanent damage to her health; to avoid physical and mental harm to her and her existing children and to avoid the birth of a defective infant. Accordingly, the grounds can be

[61] Ibid. p.59

divided into three types: therapeutic terminations (to save the life of the pregnant woman and to avoid serious permanent harm to the pregnant woman;); eugenic abortions (to forestall the birth of an infant with congenital defects) and abortions on so-called social grounds (with the time limit of 24 weeks, to obviate relatively minor severity of physical and mental injuries to the women or her children). A woman's request for abortion on any one of these grounds must be verified by two doctors. Consequently, whether a woman is able to act on her freely held desire for abortion is not dependent on her inner competency to critically think according to her convictions, but medical professionals' conception of what is the best for her or her family. Similar to abortion regulation in the era of criminalisation, the 1967 reform denies women the right to make decisions and does not regard them as autonomous persons. Therefore, building a regulatory model according to the principle of respect for autonomy requires decreasing the medical monopoly by challenging the four abortion grounds in the 1967 Act. Given that the task of suggesting reform proposals is undertaken in chapter 5, this section mainly scrutinises how the four reasons have increased medical control over abortion at the expense of women's reproductive autonomy.

The two grounds in s. 1(1)(b) – (c) are not new. They just affirm the legality of therapeutic abortions regulated in the 1929 Act and codify the judicial decision in *Bourne*. The three adjectives in italics in s. 1(1)(b) suggest that doctors are better placed than pregnant women to decide whether physical or mental injury caused by their pregnancy is 'grave permanent' and whether an abortion is necessary in their cases. Thus, the definition of abortion as a medical decision has not changed. Moreover, another problem is that the arguments in s. 1(1)(b) and (c) are not logical. If an abortion should be lawful when it is to prevent 'grave permanent' mental and physical injury to the pregnant woman, then clearly a life-saving termination should be legal. Thus, it is unnecessary to make a separate argument in ground (c). In addition, the grounds in s.

1(b) and (c) imply that unless women's lives and health are under serious threat, they should continue gestation even if it is unwanted. Since abortion is still legally defined as undesirable, women are required not to voluntarily access abortion services unless in extreme circumstances.

In parliament, restricting abortion to strictly therapeutic reasons was justified by the anti-choice lobby's concern for unborn life. In 1966 parliamentary debates on the 'Medical Termination of Pregnancy Bill', anti-choice conservatives emphasised that if termination is permitted for non-medical reasons, women will be able to kill their unborn baby, like jerking out bad teeth, for a 'trivial' reason.[62] Nevertheless, their argument for protecting embryos/foetuses by imposing restrictions on abortion is not a convincing one. Embryos/foetuses are still not considered as entities with any personhood or having any values or interests after the 1967 reform. As Fox has observed, law's sidestepping of the status of unborn life makes it hover 'uneasily between personhood and property' in England.[63] While law's uncertainty about the status of embryos and foetuses largely erases moral elements in abortion decisions, it eliminates the possibility of representing abortion as a woman-centred moral choice.[64] As a result, pregnant women are denied the right to exert their own agency over passing judgement on the morality of abortion which, as discussed in chapter 2, should be reliant on individual women's beliefs.

Furthermore, the legal uncertainty facilitates medical control over abortion and the use of embryos for so-called medical or research purposes. According to s. 3(4) of the Human Fertilisation and Embryology Act 2008, human and interspecies embryos created for bio-medical research can be kept for 14 days beginning with the day on which the process of creating the

[62] See the parliamentary debates on 'Medical Termination of Pregnancy Bill', HC Debates, vol 696 col 1105 (22 June 1966)
[63] Marie Fox (2000) 'Pre-Persons, Commodities or Cyborgs: the Legal Construction and Representation of the Embryo' 8(2) *Health Care Analysis* 171-188 p.172
[64] Marie Fox (2012) 'The Case for Decriminalising Abortion in Northern Ireland' in Amel Alghrani and Rebecca Bennett *The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge: Cambridge University Press) (forthcoming) (the chapter on file with author)

embryo began. Thus, while embryonic life before 14 days is treated by law makers as property-like in labs, it is constructed as more person-like in parliament's discussion of abortion issues. This uncertain situation to some degree is caused by the fact that the regulation relating to embryos/foetuses is heavily reliant on medical knowledge. As suggested later in this section, law's adoption of the 24-week time limit for abortion requests made on the grounds in s. 1(1)(a) is due to the fact that in accordance with 'medical research', foetuses after 24 weeks' gestation are thought of as capable of being viable. However, medical attitudes towards unborn life are often inconsistent and uncertain. From removing 'quickening' in the 1861 Act, using the time limit of '28 weeks' in the 1929 Act to adopting the cut-off date of '24 weeks' in the 1967 Act, it can be seen that changes in abortion regulation are often dependent on the availability of different medical knowledge. In the meantime, doctors' role has become one of moral arbiters of abortion decision-making, so women who need abortion have been subjected to the censorship of medical professionals.

My criticism of law's uncertainty about the status of embryos/foetuses does not aim to suggest that law should adopt one of the two existing main legal models of understanding embryos/foetuses – viewing them as independent persons or defining them as properties.[65] As discussed in chapter 2, neither of them stresses the importance of women's reproductive experience to embryonic/foetal development or accurately describes the unique relationship between a pregnant woman and the embryo/foetus inside her body. Law's attitude towards embryos/foetuses should be reliant on women's relations with them rather than medical knowledge. As Karpin has observed, embryos/foetuses are only ever connected with their 'potential for personhood by female embodiment'.[66] Rather than struggling to use medical knowledge to resolve the dilemma of choosing between personhood and property, I suggest that

[65] Marie Fox (2000) p.171

[66] Isabel Karpin (2006) 'The Uncanny Embryos: Legal Limits to the human and Reproduction without Women' 28(4) *Sydney Law Review* 599-623 p.603

one productive means of removing this uncertainty and centralising pregnant women's experience in abortion legislation is to respect women's right to express their own thoughts on whether their pregnancy should be discontinued.

Compared to the grounds in s. 1(1)(b) and (c), the other two have aroused more controversy. The so-called social reason in s. 1(1)(a) has received harsh criticism. For example, Jill Knight, an MP from the anti-reform lobby, has commented that s. 1(1)(a) allows women to make an unethical and irrational decision to kill healthy babies and makes controlling terminations particularly difficult for medical professionals.[67] While anti-choice MPs expressed their intense dislike for abortion on 'social' grounds in parliament, they did not raise any similar concern for the ethics of terminations on the grounds of therapeutics and embryonic/foetal abnormality. Therefore, similar to the medical and legal opposition to abortion in the nineteenth century, anti-choice MPs' hostile attitude to 'social' terminations could still be regarded as the fear that losing medical control over women's autonomy may pose a serious threat to the maternal role that is constructed for women in the existing gender system. As argued in chapter 2, since women are expected by society to welcome a self-sacrificing maternal life, their voluntary termination decisions could be thought of as irrational and irresponsible.

Although in practice the majority of abortion requests, as will be discussed in section 3, are made on the grounds in s. 1(1)(a), this section does not give women a substantial right to make decisions. Section 1(1)(a) allows a woman to decide whether she wants an abortion, but eventually her doctor decides whether she can have it. Section 1(2) says:

[67] Jill Knight, the parliamentary debates on 'Medical Termination of Pregnancy Bill', HC Debates, vol 732 col 1100 (22 July 1966)

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection (1) of this section, account may be taken of the pregnant woman's actual or *reasonably* foreseeable environment.

Section 1(2) suggests that requests for terminations on social grounds are also dependent on doctors' subjective judgements on 'pregnant woman's actual or reasonably foreseeable environment'. The word in italics indicates that a woman's request for abortion on the grounds in s. 1(1)(a) can be refused by her GP if he does not believe that she foresees her own environment reasonably. Thus, the GP is better placed than the woman to 'reasonably' assess the impact of termination on her personal conditions and home environment. As has been argued in chapter 2, people's various backgrounds and environment determine that the strain caused by unwanted gestation put on different abortion-seeking women will not be identical, so a pregnant woman will be the person who knows the answer best to the question of whether the risk of continuing the pregnancy is greater than that of the termination. As Sheldon and Wilkinson have observed, the responsibility to care for the child(ren) in a family is normally taken by the parent, particularly the mother.[68] Therefore, the woman should be best placed to make the decision of whether or not to continue her pregnancy and the provision of abortion services on grounds in s. 1 (1)(a) should be subject only to the pregnant woman's informed consent.

The argument in s. 1(1)(d), like the other three in s. 1(1)(a) – (c), is also significantly dependent on medical knowledge, but it is even more controversial because of foetal disability grounds created in this subsection and its reliance on the medical profession's intervention. The discussion provided below aims to achieve three goals – first, to explore the problems with law's differentiating abortions on disability grounds from those on other grounds; second, to assess its negative effects on abortion-seeking women and human beings currently living with disabilities;

[68] Sally Sheldon and Stephen Wilkinson (2001) 'Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for A Special Exception in Law?' 9(2) *Medical Law Review* 85-109 p.99

and third, to explore the possibilities of eliminating these effects by bringing the provision of abortion services into line with the principle of respect for autonomy.

From the two italic words in s. 1(1)(d), it can be seen that when a woman decides to have an abortion on foetal abnormality grounds, her request must be approved by her doctors and relies on the latter's judgment about what can be considered as a 'substantial risk' or 'seriously handicapped'. Thus, neither pregnant women nor putative fathers have the ultimate authority to decide whether they are able to access termination services when the foetus is diagnosed with a disability, because law adopts medical knowledge as the only legal criterion. This raises two questions: first, should doctors have the final say in the individual woman's request for an abortion on disability grounds? And second, if so, how can they accurately access pregnant women's ability to deal with the stresses and strains caused by having a child with a certain disability?

The people whose lives are affected most directly and significantly by the birth of a (disabled) child are her parents, especially her mother. In the current social system, caring for a disabled child is often more difficult and costly than caring for a non-disabled one.[69] A woman with great social support may feel less stressed by caring for a child with a disability than another woman without this support. Moreover, the extent of pain and strain that different women may have following the birth of a disabled child is not identical. As Hewson has observed, what one woman is willing to accept by way of a foetal abnormality may be intolerable to another woman.[70] For some people, the severity of a disability needs to be lethal for an abortion; but for

[69] Sally Sheldon and Stephen Wilkinson (2001) p.89
[70] Barbara Hewson (2003) 'Abortion and Disability: Who Should Decide What Abortion Laws We Should Have' *Prochoice Forum* available at http://www.prochoiceforum.org.uk/ocrabortdis1.php (last accessed 9 January 2010)

some others, a learning disability is worse than one requiring surgical treatment.[71] As has been argued in chapter 2, competent human beings should have actual governance over acting on their autonomously held desires and this is particularly important for women in the context of reproduction. Consequently, pregnant women should be trusted by law to form their own understanding of 'a serious disability'. A competent pregnant woman should be granted the ultimate power to make the decision of whether or not the pregnancy should end in an abortion when the foetus is diagnosed as disabled. While doctors are able to offer some information and guidance on the nature and extent of a possible disability, the child's life expectancy and the degree of any pain and discomfort which the pregnant woman may suffer, doctors are not more capable than individual women of predicting whether they can cope with difficulties caused by raising a disabled child.[72] Therefore, defining abortions on disability grounds as medical decisions is neither reasonable nor realistic.

Additionally, since s. 1(1)(d) does not refer to anything relating to pregnant women, it can convey a piece of discriminatory information against existing people currently living with disabilities. The wording of s. 1(1)(d) and the different time limits between seeking abortions on 'social' and disability grounds indicate that compared to aborting an able-bodied foetus, aborting one with a disability is more legally acceptable. It also implies that unhealthy foetuses do not deserve to live (at least, not as much as able-bodied foetuses do) or should be valued less than normal ones. In reality, although some of the inconveniences that people with a disability have are related to their physical conditions, many are caused by social discrimination and lack of adequate public support. For example, a wheelchair user who lives in a society where facilities to assist the disabled, such as lifts and broad doors, are readily accessible, can be much less

[71] Helen Statham (2004) 'Termination of Pregnancy after Prenatal Diagnosis of Fetal Abnormality' in Pro-Choice Forum (Compiled) *Late Abortion: A Review of the Evidence* available at www.prochoceforum.org.uk (last accessed 9 January 2010)
[72] Sally Sheldon and Stephen Wilkinson (2001) p.108

disabled and experience fewer difficulties than a wheelchair user who lives in a society without the support of these services and facilities. Moreover, some of the limitations and problems that people with disabilities experience could also be attributed to discriminatory attitudes and practices.[73] As Tom Shakespeare has explained, the socialisation of disability can produce disabled people's experience of oppressive social relations and lead to their negative self-identity.[74] Disability discrimination and sex discrimination caused by a cultural preference for boy babies seem very different, because some difficulties that disabled people have stem from their physiology, but what the preference for boys embodies can be more or less attributed to cultural construction based on gendered social orders. Nevertheless, there is a similarity between these two kinds of discrimination, namely, the identities of the disabled person and the female have been constructed as different from and also inferior to the mainstream identity – masculine and able-bodied.[75]

As has been discussed in chapter 2, law is traditionally defined as a neutral institution which represents 'truth' and provides just and fair solutions to social debates, though it is far from this image in practice. Law's distinguishing of abortions on disability grounds from those on social grounds and adopting a less permissive attitude to abortions on social grounds can represent a statement that disabled foetuses are valued less. In this regard, the statement in s. 1(1)(d) contains some 'eugenic' elements. As discussed in chapter 2, termination of a pregnancy should be considered as a woman-centred decision no matter whether it is made because the foetus is diagnosed as disabled. In other words, neither law nor medicine should exercise controlling influences over women's decision-making. While s. 1(1)(d) does not involve very state-coerced eugenic-inspired activities, like the Nazi programmes and the Law on Maternal and Infant Health

[73] Adrienne Asch (1998) 'Distracted by Disability' 7(1) *Cambridge Quarterly of Health Care Ethics* 77-87 pp.77-78
[74] Tom Shakespeare (1996) 'Disability, Identify and Difference' in Colin Barnes and Geof Mercer (eds) *Exploring the Divide: Illness and Disability* (Leeds: The disability Press)
[75] Tom Shakespeare (1999) 'The Sexual Politics of Disabled Masculinity' 17(1) *Sexuality and Disability* 53-64 p.61

in China,[76] it to some degree discourages people from critically thinking about the limitations and problems of people with a disability and may even influence some people's opinions about the disabled in a negative way. In other words, it fails to respect people's autonomy, particularly putative mothers' decision-making. As argued earlier in this section, the person whose life is significantly influenced by the birth of a (disabled) child is the putative mother, so she should be granted the authority to end the unwanted pregnancy regardless of the fact of whether the foetus is (dis)abled.

Undesirable procreation, no matter whether it ends in a (dis)abled child or not, violates women's basic needs for health and for control over their lives. Therefore, the decision made by a woman to end the pregnancy when the foetus is diagnosed as having a disability means that she is using her own critical thinking to form and pass judgement on her personal ability to cope with mothering a disabled child rather than that she is discriminating against existing disabled people. In real life, a number of women choose to continue their pregnancy when they find the foetus is affected by a disability, such as Down's syndrome because they feel able to cope with the strains put on them by the birth of a Down's syndrome child.[77] Thus, based on the principle of respect for autonomy, when pregnant women make up their mind to have an abortion, there is no need for law to draw a distinction between requests made on disability grounds or those made on social grounds so long as they are both free of coercive influences, such as medical and state-controlling intervention. In other words, the statement in s. 1(1)(d) will not be problematic if it is built on the principle of respect for autonomy. Therefore, I suggest that the argument in s. 1(1)(d) should be rephrased in a way directly related to the idea of respect for pregnant women's procreative autonomy. In chapter 5, I will provide a detailed analysis of feasible legislative proposals to reform the existing statutory abortion grounds in accordance with the principle of

[76] For a discussion of the Law on Maternal and Infant Health in China, see chapter 4
[77] Emily Jackson (2000) 'Abortion, Autonomy and Prenatal Diagnosis' 9(4) *Social & Legal Studies* 467-494

respect for autonomy. The rest of this section investigates the legal cut-off point for seeking abortions on different statutory grounds in order to further explore the problems of the English regulatory model of abortion.

2.2.2. The Cut-off Point and Embryonic/Foetal Images

Since 27 April 1968 when the 1967 Act came into force, it has remained intact. After several failed attempts to restrict the act,[78] a change to reduce the upper time limit of abortion on the grounds in s. 1(1)(a) from 28 to 24 weeks was made in 1990 by way of section 37 of the 1990 Act. Nonetheless, there is no time lime on the grounds in s. 1(1)(b)-(d) after the 1990 amendments. As has been argued above, law's adoption of different cut-off points for abortions on 'social' and 'disability' grounds implies that able-bodied foetuses deserve to live more than those with a disability. Moreover, creating legal time limits has strengthened medical control over the provision of abortion services. Since increasing medical evidence suggested that foetuses have viability before 28 weeks, setting up a cut-off date for abortions on 'social' grounds became a very contentious issue in the 1990 parliamentary discussions. The adoption of the limit of '24 weeks' rather than 18, 20, 22, 26 or 28 by a majority of 206 votes is due to the fact that it was recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) in a report which comments that at around 24 weeks foetuses become viable. This RCOG report is often referred to in the parliamentary debates relating to termination regulation. For example, Harriet Harman told parliament that:

> The time limit of 24 weeks was not arrived at arbitrarily. When deciding on an abortion, doctors err on the side of caution and, in practice, a 24-week limit would mean something like a 22-week limit or even a 20-

[78] See the St John-Stevas Bill (1969), the Irvine Bill (1970), the Grylls Bills (1973 and 1974), the White Bill (1975), the Benyon Bill (1977), the Braine Bill (1978), the Corrie Bill (1979), The Powell Bill (1984), the Burt Bill (1987), the Alton Bill (1988) and the Houghton Bill (1989)

week limit. Medical opinion – and the view of the Department of Health – is that the chances of survival at 22 weeks are negligible. *The presumption is that the foetus is not viable at 22 weeks, so a 24-week time limit would effectively be a 22-week time limit, at which, I repeat, medical opinion is agreed that the foetus is not viable.* For the future, doctors believe that they can increase the chances of survival for babies after 24 weeks, but because of the insufficiency of development, they do not expect to be able to keep babies born at 22 weeks alive in the foreseeable future.[79]

While '24 weeks' appears to be relatively high by comparison with time limits in other European jurisdictions, such as French abortion law,[80] it is not targeted at promoting women's procreative decision-making. As will be demonstrated in section 3, this limit may force women who need termination of pregnancy after 24 weeks on the grounds in s. 1(1)(a) to travel to other countries where for the abortion services they seek. The parliamentary discussion of amending the upper limit for legal abortion on 'social' grounds made no reference to women's life experience and procreative autonomy. The adoption of the cut-off date of '24 weeks' in the 1990 Act is completely dependent on medical knowledge. As a result, medical control not only over abortion services but also over human embryonic/foetal development has been strengthened. As discussed above, embryonic/foetal development has been separated from women's gestational experiences and defined in terms of medical language. The moment of birth has been regarded by English law as the point of transition from a life form with unknown status to a fully formed person. This means that before birth there are no legally relevant differences between a 20-day embryo and a 20-week foetus. Nevertheless, law's acceptance of the upper limit of 24 weeks suggests that after this cut-off point, foetuses are able to automatically gain a legal position, so they are worthy of more legal consideration than 23-week foetuses. Instead of drawing a clear definition of the legal status of foetuses after 24 weeks' gestation or giving an adequate explanation of differences among women's gestational experiences of 22 weeks, 23 weeks, 24 weeks and 30 weeks, law

[79] See the parliamentary debates on 'Amendment of Law Relating to Termination of Pregnancy', HC Debates, vol 171 col 262 (24 April 1990)
[80] Sally Sheldon (1997) p.160

makers have simply used 'medical evidence' to cover all unanswered ethico-legal issues relating to the embryonic/foetal status and a wide range of social reasons behind women's unwanted pregnancy.

Furthermore, according to the Warnock Committee, the cut-off point of '14 days' is used to regulate early human embryo research, because it is treated as the point at which the primitive streak emerges and the precursor of the development of a nervous system begins to appear and which marks the beginning of individual growth of the embryo.[81] The Human Fertilisation and Embryology Act 2008 (the 2008 Act) has further liberated bio-medical research by allowing medical scientists to create interspecies embryos and keep them for 14 days from the day on which the process of creating them began.[82] Time limits of '14 days' and '24 weeks' suggest that the legal status of unborn lives remains inconsistent and even self-contradictory: on the one hand, embryo experimentation is only permitted up to 14 days; on the other, abortion on the grounds in s. 1(1) a could be performed at up to 24 weeks and even up to birth on the therapeutic and disability grounds. While the adoption of 14 days in the law of embryo research seems irrelevant to women's reproductive autonomy, one real concern, as has been discussed above, is that the medical control over embryonic/foetal development may further separate pregnant women's life experiences from embryonic/foetal growth and eventually weaken their say in abortion decisions. While early embryos can be used as biological material in scientists' labs, women have to gain medical professionals' permission in order to access early medical terminations. Seemingly, the legal and medical professions have a more permissive attitude to abortion but a conservative one to embryo research. In fact, this difference serves to enhance medical control over the provision of abortion services and also facilitated embryo research.

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[81] Marry Warnock (1985) *A Question of Life: The Warnock Report on Human Fertilisation and Embryology* (Oxford: Blackwell) pp.58-59

[82] The Human Fertilisation and Embryology Act 2008 s. 3(4) and s. 4(6)

Moreover, medicalising the debates relating to abortion and embryonic/foetal development has produced irreconcilable conflicts between a pregnant woman and the embryo/foetus inside her. From removing 'quickening' to adopting the 24 week limit, it can be seen that the figure of embryos/foetuses has changed from a unit dependent on female bodies to a separated patient.[83] This has blurred the important connection between broader social factors relating to unwanted pregnancies and women's basic needs for safe termination services. Thus, another concern is that new platforms for the anti-choice lobby will be built inside and outside parliament and more restrictions could be imposed on women's autonomy in termination decisions. For example, Paul Deacon of the Society for the Protection of Unborn Children (SPUC) has claimed that images of foetuses demonstrated by prenatal scanning medical techniques suggest that they have social emotions, so abortion, like murder, has 'no place in a civilised society'.[84] Although not all people believe that the meaning of foetal natural reactions is similar to that of existing people's socialised facial expressions, the attempt to limit women's abortion decision-making by making foetuses visible is strategic and effective because foetal images from prenatal screening techniques are consistent with the figure of embryos/foetuses constructed by popular culture as persons[85] and also attract the public's sympathy for the vulnerable.

In addition to 'foetal images', relevant medical knowledge about 'foetal pains' is also used to argue for a reduction in the time limit for abortion on 'social' grounds. For example, Professor Sunny Anand, of the Commons Science and Technology Committee, told parliament that the cut-off point for legal terminations should be reduced to 20 weeks when the part of the brain

[83] Sheila McLean (2010) *Autonomy, Consent and the Law* (Oxford: Routledge-Cavendish) p.129. For more information about how the pregnant woman and the foetus have been treated as two different patients in medical practice, see Michael Harrison and Scott Adzick (1991) 'The Fetus As A Patient' 213(4) *Annals of Surgery* 278-27
[84] Isabel Oakeshott (12 September 2003) 'Proof Babies Smile in Womb' *Evening Standard*
[85] Marie Fox (2000) p.172

which can feel pain develops, so aborted foetuses may feel 'excruciating pain'.[86] Although this attempt to change the cut-off point of 24 weeks was unsuccessful, women have not been granted any more control in abortion decisions. As has been discussed above, parliamentary debates on terminations have still made no reference to women's procreative rights or freedom; on the contrary, more sophisticated medical statements have been cited. Thus, the regulation of abortion has become subject to medical authority. This is the main cause of the phenomenon which will be discussed below – the adoption of such a comparatively high time limit in the Abortion 1967 Act has not effectively empowered women to exert actual governance over their abortion decisions.

As has been argued in chapter 2, in abortion decisions embryos/foetuses and putative fathers should also be under moral consideration and their rights should be given some legal protection. Nevertheless, law should give a pregnant woman the ultimate authority to make the decision of whether or not to continue the pregnancy because of her unique relation with the embryo/foetus, the importance of maternal autonomy and the detrimental effects of unwanted fertility on her health and future life. The analysis of problems with the statutory reasons and the upper time limit for abortion offered above has suggested that the current model of abortion regulation in England has been built on 'medical' rather than 'autonomy' grounds. Under this medical-centred model, abortion has been defined as an issue which is only reliant on medical knowledge, so those more important social elements relating to unwanted gestation and consequences of involuntary fertility for women have been obscured. Thus, I suggest that to establish an autonomy-based model of abortion legislation, the current statutory grounds and the upper limit should be challenged. Furthermore, after comparing with the Chinese model of abortion regulation in chapter 5, I argue that not only the current statutory grounds and upper time limit,

[86] Daniel Martin (29 January 2008) 'Abortion Time Limit Should Be Reduced as Foetuses Feel Pain before 24 Weeks' *MailOnline* available at http://www.dailymail.co.uk/health/article-510975/Abortion-time-limit-reduced-foetuses-feel-pain-24-weeks-MPs-told.html?printingPage=true (last accessed 7 January 2010)

but restricting requests for abortion to any statutory reasons and setting up any cut-off point for access to termination services can lead to oppression against women, particularly those from disadvantaged backgrounds and can therefore cause social class injustice.

2.3. Law's Construction of Abortion as a Medical Procedure

This section further examines how abortion has been constructed as a medical procedure under the English regulatory model by exploring issues relating to the following two aspects of the provision of termination services: places where legal abortions can be carried out and people who have the authority to carry out legal terminations. The analysis offered in this section suggests that law's embrace of medical intervention to define abortion has shifted it away from women's life experiences and ruled out the possibility of taking procreative autonomy into consideration. The principle of respect for autonomy still has not been taken into consideration in law-making on abortion, despite this principle having been placed at the very centre of ethico-legal thinking and medical practice since the second half of the twentieth century.[87] Therefore, it is not surprising that England has one of 'the formally most restrictive abortion laws of those countries where abortion has been legalised,[88] although a comparatively high time limit for legal abortions is adopted.

As the analysis offered earlier in this section indicates, there are continuities between abortion legislation in the era of criminalisation and that in the era of medicalisation, although abortion has been conditionally legalised since 1967. Under the current model, termination is still construed as a procedure which must be left in the hands of medical professionals rather than a decision that is reached solely by pregnant women. Section 1(3) of the 1967 Act states:

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[87] Mary Donnelly (2010) *Healthcare Decision-making and the Law* (Cambridge: Cambridge University Press) p.269
[88] Ellie Lee (2003) 'Tensions in the Regulation of Abortion in Britain' 30(4) *Journal of Law and Society* 532-553 p.533

> Except as provide by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 1977 or the National Health Service (Scotland) Act 1978 or in a hospital vested in a National Health Service trust or in a place approved for the purposes of this section by the Secretary of State.[89]

Accordingly, abortion can only be lawfully performed by 'a registered medical practitioner' and in an NHS hospital or in an approved independent sector unit, such as provided by Marie Stopes International and the British Pregnancy Advisory Service (BPAS). Terminations after 24 weeks can only be carried out in NHS hospitals. Section 1(3) suggests that termination is a complicated (can only be carried out in specified medical places) and highly skilled (must be performed by doctors) medical procedure. However, law's construction of abortion is far away from representing the reality where current means of ending gestation, particularly using mifepristone and misoprostol (known as early medical abortion), have proved to be much safer than continuing pregnancy and giving birth.[90] According to the RCOG's recent guidance, 'The Care for Women Requesting Induced Abortion', published on 22 January 2011, abortion is one of the most commonly performed procedures in the UK where around 200,000 terminations are performed each year; around 90 per cent are carried out at under 13 weeks' gestation, and at least one-third of women will have had an abortion by the time they reach the age of 45 years.[91] Thus, access to abortion, as a main family planning method, should be effectively promoted because birth control cannot be solely reliant on contraception. Nonetheless, restricting abortion to NHS hospitals and limited authorised private medical sectors cannot satisfy women's growing need for termination services.

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[89] Abortion Act 1967, s. 1(3)
[90] Ellie Lee (2007) 'The 1967 Abortion Act: Four Reasons to Fight for Choice' *Prochoice Forum* available at http://www.prochoiceforum.org.uk/ocrabortlaw12.php (last accessed 10 January 2011)
[91] RCOG (2011) 'The Care for Women Requesting Induced Abortion' available at http://www.rcog.org.uk/files/rcog-corp/uploaded-files/NEBInducedAbortionfull.pdf (last accessed 8 April 2011)

The current regulation of abortion was enacted and amended in 1967 and 1990 respectively when terminations were mainly performed by surgical means. Abortion drugs, such as mifepristone, were not licensed and became alternatives to surgical abortion in England until 1991.[92] However, the abortion statistics issued by the Department of Health indicate that there has been a steady increase in the use of medical abortion – in 2009, medical abortions accounted for 40 per cent of the total compared with 12 per cent in 2002.[93] Based on RCOG's evidence-based guidance, there is no clinical reason why women should remain in a hospital during a medical termination which can be safely administered by women themselves at home.[94] Additionally, a government-based pilot project conducted in 2006 shows that women whose pregnancy is less than nine weeks' long can safely have medical abortions at home.[95] Many women who experienced both hospital and home abortion expressed a preference for the latter.[96] A woman who had a home termination of nine weeks' gestation has commented on the BBC website:

> It doesn't hurt apart from some mild discomfort ... I have had a 'standard' abortion when I was much younger which was 100 times more traumatic due to being in a hospital and being surrounded by other women in various states of distress waiting for the same procedure in an open waiting room ...[97]

A study undertaken by Patricia Lohr et al. in 2010 suggests that the above comment can represent many women's voices.[98] In accordance with this study, most women reported a

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[92] See *British Pregnancy Advisory Service v Secretary of State for Health* [2011] EWHC 235

[93] Department of Health 'Abortion Statistics, England and Wale 2002, 2009' available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4080059.pdf and http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116336.pdf (last accessed 9 April 2011)

[94] RCOG (2011)

[95] The Guardian (16 February 2006) 'Abortions at home are safe - pilot study' available at http://www.guardian.co.uk/society/2006/feb/16/health.medicineandhealth1 (last accessed 8 April 2011)

[96] RCOG (2011) see footnote 87

[97] BBC News (15 February 2006) 'Study Find Home Abortion Safe' available at http://news.bbc.co.uk/1/hi/health/4717786.stm (last accessed 8 April 2011)

preference for going home after taking misoprostol as opposed to returning to a clinic for administration.[99] To enhance women's choices, law should permit them to administer medical abortions in places which they may find more comfortable and confidential than hospitals. Nonetheless, as usual, women's preferences were not taken seriously in the legislation on abortion. As the following discussion of the missed chance to introduce the amendment about 'statutory abortion location' in the 2008 Act and the failed attempt to extend the range of abortion locations in *British Pregnancy Advisory Service v Secretary of State for Health (BPAS)*[100] suggests, the possibility of bringing the provision of abortion into line with the principle of respect for autonomy has been denied again in parliament and law courts. As a result, the legal definition of termination as a medical procedure has remained unchanged.

A recent opportunity to modernise the regulation of places where abortion can be carried out was introduced with amendments to the 1967 Act in 2008, which also included removing the requirement of two doctors' signatures, permitting skilled nursing staff to perform abortions and extending the range of locations where abortions can be performed to include primary care level.[101] According to 'Scientific Developments Relating to the Abortion Act 1967' issued by the Science and Technology Committee, the above amendments would have significantly reduced service-related delays.[102] Nonetheless, a motion has been intentionally tabled by the government in order to block parliamentary discussions on these changes.[103]

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[98] Patrica Lohr, Josephine Wade, Laura Riley, Abigail Fitzgibbon and Ann Furedi (2010) 'Women's opinions on the home management of early medical abortion in the UK' 36(1) *Journal of Family Planning Health Care* 21-25 p.22

[99] Ibid.

[100] [2011] EWHC 235

[101] Secretary of State for Health (2007) 'Government Response To The Report From The House Of Commons Science And Technology Committee On The Scientific Developments Relating To The Abortion Act 1967' available at http://www.official-documents.gov.uk/document/cm72/7278/7278.pdf (last accessed 10 May 2011)

[102] House of Commons Science and Technology Committee (2007) *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006-7* available at http://www.parliament.the-stationery-office.co.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf (last accessed 8 April 2011)

[103] Sally Sheldon (2009) 'A missed opportunity to reform an outdated law' 4(1) *Clinical Ethics* 3-5

[103] The Human Fertilisation and Embryology Act 2008 s. 3(4) and s. 4(6)

Furthermore, a High Court challenge to the current regulation of statutory places brought by the UK abortion provider, BPAS, on 4 February 2011, has also failed. In *BPAS*, BPAS argued that women ought to be allowed to administer their second-stage early medical abortion at home, because the definition of 'any treatment for the termination of pregnancy' in the 1967 Act only includes the prescription rather than the administration of abortion drugs. Currently, women who seek early medical abortion, which means within the first 9 weeks of pregnancy, have to make two visits to a hospital or an authorised private sector unit and are given pills each time. More specifically, the first stage is visiting a hospital or clinic for consultation and counselling. If two doctors believe that the woman is legally eligible and clinically suitable for an abortion, a dose of abortifacient drug will be given. After a short wait to ensure that the drug is absorbed, the woman will leave the hospital. After two days, she has to make her second visit in order to be administered with another abortifacient drug.[104]

Therefore, if BPAS's attempt had been successful, women would be able to have more control over termination choices because travelling time could be saved, the risk that they may start to bleed on the way home could be reduced, more respect could be given to abortion-seeking women's privacy, and support from their partner, family members or friends could be more accessible if procedures took place outside hospitals or clinics. Nevertheless, the judge did not take women's autonomy and evidence-based arguments for the safety of home abortion into consideration. He refused BPAS's application by subjecting the meaning of 'treatment' to the interpretation of the Secretary of State. Judge Supperstone noted:

> However, in my view, section 1 (3A) is consistent with the Secretary of State's submission as to the meaning of the concept of 'treatment'. Section 1 (3A) refers to treatment consisting primarily in the 'use' of medicine; it is not limited to the prescription of medicines... Section 1 (3A) makes clear that 'treatment' which in 1967

[104] [2011] EWHC 235

was normally surgical treatment covers medical treatment. Moreover, it enables the Secretary of State to react to further changes in medical sciences. He has the power to approve a wider range of place, including potentially the home, and the conditions on which such approval may be given relating to the particular medicine and the manner of its administration or use.[105]

It is not surprising that the judge was reluctant to pose any challenge to limits on the provision of abortion under the existing regulatory model. From the analyses of *Bourne* and *Royal College of Nursing of the United Kingdom Respondent v Department of Health and Social Security Appellant* (*RCN*) offered earlier in this chapter, it can be seen that historically there has been a tendency for British judges to keep the medical authority on abortion intact and protected. As discussed above, law's deference to the medical profession does not change even when the current means of ending gestation have become much safer and less traumatic than those from around 1967. As Sheldon has observed, the development of early medical terminations has even made the boundary between preventing conception and termination gestation become blurred.[106] Based on the principle of respect for autonomy, abortion law should facilitate the use of new abortion methods and reduce the stresses and strains on women caused by seeking termination. Nevertheless, the judge's refusal to permit home use of misoprostol indicates that medical abortion procedures have to be more uncomfortable and unpleasant than they need to be. It seems that the English regulatory model of abortion in the era of medicalisation continues to punish women for making termination decisions.

In addition to defining abortion as a treatment which must be carried out in authorised hospitals and clinics, both codified and case laws have constructed terminations as a doctor-only procedure. As discussed above, according to the 1967 Act, terminations can only be lawfully prescribed and performed by doctors. During the four decades after the enactment of the 1967

[105] Ibid.
[106] Sally Sheldon (1997) p.131

Act there was a failed attempt to remove this restriction – introducing the amendment that permitted greater responsibility for nurses in abortion provision. As will be discussed in section 3 of this chapter, the majority of abortions in England are performed before 13 weeks, when they are a common and simple procedure. Furthermore, nowadays, nurses are taking a more active role than doctors in carrying out this procedure. Due to the shortage of registered practitioners who are willing to perform abortions and the strong demand for early termination in practice, legalising nurses' independent participation in prescribing and performing abortion can reduce service delays and increase women's actual governance of abortion decision-making. Nonetheless, as has been discussed above, the Labour government blocked the chance to discuss this amendment in parliament. As a result, the construction of abortion as a doctor-only procedure has not changed in the English codified law of abortion.

Before this missed chance to change the statute law of abortion, the legitimacy of restricting termination to doctors in the case law was also questioned in 1981. In *RCN*, a letter was sent by the Department of Health and Social Security to regional and area medical officers and regional, area and district nursing officers purporting to explain the law relating to abortion in connection with the termination of pregnancy by medical induction. The department's advice was that termination by medical induction using the extra-amniotic method could properly be said to be termination by a registered medical practitioner provided it was decided on and initiated by him and provided he remained throughout responsible for its overall conduct and control in the sense that acts needed to bring it to its conclusion were done by appropriately skilled staff acting on his specific instructions, but not necessarily in his presence. The department stated that the first stage of the procedure, insertion of an extra-amniotic catheter and an intravenous infusion cannula, must be carried out by a registered medical practitioner, but that the second stage, connection of infusions of the abortifacient drugs to the catheter and, if appropriate, to the

cannula, and regulation of the infusions, could be carried out by an appropriately skilled nurse or midwife acting in accordance with precise instructions given by the registered medical practitioner. The Royal College of Nursing sought a declaration that the circular was wrong in law.[107] Lord Brightman noted:

> In a case in which there is 'maximum nurse participation' as contemplated by Annex B, the roles of registered medical practitioner ('doctors') and nurse will be as follows: (1) The doctor inserts the catheter into the womb, but does not pass fluid through it. (2) The nurse attaches the catheter to the pump, or to the gravity feed drip apparatus. (3) The nurse switches on the pump or turns the feed drip valve, in order to administer the prostaglandin infusion to the patient. (4) The doctor inserts the cannula into the vein, but does not pass fluid through it. (5) The nurse links up the oxytocin drip feed, in order to administer the infusion to the patient. (6) The monitoring of the patient, and the monitoring of the drip rate, are carried out by the nurse. (7) The nurse replaces or replenishes the syringe and infusion bottle as necessary in order to administer the correct quantities of the infusions. (8) The nurse adjusts the flow rates of both the infusions. (9) The nurse discontinues the treatment, either because the foetus has been discharged, or because the allotted period has elapsed and the operation has failed...In the case supposed of 'maximum nurse participation', the doctor will be on call; however, it is implicit in Annex B that he may not in fact be called, and therefore he may be *absent throughout except for steps 1 and 4 (insertion of catheter and cannula)...*

From Lord Brightman's comment it can be seen that nursing staff's participation in conducting surgical abortions is more proactive than that of doctors. The substantial process of a surgical abortion is carried out by nurses. Today, because of nurses' growing training and expertise, they tend to carry out many even more complex gynaecological operations which were traditionally performed by doctors.[108] Nevertheless, as has been argued above, *RCN* suggests that as usual, the judges, like those in *Bourne* and *BPAS*, were reluctant to interfere with doctors' 'good medical

[107] [1981] 2 WLR 279
[108] Emily Jackson (2006) p.607

practice'.[109] To protect doctors' discretion, the law lords have bypassed the fact that abortions in practice are mainly performed in doctors' absence and defined doctors as having the leading role in service provision. Consequently, nurses have been reduced to the inferior and accessory actor in the common law. Lord Keith commented:

> It is he who decides that it is to be carried out. He personally performs essential parts of it which are such as to necessitate the application of his particular skill. The nurse's actions are done under his direct written instructions. In the circumstances I find it impossible to hold that the doctor's role is other than that of a principal, and I think he would be very surprised to hear that the nurse was the principal and he himself only an accessory...[110]

Accordingly, a half century after *Bourne*, which drew a line between abortions performed by doctors and those performed by abortionists, *RCN* has also made one between those performed by doctors and the ones performed by nurses. It therefore stresses that the only authority to provide abortion services is that of doctors. Moreover, in both *Bourne* and *RCN*, women's need and voices are ignored, though abortion is most closely related to women. As a result, abortion has been construed as a completely medical issue which is separated from women's life experiences. Woman-related questions are rarely raised and answered in law courts. For example, what do women think about having an abortion performed by a nurse? Are hospitals the best place for women to have a termination? And what are the harmful effects on women of the current construction of abortion as a medical procedure?

My criticism of law's construction of abortion as a doctor-only procedure does not defend using unsafe termination methods in unhygienic 'back-street' clinics. However, as has been argued

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[109] Sally Sheldon (1996) 'Subject Only to the Attitude of the Surgeon Concerned: the Judicial Protection of Medical discretion' 5(1) *Social and Legal Studies* pp.95-112
[110] [1981] 2 WLR 279

earlier in this chapter, in the era of criminalisation, the imposition of limits on abortion provision did not stop terminations being performed in unsafe and unhygienic circumstances. Furthermore, the analysis of abortion in practice offered in section 3 of this chapter will show that the current regulatory model may still force some women to buy and use illegal abortion drugs. Therefore, it is time for law makers to reflect on the legal construction of abortion as a medical procedure and bring service provision according to the principle of respect for autonomy. In chapter 5, I will offer a detailed analysis of how the current definition of abortion in law can be challenged and women's decision-making can be significantly promoted under a model of abortion regulation grounded in this principle.

2.4. Conscientious Objection and Professional Obligations

The discussion offered in this section attempts to explore the relationship between doctors' right to conscientious objection to providing termination treatment and their obligations to women who need abortion. It aims to examine to what extent the current regulation of conscientious objection infringes women's right to exert autonomy over decision-making concerning reproduction and whether there is a possibility of using alternative criteria to keep a balance between protecting doctors' right to conscientious objection and their professional obligations analysed in chapter 2.

While women are not granted any substantial right to decide whether they can have an abortion by the 1967 Act, doctors are entitled to refuse to attend any non-emergency treatment relating to abortion by claiming a conscientious objection to termination. Sections 4(1) and (2) state:

> (1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this Act to which he has a

conscientious objection: provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it;

(2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

Accordingly, even if a woman satisfies one of the grounds in Section 1(1), her GP may turn her away by claiming to be a conscientious objector. In practice, a woman normally will not know whether or not her doctor is a conscientious objector until actually requesting an abortion, since the doctor has no obligation to publicise his conscientious objection in advance. Since having an unwanted pregnancy is not likely to be a pleasant experience, this unpredictable situation may make seeking abortion even more stressful than it needs to be. When the woman's doctor conscientiously objects to providing an abortion, she can be misled by the doctor's lack of cooperation and mistakenly think that she is not eligible for termination.

Furthermore, the unpredictable situation may also lead to ineffective communication between women who request abortion and their doctors, so the former could find it difficult to get adequate and accurate treatment information. For example, in *Barr v Matthews*,[111] B visited M, her GP, to seek advice on her unwanted pregnancy. B did not know that M opposed abortion on ethical and religious grounds. However, B was told that she was 16 weeks pregnant and it was too late to have an abortion. Although M referred B to an abortion counsellor who raised the possibility of abortion, B finally decided to carry her pregnancy to term and the child was born with brain damage caused by a disastrous antepartum haemorrhage. B therefore sued M for negligence in the provision of advice on the viability of abortion. While there was no evidence

[111] [2000] 52 BMLR 217

that the wrongful birth was directly caused by B's inaccurate information, a question raised here is to what extent doctors' right to refuse to provide abortion services because of their moral convictions should be protected by law. Although doctors' right to express their personal belief by refusing service provision should be treated with some respect by law, I argue that it has been given too much protection under the medical-centred model of abortion. This right is even treated as more important than their professional obligations to offer health care services. The imbalance between doctors' right to conscientious objection and their professional obligations can cause oppression of and social injustice against women who need abortion, particularly those who are socioeconomically disadvantaged and not able to afford a private service.

As has been discussed in chapter 2, according to the principle of respect for autonomy health professionals have two obligations in the provision of abortion services: a negative one and a positive one. In brief, first, health professionals should treat women who need abortion as independent moral agents by not exerting their own moral judgement on their patients' decision-making; second, they are also under a positive obligation to increase women's actual governance over abortion decisions, such as offering non-directive information and improving their patients' understanding of possible treatment options and relevant effects. Since healthcare providers are under an obligation to promote patients' welfare and interests, their right to conscientiously object to providing relevant health care services should be restricted.[112] However, the current regulation of conscientious objection gives doctors too much freedom to claim this right, so women are put in a disadvantaged position from which to request a medical procedure that only women need. For example, in addition to refusing to attend actual abortion treatment, doctors can refuse to refer women for termination. In *Saxby v Morgan*, S, a mother of two (one is autistic and has special needs) had an unwanted pregnancy although she was taking contraceptive pills.

[112] Dorothy Shaw (2006) 'What is the Relevance of Women's Sexual and Reproductive Rights to the Practising Obstetrician/gynaecologist?' 20(3) *Best Practice & research Clinical Obstetrics and Gynaecology* 299-309

She wanted an abortion because of 'the special needs of her first child, the cost of bearing children and the limited space available in her home'.[113] S requested a termination, but was told by her conscientious objecting doctor that the pregnancy was too advanced. S later gave birth to a child, but it was revealed that the time of her request she had been at 18 or 19 weeks' gestation and within the statutory time limit for an abortion. To avoid cases like this, I suggest that the scope of abortion provision that health professionals can refuse to participate in by claiming to be a conscientious objector should be restricted to actual surgical treatment. This would mean that conscientious objecting health professionals would be under an obligation to refer their patients who need abortion for a termination procedure.

Nevertheless, the 1967 Act does not clearly define the scope of abortion services where a doctor can claim the right of conscientious objection. It only vaguely states that the right can be claimed 'in any treatment authorized by this act'.[114] Therefore, GPs who only participate in preliminary stages of an operation, such as signing the blue form, are also allowed to claim this right. In *Janaway v Salford Area Health Authority*, the Law Lords rejected a doctor's receptionist's claim that she had been wrongfully dismissed for refusing to type a letter of referral for an abortion. They held that as the activity of an accessory, typing the letter by the receptionist is not included in 'any treatment authorized by this act'. Lord Keith noted:

> The word 'participate' in s4(1) did not import the whole concept of principal and accessory residing in the criminal law, but in its ordinary and natural meaning referred to actually taking part in treatment administered in a hospital or other approved place in accordance with s1(3), for the purpose of terminating a pregnancy .... It is unclear whether or not there are any circumstances under which a doctor might be under any legal duty to sign a green form, so as to place in difficulties one who had a conscientious objection to doing so. The fact that during the 20 years that the 1967 Act has been in force no problem seems to have

[113] [1997] PIQR P531
[114] The Abortion Act 1967 s. 4 (1)

surfaced in this connection may indicate that in practice none exists. So I do not think it appropriate to express any opinion on the matter.[115]

On the one hand, the Law Lords defined the range of abortion treatment where medical personnel can claim the right to conscientious objection as 'actual participation' in hospitals or approved places, so they could successfully deny the receptionist this right. On the other hand, according to the narrow meaning of 'participate in any treatment', signing a referral form, as a preliminary step of termination, should not be included. If the right to conscientious objection does not apply to this step, a GP will have a duty to sign the referral form. In addition, as the discussion of *RCN* offered above has suggested, the main role in providing the substantial process of abortion is undertaken by nurses. Surgical termination is often performed in the absence of doctors' actual participation, so nursing staff rather than doctors should be more eligible to claim the right to conscientious objection. However, the Law Lords, as usual, were not willing to interfere with doctors' discretion on the provision of abortion services. Once again, they protected the law's construction of abortion as a medical procedure at the expense of women's autonomy. As will be discussed in section 3, due to a lack of limits on doctors' right to conscientiously object to abortion, women may have to wait longer, pay for a private service, resort to illegal termination means and even carry unwanted gestation to full term.

In chapter 5, I will offer a detailed discussion of how to redress the power imbalance between health professionals and women who request abortion by reform of the regulation of conscientious objection. Furthermore, this discussion aims to examine whether feasible proposals can be developed from China's experiences of having a state-centred model. Nonetheless, it does not argue for copying the Chinese method of assessing the value of doctors' right to express their personal belief, but suggests that contextual differences should be taken

[115] [1989] AC 537

into consideration. This means that a complete removal of the conscientious objection right in the English jurisdiction is neither possible nor realistic. Nevertheless, China's legal experiences of defining abortion providers and their professional obligations may be helpful in addressing the question of how to properly restrict the right of conscientious objection.

Summarising from the discussion provided in this section, both English codified law and case laws have severed abortion from the complex and broad social factors behind unwanted pregnancy. Abortion law-making has therefore been separated from women's need and life experiences. As a consequence of entrenching the medical monopoly, abortion has been shifted away from a woman-centred choice toward a purely medical decision. Law's marginalisation of women's voices and centralisation of medical discretion are two interrelated and simultaneous processes. The more termination has been defined in a medical-centred way, the more difficult it becomes to see an abortion decision as 'one which fundamentally belongs to women rather than to doctors'.[116] While the 1967 reform has conditionally decriminalised termination, it has not granted women any substantial right to make abortion decisions. Distinct from imposing severe punishment in the era of criminalisation, the medicalised law has punished women by making abortion more unpleasant and stressful than it needs to be. Thus, to reduce women's strains caused by unwanted pregnancy and increase control over their abortion decisions, law's construction of abortion as a crime or a medical procedure should be replaced with one grounded in the principle of respect for autonomy. The discussion in chapter 4 will examine the Chinese regulatory model of abortion under which law's construction of abortion is very different from the English one. As will be analysed, while compared with their English sisters, Chinese women's right to autonomy in abortion decisions has been infringed more acutely in practice

[116] Sally Sheldon (1997) p.157

because of the current population policy, Chinese law's definition of abortion as a family planning method can pose strong challenges to the current English legal construction of abortion.

3. Legal Images of Doctors/Women and Abortion in Practice

The above analysis has suggested that because of the medical profession's assertion of power and exercise of discretion, abortion has been constructed as a medical procedure at the expense of women's procreative autonomy. In order to further examine the instrumental role of the medical profession in partially decriminalising abortion and entrenching their monopoly, in this section I will first discuss how doctors actively sought to produce different portrayals of themselves and women who need abortion. As a consequence, the power imbalance between them was established. Furthermore, I will assess the harmful effects of the professionalization of abortion services on abortion-seeking women. To do so, I will scrutinise abortion in practice by analysing the official abortion statistics for England and Wales in the first decade of the twenty-first century, abortion tourism and service-related delays. The discussion of abortion practice offered in the following section also suggests the necessity of demedicalising abortion in accordance with the principle of respect for autonomy.

3.1. The Construction of the Images of Doctors and Women

From *House* and *Grey's Anatomy*, two of the most popular TV medical drama series, it can be seen that doctors embody everything social elites should have: they are intelligent, rich, skilled, upright, humane, sensitive and supportive. They can be any normal person on the street if they want to be; but once they are in a white gown they become 'white angels' immediately. They have a strong sense of responsibility of using professional knowledge to heal the wounded and

rescue the dying. The figure of doctors in popular culture is surprisingly identical to that in law courts and parliamentary debates. Also, they are often referred to as a male figure. As Thomson has observed, while medicine is neither monolithic nor exclusively male, 'a model of the doctor' which is often 'privileged, arguably valorised within the discourses of law, popular culture and elsewhere often represents "exclusively he"'. [117] 'He' is 'responsible', 'highly skilled', 'dedicated', 'sensitive sympathetic' and always acts according to his own ethical and medical standards. These adjectives are not products of the author's imagination but collected from parliamentary discussions of the legislation on abortion.[118] As a result, in legal discourse, doctors are constructed as parallel judges or moral arbiters.

As has been discussed earlier in this chapter, in the era of criminalisation, while a complete ban appeared to be imposed on abortion, a free zone was reserved by law makers for doctors to carry out 'good practice'. As the analysis of *Bourne* has suggested, the judge described the doctor as the highest skilled, humane, responsible, rational practitioner, completely different from greedy and selfish 'back-street' abortionists.[119] Instead of being punished for challenging law's authority, the doctor Bourne's decision to perform the abortion was defined 'as an act of charity'.[120] The discussion of the cases has indicated that doctors' professional qualifications and knowledge are usually treated as the best defence in law courts for their intentionally or unintentionally breaching law. Their knowledge, 'altruistic values' and 'the legitimacy of their claim to self-regulation'[121] have effectively protected them from outside interrogation and scrutiny.

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[117] Michael Thomson (1998) p.179
[118] See HC Debates (23 October 1966) vol 732 col 1104 (22 June 1966) vol 732 col 1235
[119] [1939] 1 KB 687
[120] Ibid.
[121] Jonathan Montgomery (1998) 'Professional Regulation: A Gendered Phenomenon?' in Sally Sheldon and Michael Thomson (eds) *Feminist Perspectives on Health Care Law* (London: Cavendish Publishing Limited) p.33

Law's construction of abortion as a medical procedure has produced very different images of abortion-seeking women who have been regarded as the object of their doctors' scrutiny and normalisation. In both parliament and law courts, abortion-seeking women's figures have been construed as opposite to those of their doctors. The parliamentary debates discussed in the first section of this chapter have indicated that women who request abortion were described either as broken housewives who were exhausted by living with a violent husband or maintaining a multi-child family or as cold-blooded killers who refused their maternal instincts for unbelievably trivial matters. As Thomson has claimed, the legal image of women who need abortion is either 'tarts' or 'tired housewives' [122] who are considered as incapable of making rational and responsible decisions. According to Jill Knight, an anti-choice MP, contraceptive failures are only inhuman and irresponsible women's excuses for seeking termination, which is a 'flippant' decision and allows women to kill their babies in order to carry on with relatively trivial activities such as their planned holidays. She notes:

> I absolutely reject the argument used by some emotional do-gooders that poor people do not understand how to use contraceptives. Of course they do; they are not stupid ... For goodness sake, let us bring up our daughters with love and care enough not to get pregnant... [123]

For Jill Knight, a 'normal and rational' woman will definitely not have an unwanted pregnancy; only those who are tarts or who were brought up by a mother who did not give 'love and care enough' to her daughters will seek termination.[124] The anti-choice MPs like her obviously forget that there is no contraceptive method which is proved to be 100 per cent effective.[125] Moreover, women are not always in charge of their sexual lives and the relationship with their partner. As the discussion of abortion in practice provided below will show, reasons for having unwanted

[122] Michael Thomson (1998) p.68
[123] HC Debates, vol 732 col 1104 (22 June 1966)
[124] Ibid.
[125] James Trussell 'Contraceptive Failure in the United States' 70(2) *Contraception* 89-96

pregnancies are often beyond women's control. Additionally, some other anti-choice MPs, such as Peter Mahon, told parliament that 'it has always been the glory of a mother to defend her child, in the womb or outside it', so that abortion is a 'travesty of motherhood' regardless of the fact of how she gets pregnant.[126] This argument has also implied that only irrational and irresponsible women have an 'unwanted' pregnancy. According to anti-choice MPs, women who need abortion are persons who 'must be helped to be responsible'.[127] Nevertheless, distinct from irrational and irresponsible abortion-seeking women, 'medical men' are often reluctant to perform this 'immoral, upsetting and inhumane' surgery. Jill Knight has noted that 'normally, medical men do not talk about this kind of operation because it is very upsetting ....'[128] For anti-choice MPs, health professionals who represent responsibility and humanity are willing to stop their irrational and irresponsible female patients from making a 'flippant' decision to kill their unborn children.

Even for those MPs in favour of abortion reform, their way of describing doctors and women who need abortion is not essentially distinct from that of anti-choice MPs. For the former, conditionally allowing certain women to have abortions is a necessary method of maintaining their maternal capacities and making these capacities more effective. In pro-abortion MPs' descriptions, women who seek abortions are usually desperate multi-child housewives whose housing situation is intolerable and whose husband is either 'absent or an alcoholic'.[129] Consequently, the ban on abortions should be lifted, so those tired mothers and their 'problem families'[130] can be rescued. Gwyneth Dunwoody, a proponent of abortion reform, has told parliament that many women in over-large families, are 'so broken down physically and

[126] HC Debates, vol 750 col 1356 (22 July 1967)
[127] HC Debates, vol 696 Col 1101 (22 June 1966)
[128] HC Debates, vol 732 col 1104 (22 June 1966)
[129] Sally Sheldon (1993) 'Who is the mother to make the judgment? The constructions of woman in English Abortion law' 1(1) *Feminist Legal Studies* 15-21 p.15
[130] HC Debates, vol 732 col 1099 (22 July 1966)

emotionally with the continual bearing of children' that they may fail to fulfil their real and worthwhile function as 'a mother, of holding together the family unit' if they are not given access to abortion.[131] Thus, in some circumstances, abortion does not damage women's maternal instincts, but facilitates women's maternal capacities. She told parliament that the capacity to mother means:

> Something much more than the ability to bear a child or to wean a child. It means the ability to be the person who brings the family together, who knits the various children and the mother and father together, so that the mother can play the part she ought to play in building and maintaining the family unit.[132]

Although the proponents and opponents have created two different figures of women who need abortion, their strategies are both based on the compulsory assumption of the normal female role as maternal analysed in chapter 2. The bone of contention between the two groups is not whether women's reproductive autonomy should be respected, but whether their maternity will be destroyed or facilitated by abortion. For anti-reform MPs, women must be stopped from having abortions because it helps women escape maternal responsibility, such as bearing and rearing children. For reformers, women's requests for termination should be allowed in some special circumstances, so they can better perform their maternal tasks.

In the parliamentary debates on the time limit for abortion, reformers continued to use the same strategy to construct images of women who request late abortion as victims or desperate mothers. For example, Harriet Harman, an MP in favour of the 24-week cut-off point, told parliament that late abortion services can help teenage victims of accidental pregnancies and desperate housewives. She comments:

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[131] Ibid.
[132] Ibid.

> First, young girls who at first do not realise that they are pregnant, and although desperate to end the pregnancy, are afraid to seek help and therefore do not go to the doctor until the pregnancy is 22 weeks, say, because they are afraid that they might be kicked out of the home and they do not know where to turn; and, secondly, women who develop pregnancy- induced hypertension, who continue with a planned pregnancy for as long as possible, but it becomes clear at 24 weeks, say, that the continuation of the pregnancy could mean kidney damage for the woman or even permanent blindness...[133]

Rather than making reference to reproductive autonomy or rights, parliamentary discussion from reformers has suggested that even women who seek late abortions should welcome motherhood, so allowing certain women to access late abortion can prevent their maternal capacities from being damaged. For example, law should give a chance to those teenage victims, so they can become an effective mother for future children. Also, law should allow those desperate mothers, like Meriel Gillman,[134] who are eager to become a mother but whose lives are threatened by continuing their pregnancies, because they deserve a chance to effectively mother existing or future children. While supporting late abortion access, reformers are not motivated by the desire to enhance women's autonomy. They define late abortion as an issue according to doctors' good practice. For example, MP Frank Doran notes:

> We need to establish a principle that is related to the best medical practices. We should not have to debate the matter year in, year out but should place our trust in medical practitioners and give them a legal framework with which they can operate and which the public can understand.[135]

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[133] HC Debates, vol 171 col 262 (24 April 1990)
[134] Ibid. Harman used Meriel Gillman's story as an example to justify keeping the high upper limit, which could save 'desperate mothers'. Meriel Gillman had a son and had been trying for another child for 10 years. She finally became pregnant again at 40. However, Meriel's blood pressure became raised at 27 weeks. After the blood pressure test, the foetus had been diagnosed as having severe spina bifida, urino-genital problems, a deformed rib cage, small lungs and numerous other problems. Finally, she had to choose to have an abortion.
[135] Ibid.

From the parliamentary debates it can be seen that the MPs' argument for a comparatively high upper limit is based on the following assumptions – first, that women should be encouraged and helped in order to undertake their maternal role effectively, second, only those women who are willing to take maternal responsibility should be allowed to access abortion, and third, the ultimate authority to make decisions must be left in the hands of doctors. While the enactment of the 1967 Act and the adoption of the upper time limit of '24 weeks' mean that reformers have won the battle in parliament, women have not won any substantial rights in abortion decisions. As has been argued earlier in this chapter, the strategy of reformers to construct abortion as a medical procedure in law has disempowered women in abortion decisions. As Sheldon has suggested, feminists should be aware of the danger of reformers' victory, which can lead to a failure to direct attention to broader social issues and a failure to locate abortion in relation to issues of 'contraception, sex education, welfare benefits and gender discussion over women's sexuality and position in society'.[136]

As the analysis of abortion in practice offered below will indicate, reasons for having unwanted gestation and seeking an abortion late are often more complicated and complex than those listed in s. 1(1) of the 1967 Act and mentioned in parliamentary debates. A simple reason for having unwanted pregnancy could be failed contraception, since no contraceptives can guarantee 100 per cent success, and a deeper cause may be related to gender inequality and social injustice. Morally assessing women's requests for abortion services is beyond doctors' professional knowledge and personal ability. However, law's acceptance of the strategy of reformers means that women are only allowed to hold certain reasons to seek abortion. To make a successful request for abortion, women are expected to have a reason which shows that what they are attempting to refuse is this particular pregnancy, but not their maternal responsibility. Doctors

[136] Sally Sheldon (1997) p.106

therefore have been defined as parallel judges who can vet women's eligibility for accessing abortion.

The above analyses suggest that both reformers and 'conservatives' have shared the view that the decisional authority should not be given to abortion-seeking women because of their irrationality caused by either desperation or selfishness. Law makers' methods of drawing different legal images of doctors and abortion-seeking women have established a paternalist relationship between them. In this relationship, women have to be subject to their doctors' understanding of what is best for them. Although the principle of respect for autonomy has begun to be at the centre of medical practice and legislation for almost a half century,[137] the regulatory model of abortion has still worked within the framework of 'doctor knows best'. Thus, I suggest that to bring the provision of abortion into line with the principle of respect for autonomy, in addition to reshaping law's construction of abortion, legal figures of doctors and abortion-seeking women should also be dismissed. After examining the Chinese law and policy of abortion in chapter 4, I will attempt to derive some proposals to challenge the above legal images from Chinese legislative experience in chapter 5.

3.2. Problems with Access to Abortion in Practice

This section first offers a discussion of abortion statistics issued by the Department of Health for England and Wales in the first ten years of the twenty-first century in order to examine the provision of termination services in practice. Furthermore, the analysis of the recent abortion statistics aims to show that the 1967 Act, which was enacted about 45 years ago and amended more than 20 years ago, cannot fit abortion provision in practice. Then the discussion offered in

[137] Mary Donnelly (2010) p.268

this section explores two issues in practice – 'service-related delays' and 'abortion tourism' – in order to demonstrate that women's decision-making is not respected sufficiently under the medical-centred regulatory model. Moreover, the analysis of these two problems suggests that law's lack of respect for autonomy in the context of abortion can impose considerable stresses and strains on women, particularly those from disadvantaged backgrounds. For example, working class women may find it difficult to afford private services if they are not eligible for NHS-funded ones; women whose GP is a conscientious objector may have to bear the pressure of travelling in order to access abortion. Thus, the medical-centred regulatory model has also increased injustice. As has been argued in chapter 2, establishing a regulatory model grounded in the principle of respect for autonomy can effectively promote other values, such as social justice and gender equality. In brief, the analysis provided in this section aims to stress the importance of the task of bringing law into line with this principle. This task will be undertaken in chapter 5.

3.2.1. Abortion Statistics

As has been discussed earlier in this section, under the existing regulatory model abortion is defined as a complex and highly skilled medical procedure which must be controlled by doctors. Consequently, women's termination requests have to be vetted by medical discretion, so abortion services can be limited to those who have a reason which can satisfy the requirements of the medical and legal professions. Thus, abortion has still been construed by law as an undesirable decision which should only be made in some special circumstances.

Nevertheless, the reality is that in the past 10 years, around 200,000 abortions have been performed each year,[138] which suggests that abortion is now the most commonly performed medical treatment for women of reproductive age in the UK.[139] The majority of abortions (around 90%) were performed at under 13 weeks' gestation when termination is 'an extremely simple procedure'.[140] There was a stable increase in terminations performed earlier than at 13 weeks' gestation (87% of the total in 2000, 88% in 2004, 87% in 2006, 90% and 91% in 2008 and 2009). The growth in abortions performed earlier than 10 weeks was remarkable (57 % of the total in 2002, 60% in 2004, 67% in 2005 and 73% in 2008). The recent statistics show that in 2009 75% of terminations were performed before 9-week gestation when women may choose between medical and surgical methods.[141] There was a tendency towards using the former. Medical abortions only accounted for about 12% of the total in 2001, but increased to 40 percent in 2009. This indicates that medical development has significantly changed traditional surgical means and enhanced abortion choices. Nevertheless, the current regulation of abortion prevents women from benefitting from new abortion medicine by making the use of it more difficult and complicated than it needs to be.

From the discussion provided earlier in this chapter, it can be seen that abortion can only be requested on the four statutory grounds in s. 1(1) and under 24 weeks' gestation if on the 'social grounds' in s. 1(1)(a). Nevertheless, what happens in real life is that apart from very rare terminations on the grounds of foetal abnormality, the majority have been performed on the grounds in s. 1(1)(a) and at under 13 weeks. From 2000 to 2009, there were less than 140

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[138] Department of Health (2001-2009) Abortion Statistics for England and Wale available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/index.htm (last accessed 11 April 2011)

[139] See Ellie Lee (1998) 'Introduction' in Ellie Lee (ed) *Abortion Law and Politics Today* (London: Macmillan Press Ltd and ST. Martin's Press) p.xi

[140] Emily Jackson (2001) *Regulating Reproduction* (Oxford: Hart Publishing) p.72

[141] Department of Health (2001-2009) *Abortion Statistics for England and Wale* available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/index.htm (last accessed 11 April 2011)

abortions carried out at over 24 weeks and they were mainly on foetal disability grounds. Moreover, while there are four statutory reasons, abortions in practice were normally requested on the 'social' grounds in s. 1(1)(a). For example, in 2009, around 98 per cent of abortions were undertaken on these grounds. This suggests that in reality women's reasons for having an abortion are usually not medical/therapy-related. Ironically, even the wording of the so-called social grounds in s. 1(1)(a) makes reference to the health benefits of pregnant women and their children rather than reproductive freedom or rights. Therefore, there are only two types of reasons which are treated as lawful in practice – therapeutic and foetal disability-related. Law makers have turned a blind eye to the fact that terminations today are being used much more as a means of avoiding unwanted pregnancy and involuntary parenting than one of pursuing a therapeutic goal or avoiding offspring with undesirable traits. In this regard, around 200,000 women each year have to be 'formally certified as mad' before they are able to end an unwanted pregnancy.[142] Moreover, the small number of abortions performed after the first trimester implies that women are not opting to seek abortion at a late stage, so they do not need controlling intervention, such as an upper limit, to make responsible and rational decisions. Based on the above statistics, I argue that there is an urgent need to challenge the current legal definition of abortion as a medical procedure and redress the power imbalance between women who need abortion and their doctors.

3.2.2. Service-related Delays

One serious problem caused by law's lack of respect for procreative autonomy is delays in the provision of abortion services. As has been discussed in chapter 2, to reduce unnecessary strains, when a woman makes her mind up to discontinue a pregnancy, she should be able to have an

[142] Jennie Bristow (14 Feb 2011) 'How Britain's Abortion Law Punishes Women' *Spiked* available at http://www.spiked-online.com/index.php/site/article/10190 (last accessed 14 April 2011)

abortion as soon as possible. Abortion performed at an earlier stage means less trauma and stresses. According to RCOG's recommendations for abortion waiting time:

> Ideally, all women requesting abortion are offered an assessment appointment within 5 days of referral;
>
> As a minimum standard, all women requesting abortion are offered an assessment appointment within 2 weeks of referral; ideally, all women can undergo the abortion within 7 days of the decision to proceed being agreed;
>
> As a minimum standard, all women can undergo the abortion within 2 weeks of the decision to proceed being agreed;
>
> As a minimum standard, no woman need wait longer than 3 weeks from her initial referral to the time of her abortion;
>
> Women should be seen as soon as possible if they require termination for urgent medical reasons.[143]

However, a survey conducted by Lee et al. has demonstrated that a large proportion of the sample (60 per cent) reported a delay between requesting an abortion and having the procedure. Out of all the respondents, 40 per cent waited more than two weeks between requesting and having an abortion and 23 per cent waited more than three weeks more than the standard recommended by the Royal College of Obstetricians and Gynaecologists (RCOG).[144] These service-related delays can be largely avoidable if the requirement of two doctors' signatures is removed. As has been discussed in section 2, the current regulatory model has overemphasised doctors' right of conscientious objection to participation in abortion provision, but has not given due consideration to their professional obligations. The possibility for a woman of ending the unwanted pregnancy is reliant on her doctor's personal judgement. This means that when a woman is unlucky enough to have a GP who is against abortion, service-related delays may occur. The discussion of *Barr v Matthews* and *Saxby v Morgan* offered earlier in this chapter has

[143] RCOG (2004) 'The Care of Women Requesting Induced Abortion' available at http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion (last accessed 11 April 2011)

[144] Ellie Lee, Steve Clements, Roger Ingham and Nicole Stone, *Second-trimester Abortions in England and Wales*, available at http://www.soton.ac.uk/lateabortionstudy/late_abortion.pdf the access date: 10-Jan-2010

suggested that there is no lack of unsympathetic doctors. *BBC News* has highlighted the problem that in many cases women had to wait longer because they found it hard to discuss abortion with their GPs. In the BBC report, Cath Elliott, a 32-year-old mother of four, who became pregnant for the fifth time and decided to have an abortion, comments:

> My GP in Milton Keynes, where I was living at the time, was not helpful at all. He kept saying he had lost my results and it took a long time until we were referred to hospital ... Even though he didn't say it, it was clear he did not agree with abortion ... There is the abortion pill which could be administered by nurses. Why should women who want abortions have to see a doctor at all when it is in the early stages?[145]

Moreover, service delays may force some women to pay for private abortions. *BBC News* also highlighted the fact that in 1999 a survey has shown that 47% of the women in the report who paid for an abortion had originally sought help from the health service; 53% of them bypassed the NHS entirely and went straight to a private clinic and 44% of the 53% who bypassed the NHS chose to do so because they knew they would have to wait too long for a free abortion. Some women were told by their GP that they would have to wait up to eight weeks for an abortion.[146] Given that the paternalistic relationship between abortion-seeking women and doctors has caused considerable service-related delays, the power imbalance in their relationship should be readdressed in order to increase women's actual governance over abortion decisions. In chapter 5, I will examine how to reform the medical-centred regulatory model in accordance with the principle of respect for autonomy and scrutinise how an autonomy-based model can readdress the power imbalance between women who need abortion and their doctors.

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[145] BBC News (28 November 2008) 'Still Hard to Discuss Abortion' available at http://news.bbc.co.uk/1/hi/health/6189414.stm (last accessed 7 January 2010)

[146] BBC News (7 December 1999) 'Women Forced to Pay for Private Abortions' available at http://news.bbc.co.uk/1/hi/health/553204.stm (last accessed 13 April 2010)

3.2.3. Abortion Tourism

Law's lack of respect for women's autonomy can also boost abortion tourism, by which I mean that when being denied access to abortion, women are forced to travel to another part of the UK or another country in order to have an abortion. It can be seen from the discussion offered below that tourism in this chapter is different from its traditional meaning and involves strains, stresses, stigma, loneliness and pain. Abortion tourism normally exists in jurisdictions where abortion is completely prohibited or only allowed in very strictly therapeutic circumstances, such as in Ireland, Poland and Chile.[147] This section aims to show that while abortion has been legalised in England, law's lack of respect for autonomy may force women who need abortion to travel. Since the 1967 Act does not extend to Northern Ireland, each year a large number of women have to travel from Northern Ireland to England to access abortion services. Many legal scholars have argued for the extension of this act to Northern Ireland in order to eradicate abortion tourism [148] and I strongly agree with them. Nevertheless, as the main emphasis of this chapter is to examine the English regulatory model, this subsection does not discuss the law and practice of abortion in Northern Ireland. Abortion tourism in this chapter includes two phenomena – first, women who live in an English county have to travel to an abortion provider in another county and second, women have to travel outside England to have an abortion.

Under the current regulatory model, whether a woman is eligible for termination services is largely dependent on medical discretion. While abortion is a significant family planning means, it is not available on demand. Therefore, doctors' non-cooperation, such as GPs' refusal to refer women to termination services, can cause the first type of abortion tourism. As has been

[147] Marie Fox and Therese Murphy (1992) 'Irish Abortion: Seeking Refuse in a Jurisprudence of Doubt and Delegation' 19(4) *Journal of Law and Society* 454-466 and Amew Sterling (1997) 'European Union and Abortion Tourism: Liberalizing Ireland's Abortion Law' XX(2) Boston College International and Comparative Law Review 385-407

[148] Marie Fox and Therese Murphy (1992); Ruth Fletcher (2000) 'National Crisis, Supranational Opportunity: The Irish Construction of Abortion as a European Service' 8(16) *Reproductive Health Matters* 35-44; (2005) 'Reproducing Irishness: Race, Gender and Abortion Law' 17(2) *Canadian Journal of Women and the Law* 365-404 and 'Abortion Needs or Abortion Rights? Claiming State Accountability for Women's Reproductive Welfare' 13(5) *Feminist Legal studies* 123-134

discussed in the second section of this chapter, if a woman has an anti-abortion GP, she may have to travel to another health centre or a private sector in order to be referred for an abortion. Compared with travelling inside England, travelling outside England to access abortion services may impose more stresses and strains on women. As has been analysed in section 2 of this chapter, the amendment to the 1967 Act in the 1990 Act that has reduced the time limit of abortion on the most commonly held grounds in s. 1(1)(a) to 24 weeks means that women are not able to access abortion beyond this cut-off date unless their foetus is diagnosed with a disability or there is a very strictly therapeutic reason. According to the report, 'An Investigation into the BPAS Response to Requests for Late Abortions' issued by the Department of Health in 2005, some women whose gestation is around the upper limit have to travel to Spain.[149]

While the abortion statistics for England and Wales in the past decade have indicated that, in practice very few abortions were performed after 24 weeks for the reasons in s. 1(1)(a), abortion in the second and third trimesters should not be prohibited. Women's reasons for not accessing abortion earlier are often beyond their control. As Lee has observed, at least 80 per cent of women accessing abortion after the first trimester did not realise that they needed an abortion until they were more than three to four months pregnant. Some of them were not sure about having an abortion, so it took them a while to make a decision; some did not realise they were pregnant earlier because their periods were irregular and some felt that they could not deal with single parenting, which would be the consequence of the ending of their relationship with their partners.[150] Compared to service-related delays, analysed above, these 'woman-related' ones are usually unavoidable or at least cannot be reduced by law. In real life, reasons for requesting

[149] Liam Donaldson (Sepember 2005) 'An Investigation into the BPAS Response to Requests for Late Abortions' available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4119618.pdf (last accessed 13 April 2011)

[150] Ellie Lee, Steve Clements, Roger Ingham and Nicole Stone (2002) *A Matter of Choice?* (New York: Joseph Rowntree Foundation); Ellie Lee (2004) 'Why Women Have Late Abortion' in *Late Abortion: A Review of the Evidence, A Briefing Compiled* available at www.prochoceforum.org.uk (last accessed 13 April 2011)

abortion after 24 weeks may be even more complex than those summarised in the survey conducted by Lee et al. Law's use of medical knowledge about foetal viability as an abortion deadline has acutely violated women's right to author their lives by assessing and judging their personal circumstances. As McNeil has commented:

> Saying that it is theoretically possible to plug a 24-week-old fetus into life support apparatuses is very different from saying that you personally will take primary responsibility for supporting – in every sense – a child through to adulthood.[151]

According to the analysis offered in chapter 2, when a woman lets her very late pregnancy end in an abortion it is not an easy decision for her to make. She must have already carefully reflected on it and thought that it is the best for her or other existing family members. Since waiting for a termination service and ending a pregnancy after the second trimester can be very stressful, instead of placing any legal limits on this, more support should be available for women who request late abortion. In chapter 5, I will provide a discussion which examines the problems with law makers' attempt to restrict late terminations by setting up the upper abortion cut-off point according to scientific evidence. I suggest that not only reducing the current time limit, but also adopting any cut-off point for legal abortion services breach the principle of respect for autonomy and can cause oppression, like service delays and abortion tourism, of women, particularly those from comparatively disadvantaged social classes. In chapter 5, I will offer a discussion which suggests that the removal of the time limit does not only enhance abortion choices in late stages of gestation but, more importantly, can challenge the medical monopoly and raise the possibility of rebuilding the regulatory model in accordance with the principle of respect for autonomy.

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[151] Maureen McNeil (1991) 'Putting the Alton Bill in Context' in Sarah Franklin, Celia Lury and Jackie Stacey (eds) *Off-Centre: Feminism and Culture Studies* (London: Harper Collins Academic) p.156

Conclusion

I want to begin the conclusion of this chapter with the observation that when a woman decides to terminate an unwanted pregnancy, this decision might often prove to be responsible and rational. 'Planned parenthood' is advocated by most modern regimes. Reproduction should be voluntary and children should be wanted, so that parents are able to take responsibilities for their offspring effectively. As Furedi and Lee have observed, growing social concern about unfit or problem parents does not easily co-exist with a disposition to force people to bear children they do not want and by their own admission cannot care for.[152] Continuing a pregnancy to full term and giving birth are one of the most intimate life decisions. First, it changes a woman's physical state for at least nine months. Second, the process of giving birth requires hard work which is normally painful and sometimes even dangerous. Third, even after giving birth, it takes time for her body to return to its pre-pregnancy state. Finally, and probably most importantly, once the woman's pregnancy ends in the birth of a baby, many changes in the rest of her life could then just start. For instance, she has a day-to-day responsibility to care for and support this child until the child becomes mature enough to take care of herself. Even after the child grows up, the connection between them may continue to effect change in her life. Forcing a woman to accept these significant changes by imposing legal limits on abortions violates her basic needs for health and exercise of control over her life. As MacKinnon has observed, because of 'the unequal social predicates and consequences pregnancy has for women', unwilling pregnancy will always 'deprive and hurt one sex only as a member of her gender'.[153] The imposition of legal restrictions on a health care procedure that only women need is a form of social injustice that prevents women from having equal reproductive liberty with their male peers. Moreover, it

[152] Ann Furedi and Ellie Lee (2001) 'Defending Abortion—in Law and Practice' *Prochoice Forum* available at http://www.prochoiceforum.org.uk/comm65.php (last access 16 April 2011)
[153] Catharine MacKinnon (1991) 'Reflections on Sex Equality under Law' 100(5) *The Yale Law Journal* 1280-1328 pp.1319-1320

also increases social class inequality against women from disadvantaged backgrounds. As has been discussed earlier in this chapter, those women who have a conscientious objecting GP but cannot afford a private service have to bear more strains.

Furthermore, when a competent woman decides not to continue a pregnancy, she has certainly thought about personal conditions and found that she was not prepared to take maternal responsibility. In this regard, abortion, as a means of avoiding unwanted fertility and undesirable mothering, should also be considered as rational. An argument is that when a pregnant woman is not ready for taking maternal responsibility, she can continue the pregnancy and offer the baby for adoption. It can be an option if a woman is willing to carry an unwanted pregnancy to term and give the baby to somebody else. Nevertheless, the woman should not be forced to do so. Asking her to continue a 9-month unwilling gestation, to give birth and finally to give up the baby against her free will is a much more irrational solution by comparison with termination of pregnancy. As has been argued in chapter 2, imposing legal limits on people's reproductive freedom, particularly women's, violates their basic needs for health and for control over their life choices. Therefore, law should ensure that the ultimate authority to make the decision (not) to terminate a pregnancy is left in the hands of pregnant women.

Nonetheless, the discussion of the English model of abortion regulation offered in this chapter has suggested that law makers have shifted their attention away from women's life experiences and voices towards medical knowledge. From the analysis provided in section 1 of this chapter, it can be seen that medical intervention to change the codified law and case law relating to abortion emerged around the second half of the nineteenth century. As a result, abortion was defined as a crime which could only be performed by 'medical men' in extreme circumstances. In seeking to entrench the medical authority on the performance of abortions, the regulation of

abortion has blurred broad social and moral factors in termination decisions, such as complex reasons for having unwanted pregnancies and the status of embryos/foetuses, and only highlighted medical elements. In sections 2 and 3, I have argued that the enactment of the 1967 Act is more a mark of the establishment of the medical-central regulatory model than of the liberation of abortion. Law's adoption of limited statutory reasons for having an abortion and restricting abortion to doctors means that the 1967 reform does not grant women any more substantial right to reproductive autonomy, but reserves a protected zone for doctors' exercise of professional power. Abortion laws in the era of criminalisation and that of medicalisation both fail to treat women's procreative decision-making with seriousness. Women in these two eras are construed as either potential criminals or irrational patients and are denied the capacity to act on their autonomously held desires concerning reproduction.

Since abortion is constructed by law as a medical procedure, every single change in the English regulatory model of abortion is reliant on medical knowledge. Ironically, 'medical science', at least in the context of abortion, is often unstable and uncertain. For example, as has been analysed in section 2 of this chapter, relevant medical evidence of foetal viability has triggered long-running and fierce debates on so-called late abortion in parliament and in public. Law's adoption of the cut-off point of '24 weeks' for legal abortion on 'social' grounds is due to medical evidence that foetuses can have viability from then. However, more medical evidence, such as the report on the value of human life issued by the Nuffield Council on Bioethics in 2006, has shown that only 26 per cent of premature babies born alive between 24 to 25 weeks in 1995 survived to leave hospital after being given intensive care and 74 per cent died by the age of 6.[154] Moreover, according to some medical findings, foetuses are able to experience pain at around 20

[154] Niffield Council on Bioethics (2006) 'Critical Care Decisions in Fetal and Neonatal Medicine' available at http://www.nuffieldbioethics.org/neonatal-medicine/neonatal-medicine-background-extremely-premature-babies (last accessed 15 April 2011)

weeks' gestation;[155] but based on some other evidence, foetal pain does not occur until 26 weeks.[156] It seems that the more medical evidence relating to abortion is available, the more confusing the legislative situation will become and the less possible it will be to view abortion as a woman-centred decision.

After the last amendment in 1990, the next chance for the 44-year-old Abortion Act to be modernised is probably still reliant upon the availability of new medical evidence. Under the medical-centred model, such a chance, similar to previous ones, is likely to bring disappointing news to women who need abortion, particularly those from socioeconomically disadvantaged backgrounds. For instance, recently a Conservative and Labour Party alliance of MPs, Nadine Dorries and Frank Field, tabled amendments to the Health and Social Care Bill in order to reduce the number of abortions by restricting counselling provision to independent counsellors and NHS hospitals/clinics. According to the Dorries amendment, non-statutory abortion providers, such as the BPAS and Marie Stopes International, should not be allowed to offer abortion counselling services to women.[157] The amendment aims to make access to abortion more difficult by giving greater counselling responsibility to independent counsellors, 'some of whom are influenced by pro-life groups'.[158] If it becomes law, no matter whether a woman wants to or not, before accessing abortion provided in the private sector, she has to visit a hospital or independent counsellor for counselling services and is likely to be asked to rethink her termination decision. While Nadine Dorries lost this amendment by 118 votes to 368, in a vote in the House of Commons on 7 September 2011, women's autonomy in this sphere is still constantly under threat.

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[155] Daniel Martin (29 January 2008) 'Abortion Time Limit Should Be Reduced as Foetuses Feel Pain before 24 Weeks' *MailOnline* available at http://www.dailymail.co.uk/health/article-510975/Abortion-time-limit-reduced-foetuses-feel-pain-24-weeks-MPs-told.html?printingPage=true (last accessed 17 April 2011)

[156] The Royal College of Obstetricians and Gynaecologists (1997) *Fetal Awareness: Report of a Woking Party* (London: RCOG Press)

[157] Nadine Dorries, HC Debates, vol 524 col 124 (2 March 2011)

[158] Nicholas Watt (7 September 2011) 'Dorries abortion amendment defeated in House of Commons' *Guidian* available at http://www.guardian.co.uk/world/2011/sep/07/dorries-abortion-amendment-defeated (last accessed 7 September 2011)

Dorries has commented that 'we lost the battle but we have won the war'. A sign of Dorries and her supporters' victory can be seen from the announcement made by the health minister:

> The government is ... supportive of the spirit of these amendments and we intend to bring forward proposals for regulations accordingly, but after consultation. Primary legislation is not only unnecessary but would deprive parliament of the opportunity to consider the detail of how this service would develop and evolve.[159]

This implies that the government does have a plan to complicate abortion counselling and make access to termination services more difficult, although not by legislating. In this battle, autonomy-related issues are accorded little importance. In chapter 5, I will return to abortion counselling and address the question of why this should not be compulsory. I argue that compulsory abortion counselling is built on the assumption discussed earlier in this chapter, which is that women need professional help to make responsible reproductive decisions. According to the analysis of the principle of respect for autonomy offered in chapter 2, I suggest that rather than forcing women to take pre-abortion counselling, law makers should ensure that health professionals fulfil their positive obligation to promote the provision of non-directive information. Therefore, in chapter 5, I will also scrutinise differences between abortion counselling that is claimed by anti-choice MPs to help pregnant women make rational procreative choice and non-directive information which I argue could enhance women's understanding of possible termination options and relevant effects.

I would agree that medical science is important for improving the provision of termination services, because, as discussed in section 3 of this chapter, medical development makes modern means of ending a pregnancy much less complex and traumatic than traditional ones. However, medical science cannot predict how many stresses and strains women are able to cope with when facing an unwanted pregnancy. Furthermore, as has been argued in chapter 2, health

[159] Ibid.

professionals can play a role in increasing women's actual governance over reproductive decisions, because their cooperation can help women gain and understand relevant information about termination options. Nonetheless, they do not have the capacity to evaluate their patients' personal circumstances and decide whether a pregnancy should be ended for them. Thus, instead of regulating abortion in an evidence-based way, law makers should bring the provision of abortions into line with the principle of respect for autonomy. In chapter 4, I will examine whether abortion is regulated in accordance with this principle under the Chinese regulatory model of abortion. Although in practice it does not take women's autonomy any more seriously than the English one, exploring alternative legal methods of constructing abortion, women who need abortion and health professionals can provide feasible proposals to challenge the current English regulatory situation. The tasks of conducting a comparative study of these two regulatory models and suggesting feasible reforms will be undertaken in chapter 5.

Chapter 4

The Law and Policy of Abortion in China

Introduction

> It is women who bear the burden of their own and their male partners' infertility in the so-called First World, and their own and their male partners' fertility in the so-called Third World.[1]
>
> Janice Raymond, 1993

As Raymond has described above, while women's procreative experiences in the developed world and the developing world appear not to be identical, they are not fundamentally different. On the one hand, as the analysis offered in this chapter will show, women's experience in seeking abortion services in China, the biggest developing country, is obviously different from that of their English sisters. On the other hand, a very important issue in common is that both the English and the Chinese regulatory models do not respect women's reproductive autonomy adequately. Thus, under these two models, women may not be free to act on their autonomously held desires concerning reproduction.

The first objective of this chapter is to draw a picture of how abortion is provided in China and to examine how and why women's reproductive decision-making is restricted by the Chinese regulatory model. To achieve this goal, I will refer back to the discussion of law's embrace of the compulsory cultural assumption of womanhood as maternal provided in chapter 2. The second objective is to lay the ground for the comparative study provided in chapter 5 by examining how

[1] Janice Raymond (1993) *Women As Wombs* (Melbourne: Spinifex Press) p.xx

abortion is regulated under the Chinese regulatory model in a way that is different from how it is regulated under the English medical-centred model.

As has been suggested in the introduction to this thesis, exploring legal and cultural differences between England and China is helpful in gaining a better understanding of their regulatory models of abortion. Therefore, this chapter will provide a discussion of the Chinese legal, health care and family planning systems in order to scrutinise how Chinese methods of providing abortion and of treating women who need abortion are different from those in England. In addition, as has been argued in chapter 3, making effective proposals to promote women's reproductive autonomy should take contextual differences into account. Thus, drawing out legal and cultural differences between two jurisdictions in this chapter is fundamental to the task of suggesting feasible strategies for law reform undertaken in chapter 5. As a country that has a codified law, the main legislative method in China is distinct from that used in England. The analysis provided in section 1 of this chapter will explain how the Chinese-style socialist legal system works. Furthermore, an introduction to the Chinese health care system is given in this section, which aims to offer some background information on the provision of abortion services in China.

In sections 1 and 2 of this chapter, I will discuss how the existing Chinese regulatory model of abortion was established in the Maoist era and how it has been developed in the post-Maoist era. Section 1 will first examine access to abortion before the state started to exert control over it, when it was mainly regulated by Confucianism-dominated family values. Then, section 1 will provide an investigation of the changes made to the regulation of abortion from the era of Confucianisation to the Maoist era. This aims to assess whether the Maoist government's abortion law or its policy-making concerning population figures empowered women to exert

autonomy over their procreative choices. In the post-Maoist era, the pro-natalist population policy implemented during the Maoist era is replaced with one which is targeted at significantly reducing the national birth rate.

The analysis provided in section 2 will first look at how this significant change in the national policy-making relating to population figures influenced the legislation on abortion and its provision in the Chinese family planning context. Furthermore, in order to understand how women's (in)fertility is used as a tool by successive governments to achieve their population goals, section 2 will explore the medical limits on access to abortion services under the Chinese regulatory model and compare them with those under the English medical-centred model. Additionally, this section will discuss the state's role in providing abortion services by scrutinising its restrictions on access to financial support.

From the discussion offered in sections 1 and 2, it can be seen that the Chinese family planning context provides a site for observing and studying the roles of state intervention, law and medical power in interpreting, governing and constructing female citizens' reproductive bodies and their relationships with one another. By analysing their relationships, I suggest that under the current Chinese regulatory model the state fails to fulfil its negative and positive obligations to promote women's procreative autonomy; on the contrary, it uses law and medical power to justify and maintain its control over female fertility.

In section 3, an analysis will be provided in order to examine how abortion, female citizens of reproductive age and the state are constructed under the Chinese regulatory model. This section will also scrutinise how women's reproductive decision-making is subject to the state's population policies. This analysis also serves to contrast Chinese law's construction of abortion

and women who need abortion with their construction under the English medical-centred model. By doing so, the underlying causes of women's powerlessness in abortion decisions under the two models can be found and possible solutions can be suggested.

In chapter 2, I have been critical of the argument that the values derived from the concept of autonomy are substantially inconsistent with Chinese Confucian family-orientated culture. I have emphasised that bringing the provision of abortion services into line with the 'respecting autonomy' principle is important for both English and Chinese women, in order to satisfy their basic needs for health and for control over their lives. Section 4 of this chapter will further discuss the significance of and the possibility of transplanting the principle of respecting autonomy into the Chinese legal context. To achieve this goal, this section will firstly scrutinise how establishing a regulatory model according to the principle of respect for autonomy can increase women's actual governance over their procreative decision-making, particularly those women who are comparatively socioeconomically disadvantaged. Secondly, in seeking to assess whether the introduction of this principle into Chinese jurisdiction is possible, the autonomy-friendly thinking in Chinese Confucianism will be explored in section 4.

1. The Legal System and the Health Care System in China

1.1. The 'Chinese-style' Socialist Legal System

In order to give some background information on the provision of abortion in the Chinese family planning context, this section explains how the Chinese legal and health care systems work. The Chinese legal system has a long and complicated history which cannot be fully explored in this chapter. Thus, the analysis offered in this section mainly focuses on the existing Chinese legal system, which was established in 1949 when the Communist Party came to power.

Before the foundation of the communist state, Chinese legislative history can be divided into two parts: the imperial era (from 359 BC to 1912) and the nationalist era (from 1912 to 1949).[2] During the imperial era, the Chinese system of codification was based on the Confucian Philosophy of social control over moral education and hierarchal relations. For example, a fundamental principle of Confucian hierarchy is that the emperor rules his subjects, a husband rules his wife and concubines and a father rules his children. Furthermore, great importance was attached to criminal law in this era by emperors in order to maintain their authority.[3]

In 1911, when the Nationalist Party took over China, it began to modernise the imperial codification. Because of a series of successful legal and political reforms in Japan in the second half of the nineteenth century, the Chinese nationalist government hoped that adopting Japanese codes could modernise the outdated imperial legal system and that as a consequence the economy could also be strengthened. Japan's experience of copying German codes and its successes in relinquishing Western control motivated the Chinese nationalist authority to follow suit.[4] Nevertheless, the reform failed to serve its purpose because it was 'simply too little too late'.[5] In the meantime, during the nationalist era, many Western concepts, such as 'justice', 'democracy' and 'equality', along with human rights thinking, were introduced into China. They challenged the traditional Confucian definitions of various relations between the rulers and their subjects, and between men and women mentioned above.[6] Although not all of these Western human rights ideas were accepted by Chinese people, they had positive effects on the

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[2] Werner Menski (2006) *Comparative Law in Global Context: the Legal Systems of Asia and Africa* (Cambridge: Cambridge University Press) p.494
[3] Chin Kim (1987) 'The Modern Chinese Legal System' vol.61 *Tulane Law Review* 1413-1452 p.1438
[4] Zentaro Kitagawa (2006) 'Development of Comparative Law in East Asia' in Mathias Reimann and Reinhard Zimmermann (eds) *The Oxford Handbook of Comparative Law* (Oxford: Oxford University Press) p.240
[5] Albert Chen (1998) *An Introduction to the Legal System of the People's Republic of China* (Singapore: Butterworths Asia) p.21
[6] Randle Edwards, Louis Henkin and Andrew Nathan (1986) (eds) *Human Rights in Contemporary China* (New York: Columbia University Press) p.125

development of human rights thinking in China. As Peerenboom has observed, the development of human rights thinking in China has 'Chinese characteristics' that can be viewed as 'a product of Chinese culture, traditions, and historical and economic conditions'.[7] In section 4, I will further discuss these Chinese characteristics and assess the possibility of integrating the principle of respect with Confucian family-orientated values.

Since 1949, when the communist government came to power, most of the imperial and nationalist codes have been repealed. The communist government in the Maoist era (1949–1979)[8] copied most of the legal and political systems from the former Union of Soviet Socialist Republics, where the regulatory methods were state-centred and coercion-orientated. The post-Maoist era (1979–present) is a crucial transitional period socially for China. From around the start of the 1980s, the first post-Maoist communist government implemented the policy of 'reform the inside and open to the outside world' and tried to develop a socialist market economy, that is, a combination of socialism and market economics. Moreover, much more importance is attached to the principle of 'rule by law' in the post-Maoist era than was attached to it in the Maoist era. Consequently, the first post-Maoist government began to establish a Chinese-style socialist legal system. However, as Potter has observed, the task of building the Chinese-style socialist legal system is still 'a work in progress',[9] which needs further improvement and development by learning and using successful legislative and regulatory experiences of other jurisdictions. In the beginning of the 1990s, when the Cold War ended and the Soviet Union collapsed, the post-Maoist communist state considerably changed its hostile attitude to capitalist jurisdictions. It attempted to learn lessons from capitalist regulatory

[7] Randall Peerenboom (1993) 'What's Wrong with Chinese Rights: Toward a Theory of Rights with Chinese Characteristics' vol.6 *Harvard human rights journal* 29-59 p.53

[8] Zengdong Mao was the first president of communist China for almost 30 years. Maoist China is used to name this era in this thesis.

[9] Pitman Potter (2004) 'Legal reform in China: Institutions, Culture and Selective Adaptation' 29(2) *Law & Social inquiry* 465-495 p.486

experiences and even applied some Western approaches to Chinese social problems. For example, as has been discussed in chapter 3, the means of governing human embryonic research in China has been learnt from that used in England. Against this background, the attempt to use the proposals which stem from some English experiences of regulating abortion to reform the existing Chinese abortion law has good chances of success.

Nonetheless, governments in the post-Maoist era have not completely abandoned the Maoist state-centred and coercion-orientated regulatory approaches.[10] As mentioned above, before 1978 the Maoist government simply copied the legal and political systems of the former Soviet Union. Thus, similar to the boundary between policies and laws in the former Soviet Union, that in China was very blurred in the Maoist era. It is accurate to say that Maoist China was ruled by the state's policies or the party leader: by Mao, rather than by law. Although some codes, such as the Constitution of 1954, were made and enacted in the Maoist era, they were more like political than legal documents. These codes were not made by China's legislative organ or through formal legislative procedures. However, this situation was not unusual in the Maoist era, when state policies and party norms rather than legal codes served a function equivalent to that of laws in Western countries. Additionally in the Maoist era, China suffered greatly from the three-year 'Great Leap Forward' (1958–1960) and the ten-year disaster of the 'cultural revolution' (1966–1976). The major aim for the Maoist government was to carry out class struggle. As a result, during the twenty years from 1958 to 1978, China was hesitant and virtually at a standstill: there was no economic growth, no rise in the standard of living and the legal system was in an even poorer state than before the Maoist era began.[11] In seeking to redress these problems, the first

[10] Jingbao Nie (2010) 'Limits of State Intervention in Sex-selective abortion: the case of China' 12(2) *Culture, Health & Sexuality* 205-219 p.210

[11] Guangfu Han and Yongqiang Hu (2009) 'Deng Xiaoping De Gaige Suiyue' *China Academy of Safety Science and Technology* available at http://www.chinasafety.ac.cn/detailnews.aspx?nid=1435 (last accessed 11 February 2010)

post-Maoist government carried out a series of wide-ranging reforms, including law reform.[12] Enormous progress has therefore been made in China since the start of the 1980s in terms of the construction of a formal and official Chinese-style socialist legal system. Against this background, from 1979 to 1989, about 3,000 laws and regulations were enacted.[13]

The main means of making law in China is making and enacting written codes. Depending on which legislative organ makes the law, Chinese statutes have different levels of legal force. In general, laws which have low levels of legal force must not override those which have comparatively high levels of legal force. Also, laws with low levels of legal force are usually only applicable to a particular province, but those with high levels of legal force may be applicable more widely or even nationwide. In descending order of force levels, these laws are composed of the Constitution, departmental codes, basic laws, administrative regulations, local regulations, self-governmental acts and special acts/rules. The Constitution, as a supreme source of law, is at the highest level. Primary legislation, such as departmental codes and basic laws, have higher levels of legal force than secondary legislation, such as administrative regulations, local rules, self-governmental acts and special acts. The Constitution and primary legislation apply to all provinces, autonomous regions and municipalities in the mainland of China.[14] The Constitution includes a set of basic laws and principles relating to the state's governance and every aspect of citizens' lives. It can override other primary legislation, such as departmental codes and basic laws. The enactment of departmental codes and basic laws is aimed at regulating a/several particular aspect(s) of citizens' private lives or public affairs. The title of a departmental code or a basic law normally describes the issue(s) it regulates and the year it came

[12] China Year Book Committee (1995) *China Law Year Book* (Beijing: Law Press) p.20
[13] Werner Menski (2006) p.584
[14] It does not extend to Hong Kong and Macao.

into force. For example, the 'Code on Population and Family Planning 2002' (the 2002 Code)[15] regulates the issues relating to the state's population development and citizens' family planning and was enacted in 2002.

Compared to primary legislation, secondary legislation, such as administrative regulations, local rules and special acts, has a lower level of legal force. Secondary legislation must not override the Constitution, departmental codes or basic laws. It only applies to a/several issues in a/some regions. For example, the 'Shanghai Regulations of Family Planning 2000' regulates family planning issues in the city of Shanghai.[16] The laws relating to abortion discussed in this chapter are mainly primary legislation, namely relevant departmental codes and basic laws relating to the provision of termination services in the mainland of China. As will be indicated in section 3 of this chapter, unlike the Abortion Act 1967 in England, Chinese statutes with regard to abortion are not included in a specific code or act, but in several departmental codes and basic laws. In addition, abortion is normally regulated in these codes and laws together with other issues, like the state's population policies and citizens' family planning responsibility. In section 4 of this chapter, I will suggest that this legislative and regulatory method leads to the entrenchment of state-controlling intervention and the unclear definition of the medical obligations to provide abortion services. The task of drawing up possible suggestions will be undertaken in chapter 5.

According to the 'Law of Legislation 2000'[17], the National People's Congress (NPC) and the Standing Committee of the NPC (the NPCSC)[18] can enact primary legislation. The NPC is the

[15] It was issued by the twenty-fifty meeting of the Ninth Standing Committee of the National People's Congress on 29 December 2001 and came into effect on 1 September 2002.
[16] It was enacted by Shang People's Municipal government on 11 October 1990 and came into effect in 2000.
[17] It was passed in the Third Meeting of the Ninth National People's Congress in 15 March 2000 and came into effect in1 July 2000.
[18] It has power to modify law within limits set by the NPC, and thus acts as a *de facto* legislative body. A Chairman leads it. The current Chairman is Bangguo Wu who is ranked third in the Chinese political ranking system after the General Secretary and President (these two political roles are conventionally taken by one person).

highest organ of state power in China. Its main functions include formulating laws and policy, delegating authority and supervising other governing organs. The NPC is entitled to draft and amend the Constitution, departmental codes and basic laws. Between NPC sessions, the NPCSC can supplement and amend statutes which are enacted by the NPC.[19] Additionally, the NPCSC has power to interpret the Constitution, departmental codes and basic laws. The NPCSC's constitutional and legal interpretations are a legislative rather than a judicial activity. They do not affect previous cases, only future ones. According to the 'Law of Legislation 2000', legislative procedures of the NPC and the NPCSC are similar, but the latter's procedures are simpler. The NPC's legislative procedure can be summarised below:

Submitting bills to the NPC[20]

The NPC Presidium can submit a legislative bill to the NPC. The bill will be deliberated during the session of the NPC. Furthermore, the NPCSC, the State Council, the Central Military Commission, the Supreme People's Court, the Supreme People's Procuratorate and the special committees of the National People's Congress are also able to submit bills to the NPC. Whether bills submitted by these bodies can be put on the agenda of a discussion session depends on the Presidium's decisions. Additionally, a delegation or a group of thirty or more delegates can submit a legislative bill to the NPC. The Presidium then decides whether to put it on the agenda of a session. A legislative bill to be submitted to the NPC has to be submitted first to the NPCSC when the NPC is not in session.

[19] The NPC consists of about 3,000 delegates and meets for about two weeks each year at the same time as the Chinese People's Political Consultative Conference, usually in springs. The combined sessions have been known as the 'Two Meetings'.
[20] See Articles 12-14 of the Law of Legislation 2000

Deliberating a legislative bill[21]

A bill placed on the agenda of a session of the NPC will be explained by its sponsor at a plenary meeting of the session and then reviewed by all delegates. A bill placed on the agenda of a session of the NPC is subject to the view of the Law Committee. Then, the Law Committee has to summarise its opinions and submit this summary to the Presidium. After being examined and approved by the Presidium, a report and a revised draft of the bill will be distributed to all delegates at the session.

Voting[22]

After discussing the revised draft, the Law Committee will modify it again and prepare a new draft on which to vote. The vote on the draft will need a simple majority of all delegates in the plenary meeting of the session.

Adopting and Promulgating[23]

If the draft is passed, it will be accepted by the NPC and promulgated by Order of the President and signed by the president before it comes into effect.

The status of legislation made by the NPC and the NPCSC is similar to that of an Act of Parliament in the UK. In China, when judges consider a verdict they only have to cite statutes if they are relevant as the legal basis of their judgements. They do not have to cite previous cases as British judges normally do. Since the statutes in the Constitution, departmental codes and basic laws are usually simple and abstract, judges could find it difficult to apply them to making decisions in some cases anyway. In order to avoid potential misunderstanding and confusion caused by short and abstract articles, the State Council, the highest administrative organ in China,

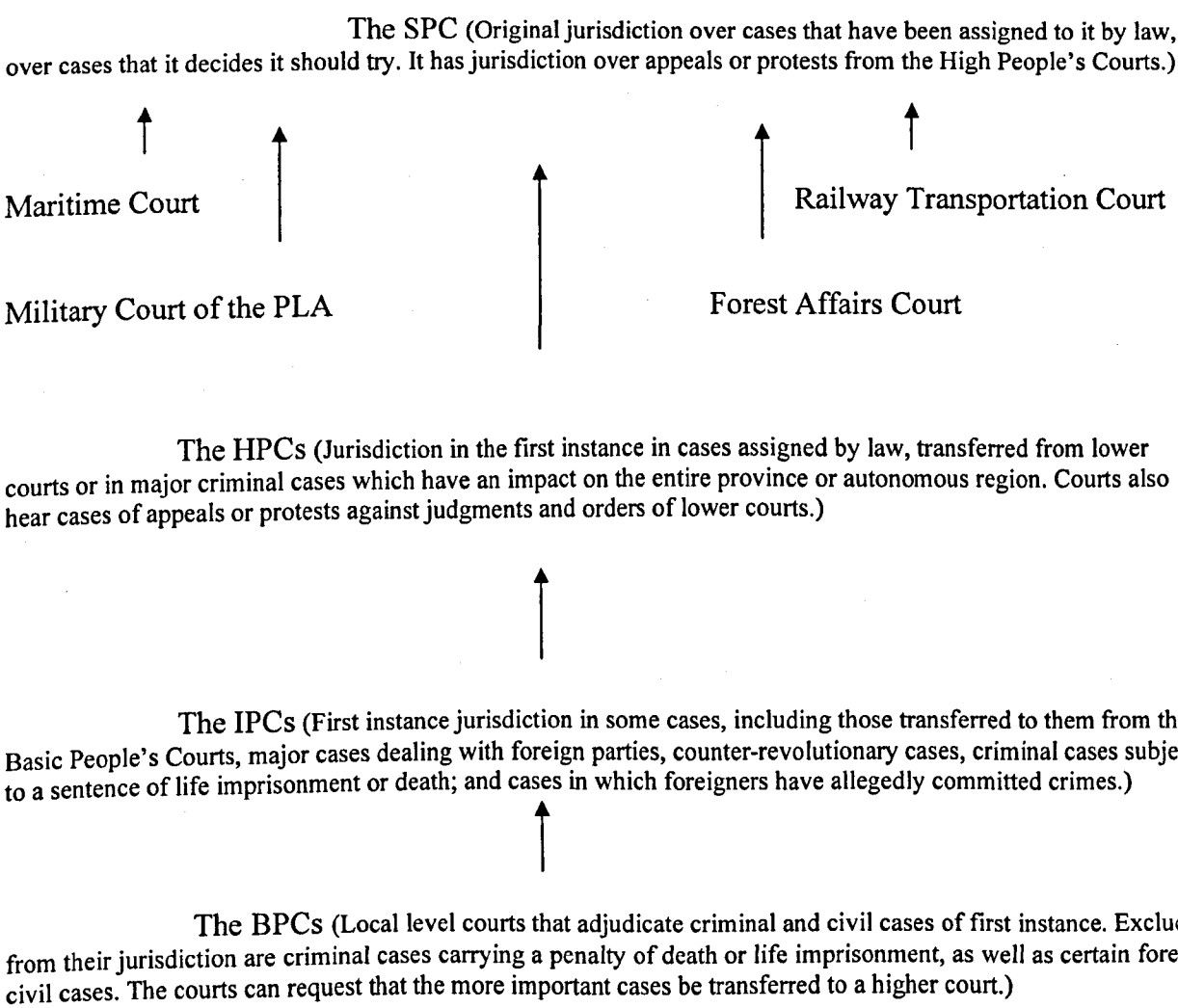
[21] See Articles 16-19 of the Law of Legislation 2000
[22] See Articles 21 and 22 of the Law of Legislation 2000
[23] See Article 23 of the Law of Legislation 2000

can pass administrative regulations in order to explain primary legislation. The relationship between the NPC and the State Council is equivalent to that between parliament and the Cabinet in the UK. Administrative rules and acts shall be promulgated by the order of the State Council and signed by the Premier of the State Council.

In order to facilitate the implementation of the Constitution, departmental codes, basic laws and administrative regulations, all ministries and commissions under the State Council, such as the Ministry of Health and the Population and Family Planning Commission, are also able to formulate rules within the limits of their authorised power. For example, according to the 2002 Code, the Ministry of Health can make administrative acts in order to facilitate the provision of contraceptive services. Before coming into effect, administrative acts must be promulgated by an order signed by the minister of health. The local government of a province, an autonomous region or a municipality which is directly under the central government's control has its own people's congresses and standing committee. In the light of its specific conditions and actual needs, the local government can formulate local rules, which must not be inconsistent with the Constitution, departmental codes, basic laws or administrative regulations.

Besides the legislative system, the trial system in China was also largely developed after the Maoist era. In brief, there are four levels (from the top down): the Supreme People's Court (the SPC), the High People's Courts (the HPCs), the Intermediate People's Courts (the IPCs) and the Basic People's Courts (the BPCs). Furthermore, there are four specialised courts: the Maritime Courts, the Military Court of the People's Liberation Army (the PLA), the Railway Transportation Courts and the Forest Affairs Courts. Litigants are generally limited to one appeal. Requests for appellate review take the form of appeals and protests (in criminal cases). Protests are filed by the procuratorate in criminal cases when it is believed that an error has occurred in

law or fact in the judgement or order of the court of first instance. In civil cases the procuratorate does not possess a right to file a direct protest, but it can initiate adjudication supervision via a protest.[24] The court hierarchal system is summarised below:[25]



Generally, Chinese courts apply the systems of panels, recusal and public trial. Trials of criminal cases of first instance in the Basic and Intermediate People's Courts must be conducted by a panel composed of three judges or of judges and people's assessors totalling three. However, trials of criminal cases of first instance in the Higher People's Courts or the Supreme People's

[24] See the Law of Courts Organisation 1980 (as amended in 2006)
[25] This diagram is drawn by the author of this thesis according to the Law of Courts Organisation 1980 (as amended in 2006).

Court shall be conducted by a panel composed of three to seven judges or of judges and people's assessors totalling between three and seven. When performing their functions in the People's Courts, the people's assessors shall enjoy equal rights with the judges. Trials of appealed and protested criminal cases must be conducted by a panel composed of three to five judges. The number of members of a panel must be odd. Similarly, civil cases of first instance can be tried in a court by a panel consisting of both judges and assessors or judges alone. The number of members of a panel should also be odd. In addition to civil and criminal cases, administrative cases are another important type in China. Administrative cases mainly involve conflicts between non-governmental individuals and bodies and governmental organisations. Administrative cases in the People's Courts are tried by a panel of judges or a panel of judges and assessors. The number of members of a panel must also be odd and three or more.[26] Distinct from the role of English judges, Chinese judges in court cases mainly play a role in applying law rather than making law. In order to learn more about how to apply statutes to cases, Chinese judges also read previous court decisions, but their judgements do not rely significantly on the binding parts of previous decisions. Thus, judges do not normally refer to previous court decisions in their written decisions.

1.2. The Health Care System

The Chinese health care system also changed dramatically in the post-Maoist era. In the Maoist era, all hospitals and clinics in the mainland of China were state-owned. This meant that health care services had to be provided in accordance with the state's 'plans'. For example, contraceptive services were not readily accessible in Maoist China because the government advocated for a pro-natalist population plan. The health insurance system in urban areas mainly

[26] The Law of Courts Organisation 1980 (as amended in 2006)

consisted of two schemes: the labour insurance scheme, which was a work unit-based self-insurance policy that covered 'medical costs for the workers and often their dependents as well'[27] and the government employee insurance scheme, which was financed by general revenues and covered employees of the state-owned institutions. In rural areas, a cooperative medical policy was applied, which was community-based and covered 90 per cent of Chinese rural residents.[28] While almost all medical services offered in state-owned hospitals were free, the quality of them was quite poor.[29] For example, by 1965 in Shanghai – the biggest city in China – around 50 per cent of community health clinics did not have enough medical equipment or staff members to perform surgical abortions and Caesareans.[30] Health care services provided in rural hospitals and health care clinics were even worse because medical resources were more limited compared to funding of these services in cities. Thus, in the Maoist era, many women who had an unwanted pregnancy were forced to continue it to full term or resort to a backstreet abortion. As will be discussed in section 2 of this chapter, the rate of morbidity and mortality was very high in the Maoist era.

Against a background of the first post-Maoist government's moving away from central planning to a market economy at around the start of the 1980s, the provision of health care services became more market-orientated than plan-based. As Liu has observed, because of increasing commercialisation, access to health care services in post-Maoist China can be reliant on citizens' ability to pay.[31] This means that those citizens who are not covered or not fully covered by medical insurance have to pay for their treatments out of their own pocket. The post-Maoist state's method of providing health insurance is also different from the Maoist one. First, the

[27] Yuanli Liu (2002) 'Reforming China's Urban Health Insurance System' 60(2) *Health Policy* 133-150 p.138
[28] Villages were called 'communes' in the Maoist era. For more information see Liu Yuanli (2004) 'Development of the Rural Health Insurance System in China' 19(3) *Health Policy and Planning* 159-165 p.159
[29] Xiang Zheng and Sheila Hillier (1995) 'The Reforms of The Chinese Health Care System: County Level Changes: The Jiangxi Study' 41(8) *Social Science & Medicine* 1057-1064 p.1060
[30] Peiyun Peng (1997) *Zhongguo Jihua Shengyu Quanshu* (Beijing: China Population Press) p.7
[31] Yuanli Liu (2002) p.149

cooperative insurance system in rural areas, mentioned above, which was financed by *gongshe* (village communes) collapsed.[32] Access to medical services for people who live in rural areas is dependent on their ability to afford them. This means that if they have savings then they have to use them to pay for most of their medical treatments, but if they do not have saving, they cannot access health care services. In urban areas, a city-based social health insurance scheme is used, which includes individual medical savings accounts and also catastrophic insurance (similar to medical insurance in the United States).[33] This scheme does not cover all urban citizens: only urban employees are included and even then not their dependents or the unemployed. The percentage of both the urban and the rural population that is covered by health care insurance is very low compared to the same type of cover in the UK. The rate of out-of-pocket payments increased quickly from 20 per cent in 1978 to 70 per cent in 2003, which was three times the British private expenditure in 2000.[34]

The current health care insurance system, like the legal system, is also considered by post-Maoist governments as 'a work in progress', which means that it needs further reform in order to cover more people and offer public funding more equally. While the percentage of the population covered by health insurance is lower in the post-Maoist era than in the Maoist era, I argue that, the post-1980 reform has enhanced people's control over their medical decision-making in at least two ways. Firstly, it allows authorised private medical sector units to provide health care services, so people's treatment choices are not restricted to those low quality services provided in public hospitals. Secondly, the customer-based model of providing health care services promotes competition between service providers and encourages them to improve their service quality. For example, currently, abortions can be carried out in both public and approved private hospitals.

[32] Winnie Yip and William Hsiao (2008) 'Market Watch: the Chinese Health System at a Crossroads' 27(2) *Health Tracking* 460-468 p.460
[33] Ibid. p.461
[34] Ruiping Fan (2008) 'Toward a Directed Benevolent Market Polity: Rethinking Medical Morality in Transitional China' 17(3) *Cambridge Quarterly of Healthcare Ethics* 280-292 pp.288-289

To increase competitiveness, many private medical sector units attempted to improve their abortion services by offering free pregnancy tests, publicising termination options on the internet, on TV and in newspapers and by providing a discounted fee for students or unemployed women.[35]

Abortion in Chinese is *rengong liuchan* (literally, artificial slipping delivery and artificial induced delivery).[36] The former process involves the use of abortion drugs and vacuum aspiration end gestation within 13 weeks and the latter process means termination of middle-term (from 14 to 24 weeks) or late-term (more than 24 weeks) gestation by Dilatation and Evacuation.[37] Similar to abortion services in England, those in China also include two types: medical and surgical. Both can be performed in both public and approved private medical institutions. Abortion (*rengong liuchan*) is different from unintentional termination of gestation, such as *xiaochan* (miscarriage) and *xiji liuchan* (literally, termination of pregnancy by assault). In order to avoid confusion, the analysis offered in this chapter focuses on law and policy relating to abortion rather than those in regard to miscarriage and miscarriage caused by assault. As will be discussed in section 3 of this chapter, the Chinese regulatory model of abortion does not currently treat the above means of terminating differently; in other words, the model does not apply different regulatory approaches to providing abortions at different stages or have a time limit for legal termination of pregnancies. Nevertheless, this does not mean that women's reproductive autonomy is treated seriously in China. From the analysis provided in section 3, it can be seen that this regulatory situation was designed by the post-Maoist governments from the start of 1980s to the late 1990s to justify and facilitate their use of abortion as a compulsory

[35] Medical and surgical abortion services are often advertised on television, in newspapers and on the internet. For example, http://www.hzrl120.cn/ is the website of a private hospital called Hang Zhou Maria Women Hospital. The information about early abortion services is available on this website.
[36] Bernard Hung-kay Luk (1977) 'Abortion in Chinese Law' 25(2) *The American Journal of Comparative Law* 372-392 p.389
[37] Qiufang Lü and Mingying Gai (2004) *Handbook of Obstetrics and Gynaecology* (Beijing: Xiehe Medical University Press) pp.341-347

method of reducing the national birth rate, particularly when terminations of pregnancies were at late stages. As will be analysed in section 4 of this chapter, those unwilling or coerced abortions that occurred in the first two post-Maoist decades were normally performed at late stages of gestation because it might take several months for local family planning centres to find the women whose pregnancies were not approved. Therefore, the Chinese regulatory model conveyed a message to women that abortions at any stages of gestation are identical if they are necessary for avoiding 'unauthorised' births. As has been discussed in chapter 3, access to late abortions should also be subject to women's decision-making. Liberal law without a cut-off point for seeking legal abortions will not encourage women to seek late abortions: this is because they do not usually opt to have an abortion at a late stage of gestation, which involves more complicated and stressful processes than an early medical or surgical termination. Moreover, as making the decision to end gestation in the second or third trimester is often a stressful experience, when women make up their mind to end their pregnancy, late gestation law should facilitate their decisions rather than imposing any more strains. However, this does not mean that law should force or persuade women to view the experiences of having early and late abortions in the same way. As discussed in chapter 2, women from various backgrounds and with various beliefs have different benchmarks for measuring the morality of (late) abortions, so they should be allowed and trusted to apply their own moral standards to (late) abortion decisions. Thus, neither the regulatory method of imposing time limits on access to abortions nor the act of convincing women of the same morality of terminating pregnancies at different stages is consistent with the principle of respect for autonomy. In the following sections, I will further discuss Chinese abortion law's lack of respect for women's autonomy and explore its underlying cause.

2. The Regulation of Abortion in the Era of Politicisation

2.1. The Confucianism-dominated Regulation of Abortion

Abortion was unregulated before the twentieth century in China. In pre-twentieth-century China, law did not prohibit women from using herbs to end their pregnancies.[38] In traditional Chinese society, an abortion was treated as a choice which was only related to the woman or her family. There is a long history of applying Chinese herbs to terminate. According to Rigdon, references to ending unwanted pregnancy appear in Chinese medical books written more than 2,000 years BC. She describes these in some detail:

> A number of ingredients commonly used in traditional Chinese medicine were known for their abortifacient properties, including aromatic stimulants and drugs used to invigorate blood circulation. A list of toxic herb contraindicated for use by pregnant women because of their abortifacient properties included: croton fruit, morning glory seed, Peking spurge.[39]A

Many legal documents in pre-twentieth-century China also show that abortion was unregulated. For example, according to Datang Shu yi (the Tang Code) which was passed in 625AD, there was no punishment for seeking or performing abortions in the Tang Dynasty (618AD–709AD). Nonetheless, this code did punish any person who attacked a pregnant woman and caused her miscarriage. The Tang Code refers to abortion as 'an unborn child dropping out of the womb as a result of the assault on the mother'. [40] It states:

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[38] Self-abortions were criminalised in China from 1910 to 1948 when the nationalist government was in power. Any woman who attempted to abort would be fined and imprisoned. Any person who assisted a pregnant woman in a successful or unsuccessful attempt to abort would be imprisoned. However, abortion law in this era was completely copied from Japan and Germany because of the nationalist government's modernisation and westernisation programme. Abortion law did not work effectively in practice. See Susan Rigdon (1996) 'Abortion Law and Practice in China: An Overview with Comparisons to the United States' 42(4) *Social Science & Medicine* 543-560 p.544
Rigdon has claimed that in the nationalist era, in cities like Shanghai and Beijing, there were clinics, with a range of trained and untrained personnel where women could have an abortion. Thus, the regulation of abortion in this special and short period is not considered as part of Chinese traditional law in this chapter.

[39] Susan Rigdon (1996) p.547

[40] Bernard Hung-kay Luk (1977) p.390

> Any one who injures another with any metal weapon, such as breaking bones, damaging the sight of both eyes and inducing abortion, shall be kept in penal servitude for a term 2 years. The assailant should be guilty of abortion only if the child dies within the victim-protection time imit. If the child dies beyond that limit, punishment shall be meted out only for other injuries (to the mother).[41]

Zhang Sun, the person who drafted the Tang Code, added the following notes:

> If the child is wounded by (the assault) but dies after the time limit protecting the mother, or if it dies within the time limit but has not yet assumed (human) shape ... the assailant is not guilty of abortion. If the act of assault is committed against a relative or against another person of a higher or a lower rank, resulting in abortion, the penalty is increased or decreased from the two years accordingly; but this must be based on the status of the mother, not of the child. If the penalty is determined according to (the status of) the child, it may be unfair. Hence the time limit is established for the protection of the mother, not of the child, because the intention (of the assailant) is not to harm the foetus.[42]

According to another two statutes in the Chinese imperial era: Daming lü (the Ming code), dated 1368, and Daqing lü (the Qing Code), dated 1646, there were similar penalties for a person who attacked a pregnant woman and caused her miscarriage: about 80 heavy blows and two years of penal servitude. Furthermore, the punishment for miscarriage caused by assault would be more severe if pregnancies were beyond a cut-off point when the foetus was thought of as an entity with a humanoid shape (*renxing* in Chinese). The reason for this was because women who were carrying foetuses at the later stages of gestation were treated as more vulnerable to attacks and their ability for self-defence against violence was regarded as more difficult by comparison with those whose pregnancies were at early stages. Thus, the adoption of the cut-off point in Chinese imperial statutes was mainly aimed at giving special protection to pregnant women whose

[41] It was adopted in 625A.D and was effective between 625A.D and 838 A.D. The original text is in Article 15 of Tanglü Shuyi 625. Its English version is cited from Bernard Hung-kay Luk (1977) p.374
[42] Bernard Hung-kay Luk (1977) p.390

gestation was beyond this point. Nevertheless, the regulation of the cut-off point at which foetuses could be thought of as an entity with a humanoid shape varies slightly from dynasty to dynasty. For example, it was 90 days in the Tang Code, but 108 days in the Ming Code.

From the analysis of the pre-nineteenth-century English law of abortion, it can be seen that the cut-off point – 'quickening' – was used to distinguish criminal abortions from non-criminal ones. After 'quickening', English law considered foetuses as entities which had viability.[43] Self-abortion was treated as a criminal offence after 'quickening' in England before the nineteenth century, but it was not heavily punished. As has been discussed in chapter 3, both abortion and miscarriage caused by assault were treated as homicide after quickening before the nineteenth century in England.[44] In China, only miscarriage by assault was dealt with under criminal law. However, in accordance with the Tang Code, the penalty of miscarriage by assault was not heavy. It was only seen as slightly more serious than breaking two of the victim's fingers or knocking out two teeth and less serious than breaking a limb or causing permanent blindness in one eye. Even if a woman's gestation was more than 90 days, the foetus was still not treated as an entity independent from the pregnant woman. As has been discussed in chapter 2, this difference between the two jurisdictions might be due to the fact that the moral status of unborn human lives was not understood in the same way by English and Chinese traditional cultures. From the analysis of the regulation of abortion before the nineteenth century offered in chapter 3, it can be seen that before medical involvement in the provision of abortion, the religious cultural climate played a significant role in formatting the regulation of abortion. Similarly, before abortion began to be politicised around the late1940s, the religious cultural climate also effected change in shaping the regulation of termination in China.

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[43] Rosemarie Tong (1997) *Feminist Approaches to Bioethics* (Boulder: Westview Press) p.185
[44] Malcolm Potts, Peter Dggory and John Peel (1977) *Abortion* (Cambridge: Cambridge University Press) p.79

It is impossible in this chapter to discuss in full detail the Chinese imperial governments' use of Confucian values in various dynasties to establish their legal frameworks within which they could justify imposing control over people's daily lives. In the rest of this section, I will analyse some Confucian ideas about social hierarchy and the division of labour between the sexes in order to scrutinise their influence on women's reproductive lives. This analysis will help the reader to understand why Chinese women's procreative autonomy was violated more acutely compared with their English sisters before the twentieth century. It should be noted, though, that abortion was completely unregulated in China at that time.

In its 3,000-year imperial history, Confucianism dominated Chinese society in both official and informal ways, such as formulating law and governing people's everyday lives. The Confucian principle of 'Three Obedience' was treated as the code of female conduct in the imperial era; this could be traced back to the eleventh century BC. The 'Three Obedience' principle was part of the theory of 'li', which can be described as Chinese-style self-controlled order and 'the idealised form of appropriate behaviour in human conduct'.[45] In accordance with this principle, a virtuous woman is required to obey her father before her marriage, her husband during married life and her eldest son in widowhood. In imperial China, women were not entitled to exert any power on their procreative choices. During married life, women normally had no say in their (in)fertility, because their reproductive preferences had to be subject to the needs of their husband and family-in-law. Therefore, the fact that the imperial authorities did not regulate abortion left the power to decide women's fertility in the hands of the male head of their households.

Furthermore, according to the Confucian division of labour between the sexes, reproduction was treated as women's main contribution to their family and community. Infertility could be used by

[45] Reinhard May (1985) *Law and Society East and West: Dharma, li and Nomos, Their Contribution to Law and to Life* (Stuttgart: Franz Steiner) p.56

husbands as a legally acceptable reason to divorce their wife or concubines, but women could not divorce their infertile husbands. In addition, in the Confucian hierarchy, emperors who were treated as 'the son of heaven' could rule all male subjects, and married men ruled women and children in their households. Within this hierarchical system, domestic issues were normally regulated by the male head of the individual family. As an old Confucian saying goes, the state has its rules and so does each family. From the above discussion, it can be seen that Chinese imperial rulers intentionally left abortion and other issues relating to reproduction unregulated, so enough space could be left for married men, as the head of their households, to exert control over their female family members as their property. Individual men therefore did not need national legislation to force their wife or concubines (not) to have an abortion in their own territory, but only required it to stop other men from invading their territory and damaging their property. As has been indicated earlier in this section, this could be a reason why miscarriage caused by assault was part of criminal law while self-abortion/miscarriage was not. Therefore, the unregulated access to abortion in imperial China did not mean that women were empowered to exert control over their reproduction; on the contrary, they would be pressurised or abused by their husbands and in-laws if they could not produce male offspring. As has been suggested in chapter 2, since women historically have proved to have much less power to control their fertility when they are not able to freely act on procreative desires, governments ought to provide adequate support by which women can be effectively empowered to exercise this control. In section 3 of this chapter, I will examine how the communist state also fails to perform this task and discuss the harmful effects of this failure on women's needs for health and for control over their lives.

2.2. From Confucianisation to Politicisation

At around the beginning of the twentieth century, the above mentioned traditional Confucian values were strongly challenged by the introduction of Western modern medical science, human rights and feminist thinking.[46] As has been discussed in chapter 3, against the background of the cultural climate changing from religious to therapeutic in nineteenth-century England, law makers needed a new strategy to restrict women's decision-making on abortion. Similarly, in China, communist governments have established a state-centred regulatory model which serves to exert control over women's fertility. In this section, I will discuss why the regulatory model in communist China imposes limits on women's decision-making on abortion. Then I will examine how it fails to enable the state to fulfil its negative and positive obligations to promote women's reproductive autonomy.

When the communist state was founded in 1949, the Maoist government (1949–1976) repealed all imperial law and rules and enacted the Constitution in 1954. The Constitution states that all forms of discrimination against women should be eliminated and that women should enjoy equal rights with men in all aspects of political, economic, cultural, social and family life.[47] Nevertheless, from the discussion of the Maoist population policy below, it can be seen that gender equality in the Constitution does not grant women any substantial right to make reproductive decisions. The Maoist government defined abortion as an issue which was closely connected with its policy-making on population figures and had to serve to facilitate the population objectives set by the party state.[48] From then on, the communist state's politicisation

[46] See Fu-Mei Chang Chen, Fu-Mei Chang (1970) 'On Analogy in Ch'ing Law' vol.30 *Harvard Journal of Asiatic Studies* 212-224 and Dorothy Ko and Wang Zheng (2007) *Translating Feminisms in China* (Australia: Blackwell Publishing)

[47] The Common Programme of the National People's Political Consultative Conference came into force in September 1949 and was repealed in 1954.
It is available at www.zxls.com/Article/Class109/Class106/200901/20090114171928_66812.html (last accessed 17 July 2011)

[48] According to the Constitution, the Communist Party is the only party in power. Thus, some scholars put 'party' and 'state' together as there is no clear boundary between them. For example, see Zhiyue Zhao (2006) 'From

of abortion started. As a result, abortion and contraception were prohibited in the Maoist era. I suggest that there were two main reasons why a ban was imposed on abortion and contraception services by the Maoist state. Before discussing these two causes, I briefly explain my understanding of the politicisation of abortion in communist China.

Compared to the medicalisation of abortion in England, abortion has been politicised in China since the foundation of the Communist Party state. The Chinese-style politicisation of abortion is different from the American one. According to Ellie Lee, the latter means that the issues and debates relating to abortion in the United States are 'very clearly focused from the start on a polarized debate that sets women's rights against those of the fetus'.[49] From the case of Roe v. Wade it can be seen that law makers in the US tried to keep a balance between 'the recognition of a fundamental right of reproductive choice' and 'the protection of unborn life'.[50] However, politicising abortion in China does not indicate that the party state attempted to balance the interests of pregnant women and embryos/foetuses. The term *zhengzhihua* (literally, politicisation) is equivalent to the term of *guoyouhua* (literally, nationalisation), which both mean that abortion is defined as a state-centred decision. The provision of abortion services is subject to China's population policy rather than women's reproductive preferences. Thus, (not) to reproduce is treated by law makers as a decision which should be made by the state rather than individual women. Within this politicised framework, the party state's legislation on abortion is not targeted at facilitating women's decision-making relating to abortion, but at enabling them to effectively fulfil the duty to increase or reduce the birth rate. Consequently, access to abortion services did not depend on whether women were able to reflectively form high-level desires, but

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Commercialization to Conglomeration: The Transformation of the Chinese Press Within the Orbit of the Party State' 50(2) *Journal of Communication* 3-28 and Jingbao Nie (2010) 'Limits of state intervention in sex-selective abortion: the case of China' 12(2) *Culture, Health & Sexuality* 205-219

[49] Ellie Lee (2003) *Abortion, Motherhood and Mental Health* (New York: Aldine de Gruyter)

[50] N. E. H Hull and Peter Hoffer *Roe v Wade* (USA: University Press of Kansas) p.272

whether it was thought of as a rational and reasonable decision in accordance with the party state's population policy.

I suggest that the following two reasons led to the ban on abortion in the Maoist era. The first cause of a ban on abortion in the Maoist era was that the first communist government implemented a pro-natalist population policy. Due to tumultuous decades of famines and wars in the period from the late Qing dynasty to the nationalist era (between about 1900 and 1949), the Chinese population was small and the birth rate was relatively low in the early 1950s. After the communist takeover, 'the nation celebrated large birth numbers as a sign of recovery'.[51] Mao believed that the more people there were, the greater the energy for socialist revolution, so he put forward the slogan of 'strength in numbers' and emphasised that a large population was a great advantage and essential to national economic development.[52] To enable women to produce more children, the Maoist government prohibited them from accessing abortion and contraception. The second cause for a ban on abortion was the former Soviet Union's influence over the Maoist government's policy-making relating to population. As has been indicated in section 1 of this chapter, many of the Soviet Union's policies and laws were adopted by China in the Maoist era. Two of them were the population policy and the regulation of abortion. Thus, similar to the regulatory model for abortion in the former Soviet Union, a fundamental characteristic of the Chinese model of the regulation of abortion was that the legislation on abortion was not made or passed by the national legislative organ, but derived from the party state's population policy, the party's norms and the party leader's personal beliefs. As Savage has argued, the regulation of abortion did not exist as law 'in its sense in the common law or the civil law',

[51] Thomas Scharping (2003) *Birth Control in China 1949-2000: Population policy and demographic development* (London: Routledge)
[52] Cited from Peiyun Peng (ed) (1997) *Zhongguo Jihua Shengyu* (Beijing: China Population Press) p.289

> But as an amalgam of constitutional duties, regulations of the Ministry of Health, state policies, Party policies, Party enactments, provincial policies, provincial administrative regulations, and local supplementary regulations.[53]

Therefore, Mao's advocacy for a large population was translated into the pro-natalist policy and the ban on abortion and contraception. Furthermore, reproduction was considered by the Maoist government as female citizens' main contribution to the state. For example, women who had more than ten children would be awarded the designation of 'Glorious Mother' by the government. To enable them to effectively fulfil the pro-natalist duty and become 'glorious mothers', the government placed a ban on contraceptive and abortion services. According to a political document issued by the Ministry of Health in 1950, abortion was only allowed in very strict therapeutic circumstances, for example, when continuance of a pregnancy threatened the woman's life or when the woman had *yanzhong yichuanxing jingshen jibing* (literally, a severe genetic mental disease). Moreover, to have an abortion the woman had to obtain her husband's written consent.[54] Due to very limited access to contraceptives and abortion, women could be forced to continue their unwanted pregnancies to full term or seek illegal but unreliable termination means. According to a study conducted by the State Bureau of Statistics, the average births per married woman were about six between 1949 and 1955.[55] According to a report in *People's Daily* published in 1956, to end unwanted pregnancies a large number of

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[53] Mark Savage (1988) 'The Law of Abortion in the Union of Soviet socialist Republics and the People's Republic of China: Women's Rights in Two Socialist Countries' 40(4) *Stanford Law Review* 1027-1117 p.1088

[54] 'Kongzhi Nvganbu Duotai Fangfa' means the government's means of restricting female cadres' access to abortion. It was passed by the Ministry of Health in 1950. According to this document, abortion is allowed when
(1) the pregnant woman has tuberculosis, heart disease, kidney disease, and pernicious anemia, or any other severe diseases which would threaten her life;
(2) abortion is necessary for saving the life of the pregnant woman;
(3) the woman has at least one child, but is physically unable to have another one;
(4) the pregnant woman has serious genetic mental diseases.
The original text is from Peiyun Peng (1997) p.889 and translated in England by the author of this chapter.

[55] Chinese Bureau of Statistics (1966) available at http://www.stats.gov.cn/english/ (last accessed 20 July 2011)

women had to adopt unsafe means, such as jumping from a height, eating river snails or herbs.[56] While there is no official figure which could show how many women died or were permanently injured because of using these unsafe methods, the number is reckoned to be huge according to a bulletin issued by the Ministry of Health in 1956. It indicates that in the 1950s the use of unsafe means of terminating gestation was very common and many women were poisoned and died from dangerous termination methods, such as eating living tadpoles or river snails and taking quinine.[57] From the above discussion, it can be seen that the Maoist abortion law's lack of respect for women's autonomy led to a high maternal morbidity and mortality.

As has been indicated in chapter 3, in the era of criminalisation in China the ban on abortion forced a large number of women, particularly socioeconomically disadvantaged women, to seek backstreet abortions and there was a similar consequence in England. Another similarity is that although the English and Chinese governments realised that unsafe abortions caused a high maternal mortality rate, they did not make any attempt to enhance access to abortion services. The analysis provided in section 3 of this chapter suggests that the ban was not relaxed until the start of the 1960s when the population increased to 0.72 billion and the party state's population policy changed.[58] Thus, while Confucianism-dominated control imposed by the male head of individual households over women's reproduction has been removed since the beginning of the Maoist era, the ultimate decisional authority has not been given to women. Their procreative biology was used by the party state as a method of implementing its population policy. The Communist party state replaces the male head of individual households and becomes the only procreative decision-maker for women. As will be analysed in the following section, although the ban is lifted in the post-Maoist era, the state does not stop performing this role. By further

[56] Huilan Zhong (1957) 'Bixu Youjihuade Jiezhi Shengyu' (17 March) *People's Daily*
'People's Daily' is an official newspaper of the Chinese Communist Party.
[57] Peiyun Peng (1997) p.279
[58] The data is from the Second National census which was conducted by China's Bureau of Statistics in 1964 available at http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20060316_402310923.htm last accessed 21 July 2011

examining, in section 3 of this chapter, the post-Maoist methods of exerting control over women's decision-making concerning reproduction, I will examine how establishing a regulatory model of abortion according to the principle of respect for autonomy can challenge the state's patriarchal role.

3. The State-centred Regulatory Model in the Era of Post-Maoist Politicisation

3.1. Post-Maoist Policy-making on Population Control and the 'One Child' Policy

As has been analysed in chapter 3, if the nineteenth century was the era when medical involvement in the regulation of abortion emerged, then the twentieth century was the time when the main strategy of governing abortion shifted to medicalisation in England. A similar change occurred in China: if the era of Maoist politicisation was the time when the state-centred interference in the provision of abortion emerged, then the era of post-Maoist politicisation is the time when a state-centred regulatory model has been and is being constructed. To provide background information on the state-centred regulatory model, in this section I first discuss the changes in post-Maoist policy-making on population control.

At the start of the 1960s, ten years after implementing the pro-natalist policy, the party state's objective of increasing the national population was achieved.[59] Thus, the Maoist government slightly revised the restrictive regulation of contraception and abortion in 1963. A woman's request for abortion could be allowed if her pregnancy had not exceeded five months and she had not had any terminations in the past year. The less restrictive regulation of abortion was not developed because of the government's desire to grant women any substantial right to make reproductive decisions. Therefore, abortion was not available on demand, but only allowed in

[59] The Chinese population had increased dramatically by 11% in the period from 1949 to 1954). See Peiyun Peng (1997) p.298

very strict therapeutic circumstances. Moreover, a document issued by the Ministry of Health in 1963 states that before processing a woman's request for an abortion, her doctor shall 'try his best to convince the woman to continue gestation'.[60] Although Chinese doctors, in accordance with the document of 1963, could take a role in persuading women not to access abortion, this task was very different from that played by English doctors. Comparatively speaking, Chinese doctors' power in abortion decisions was much weaker because they did not have the authority to decide whether their patients were eligible for an abortion. The state's population policy, rather than medical professionals' discretion, determined the extent to which abortion was accessible. As Nie has clearly observed, the situation in which the government intentionally mutes doctors' voices is specifically designed to implement the instruction on advocating the population plans made by the central government.[61] Thus, medical professionals were not required by law makers to air their perspectives, but to perform a role as gatekeepers of abortion services in order to achieve the state's population goals. In the rest of this section, I will further analyse how successive post-Maoist governments use medical power to facilitate their exercise of control over women's procreative decision-making. In addition, I will demonstrate the differences between medical power under the English medical-centred model and that under the Chinese model. By doing so, I attempt to examine how Chinese women's autonomy is violated even more acutely under the state-centred model in comparison with their English sisters.

The Chinese population increased by about 20 per cent in the first five years of the communist state.[62] However, because the first post-Maoist government advocated for a 'Malthusian' population strategy, it claimed that the pro-natalist policy was a historic mistake.[63] In order to bring the national population development back under the party state's control, the first post-

[60] Peiyun Peng (1997) pp.893-894
[61] Jingbao Nie (2005) *Behind the Silence* (Oxford: Rowman & Littlefield Publishers) p.44
[62] Thomas Scharping (2003) p.5
[63] Peiyun Peng (1997) p.485

Maoist government enacted a series of birth control programmes at the beginning of the 1980s and defined them as 'must-do' tasks.[64] One of these programmes stipulated that couples in urban areas were only allowed to have one child, which was the so-called 'One-Child' policy. It has been suggested that this might be 'the most rigorous, comprehensive, and ambitious birth program in the world'.[65] Nevertheless, because of strong resistance from rural areas and ethnic groups, the 'One Child' policy did not apply to all areas or all citizens. In general, it was applicable to the Han population who lived in urban areas. This was because, firstly, the urban Han population accounted for 90.56 per cent of the total population, so the imposition of the 'One Child' policy on them should result in reaching the birth control goal quickly.[66] Secondly, as will be discussed in the rest of this section, the enforcement of this policy could be more effective among the urban population because the government set up more family planning centres in cities, which were used to ensure that female citizens of reproductive age were under the government's surveillance.

Nevertheless, successive post-Maoist governments' strategies to enforce the 'One Child' policy were not identical. As I will further analyse later in this chapter, the governments after the 2000s adopted more incentive-orientated methods, while those between the 1980s and 1990s mainly used punishment-based coercive means. From the analysis offered in the rest of this section, it can be seen that this change is due to the fact that the national birth rate has been significantly reduced since the late 1990s. The post-Maoist governments have been subject to strong criticisms about their population control programmes, particularly the 'One Child' policy, from the outside world, which are targeted at either the violation of human rights or at the widespread

[64] Xiaoping Deng (1981) 'Guanyu Jihua Shengyu de Zhishi' 17 January 2011 *People's Daily*
[65] Susan Rigdon (1996) p.545
[66] The data is collected by the Fifth National census conducted by China's Bureau of Statistics in 2005 available at http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20060316_402310923.htm (last accessed 21 July 2011)

use of sex-selective techniques.[67] However, the voice of the Chinese government is the complete opposite of the voices of criticism: it has claimed that the 'One Child' policy is in the best interests of individual women and society as a whole.[68]

Nevertheless, the above two views should be treated more critically. First, as I will discuss later in this section, in the 1980s and the 1990s the governments' methods of implementing the 'One Child' policy were mainly based on a coercive stand, for example women might be forced to have an abortion. The coercive enforcement of the 'One Child' policy indicates that women's reproductive bodies were used by these governments as tools to achieve their population goals. According to the analysis of the principle of respecting autonomy offered in chapter 2, this violates women's procreative liberty, which is essential to satisfy their needs for health and for control over their lives. Moreover, promoting the good of society does not necessarily need to be reliant on maintaining a small population. Even it does, forcing women to sacrifice themselves for the creation of a small population is harmful to the good of the nation, particularly when men, as will be demonstrated in the following subsection, are currently taking much less responsibility to obey the state's birth control policy in the Chinese family planning context.

Second, I also would not agree with those scholars who have claimed that the 'One Child' policy is all about the violation of human rights and is the direct cause of the huge amount of non-medical abortions of female foetuses in China. The sexist belief that female offspring is inferior to male is the fundamental reason for non-medical sex-selective abortions. This belief can exist in the regions which do not have the 'One Child' policy. When the wrong belief is widely shared

[67] John Aird (1991) *Slaughter of the Innocents* (Washington: the Aei Press) and Avraham Ebenstein (2010) 'The "Missing Girls" of China and the Unintended Consequences of the One Child Policy' 45(1) *Journal of Human Resources* 87-115

[68] Jingbao Nie (1999) 'The Problem of Coerced Abortion on China and Related Ethics Issues' 8(4) *Cambridge Quarterly of Healthcare Ethics* 463-479 p.469 and Susan Greenhalgh (2008) *Just One Child: Science and Policy in Deng's China* (London: University of California Press) p.xi

in a community, neither a ban on abortion nor the removal of the 'One Child' policy can effectively discourage people in that community from attempting to have (more) male offspring by aborting female foetuses. Moreover, the upside of implementing the 'One Child' policy in China is that it, to some extent, promotes women's welfare and increases their control over life choices. Thus, I am not surprised that many women are not hostile to this policy and some women even have a supportive attitude towards it.[69] As has been discussed in chapter 2, people's awareness of women's rights has historically proved weak and it is still not adequately developed in Chinese Confucian society where the traditional image for women was defined as mothers of multiple children and their main contribution was thought of as reproduction. The equal education and employment between men and women advocated in the Constitution does not represent the reality that women generally have less social resources and economic opportunities compared to their male peers. Because of the state's intervention, aimed at carrying out the national population control programmes and the 'One Child' policy, women can avoid high fertility and greater domestic responsibility. Thus, their opportunities to enter the public arena increase.

Furthermore, low fertility in individual households can 'intensify parental care and investment in whatever children they have', so the daughters in smaller families can receive more family care and resources for personal development in comparison to those who are in high-fertility households.[70] In addition, the decline in fertility caused by carrying out the 'One Child' policy, combined with quick economic development in China, pose a challenge to the above traditional image of women and change people's negative stereotype of having female offspring. The facts that more women from single-child families are able to be well-educated and that they have their economic value increased for their families and society create new social roles for women, such

[69] Jingbao Nie (1999) p.471
[70] Hong Zhang (2007) 'China's New Rural Daughters Coming of Age: Downsizing the Family and Firing Up Cash-Earning Power in the New Economy' 32(3) *Signs* 671-698 p.639

as breadwinners and family supporters. As a result, the patriarchal norms and practices that 'marginalize daughters and favour sons exclusively' can also be revised.[71]

I should stop discussing the 'One Child' policy any further because it is not the main theme in this chapter or this thesis. There are two reasons why I think that it deserves some discussion in this chapter. First, as has been argued earlier in this chapter, the legislation on abortion in China is closely related to and sometimes even reliant on its policy-making on population. Thus, understanding post-Maoist population programmes and the 'One Child' policy can help the reader gain a thorough insight into the current model of abortion regulation. Second, from the analysis of the state's enforcement of the 'One Child' policy, it can be seen that by enacting and enforcing law and policy, the state is able to effect improvement in women's social status and welfare. As has been argued in chapter 2, the state's fulfilment of its negative and positive obligations can effectively facilitate women's procreative decision-making. This is particularly true in a context like China, where women's consciousness of their oppressed position and human rights has not been adequately raised. Therefore, the state's supportive involvement is essential to empowering women, particularly those from socioeconomically disadvantaged backgrounds, to act on their autonomously held reproductive desires. Nevertheless, I have emphasised that the above discussion of the 'One Child' policy does not serve to defend post-Maoist governments' coercive methods of reducing the national birth rate, which includes forcing women to have an abortion. In the rest of this section, I will discuss the Chinese-style family planning context and the state-centred regulatory model in order to examine the harmful effects on women's health and control over their lives caused by the state's exercise of controlling influences over the provision of abortion services.

[71] Hong Zhang (2007) p.694

3.2. The Chinese Family Planning Context

The idea of 'family planning' was officially introduced into the Chinese political and the legal systems at the start of the post-Maoist era. The introduction of this idea was significantly affected by Malthusian demographic theory in China.[72] To justify implementing a strict birth control plan, the government advocated a Malthusian argument: economic production cannot keep pace with population growth without family planning. Thus, reducing the national birth rate was treated as essential to the development of the state's economy. Deng, the first president in the post-Maoist era, claimed that the state must fulfil the birth control task, which was of major importance for the national economy. In order to achieve this population goal, the government stated that all married citizens must take up family planning and downsize their families. Therefore, essentially, it is more accurate to say that accessing family planning services, for Chinese citizens, is performing a duty rather than exercising a right.

Furthermore, in the Chinese family planning context, post-Maoist governments impose the duty to take up family planning mainly on wives, and most of the compulsory birth control methods are also targeted at them. Because successive governments' implementation of the population policy is heavily reliant on being targeted at controlling married women's fertility, oppression of and inequalities for women are increased. According to a survey conducted by the National Population and Family Planning Commission in 1995, in more than 80 per cent of the families studied only wives undertook contraceptive responsibility.[73] In addition, the contraceptive means which were mostly used among the families which already had one or two children were female sterilisation and intra-uterine device (IUD). These two female contraceptive methods were adopted by about 79 per cent of married women between 1985 and 1994. In the meantime, in the

[72] James Lee and Feng Wang (1999) 'Malthusian Models and Chinese Realities: The Chinese Demographic System 1700-2000' 25(1) *Population and Development Review* 33-65 p.34
[73] Peiyun Peng (1997) p.887

ten years from 1985 to 1994, when the birth control policy was particularly strict, there was even a steady decline in the use of male contraception, such as male sterilisation and the condom. [74]

Moreover, in the Chinese family planning context, normally wives rather than husbands are kept under surveillance conducted by the National Population and Family Planning Commission (NPFPC), which is the national administrative organ in charge of keeping birth control programmes running smoothly.[75] In order to enable women to effectively undertake birth control duties, the NPFPC formed a vertical structure in 1981: downwards from the NPFP to province, city, district (urban) or county (rural), street/township, neighbourhood Family Planning and village family planning centres. At the beginning of the 1990s, there were an estimated 300,000 family planning officials and hundreds of thousands of part-time family planning workers in villages who were called cadres.[76] Generally, a high-level family planning centre, such as a typical city-based one, sets a target of reducing the birth rate to a certain point for those centres at lower levels, such as district family planning centres. The target is usually set according to the number of married women of reproductive age in an area. If the family planning centres at the lower levels meet the target, the cadres in that centre can receive financial rewards. Family planning centres at grass roots level directly guide and supervise individual women's practice of controlling their birth rate. To meet the target and to avoid 'out of quota' births, the cadres in a local family planning centre can check and record detailed information about local married women of reproductive age, give birth permission to pregnant women if their pregnancy is authorised in accordance with the central government's population policy and persuade or even force married women to use an IUD after giving birth to one or two children.[77] By establishing

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[74] Ibid.
[75] For more information of the Population and Family Planning Commission of China, see the government website available at http://www.npfpc.gov.cn/en/about/index.aspx (last accessed 21 July 2011)
[76]Elina Hemminki, Zhuochun Wu, Guiying Cao and Kirsi Viisainen (2005) p.6
[77] In 2009, He, a deputy of the Guangdong People's Congress made an E-proposal (submitted via internet) to repeal the some local family planning policies which promoted the compulsory use of IUDs. The proposal was written in

family planning centres at different levels, post-Maoist governments are able to monitor whether and how married women fulfil the duty to avoid 'out-of-quota' births. An 'out-of-quota' birth, namely an unauthorised birth, means that the birth of a child is against the state's population policy and is not approved by the local family planning centre. To have their births authorised, pregnant women have to obtain permission from the local family planning centre before giving birth. Children who are born 'out of quota', namely without birth permission, will be treated differently from those who have been authorised. For example, they might not be able to be registered in the local household system or gain an ID card until their parents pay the 'out-of-quota' fines.[78]

Additionally, the state's national population control programmes, including government family planning funding, are mainly targeted at reducing fertility among married couples. For example, generally, only married women are eligible to apply for birth permission mentioned above. Unmarried women's births are classified as unauthorised, so putative mothers have to pay the 'out-of-quota' fines in order to make their births 'authorised'. This means that in the Chinese family planning context, unmarried people are not eligible for free contraceptive and abortion services. Successive governments in the post-Maoist era turn a blind eye to the facts discussed below, which are that unmarried women are in desperate need of affordable and safe contraceptive and abortion services. A study on unplanned abortions among women aged between 18 and 45 in Sichuan province conducted in 1995 indicates that the rate of unmarried young women who were not using contraception when accidental pregnancies occurred was much higher than that of married women.[79] The rates of contraceptive failures and repeated

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Chinese and available at http://elianghui.people.com.cn/proposalPostDetail.do?id=16756&boardId=1&view=1.cn (last accessed 08 August 2011)

[78] Elina Hemminki, Zhuochun Wu, Guiying Cao and Kirsi Viisainen (2005) p.3

[79] Li Luo, Sun Wu, Xuan Chen, Ming Li and Paul Thomas (1995) 'Induced abortion among unmarried women in Sichuan province, China' 51(1) *Contraception* 59-63 p.60

abortions among unmarried young women are also higher than those of married women.[80] Based on these two observations, I argue that apart from the problematic family planning funding scheme, there are two other causes for the high rate of accidental pregnancies and repeat abortions among unmarried young women. Firstly, because premarital sex and particularly premarital fertility are still considered as social taboos in China,[81] adolescents and unmarried young women who have unprotected sex or unplanned pregnancies may be ashamed to seek help from their parents, relatives or local family planning cadres. Secondly, due to a rise in the average age for first-time marriage, more people start their sex life before marriage. This means that, unavoidably, the number of unmarried abortion seekers, including repeat abortion seekers, will increase. According to a survey of the reproductive health of unmarried young women aged between 15 and 25 conducted by Wei in 2008 at the Langfang hospital, 53% of the 115 respondents had premarital sex, 33.35% had sex before 18,[82] 49% had at least one abortion and 10% had at least two abortions.[83] Given the difficulties that unmarried women have in obtaining contraception and abortion in practice, the current government funding scheme should not exclude them. In chapter 5, I will further discuss the possible proposals for law reform that are aimed to enhance unmarried women's control over their reproductive decision-making in China.

According to this survey, 92.2% of the women reported were not using contraception when they found that they were pregnant.

[80] Yi Cheng, Xuan Gao, Ying Li, Sun Li, An Qu and Kang, Bing (2004) 'Repeat induced abortions and contraceptive practices among unmarried young women seeking an abortion in China' 87(2) *International Journal of Gynecology and Obstetrics* 199-202 p.200

33% of the abortion-seeking women surveyed have had at least one surgical abortion before. Of those who had had more than one surgical abortion, only 29.7% used contraception after the abortion. Although 65% of the young women reported said that they had used condoms at least once, only 9.6% did so consistently and correctly and 47.7% of the current pregnancies caused by not using or not properly using contraceptive methods.

[81] Li Luo, Sun Wu, Xuan Chen, Ming Li and Paul Thomas (1995) p.61

[82] According to the Civil Law 1986, a citizen aged 18 or over shall be treated as an adult with full capacity for civil conduct and independently engaging in civil activities. According the Marriage Law 1980, the minimum marriage age for men is 22 and that for women is 20.

[83] Wei Xiangdong (07 April 2008) 'Diaocha Cheng Qingshaonian Xingxingwei Riyi Yanzhong, Rengongliuchan Zaolinghua' (The premarital sex and abortions among adolescent girls) *ChinaNews* available at http://www.chinanews.com.cn/jk/kong/news/2008/04-07/1212923.shtml (last accessed 08 August 2011)

Last but not least, I suggest that usually law and policy relating to family planning in China do not remain certain and stable and that the uncertain and unstable law- and policy-making on population leave space for the state to exert its discretion over the provision of abortion services. As a result, women are put in a disadvantaged position from which they can be powerless to control both their reproductive bodies and their daily lives. At the beginning of the 1980s, a series of social changes and economic reforms 'relaxed the control of national and local authorities over individuals and also reduced their ability to implement family-planning policies'.[84] Therefore, compared to the methods of implementing the birth control policy in the first two decade of the post-Maoist era, the existing ones are less restrictive. The current government adopts more incentive-based strategies to encourage women to have a smaller family. For example, it gives single-child families some economic rewards, such as a monthly stipend, free obstetric care, increased maternity leave, priorities in education, health care for the child, housing welfare and retirement pensions. However, the government has not abandoned its attempts to use punishment to stop citizens from breaching the birth control policy. For instance, as mentioned above, couples have to pay fines for their 'out-of-quota' births. The more violent means used in the 1980s and the 1990s, such as coercive contraception and abortion, are to some degree replaced by incentives and comparatively softer punishments, such as fines.[85] Nevertheless, this does not mean that coerced abortions do not exist any more. Strategies used by family planning centres to reduce the local birth rate may vary from area to area. In some areas, the local family planning authorities can still force pregnant women who are not eligible for birth permission to abort in order to achieve their birth control targets.

[84] Edwin Winckler (2002) 'Chinese Reproductive Policy at Turn of the Millennium: Dynamic Stability' 28(3) *Population and Development Review* 379-418 p.387

[85] See Hongqing Duan (25 July 2007) 'Zhongguo Jihuashengyu Diyian' (The First Family Planning Case in China) *China Value* available at http://www.chinavalue.net/media/Article.aspx?ArticleId=10072&PageId=1.cn (last accessed 21 November 2011)

However, the relaxation of the national birth control policy is not motivated by the existing government's desire to enhance women's autonomy, so they are still not empowered to exert control over their reproductive decision-making. As the analysis of the state-centred regulatory model offered in the next subsection will suggest, the party state does not change its strategy to regulate the population by placing control over women's access to family planning services. Similar to the reason for the Maoist government's removal of the ban on abortion in limited circumstances, the main reason for this slight relaxation of the strict birth control policy is that at around the start of the 2000s, the state's population gaol made significant achievements. According to the data on the growth of the national population collected by the National Bureau of Statistics, the natural population growth rate has dropped gradually since the middle of the 1980s.[86]

The state's birth control policy does not only vary over time, but also according to place. For example, in Shanghai, the biggest city in China, the natural population growth rate has remained negative for the past sixteen years.[87] Since the start of the twenty-first century, the 'One Child' policy has been relaxed in urban areas. This relaxation allows couples who are both from single-child families to have two children. Recently, some Western media reported that in Shanghai a 'Two Children' policy is advocated and the local government encourages couples to have a second child in order to redress its ageing population.[88] It is true that because of a steady decrease in the birth rate in big cities, the 'One Child' policy has become less restrictive. Nonetheless, the media has misunderstood the so-called 'Two Children' policy in the Chinese

[86] The population grown rate dropped from 14.55‰ in 1981 to 5.08‰ in 2006. For more information, see the National Bureau of Statistics of China (2006) available at http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20060316_402310923.htm (last accessed 21 November 2011)

[87] Jian Yang (14 March 2009) 'the Negative Natural population growth rate in Shanghai' (Shanghai Ziranzengzhanglv Shiliunian Fuzengzhang) available at http://news.sohu.com/20090314/n262790262.shtml (last access 21 November 2011)

[88] BBC News (24 July 2009) *Shanghai Urges 'Two-Child Police'* available at http://news.bbc.co.uk/1/hi/world/asia-pacific/8166413.stm (last accessed 22 November 2011)

family planning context. First, the Shanghai family planning committee never 'encourage' couples to have two children, so it does not offer any benefits or allowance for couples who have two children. Furthermore, couples have to meet relevant requirements and apply for birth permission if they plan to have a second child. This means that not all couples in Shanghai are eligible to have a second child, so the couples who have a second child without birth permission still have to pay fines.[89] The 'Two Children' policy is neither a new policy nor is it only applicable in Shanghai. Since 2000, family planning authorities in many cities have gradually adopted this method in order to deal with the ageing population.

From the above discussion, it can be seen that the Chinese family planning context has its own characteristics which are different from the English ones. First, English women do not have to fulfil a birth control duty; on the contrary, law-making on abortion in England implies that termination of pregnancy is not a rational decision, so it is better that women continue their pregnancies even when they are not planned or wanted. Second, unmarried and married women are not treated differently in England. Third, currently, policy-making relating to population in England has much less influence over law-making in relation to abortion. Nonetheless, there is a strong similarity between the Chinese and the English family planning contexts, namely that women's reproductive autonomy is not treated with seriousness. As has been discussed in chapter 3, post-1967 legal reforms relating to abortion do not grant women any substantial rights to exert control over abortion choices. Women are required to lead a maternal and self-sacrificing life according to the gendered assumption of womanhood. Women in the Chinese family planning context are also not empowered to make procreative decisions. They are required to sacrifice themselves for the state's population policy. As will be analysed in the next subsection, the gendered assumption of womanhood also projects onto the legislation of abortion

[89] Longhua News (28 July 2009) *Shanghai Fuhe Tiaojian Shengdiertai Bushi Xinzhengce* (The Shanghai 'two child' Policy Is Not New) available at http://news.cqnews.net/sh/shzh/200907/t20090728_3464687.htm (last accessed 22 November 2011)

in China, which implies that women ought to lead a 'glorious' maternal life. While the requirements of becoming 'glorious' in the Chinese family planning context are different from those of being rational in the English one, they are similar in as much as that to be considered as glorious or rational women have to effectively take reproductive responsibilities. The analysis in chapter 3 of parliamentary discussions relating to abortion law reforms in England suggest that no reference was made to anything about women's reproductive rights or freedom. The reforms were based on the assumption that women only need abortion to maintain their maternal capacities. In China, in order to become glorious, women have to bear and rear more children when the state is short of labour, but reduce their fertility when the state needs fewer consumers. In chapter 5, I will further assess the differences and the similarities between England and China in regulating the provision of abortion services. This assessment is aimed at achieving two goals: first, to examine how women's autonomy is not respected adequately under these two regulatory models and second, to scrutinise what possible proposals for law reform can be derived from each country's experiences of having a different regulatory model.

3.3. The State-centred Regulatory Model of Abortion

In 1980, for the first time the party state translated the national birth control policy into national legislation: the Marriage Law 1980.[90] Section 2(16) of the Marriage Law 1980 states:

> A husband and his wife shall be under the obligation of obeying the policy of birth control.

In quick succession, this obligation was written into the Constitution in 1982. Article 49 of the Constitution says:

[90] It was adopted at the Third Session of the Fifth National People's Congress and promulgated by Order No. 9 of the Chairman of the Standing Committee of the National People's Congress on 10 September 1980.

Citizens of reproductive age have the duty to practise family planning.

While both husbands and wives should take equal responsibility for the birth control obligation in accordance with the Constitution and the Marriage Law, the reality, as has been discussed in an earlier part of this section, is that this duty is mainly undertaken by wives. For example, Hemminki et al. have observed that in only 10 per cent of the families surveyed did men say that they might consider using male sterilisation, despite being told that it was simpler and safer than female sterilisation.[91] In the meantime, at the beginning of the 1980s, abortion was officially defined by the party state as *bujiu cuoshi* (literally, a back-up family planning method of avoiding unauthorised births when contraception fails).[92] Nevertheless, from the discussion offered in the last two subsections, it can be seen that the government's motive to redefine abortion was not to enhance women's procreative decision-making, but to justify and facilitate its use of abortion as a tool to carry out the birth control policy. Although post-Maoist governments have emphasised that contraception should be treated as the main means of reducing births, they have also repeatedly claimed that when contraception fails a back-up method should be used in order to avoid unauthorised births.[93] This definition was also written into two pieces of national legislation: the Code on Maternal and Infant Health 1994 (the 1994 Code)[94] and the Code on Population and Family Planning 2002 (the 2002 Code).[95] While the state's use of abortion as a compulsory method of reducing the national birth rate violates women's bodily integrity and human dignity, the definition of abortion as a back-up method of

[91] Elina Hemminki, Zhuochun Wu, Guiying Cao and Kirsi Viisainen (2005) 'Illegal births and legal abortions—the case of China' 2(5) *Reproductive Health* 1-8 p.2

[92] Family Planning White Paper (1995) available at http://cn.chinagate.cn/whitepapers/2007-02/13/content_2367015.htm (last accessed 08 August 2011)

[93] Elina Hemminki, Zhuochun Wu, Guiying Cao and Kirsi Viisainen (2005) p.8

[94] It was passed at the Tenth Meeting of the Standing Committee of the Eighth National People's Congress in 1994. It belongs to national basic law and its legal status is equivalent to an Act of Parliament in the U.K

[95] It was issued by the twenty-fifty meeting of the Ninth Standing Committee of the National People's Congress on 29 December 2001 and came into effect on 1 September 2002

preventing unwanted fertility itself is not problematic. According to this definition, termination of pregnancies, particularly those at early stages, should not be regulated in a way which is essentially different from the means of governing the use of contraceptive drugs to prevent women from becoming pregnant, such as the morning-after pill. As has been discussed in chapter 3, the development of reproductive medicine blurs the boundaries between the drugs which are used to prevent conception and those which are for ending early pregnancies. Defining abortion, particularly medical abortion, as a back-up family planning method which is not distinct from contraception also represents the reality that medical termination and even early surgical abortion are the most used and performed treatment for women of reproductive age. Therefore, instead of restricting the provision of abortion as a routine procedure, the state should make it more readily accessible. Nevertheless, as has been analysed in chapter 3, the English medical-centred model still constructs abortion as a complicated, unusual and traumatic procedure which ought to be limited to extremely special circumstances. To challenge the medical-centred regulatory model, the Chinese experience of defining abortion as a back-up family planning method is helpful in providing feasible strategies. I shall return to this point in chapter 5.

According to the 1994 Code and the 2002 Code, citizens have the right (not) to reproduce, but also have a duty to control their fertility.[96] Since abortion becomes defined as a family planning means, the codes also claim that the party state has the obligation to provide married women with free abortion services.[97] I suggest that, technically, access to abortion in China is less restrictive than that in England. First, distinct from the Abortion Act 1967, the 1994 Code and the 2002 Code do not set a time limit, so abortion at any stage of gestation can be carried out lawfully. Second, women are allowed to access abortion for a wide range of social and medical

[96] More specifically, Article 4 and 17 of the 2002 Code and Article 21 of the 1994 Code
[97] Dong Li (2009) *Shengyuquan Yanjiu* (literally, The Analysis of Reproductive Rights) (Thesis submitted to the University of Jilin for the Degree of Doctor of Philosophy)

reasons, except when it is for non-medical sex-selection.[98] Third, according to these two codes, abortion is available on demand, so women do not have to wait for doctors' approval.

The above discussion indicates that by comparison with English legislation on abortion, Chinese legislation looks more permissive. Ridgon has observed that China has the most liberal abortion law in the world because it does not have any penalties for 'having or performing an abortion at any state of pregnancy...'.[99] Nevertheless, I do not agree with her on this argument. The Chinese regulatory model cannot be classified as a liberal one because women's procreative autonomy is not given adequate respect. As has been discussed in chapter 2, a permissive regulatory model grounded in the principle of promoting autonomy should promote women's independence and interdependence in abortion decision-making. More specifically, this model should have a commitment to facilitating women's exercise of control over their high-level procreative desires and also to establishing an environment where medical cooperation and social support are readily accessible. However, the post-Maoist legislation on abortion is not made according to the principle of respect for autonomy. The above codes appear to be very different from the Maoist ones that imposed a complete ban on abortion. Nevertheless, they are similar in the way in which they treat women's decision-making concerning reproduction, that is, women's needs for reproductive health and control over life choices are marginalised and the party state's population goals are centralised in both the Maoist and the post-Maoist eras. In other words, abortion in the post-Maoist era is still constructed as a state-centred political issue that serves as a tool for successive governments to regulate the national population. In the next subsection, I will further examine how the Chinese state-centred regulatory model imposes coercive and controlling interference on women's procreative autonomy and the relevant consequences of this.

[98] In 2002, the Family Planning Commission issued 'the Prohibition of Non-medical Prenatal Sex Diagnosis and Sex Selective Abortion Act' which came into effect in 1st, January 2003. This rule aims to eliminate abortions of female foetuses and to correct the skewed sex ratio.

[99] Susan Rigdon (1996) 'Abortion Law and Practice in China: An Overview with Comparisons to the United States' 42(4) *Social Science & Medicine* 543-560 p.546

3.4. Medical Control under the State-centred Model

From the analysis of the 1994 Code and the 2002 Code offered above, it can be seen that compared with the English medical profession, Chinese medical professionals lack discretion in abortion decisions. For example, they are not entitled to decide whether women are eligible for abortion services; they are not given the right to claim conscientious objection. Under the state-centred model, medical professionals only play a role as the state's agents and their performance of abortion is subject to the state's policy-making in the context of abortion. Nevertheless, medical professionals' lack of decisional autonomy does not mean that medical control is absent from the provision of abortion services in China. Medical control is imposed by the state under the Chinese model in order to facilitate its use of abortion as a tool to regulate women's fertility. This section aims to discuss how the role of the medical profession in abortion provision and medical control under the state-centred model are different from those under the English regulatory model. Moreover, by discussing the medical limits imposed by the party state on access to termination services, I suggest that to enable medical professionals to fulfil their negative and positive obligations to promote women's procreative decision-making, the state should stop using the medical profession as its agent for controlling women's reproductive biology. The task of making possible suggestions for law reform to redefine the role of Chinese medical professionals will be undertaken in chapter 5.

A study on the opinions of Chinese doctors of gynaecology and obstetrics on performing abortions conducted by Nie in 2005 indicates that almost all doctors surveyed accepted the official definition of abortions discussed in the last subsection – a remedial birth control measure. Furthermore, they believed that performing termination of unwanted or unauthorised pregnancies

was helping women in trouble. Additionally, the doctors who performed abortions in China were mainly female. Based on these observations, Nie has argued that doctors prefer to keep silent on the subject of abortion which is only 'a woman's story' in China. He comments:

> Almost all abortions are performed by female doctors. All thirty OB/GYN doctors I interviewed throughout China—urban and rural, northern and southern-were female, with one exception.[100]

Nie's study reveals some characteristics of the provision of abortion services in China. For example, medical professionals who perform terminations in China are normally female; they prefer the official method of defining abortion to their own. The story in the UK is very different: 80 per cent of gynaecologists in England and Wales are male, and 95 per cent in Northern Ireland.[101] As has been discussed in chapter 3, both English jurisdiction and popular culture imply that if the medical profession has a gender, it is male. Nowadays, the male-dominated medical profession does not (only) mean that the number of male doctors is larger than those of female doctors. More importantly, the standards and benchmarks adopted in the health care context, particularly in the field of reproductive medicine, can privilege men and their experiences and marginalise women's.[102] To challenge sexist medicine, some scholars have argued for an increasing number of women physicians.[103] Nevertheless, the Chinese case suggests that the number of female physicians is not the key solution to the lack of woman-friendly health care environments. While abortion is mainly carried out by female doctors in China, given the characteristics of the Chinese family planning context analysed earlier in this section, it is obviously not a woman's story, but a politicised issue subject to the state's policy-

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[100] Jingbao Nie (2005) p.163

[101] Colin Fancome (1994) 'Gynaecologists and abortion in Northern Ireland' 26(3) *Journal of Biosocial Science* 175-180 p.178

[102] Joan Callahan (1995) (ed) *Reproduction, Ethics, and the Law: Feminist Perspectives* (Bloomington: Indiana University Press) and Sally Sheldon and Michael Thomson (1998) *Feminist Perspectives on Health Care Law* (London: Gavendish Publishing Limited)

[103] Elianne Riska (2001) 'Towards Gender Balance: But Will Women Physicians Have an Impact on Medicine?' 52(2) *Social Science & Medicine* 179-187 p.180

making in relation to population. Historically, women have had a sizable representation in the field of obstetrics and gynaecology in China.[104] Nonetheless, the weak voice from these female physicians does not promote women's procreative decisions. As has been suggested in section 2 of this chapter, in the existing Chinese family planning context, the state has replaced the male head of individual households and has become women's only procreative decision maker. Under the state-centred model, women's capacity to act on their autonomously held desires cannot be enhanced solely by increasing the number of female physicians.

As mentioned above, distinct from the medical-centred model, the state-centred model does not give Chinese doctors decisional power in abortion decisions. According to the discussion of the population policies made by the Maoist and Post-Maoist governments provided earlier in this chapter, Chinese doctors are only required (not) to perform abortion under the state's guidance in order to facilitate the state's population goals. In the Maoist era, the government required health professionals to turn abortion-seeking women away because it advocated a pro-natalist policy; in the post-Maoist era when the birth control policy was implemented, they have to provide abortion services on demand. The Chinese model stops health professionals from expressing their own perspectives on the topics relating to abortion. Moreover, neither the 1994 Code nor the 2002 Code grant medical professionals a right to conscientious objection in abortion provisions. Therefore, if women's abortion requests are consistent with the state's population policy, medical professionals are required by law to offer termination services. Their lack of discretion in performance of abortion services means that their role is more like the state's agents and is subject to the state's policy-making on population figures.

[104] David Mungello (2008) *Drowning Girls in China: Female Infanticide since 1650* (Ply mouth: Rowman & Littlefield Publishers) p.18

Conrad has observed that the emergence of new engines of medicalisation in the twenty-first century means that the imposition of medical control is not only driven by doctors but also by other elements, such as the pharmaceutical industry, consumers, market interests and the internet.[105] From the analysis of the state-centred regulatory model offered below, it can be seen that state intervention can also be a powerful engine of medicalising abortion. Under the state-centred model, medical control over abortion provision is not directly imposed by the medical profession but the party state. To ensure that abortion services can be used as a tool to regulate the population, post-Maoist governments have placed medical controls over their provision. According to the 1994 Code, abortion can only be lawfully performed by a registered doctor of gynaecology and obstetrics in a public medical institution or an authorised private medical sector unit.[106] In accordance with Article 336 of the Criminal Law 1979 (amended in 1997), any person performing birth control surgery without relevant certificates will be charged with the crime of *feifa jinxin jieyu shoushu zuo* (literally, unlawfully performing birth control surgery) and will be imprisoned for up to three years.[107] Furthermore, medical limits are also placed on access to medical abortions. Currently, there is a steady increase in the use of abortion drugs.[108] Many

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[105] Peter Conrad (2005) 'The Shifting Engines of Medicalization' 46(1) *Journal of Health and Social Behaviour* 3-14 p.3

[106] Article 32 of the Code on Maternal and Infant Health 1994: health care institutions that carry out genetic disease diagnosis, prenatal diagnosis, ligation operations and termination of gestation under this law must meet the requirements and technical standards set by the administrative department of public health under the State Council, and obtain the permission of the administrative departments of public health under local People's governments at or above the country level. Prenatal sex diagnosis by technical means shall be strictly forbidden, except that it is for medical needs.

Article 33: Personnel engaged in making genetic disease diagnosis or prenatal diagnosis as provided by this Law must pass the examination of the administrative department of public health under the People's government of the province, autonomous region or municipality directly under the Central Government, and obtain a corresponding qualification certificate. Personnel engaged in making pre-marital medical examinations, performing ligation operations or operations for termination of gestation as provided by this law and persons engaged in home delivery must pass the examination of the administrative department of public health under the people's government at or above the county level, and obtain a corresponding qualification certificate.

This code was passed at the Tenth Meeting of the Standing Committee of the Eighth National People's Congress in 1994. It belongs to national basic law and its legal status is equivalent to an Act of Parliament in the UK.

[107] The Criminal Law 1979 (amended in 1997)

Article 336 Whoever unlawfully supply unauthorised birth control surgery, including abortion and taking IUDs out without permission, shall be imprisoned for up to three years.

[108] Beverly Winikoff, Irving Sivin, Kurus Coyaji, Evelio Cabezas, Xiao Bilian, Gu Sujuan, du Ming-Kun, Usha Krishna, Andrea Eschen, Charlotte Ellertson (1997) 'Safety, efficacy, and acceptability of medical abortion in China,

women who need abortion choose to buy mifepristone and misprotal tablets from online shops.[109] As has been discussed in chapter 3, removing the limits on buying and using abortion drugs can significantly enhance women's control over reproductive choices. Nevertheless, post-Maoist governments are not motivated by the desire to facilitate women's abortion choices; on the contrary, they have imposed medical power over the provision of termination drugs since 2002. Although technically medical abortion should be provided on demand, it must be prescribed by medical professionals and carried out under their surveillance. According to Article 5 of the Act on the Prohibition of Non-medical Prenatal Sex Diagnosis and Sex Selective Abortion 2002 (the Act 2002),

> Article 5 Abortion drugs shall be prescribed and used under the supervision of a registered or an associate registered physician in approved health care institutions.[110]

Those who enacted the 1994 Code and the 2002 Code have claimed that bringing abortion under medical control was aimed at eradicating unsafe 'backstreet' abortions and promoting women's well-being. Nonetheless, these two codes do not serve this purpose in practice. In 2009, *China Daily*, the only official English language newspaper in China, highlighted the problem that each year a large number of abortions are performed in 'unregistered clinics'. According to a recent survey, annually there are around 13 million abortions (compared to 20 million births) performed in registered medical institutions, but the real number is even higher because 'many abortions ... are performed in unregistered clinics'.[111] The analysis provided below suggests that one main cause of the increase in the number of illegal abortions is the medical limits placed by the state

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Cuba, and India: A comparative trial of mifepristone-misoprostol versus surgical abortion' 10(6) *International family Planning Perspectives* 73-89 p.78

[109] Fang Lü (12 November 2009) 'Abortion Drugs in the Back-street clinics of Jinan' *Shangdong Commercial Daily* According to this report, in the city of Jinan, abortion drugs are readily accessible in unregistered clinics.

[110] In 2002, the Health of Ministry issued an administrative rule called 'the Act of Prohibition of Non-medical Prenatal Sex Diagnosis and Sex Selective Abortion', which came into effect on 1 January 2003. It is not applicable to contraceptive drugs, such as 'morning-after' pills.

[111] See Juan Shan and Yanfeng Qian (30 July 2009) 'Abortion stats cause for concern' *China Daily* available at http://www.chinadaily.com.cn/cndy/2009-07/30/content_8489906.htm (last accessed 09 August 2011)

on the provision of legal abortion services. Abortion can only be legally performed by registered doctors of gynaecology and obstetrics and in public hospitals and registered private medical sector units. This means that other nursing staff members are not allowed to carry it out and women cannot administer their own early medical terminations. However, in practice, there is a lack of registered physicians who are entitled to perform surgical abortions. According to the official statistics in the *China Health Care Year Book 2008*, there were only 128,378 registered doctors of gynaecology and obstetrics in the mainland of China who could lawfully carry out terminations,[112] but 33,547,666 women between the ages of 15 and 50.[113] Moreover, as a result of differential resource allocation, the demand for abortion services is far greater than the supply in some comparatively undeveloped areas. For example, registered doctors who can carry out abortion services in the autonomous region of Tibet only account for 0.24% of the total number in mainland China compared to 7.6% in the province of Shangdong. The inequality is even greater between urban and rural areas.[114] Rural medical institutions, especially those below the township level, such as village health care centres, have a very limited number of registered physicians.[115] According to a survey conducted by the 'China Development Observation', which is a governmental research institution, there are less than 5% of registered physicians in the medical health centres below the country level, but around 63.01% of the population of 1.3 billion live in rural areas.[116] Therefore, restricting abortion services to registered physicians means that a large number of women are not able to access legal abortion services.

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[112] China Health Care Year Book 2008 (2009) (Beijing: the Press of China Xiehe Medical University) p.40

[113] The data is from the fifth national census. It was conducted by the National Bureau of Statistics of China in 2005 and available at http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20060316_402310923.htm (last accessed 10 August 2011)

[114] In 2010, *China Daily* reported that the income ratio between urban and rural residents was 3.33:1. See China Daily (22 January 2010) 'China's urban, rural income gap widens' available at http://www.chinadaily.com.cn/bizchina/2010-01/22/content_9361049.htm (last accessed 10 August 2011)

[115] Leiyu Shi (1993) 'Health Care in China: A Rural-urban Comparison after the Socioeconomic Reforms' 71(6) *WHO Bulletin OMS* 723-736 p.726

[116] The date is from the 2000 national census conducted by the National Bureau of Statistics of China and available at http://www.stats.gov.cn/tjgb/rkpcgb/qgrkpcgb/t20060316_402310923.htm (last accessed 10 August 2011)

In Chinese rural health care centres, medical services are generally provided by village doctors. In fact, they are not medical professionals in the real sense because they usually do not study in or graduate from an approved medical school and they are not registered by the Ministry of Health. Village medical professionals have a special status in the Chinese health care context, which is somewhere between lay persons and registered physicians. They were called *chijiao yisheng* (literally, barefoot doctors) in the Maoist era. The title of 'barefoot doctor' was created in 1968 in accordance with the Maoist government's policy that was targeted at quickly training paramedics to satisfy the growing need for health care services in rural places. This title has two meanings: first, a barefoot doctor is a villager or a farmer in rural areas; second, they have basic medical training and only work in villages or undeveloped rural areas. As Zhang has observed, generally, barefoot doctors graduate from secondary school education and accept training at a county or community hospital for 3–6 months. While the health care services provided by barefoot doctors were usually simple and basic, in the Maoist era they effectively reduced costs and provided timely treatments in rural areas. Maternal health services, such as delivery, were mainly undertaken by barefoot doctors in villages and undeveloped rural areas. Therefore, the Chinese barefoot doctors' programme was considered by the World Health Organization as a successful solution to the shortage of health care in developing countries. [117] As White comments:

> Barefoot doctors...reflected an approach to health care which was focussed on rural areas, and which was decentralized, deprofessionalized, grassroots-based, egalitarian, 'low-tech', economically feasible...The model became internationally renowned in public health and health development circles, and in fact served as the inspiration for the World Health Organization's Primary Health Care initiative.[118]

[117] Daqing Zhang and Paul Unshuld (2008) 'China's Barefoot Doctors: Past, Present, and Future' 327(9653) *Lancet* 1865-1867 p.1865

[118] Sydney White (1998) 'From "Barefoot Doctor" to "Village Doctor" in Tiger Springs Village: A Case Study of Rural Health Care Transformations in Socialist China' 57(4) *Human Organization* 480-490 p.480

Nevertheless, in the post-Maoist era, in order to make the provision of medical services more formal and professional, the barefoot doctor regime was repealed in 1985. Consequently, the title of 'barefoot doctor' is replaced by that of 'village doctor'. However, this change put village doctors in an embarrassing situation. First, village doctors are treated by law differently from those 'real' physicians who are registered by the Ministry of Health. According to the Law on Registered Physicians 1998, registered physician candidates should have a Bachelor of Medical Science from a medical university/college recognised by the Ministry of Education; then they have to meet two requirements: an internship of at least one year in an authorised medical institution under the supervision of a registered physician and passing the National Registered Physician Examination (NRPE), which is held annually by the Ministry of Health. The NRPE has two levels: fundamental and advanced. Candidates who pass the advanced NRPE are qualified to practise independently as a registered doctor and those who pass the fundamental NRPE can practise under the guidance and supervision of a registered doctor as an associate registered doctor. As has been discussed above, village doctors normally do not have a Bachelor's degree, so it is not likely that they can practise as a registered doctor or associate registered doctor. Second, the law conveys a message to the public that village doctors are equivalent to illegal medical providers who are not suitably qualified for carrying out even simple health care services. Moreover, this means that in villages and undeveloped rural areas where registered doctors are lacking, village doctors are not allowed to perform surgical abortions or to prescribe medical terminations.

Given that there is a shortage of registered physicians, the state's intervention to restrict the carrying out of abortion to registered doctors can force women who need abortion to use illegal means that are perhaps also unsafe. According to a report in *Shangdong Commercial Daily* in 2009, abortion drugs are sold in unauthorised clinics, online shops and even by individual

dealers whose customers are mainly working class young women.[119] As has been argued in chapter 2, women do not opt for illegal drugs if lawful services are readily affordable and accessible. From the discussion provided in chapter 3, it can be seen that even surgical termination of pregnancy is not a highly technical and complicated procedure. It does not necessarily need to be carried out by doctors. To satisfy women's needs for safe and timely termination treatments, abortion, particularly early medical termination, should not be restricted to doctors only. From the analysis offered earlier in this subsection, it can be seen that the government's intervention to exclude village doctors and health care professionals other than registered physicians from providing abortion services is motivated by the desire to bring women's reproduction under the state's control by using the medical profession as the gatekeeper of procreative services.

3.5. The State's Control over Access to Financial Support

As has been discussed in chapter 3, because of the medicalisation of abortion, doctors' attitudes towards unwanted fertility can determine whether women in England and Wales can access NHS-funded abortion services. Moreover, some women could find it difficult to obtain funding from the NHS for abortion because the local requirements for funded services are stricter than those in other areas. For example, abortion seekers in Gwent are not eligible for NHS funds if their gestation is more than 20 weeks or if they have had three terminations. These limits over the provision of financial support stimulates the backstreet abortion market and increases the strains and stresses on abortion seekers, particularly those who are from comparatively low social classes. Under the state-centred model of abortion, the limits imposed by successive governments over funded services cause similar problems in China.

[119] Fang Lü (12 November 2009) 'Abortion Drugs in the back-street clinics of Jinan' *Shangdong Commercial Daily*

According to the 1994 Code and the 2002 Code, citizens of reproductive age are eligible for free family planning services. However, the analysis of the Chinese family planning context above suggests that the current national birth control programme only includes married couples. Thus, funded abortion services are not available for unmarried women. Moreover, as has been discussed in section 1 of this chapter, the existing national health care insurance scheme only covers abortion-seeking women who are employed or those who are able to afford health care insurance. Therefore, teenagers and unemployed, unmarried women may find it particularly difficult to afford legal abortion services provided in authorised hospitals or private medical sector units. As has been analysed earlier in this section, compared to married and middle class women, teenagers, unmarried working class and poor rural women are more vulnerable to unplanned gestation because of limited access to family planning information and contraceptive services.[120] According to a study conducted by the National Research Institute of Family Planning (NRIFP) in 2004, about 60 per cent of abortion seekers surveyed were adolescents or unmarried young women.[121] Li has observed that due to inadequate financial support, many teenage and working class abortion seekers had to seek cheap but unreliable services in backstreet clinics.[122]

Furthermore, in 2005 and 2006, Sina Online News reported that facing huge social and financial pressure caused by premarital fertility, two teenage mothers killed their newborn infants and admitted that they did not know how to avoid unwanted gestation and wanted but could not afford an abortion.[123] Under the state-centred model, government intervention to restrict abortion

[120] See Juan Shan and Yanfeng Qian (30 July 2009) 'Abortion stats cause for concern' *China Daily* available at http://www.chinadaily.com.cn/cndy/2009-07/30/content_8489906.htm (last accessed 10 August 2011)
[121] Yuan Cheng, Xuan Guo, Sun Qu and Bang Kang (2004) 'Repeat induced abortions and contraceptive practices among unmarried young women seeking an abortion in China' 87(2) *International Journal of Gynaecology and Obstetrics* 199-202 p.200
[122] Fang Li (29 July 2007) 'Huaji Shaonvmen Yiwaihuaiyuan Ruhe Jiejue' (literally, teenage abortion seekers) available at http://life.people.com.cn/GB/1093/5962722.html (last accessed 10 August 2011)
[123] SinaNews (15 August 2005) 'Shisisui Huajishaonv Jiazhong Changxia Nanying Hou Cong Sanlou Chuangkou Paochu' available at http://news.sina.com.cn/s/2005-08-15/12236695100s.shtml (last accessed 10 August 2011) Li

funds to married women assumes that marriage is essential to sexual life and premarital sex is a legal taboo for women. Given the steady increase in Chinese citizens' average age for first-time marriage, there is a growing need for termination services among unmarried women.[124] While the current government is aware of this need,[125] recent trends in the legislation on abortion suggest that it does not have any plan to enhance women's reproductive decision-making by extending the national family planning funding scheme to unmarried women.

As has been discussed in the previous subsection, women in some rural areas where qualified providers are not available have to travel to gain safe and legal abortion services. However, the state's family planning funding scheme does not cover travelling expenses. This means that women from rural areas who cannot afford to travel for a legal service still have to seek unreliable providers. In the case of *Mu*[126], L lived in the village of Wuhua where the health centre did not have registered doctors who were qualified to offer abortion services. In 2007, she had an unplanned and unwanted pregnancy, but could not afford to travel to an urban medical institution for an abortion. She was told by her sister-in-law that Mu, a village doctor, could help women solve this problem. Mu agreed to perform an abortion for L. Nevertheless, because Mu improperly gave Lidocaine Hydrochloride injections, L went into a coma and eventually died. Mu was therefore charged under Article 336 of the Criminal Law 1979 (amended in 1997) with

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was a 14 years old middle school girl when she had a sex with a man and became pregnant. She is from a single parent family and could not afford an abortion. Li asked her friend, a 15 year old girl, to help her. After giving birth to a boy baby, they dumped the baby into a bin.
Also see Xialing Dai (26 September 2006) 'Zhongzhuannv Changzi Jiangqi Congsanlou Rengxia' *SinaNews* available at http://news.sina.com.cn/s/p/2006-09-16/024011020618.shtml (last accessed 10 August 2011) Hong was pregnant when she was 16 and still in a boarding school. Hong's boyfriend broke up with her after she became pregnant. She was not able to afford an abortion and ashamed to tell her parents, school tutors and friends. Hong said that 'one evening, I woke up in my dorm because of a serious "stomach ache" and then I went to the toilet and gave birth to a girl baby...I was so scared...' Finally, Hong decided to dump the baby into a bin.

[124] Xing Li and Yang Yang (12 January 2010) 'Shanghai Nanxing 09 Pingjun Jiehun Nianling Chaoguo 30' *Dongbei* available at http://internal.dbw.cn/system/2010/01/12/052305602.shtml (last accessed 10 August 2011)
According to their survey, in 2009 the female average age for first-time marriage was 30 and the male was 32 in Shanghai.

[125] See Juan Shan and Yanfeng Qian (30 July 2009) 'Abortion stats cause for concern' *China Daily* available at http://www.chinadaily.com.cn/cndy/2009-07/30/content_8489906.htm (last accessed 10 August 2011)

[126] *The People's Procuratorate of Wuhua District v Mu* (2008) wufaxingerchuno.79

the crime of *feifa jinxin jieyu shoushu zuo* (literally, unlawfully performing birth control surgery). Mu's defence is that she intended to help L as she helped her friends and did not know that performing termination of their pregnancies was illegal; eventually she was convicted. The panel of judges believed that Mu was not qualified to carry out family planning surgery and caused a serious consequence, so Mu was given a fixed-term imprisonment of three years and a fine of ¥10,000 (Chinese currency, equivalent to £1,000). In this case, the abortion provided by Mu was similar to those offered by English abortionists in the era of criminalisation. As has been discussed in chapter 3, they did not consider their services as a crime, but as sympathetic and helpful. Abortionists, like Mu, are likely to be driven by compassion rather than a financial motive. The above analysis does not aim to defend unlawful suppliers, but it suggests that instead of banning them the government could effectively promote funded abortion services and ensure that they are readily accessible to all women.

4. Law's Construction of Abortion, Female Citizens and the Party State

As has been discussed in chapter 2, the principle of respecting procreative autonomy is closely connected to human rights thinking. This section first explores the characteristics of Chinese human rights thinking and then examines the special relationship between the state's *quan* (literally, power) and citizens' *quan* (literally, rights) in the Chinese political context. These can help the reader gain a deeper insight into the state's establishment of the state-centred regulatory model and better understand how the state exerts control over law's construction of abortion, abortion seekers and the state itself.

The English terms of 'power' and 'rights' are *quan* in Chinese. In imperial China, *quan* only referred to rulers' power and there was no concept of citizens' rights. As has been analysed in

section 1 of this chapter, the theory of human rights was introduced into China from Japan and Germany in the nationalist era. In the modern political system, citizens' *quan* (rights) are distinguished from the state's *quan* (power), but the development of human rights in China has its own characteristics. As Peerenboom has observed, 'the rhetoric of absolute, ahistorical, universal rights is at odds with China's philosophical and cultural traditions', and rights in China remain rights with Chinese characteristics.[127] In brief, there are three characteristics of Chinese *quan* (rights) thinking which are different from those of human rights thinking in the English context.

Firstly, citizens' *quan* (rights) inhere in citizenship rather than in humanity; in other words, citizens' exercise of rights is reliant on their fulfilment of relevant obligations.[128] Thus, rights in China are inseparable from duties, so 'rights are but half of the picture – the other half is duties'.[129] This characteristic is derived from the Confucian understanding of people's rights: people do not have rights naturally and automatically, but have to earn rights by having a duty to act appropriately in relation to others. Secondly, in modern political and legal systems, citizens' rights are granted by the state and have 'no independent basis in human nature or human conditions'.[130] Third, as has been discussed earlier in this section, the content of citizens' rights can change depending on the state's needs. Savage comments:

> Administrative regulations that have implemented laws and established the content of rights have changed rapidly as the C.C.P and the state have re-evaluated the effects of the regulations upon socialist interests.[131]

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[127] Randall Peerenboom (1993) 'What's Wrong with Chinese Rights: Toward a Theory of Rights with Chinese Characteristics' vol.6 *Harvard human rights journal* 29-59 p.57
[128] Randle Edwards, Louis Henkin and Andrew Nathan (1986) (eds) *Human Rights in Contemporary China* (New York: Columbia University Press) pp.126-128
[129] Randall Peerenboom (1993)
[130] Mark Savage (1988) p.1070
[131] Ibid.

For example, when the pro-natalist policy was advocated in Maoist China, citizens did not have the right to obtain contraceptive and termination services. After implementing the birth control programmes, accessing contraception and abortion becomes a right and even a duty for citizens. Thus, the state's *quan* (power) can legislate to create, change and limit citizens' *quan* (rights).

However, the current government has claimed that the existing trend in the regulation of citizens' *quan* and the state's *quan* is to protect the former to a maximum degree and stop government officials' abuse of power. Article 2 of the Constitution (as amended in 2004) states that 'zhonghuarenminggongheguo de yiqi quanli shuyu renmin' (literally, all power of the People's Republic of China belongs to citizens), which suggests that the state's power should serve as a tool to promote citizens' rights. Nonetheless, the discussion of the state's intervention to regulate abortion offered in the previous section tells a different story: citizens' rights are still violated by the state's controlling involvement. Moreover, the protection of citizens' rights is still a 'work in progress' which needs further reform and considerable improvements. In the next two subsections, I will discuss law's construction of abortion, abortion seekers and the state in order to explore the causes of law's lack of respect for women's procreative autonomy under the state-centred regulatory model.

4.1. Law's Definition of Abortion as a State-centred Decision

As has been argued in the last section, the 1994 Code and the 2002 Code simply pay lip service to the idea that women should be given the right to decide whether or not to reproduce, because although this right is advocated in the codes, the state continues its controlling influence over the provision of abortion services. Moreover, since the state's population policy overrides law in China, abortion is used as a tool by the state to facilitate its exercise of control over the national

population. From the Maoist era, when abortion was completely banned, to the post-Maoist era, when women are forced to abort 'unauthorised' pregnancies, successive communist governments marginalise women's real needs. As Nie has observed, while there are dramatic changes in the legislation on abortion – from a restrictive to a permissive and even coercive stance, the reasoning or ideology behind it remain the same: a collectivist and statist one. He notes:

> It is collectivist because in China the interests of the country and collective enterprises are always given priority over the personal interests of individuals. It is statist because the state or party or government (the three terms are used interchangeably in the official discourse) represents the highest interests of China as a country and the Chinese people as a whole.[132]

Under the state-centred regulatory model, abortion is defined by the post-Maoist party state as 'an indispensable instrument of the national population control agenda'.[133] As a consequence, women can be persuaded or even forced to have an abortion if their pregnancy is not authorised by local family planning authorities or they cannot afford the 'out-of-quota' fines. The *China Health Year Book 2008* shows that after the introduction of the national birth control policy in 1979, the number of abortions in registered medical institutions increased rapidly from 539,000 in 1979 to 7,856,587 in 2007.[134] While it is impossible to find out how many abortions per year in China are coercive, the number is unlikely to be small, based on a report on family planning services in Guangdong province, which suggests that in 1982, 80 per cent of 624,000 abortions were carried out 'by order', and one-third were in the sixth month of pregnancy or later. This report shows that most of the coerced abortions were at late gestational stages. I suggest that this is due to the fact that in real life, many women have a strong desire to have a further child even though they know that they are not eligible for birth permission from local family planning

[132] Jingbao Nie (2005) p.51
[133] Ibid. p.44
[134] China Health Care Year Book 2008 (2009)

centres. Thus, they are likely to choose to hide their unauthorised pregnancy from family planning centre cadres. Nevertheless, as has been analysed earlier in this chapter, local family planning cadres regularly check whether local women of reproductive age are pregnant without applying for birth permission. When their pregnancies are at the second or the third trimesters, cadres can easily find out and persuade or even force them to have an abortion.

To entrench the state-centred control over the provision of abortion services, post-Maoist governments have also changed the definition of abortion services in medical education. Surgical abortion has been construed as family planning surgery in Chinese medical textbooks since the national birth control policy was implemented at the beginning of 1980s.[135] This is also why, as has been discussed in the last section, Chinese doctors often remain silent on the topic of abortion. Because abortion is considered as a back-up family planning means and also a tool to enhance the state's implementation of the birth control population, doctors normally view offering termination services as a duty to promote the good of the state even though it might be against women's free will. As the survey conducted by Nie in 2005 demonstrates, most of the registered physicians interviewed believed that their performing abortion was to help their patients solve problems and also for the good of the nation.[136] In practice, medical professionals do not need to bother to support anything other than actual abortion treatments, such as offering adequate information about suitable termination and contraceptive options before and after actual treatments. Thus, the state's control over access to abortion discourages medical professionals from carrying out their positive obligation to respect women's decision-making autonomy.

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[135] Zehua Wang and Xiaowen Dong (2008) *Modern Obstetrical and Gynecologic Surgery* (*Xiandai Fuchanke Shoushuxue*) (Beijing: The Second Military Medical University Press) p.221; Qiulan Lü and Mingying Gai (2004) *Handbook of Obstetrics and Gynecology* (Beijing: Hexie Medical Sciences University Press) pp.341-345 and Jie Le (2008) *Obstetrical and Gynecologic Sciences* (Beijing: Renming Health Press) p.373

[136] Jingbao Nie (2005) p.168

Moreover, under the state-centred model, abortion can be used by the state as a method of achieving its eugenic goal: avoiding the birth of babies with undesirable traits and producing more healthy citizens. In accordance with article 18 of the 1994 Code, medical professionals should inform women and persuade them to terminate their pregnancies if foetuses are diagnosed with a serious physical or mental abnormality. A document was issued by the Legal Affairs Office of the State Council to explain this article; it states that a serious abnormality is caused by (a) genetic and congenital defect(s) and may develop into a disease(s) which completely or partially deprives the child of the ability to live independently.[137] Distinct from s. 1(1)(d) of the Abortion Act 1967, article 18 of the 1994 Code does not serve as statutory grounds for abortion. However, it places a duty on medical professionals to identify foetuses with undesirable traits and to use their medical knowledge to pressurise women to make a decision on abortion. More importantly, it also imposes a duty on putative parents, particularly mothers, to produce more healthy citizens. Therefore, compared to the argument in s. 1(1)(d), that in article 18 conveys a more eugenic message which discriminates against existing persons with a disability.

Both Maoist and post-Maoist governments' intervention to subject the provision of abortion services to their population policies is based on the gendered assumption of womanhood as motherhood, discussed in chapter 2. Compared to their English sisters, under the state-centred model, Chinese women are not only required to procreate, but also to subject their decision-making to the state's strict code of reproductive conduct. To promote women's autonomy in reproductive decisions, the state should change its current role in governing access to abortion services. More specifically, the connection between its population policies and the legislation on termination should be broken and the latter would then only serve to protect women's rights to procreative health and control over their daily lives. In chapter 5, I will undertake the task of

[137] The Legal Affairs of the State Council (2008) *The Collection of Chinese Law* (Beijing: China Legal Publishing House)

drawing up possible proposals to challenge the state's controlling involvement in abortion provision.

4.2. The Images of the State and Female Citizens of Reproductive Age

As has been discussed in chapter 3, different images of doctors and abortion-seeking women are created under the English medical-centred regulatory model: the former are construed as responsible, highly skilled, rational and sympathetic, but the latter are conveyed as irresponsible, irrational and selfish. This model implies that a 'normal' woman who has maternity should have at least one of the following three characteristics: first, she does not have unplanned pregnancies; second, she continues gestation even if it is unplanned; and third, she only seeks termination services when they can help her effectively maintain maternal responsibility for her family. From the discussion offered in the above sections, it can be seen that under the Chinese regulatory model, there are also different figures created for the state and female citizens of reproductive age. In seeking to help the reader better understand these figures, in this subsection, I first offer an introduction to the designation of 'Glorious Mother', which was given by the Maoist government to reward women who had more than ten children.

The award of 'Glorious Mother' was transplanted from the Union of Soviet Socialist Republics (USSR) into China in the Maoist era. It was granted by the USSR government to mothers of multiple children. Because of the implementation of the pro-natalist policy, the designation of 'Guangrong Muqin' (literally, glorious mother) was also adopted by the Maoist government to

encourage women to have a larger family.[138] However, despite giving this award, the Maoist government did not financially support large families. Due to the limited family resources in individual households and the ban on contraceptive services, infanticide and infant abandon often occurred in the Maoist era, particularly in undeveloped rural areas. Furthermore, many of the Maoist 'glorious mothers' were permanently injured or even died because of the maternal diseases caused by excessive childbearing, poor maternal care and unsafe abortion means.[139] Since the start of the 1980s, when the birth control programmes began, the award of 'Glorious Mother' has been replaced with a certificate called 'Dusheng Zinü Guangrong Zheng' (literally, single-child glorious family certificate). Single-child glorious family certificates are issued by individual local family planning authorities in order to reward the couples in their areas who have only one child. Both awarding the designation of 'Glorious Mother' and issuing one-child glorious family certificates suggest that women's fertility is treated as a platform for the party state to pursue its population goals. Female citizens of reproductive age are required to lead a 'glorious' life according to the state's requirements. In addition, the existing government has claimed that the Chinese family planning context promotes gender equality because men and women have an equal right to family planning services and have an equal obligation to obey the birth control policy. Nevertheless, from the discussion offered in section 3 of this chapter, it can be seen that this argument is far from a representation of the reality. In practice, since the state prefers to achieve its population goals by controlling women's procreative activities, such as pregnancy, childbirth and abortion, women are more vulnerable to the state's controlling involvement compared with men.

As has been indicated in chapter 3, under the English medical-centred model, women are regarded as the figures that have to lead a self-sacrificing maternal life. Similarly, under the

[138] Yinhe Li (2003) *Shengyu yu Cunluo Wenhuai* (Reprod uction and Village Culture) (Beijing: Wenhuayishu Publisher) p.166
[139] Peiyun Peng (1997) p.549

state-centred model, Chinese women are also required to sacrifice themselves for their families and state. The population policies in both the Maoist and the post-Maoist eras have been implemented at the expense of women's health and control over their lives. Although two very different approaches to governing the provision of abortion services have been adopted by Maoist and post-Maoist governments respectively, the guidelines on these approaches are similar: female citizens should lead a glorious maternal life. More specifically, female citizens were required to produce more children when the pro-natalist policy was enacted, but to abort extra and unhealthy births when the party state needs less and better citizens. 'Glorious' women also have to undertake responsibility for birth control rather than their husbands, and take good care of their only child. Therefore, I argue that the changes in the legislation on abortion made by successive governments in England and China are both grounded in the gendered construction of womanhood that, as has been explained in chapter 2, is a self-sacrificing woman willing to effectively take maternal responsibility. Under the English regulatory model, women are constructed as figures that need medical control to be rational and responsible. In the meantime, the state-centred model assumes that the state's controlling intervention is essential to enable women to become 'glorious'. These two models therefore both imply that women cannot make responsible procreative decisions because they are irrational and inglorious, so external controlling influences should be imposed over their decision-making in order to help them become rational and glorious.

From the discussion provided in the above sections, it can be seen that the method of constructing the image of medical professionals under the medical-centred model is similar to that of producing the party state's figures under the state-centred model. Since the foundation of the communist state in 1949, successive governments have claimed that the party state represents the interests of the collective/majority/community. For example, the preamble to the Constitution

1982 (amended in 2004) states that the party state 'always' behaves in the public interest to make a marked increase in agricultural production, significant advances in education, science, culture and improvement of the life of citizens.[140] According to the 1994 Code and the 2002 Code, the birth control programmes were also carried out by post-Maoist governments in the name of improving the national interest and the good of the collective. Thus, the image of the state is described as powerful, responsible, heroic and also 'male'. As has been suggested in section 2 of this chapter, the party state replaces the male head of the individual households in the imperial era and becomes women's reproductive decision maker. Whether or not continuing a pregnancy is a proper, legitimate and glorious decision is significantly reliant on the party state's attitudes towards the development of the national population. Compared to the paternalist relationship between doctors and women who need abortion, which is grounded in the principle of 'doctor knows best' in England, the patriarchal relationship between the state and female citizens is established according to the principle of 'state knows best' in China, where the infringement of women's right to procreative autonomy is hidden behind the so-called state good. In chapter 5, I will examine how to challenge this patriarchal relationship and bring the provision of abortion services in line with the principle of promoting women's autonomy.

5. The Contextualisation of Autonomy in the Chinese Family Planning Context

5.1. Why the Chinese Family Planning Context Requires the Principle of 'Respect for Autonomy'

As has been argued in chapter 2, to satisfy women's needs for health and control over life choices, an autonomy-centred regulatory model of abortion should be established in order to

[140] The Preamble to the Constitution of the People's Republic of China 1982 (amended in 2004)

ensure that medical cooperation and state support are readily accessible. The discussion in sections 1–4 suggests that the establishment of such a model is particularly important in the Chinese family planning context where women's reproductive decision-making is subject to the state's policy-making in relation to population. Although currently in China access to abortion appears to be unrestricted because of the need to implement the birth control policy, it does not empower women to exert autonomy over their reproductive decisions. More restrictions could be imposed on the provision of abortion services when the state makes a different population plan. In this subsection, I first examine new trends in the state's policy-making in relation to population and its legislation on abortion in order to argue that women's reproductive rights are likely to be further violated if the regulatory model does not work within the autonomy-based framework.

At the beginning of the twenty-first century, a new Chinese population problem shocked the outside world: the severe gender imbalance in the national population. The BBC News reported that the culture of preference for sons stimulated the widespread practice of abortion of female foetuses by Chinese women, and that 40 million single men in China by 2020 will make it 'a nation of bachelors'.[141] The skewed sex ratio also became the concern of the existing government and the public. According to a poll conducted by the *China Youth Daily*, 88 per cent of 2,603 respondents said that they were worried about the problem of gender imbalance.[142] Officially, the government has claimed that women who sought sex-selective abortions should be blamed for the skewed national gender ratio and other related problems, such as the trafficking of women, which appears to be more serious in the areas with greater gender imbalance.[143] As a

[141] BBC News (05 April 2004) 'China Fears Bachelor Future' available at http://news.bbc.co.uk/1/hi/world/asia-pacific/3601281.stm (last accessed 11 August 2011)
[142] The China Daily News (18 July 2007) '85% Chinese concerned by gender imbalance – survey' available at http://www.chinadaily.com.cn/china/2007-07/18/content_5438730.htm (last accessed 11 August 2011)
[143] Huanqiu News (22 February 2011) 'Yuenan Guanfang Cheng Zhongguo Cheng Yuenan Beiguai funü Zuida Quxiaoguo' available at http://world.huanqiu.com/roll/2010-02/723337.html (last accessed 11 August 2011)

result, the government has argued that the skewed sex ratio is now a new population crisis, so new legislation to ban and criminalise sex-selective abortions is required in order to redress the imbalance and solve related social problems.

Against this background, the Population and Family Planning Commission enacted new legislation in 2002: the Act on the Prohibition of Non-medical Prenatal Sex Diagnosis and Sex Selective Abortion 2002 (the 2002 Act).[144] This act prevents medical professionals from informing pregnant women of the sex of foetuses. It also partially limits access to abortion when pregnancies are of more than 14 weeks. More specifically, it states that if a pregnant woman has obtained birth permission from the local family planning centre in her place of residence and her pregnancy is more than 14 weeks in duration, she must get the approval from this centre in order to access abortion. As has been discussed earlier in this chapter, birth permission is granted by family planning authorities to married women whose pregnancies are classified as authorised. Thus, technically, when married women whose applications for birth permission are approved and whose pregnancies are of more than 14 weeks' gestation change their mind and decide to terminate their pregnancies, they have to prove that their requests for abortion are not motivated by the desire for sex-selection. This means that any woman of aged twenty and upwards (twenty is the minimum age for marriage for female citizens in China) who needs an abortion service after 14 weeks' gestation must prove her marital status to medical professionals. While the enforcement of the 2002 Act, which is an administrative rule, is not as strict as that of basic or departmental law, given the trend in the current government's policy-making relating to population, it is only a matter of time before the 2002 Act is updated to a departmental code enacted by the NPC. Similar to the previous governments' strategies to deal with the so-called population crises (the labour shortage in the Maoist era and the overpopulation in the post-

[144] It belongs to secondary legislation.

Maoist era), the current means of redressing the gender imbalance is still heavily reliant on imposing control over women's procreative decision-making. While the government has realised that the root cause of the skewed sex ratio is gender discrimination, it does not have any plans to improve women's education, employment and social status, but simply resorts to coercive intervention to govern the provision of abortion services.[145]

Distinct from the two methods of increasing the population and reducing the birth rate respectively, the imposition of the ban on non-medical sex-selective abortions received more support than criticism from human rights scholars inside and outside China.[146] For example, Mary Anne Warren has claimed that the arguments for respecting people's reproductive autonomy to select the sex of their children should not be applicable to countries such as China and India, where the gender imbalance is severe and women have not enjoyed a substantial degree of personal economic autonomy.[147] In the meantime, many leading bioethical and legal scholars in China have argued for the state's intervention to prevent women from accessing pre-natal sex diagnosis and sex-selective abortion for non-medical purposes.[148] Officially, in 2005, Zhang, the director of the National Population and Family Planning Commission, announced that the state will legislate to criminalise non-medical sex-selective abortions and give a more harsh punishment to those people who perform or have abortions of female foetuses.[149] As a result, the connection of non-medical sex-selective abortions with the skewed gender rate becomes the state's new justification for exerting control over female citizens' reproductive decision-making.

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[145] Jingbao Nie (2010) 'Limits of State Intervention in sex-selective Abortion: the Case of China' 12(2) *Culture, Health and Sexuality* 205-219 p.210

[146] Anne Mary Warren (1985) 'Gendercide: the Implications of Sex Selection' (New Jersey: Rowman & Allanheld) and Zeren Qu (2005) 'Unbalanced Sex Ratio of Newborns: Ethical, Legal and Social Issues' 26(4) *Yixue Yu and Zhexue* 24-30

[147] Anne Mary Warren (1985) p.26

[148] Zeren Qu (2005) p.25

[149] China Daily News (07 January 2005) 'China to outlaw sex-selective abortions' available at http://www.chinadaily.com.cn/english/doc/2005-01/07/content_406943.htm (last accessed 11 August 2011)

Nonetheless, the question of whether prohibiting and criminalising non-medical abortions after 14 weeks could effectively solve the problem is rarely asked and never answered.

In practice, it is not difficult for women who are socioeconomically advantaged to circumvent the ban through the so-called back door by, for example, bribing doctors to inform them of the sex of foetuses. Additionally, the ban is not realistic because it is not easy to distinguish sex-selective abortions from 'normal' ones. Thus, the only women for whom there really is a ban are those who either cannot afford to circumvent the rules or who do not have the knowledge to do this. Women who are from disadvantaged backgrounds may find themselves even more pressurised if they are not able to give birth to sons. A survey conducted by Nie in 2005 indicates:

> In Hainan province, the male/female sex ratio of newborns was 135.64: 100 in 2005. Broken down further, the ratios were 170:100 for government employees, 221.7: 100 for professionals, and 250: 100 for the heads and senior officials of government babies, state-owned companies and other government organisations.[150]

The widespread practice of sex-selective abortion and the severe sex imbalance suggest that a sexist belief that female offspring are inferior to male is widely shared in China. Clearly, this incorrect belief is not produced by the practice of any reproductive technique, including pre-natal screening and abortion. As Savulescu has correctly observed, this inc orrect belief is not a productive of sex-selective abortion, but 'sex-selective abortion is the product of the belief.'[151] Nonetheless, the government's imposition of a partial ban on access to abortion services implies that women should be blamed for a sexist phenomenon that is caused by patriarchal social orders. Instead of imposing the ban, I argue that reducing gender inequality by promoting women's education, employment and welfare would be a more effective and far-reaching strategy to

[150] Jingbao Nie (2010) p.210
[151] Julian Savulescu (2006) 'Sex Selection: The Case For' in Helga Kuhse and Singer Peter (eds) *Bioethics: An Anthology* (second edition) (Oxford: Blackwell) p.120

redress the gender imbalance and to eradicate the consequences caused by this sexist belief. Usually, the problem of the skewed sex rate is less serious in Chinese regions where women's education and employment are better developed, such as Shanghai, where the sex ratio of newborns appears to be 'normal'.[152]

Furthermore, the government's two main reasons for criminalising non-medical sex-selective abortions are not well-founded. These are: firstly, many bachelors will not be able to find a wife in future and second, the trafficking of women will increase. Even if placing a partial ban on the provision of abortion services can effectively redress the gender imbalance, limiting women's procreative autonomy in order to ensure that potential bachelors find a wife is not a fair or reasonable solution. The emergence of a social phenomenon can affect individuals and society as a whole in both positive and negative ways. The phenomenon of the disturbed sex ratio is no exception, so the government's overemphasis on its dark side can be alarmist. It can, however, have advantages, such as 'an increase in influence of the rarer sex and reduced population growth'.[153] Blaming the gender imbalance on the practice of non-medical sex-selective abortions can become the government's excuse for ignoring real and more serious social problems behind this phenomenon, such as women's inferior social status and their lack of equal education and employment opportunities. Nevertheless, I suggest that even if the disadvantages of the gender imbalance overwhelm its advantages, redressing it should not be at the expense of women's reproductive autonomy. Additionally, there is no evidence that can confirm the argument that the disturbed sex ratio is the direct and main cause of the trafficking of women. This is a 'global phenomenon' and even occurs in countries where the sex ratio is relatively normal.[154] The causes of increased trafficking of women are complicated. Since it is not a topic which should be

[152] Jing Chu (2001) 'Prenatal Sex Determination and Sex-Selective Abortion in Rural Central China' 27(2) *Population and Development Review* 259-289 p.261
[153] Julian Savulescu (2006) p.121
[154] Andrea Marie Bertone (1999) 'Sexual Trafficking in Women: International Political Economy and the Politics of Sex' 18(1) *Gender Issue* 4-24 p.4

explored in this thesis, I shall not discuss any further the possible reasons for this phenomenon. However, eliminating the trafficking of women should not be used as the government's justification for restricting women's decision-making in abortion decisions.

From the ban on abortion in the Maoist era, its use as a means of reducing the population in the post-Maoist era and the recent trend towards partially criminalising abortion, it can be seen that under the Chinese state-centred regulatory model, women are not able to act on their autonomously held desires concerning reproduction. The above analysis of the new trend in the legislation on abortion suggests that the current government continues to govern the provision of abortion services within the framework of 'state knows best'. The discussion offered in chapter 3 indicates that law makers' refusal to remove medical limits shows their strong desire to maintain the existing gender relations. Similarly, successive Chinese governments' adoption of the framework of 'state knows best' to build the regulatory model of abortion indicates that they fear losing control over women's reproductive biology and also over the current gender relations. The Chinese legislation on abortion, such as the 1994 Code, states that the provision of family planning services, including abortion, shall be subject to citizens' informed consent. Nonetheless, under the current model, grounded in the principle of 'state knows best', successive governments only pay lip service to the rights of female citizens. In chapter 5, I will examine feasible law reform which can replace the principle of 'state knows best' with that of respect for autonomy, and scrutinise how women's needs for health and actual governance over their life choices can be promoted under an autonomy-centred model.

5.2. Autonomy-friendly Thinking in Chinese Confucian Culture

In chapter 2, I have offered a critical response to the argument that the principle of respect for autonomy cannot be transplanted into Chinese Confucian society. I have suggested that promoting autonomy is not to encourage people to separate themselves from networks of relationships or to make decisions which are completely free from any external influence; on the contrary, it requires positive support and cooperation. Moreover, I have argued that people who believe in family/community-orientated values should also be treated as capable of acting on their autonomously held desires. In this subsection, I explore autonomy-friendly thinking in Chinese Confucian culture in order to assess the possibility of contextualising the principle of promoting autonomy in the Chinese jurisdiction.

In chapter 2, I have claimed that the language of autonomy and human rights is less common in China than in England, and that Chinese women's rights consciousness has historically proved weaker in comparison with their English sisters. Nevertheless, this does not mean that Chinese people do not want their autonomy and human rights to be treated with respect or that Chinese Confucian culture does not have concepts or ideas which are similar to the values stemming from the principle of respect for autonomy. As Donnelly has correctly observed, the understanding of human rights in the West is not the only approach to protecting human dignity and personhood.[155] As has been analysed in section 2 of this chapter, to justify and maintain their feudal hierarchical system, the rulers in imperial China used and explained some Confucian ideas in a way in which they appear to be inconsistent with the principle of respect for autonomy. Nonetheless, Confucianism, as one of the oldest philosophies and religions, includes concepts which coincide with autonomy-friendly values, such as the terms of 'li' and 'ren'.

[155] Jack Donnelly (1982) 'Human Rights and Human Dignity: An Analytic Critique of Non-Western Conceptions of Rights' 76(2) *The American Political Science Review* 303-316 p.310

The term of 'li' (etiquette in English) means that a person should be self-governing and self-controlled in order to behave properly. If a person has 'li', this suggests that she is under an obligation to act appropriately in relation to other human beings.[156] The idea of 'ren' (kindness in English) means that a person is not just an atomistic individual but is connected to other members in her community/society, so she has an obligation to treat others as she would like to be treated; in other words, to have 'ren' she has to take others' humanity seriously.[157] The old Chinese Confucian saying, *Laowulao, yjirenzhilao; youwuyou, yijirenzhiyou*, provides an example of how to act according to the concepts of 'li' and 'ren'. Literally, this saying means that we should respect the elderly in others' families as we respect our own family's elderly members, and love the young in others' families as we love our own. Therefore, to a lesser extent, human beings should ensure that their behaviour is not harmful to the interests of others and, to a greater extent, that people should care for others and provide assistance to them. Furthermore, 'ren' is not just a code of behaviour for individuals, but also a code of medical practice and a benchmark of good government. For example, *renxin renshu* (literally, kind heart kind practice) means that health professionals should not just have high-quality skills, but also, and more importantly, ought to be motivated by a 'kind heart': to be sympathetic and considerate towards their patients. Additionally, *renzheng* (literally, kind government) is a Confucian requirement for good government, which suggests that a government's law/policy-making should be permissive and aimed at meeting people's needs.[158]

Thus, from the above analysis it can be seen that the requirements of 'li' and 'ren' are similar to the negative and positive moral obligations derived from the principle of respecting autonomy. As has been discussed in chapter 2, in terms of the negative obligation, promoting autonomy

[156] Werner Menski (2006) p.505
[157] Randall Peerenboom (1993) p.58
[158] Xianfeng Zhu (2006) *Kongmen 'Ren' Sixiang Jiqi Jiazhi* (literally, the 'Ren' thinking from Kong/Meng and its values in modern society) (Thesis submitted to the University of Anhui for the Degree of Doctor of Philosophy)

indicates that a person should respect others' moral agency and not exercise controlling influence over others' methods of leading their lives. The positive obligation in the context of abortion suggests that medical professionals and states need to offer adequate help and support to women in order to facilitate their decision-making. A person's internal capacity to critically form high-level desires does not mean that she has enough actual power to act on her freely held desires. Whether she can exercise her control over meaningful reproductive choices is significantly dependent on the extent to which medical cooperation and state support are accessible. Therefore, the commitment to autonomy not only involves admitting people's independence by not imposing controlling interference, but also requires promotion of their interdependence by establishing an environment where people can be empowered to exert autonomy over life choices. Similarly, in accordance with the ideas of 'li' and 'ren' in Confucianism in the context of abortion, first, medical professionals and the state are required not to exert controlling influence over women's procreative decision-making, because the exercise of power over women's agency is not the way in which they want to be treated. Secondly, to have 'ren', medical physicians and the state need to provide abortion seekers with adequate support in order to meet their needs for health and for control over their lives.

Compared to rights-based language and some 'strong' concepts, such as 'power', 'right', 'choice' and 'control', I suggest that the term 'respect for autonomy' could be more acceptable and productive in Chinese Confucian society. As has been argued in chapter 2, Chinese women do not experience much power, choice, control or even rights in their lives. As has been discussed earlier in this chapter, the language of 'right' is also not likely to be productive in the Chinese political context, where citizens' reproductive rights are often not stable or certain and are very dependent on the state's policy-making in relation to population figures. Furthermore, the language of 'choice' fails to fit the Chinese reality that many women are still powerless to

defend themselves from the control imposed by the state and even by their husbands or in-laws. Currently the maternal morbidity and mortality caused by unsafe termination means in still high; women may still be forced by the government to end their pregnancies and sex education and contraceptive information are comparatively lacking. Thus, the 'choice' approach can fail to stress the harmful effects of restricting abortion services on women's basic needs for health and bodily integrity. This disadvantage is particularly obvious in a context like China where women's awareness of reproductive rights is not very developed. In chapter 5, I will further examine why the language of 'autonomy' can fit the reality of Chinese women's lives better than that of 'power' and 'control', by discussing educated Chinese women's resistance to a power-based translation of the term 'feminism' and their hope for a harmonious relationship with their male peers

Conclusion

Chapter 3 ended with the observation that a woman who decides to discontinue her unwanted or unplanned gestation should be regarded as rational and responsible, given two facts: first, undertaking parenting duties should be voluntary and second, there are growing social worries about 'unfit' or 'problem' parents. The discussion of abortions 'by order' offered in this chapter suggests that since the decision to carry pregnancies to term not only involves ten months of changes in women's physical and mental status, but also requires long-term parental responsibility, a woman who makes this decision should be treated as responsible, rational and also 'glorious'. As has been analysed in chapter 2, being autonomous in abortion decisions includes being able to access safe and legal termination services and also being able to refuse coerced abortions. Human reproduction should be planned and voluntary, otherwise it can impose great psychological and physical burdens on both men and women, especially on

women.[159] However, even today when the principle 'respect for autonomy' becomes the central principle in the health care field,[160] women's autonomy in abortion decisions is not accorded adequate respect by English and Chinese law makers.

In chapter 3, I have argued that the current regulatory model of abortion in England works within the paternalist framework of 'doctor knows best' in order to maintain a closer control over women's procreative biology. Under this model, abortion is constructed as a medical-centred decision which is left in the hands of doctors. As has been discussed in this chapter, the Chinese regulatory model is built on state-centred coercive and semi-coercive interference and is reliant on the state's policy-making in relation to population. To give some background information on the state-centred model, the first section of this chapter offered an introduction to the Chinese legal and health care systems. The second and third sections examined the traditional and the contemporary regulation of abortion in China. From the era of Confucianisation to that of politicisation, women have not been allowed to exert autonomy over their reproductive decision-making. The party state has replaced the male head of individual households and become women's procreative decision maker. From the discussion of the state's intervention to construct abortion and women who need abortion, it can be seen that while the Chinese abortion 'law in the books' appears to be less restrictive than English abortion law, in practice it is less respectful of women's autonomy. Under the state-centred regulatory model, abortion is used by successive governments as a tool to facilitate the implementation of their population policies.

The Chinese regulatory model provides a lens through which the reader can see the role of state intervention in effecting change in female citizens' reproductive activities and lives in a negative

[159] John Robertson (2003) 'Procreative Liberty in the Era of Genomics' 29(2003) *American Journal of Law & Medicine* 229-487

[160] Mary Donnelly (2010) *Healthcare Decision-making and the Law* (Cambridge: Cambridge University Press) p.269

way. The discussion offered in chapter 2 indicated that promoting autonomy not only needs the exclusion of controlling and coercive influence over individual decision-making, but also, and more importantly, requires positive involvement, such as government financial support and medical cooperation. Nevertheless, under the state-centred regulatory model, state intervention is targeted at enhancing successive governments' exercise of power over female citizens' reproduction. As a result, the provision of abortion services becomes 'a strategic and most intrusive state agenda'[161] in China.

While the statutes relating to abortion under the Chinese model appear to be very different from those under the English one, their purpose is similar, namely limiting women's reproductive autonomy. Both English law's construction of women who need abortion as irrational women and Chinese governments' advocating 'glorious mothers' are built on the gendered assumption of normal womanhood as maternal. A comparative study of English and Chinese abortion law can help the reader to understand that law's lack of respect for women's reproductive autonomy is not a problem which only exists in a certain jurisdiction. Moreover, even today when feminists have fought against 'biological determinism' for almost one hundred years,[162] eliminating the negative effects of the gendered assumption of womanhood that is embedded in regulatory frameworks worldwide is still a work in progress.

As has been discussed in the introduction to this thesis, legal comparisons can deepen and broaden home feminists' insights into law's oppression against women. Moreover, it is helpful in presenting challenges to existing law and formulating alternative regulatory approaches. As Pine and Law have observed, research across nations can offer more strategic proposals to empower

[161] Jingbao Nie (2010) p.210
[162] Angela Bratton (1998) *Feminist Anthropology* available at http://www.indiana.edu/~wanthro/fem.htm (last accessed 11 August 2011)

women in the context of procreation.[163] Thus, feasible strategies to promote decision-making on abortion can stem from comparing and contrasting the English and the Chinese experiences of governing the provision of abortion services. In chapter 5, I will assess the pros and cons of these two models and draw up proposals for law reform in accordance with the analysis of the principle of respect for autonomy offered in chapter 2.

[163] Rachael Pine and Sylvia Law (1992) 'Envisioning a future for reproductive Liberty: Strategies for making the Rights real' 27(2) *Harvard Civil Rights-Civil Liberties Law Review* 407-463 p.453

Chapter 5

Towards an Autonomy-based Model: Comparative Lessons

Introduction

In this chapter, I attempt to achieve two objectives: first, to examine what lessons English and Chinese law makers can learn from contrasting their respective domestic models of the regulation of abortion, and second, to suggest feasible proposals for law reform in order to bring the provision of abortions into line with the principle of respect for autonomy. Thus, this chapter can be regarded as representing a contribution to a process of 'lesson drawing'.[1] This process is defined by Syrett as 'a mode of cross-national and/or intertemporal research and evaluation' that aims to use knowledge from 'other times and places to improve current programmes'.[2] To achieve these two goals, in sections 1 and 2 I will discuss the value of the comparative study of the English and Chinese regulatory models and assess their differences and similarities respectively. This will help the reader to understand my motive for comparing these two models and their strengths and weaknesses with regard to how women's autonomy in abortion decisions is treated. By contrasting the English and Chinese regulatory models, I argue that while the Chinese law of abortion superficially looks more respectful of women's decision-making, in practice it is less so than the English regulation of abortion. Thus, as has been discussed in the introduction to this thesis, compared to only analysing a single jurisdiction, the comparative study of two different jurisdictions is more helpful in developing a deep and profound insight into their problems. As Nie has observed, when people live under problematic conditions long

[1] Keith Syrett (2011) 'Introduction: On the Value of Lesson-Drawing in Comparative Health Law and Policy' 11(1) *Medical Law International* 45-51 p.46

[2] Ibid. Also Keith Syrett (2007) *Law, Legitimacy and the Rationing of Health Care* (Cambridge: Cambridge University Press) p.14

enough, they may get used to them and even try to justify them, no matter how wrong they are.[3] He notes:

> If a person stays for a long time in a market full of rotten fish, he will not notice how bad smelling it is; likewise, he will not notice how nice smelling it is, if one stays for long in a room full of fragrant flowers.[4]

Moreover, against the background of adding the subject of reproductive health to the area of international human rights law,[5] there is a growing need for researching the regulation of women's procreative issues in different nations. The comparative study provided in this chapter is committed to contribute to this.

Based on the discussion of the value of the comparative study and the merits and shortcomings of the English and Chinese regulatory models in promoting women's reproductive autonomy, in sections 3 and 4 I will suggest proposals for reforms of the English and Chinese laws of abortion. These proposals have three main purposes: first, to challenge how women who need abortion are constructed under the two models; second, to redress the power imbalance in the two key relationships: one between women who need abortion and health professionals and the other between female citizens and the party state; and third, to facilitate women's exercise of control of reproductive choices. I will also discuss the problems that the proposed reforms will face and examine how to solve them. In section 5, I will address the question of why some special types of abortions, such as late abortions, sex-selective abortions with no medical needs, post-IVF abortions and abortions of disabled foetuses, should be regulated according to the principle of respect for autonomy. I argue that imposing any legal limit on access to abortion services will

[3] Jing Bao Nie (2004) 'Feminist Bioethics and the Language of Human Rights in the Chinese Context' in Rosemarie Tong Anne Donchin and Susan Dodds (eds) *Linking Visions* (Oxford: Rowman & Littlefifield) p.74
[4] Ibid.
[5] Maja Kirilova Eriksson (2001) 'Abortion and Reproductive Health: Making International Law more Responsive to Women's Needs' in Kelly Askin and Dorean Koening (eds) *Women and International Human Rights Law* (New York: Transnational) pp.3-71

cause deeper inequality for and more oppression of women, especially those who are comparatively socioeconomically disadvantaged. However, the proposals suggested in this chapter to reform the existing laws in England and China have limitations that will be discussed in section 6.

1. Why Compare?

In the introduction to this thesis, I explained how it is possible to compare the laws of abortion in England and China where two different legal systems are applied. Instead of contrasting specific rules and cases, I treat them as two models of the regulation of abortion. However, this does not mean that these two models are completely different from each other. From the analysis provided in chapters 3 and 4, it can be seen that the English and Chinese regulatory models are similar in the way in which women's decision-making is treated. Moreover, in England, the state population policy played an important role in shaping the regulation of abortion; and in China, while medical professionals act as the state's agent, there are also medical limits over abortion services. However, as discussed in chapters 3 and 4, obviously these two models have distinct as well as shared characteristics. For example, although abortion is legally defined in both England and China, these ways of defining it are different. Thus, while in both England and China abortion services are provided by the medical professions, Chinese medical professionals are granted comparatively little discretion in abortion decisions. In both the English and Chinese regulatory systems the state to some degree effects changes in the legislation on abortion, however the role that the state plays in regulating abortion and the extent to which the state can exercise their power are different. As argued in chapter 1, a comparative study can help the reader see and better understand these similarities and differences between the medical-centred and state-centred models. In section 2 of this chapter, I will further discuss similarities and

differences in how abortion is regulated in England and China. In this section, I will discuss the value of contrasting these two models in order to examine why comparative law is used as an analytical approach in this thesis and how it is helpful in exploring the law's lack of respect for women's autonomy.

First, comparative analytical methods can help legal scholars to produce a more critical response to their national laws. As many comparative lawyers, such as Linders,[6] Cruz[7] and Livingstone[8] have suggested, national legal studies alone may risk relying on two fallacies: first, assuming one's own legal system or particular rules governing an issue are unique, and second, making the assumption that one's own jurisdiction is like others when it is not or that one's own jurisdiction is not like others when it is. Thus, a knowledge of other jurisdictions offers a broader and more profound insight into one's own system.[9] By contrasting and comparing the English and Chinese models of the regulation of abortion, I am able to explore their shortcomings and merits from a standpoint which is different from national scholars'. As Syrett has argued, looking beyond his or her own jurisdiction allows a medical lawyer to develop fresh insights, identify potential future problems and evaluate possible solutions.[10] For example, as will be discussed in section 2 of this chapter, although the medical-centred model of abortion law fails to respect women's decision-making, in practice it promotes access to safe and funded abortions compared to the Chinese model. Under the medical-centred model, the key relationship between health professionals and women who need abortion excludes more coercive influences imposed by other parties, such as the state. Moreover, the comparative study suggests that understanding the characteristics of Chinese policy-making on population is essential for an in-depth analysis of the

[6] Annulla Linders (1998) 'Abortion as a Social Problem: The Construction of "Opposite" Solutions in Sweden and the United States' 45(4) *Social Problems* 488-509 p.501
[7] Peter Cruz (2001) *Comparative Healthcare Law* (London: Cavendish Publishing Limited) p.5
[8] Sonia Livingstone (2003) 'Balancing Opportunities and Risks in Teenagers' Use of the Internet: the Role of Online Skills and Internet Self-efficacy' 18(4) *European journal of communication* 477-500 p.478
[9] Peter Cruz (2001) p.16
[10] Keith Syrett (2011) p.4

Chinese state-centred model of the regulation of abortion. The differences between Chinese and English policy-making on population figures suggest that while the Chinese 'law in the books' appears to be more liberal by comparison with the English law, in practice it is less respectful of women's autonomy. Nevertheless, the comparative study also highlights the upside of the Chinese model of the regulation of abortion. As will be analysed in section 3 of this chapter, the Chinese model, defining abortion as a back-up family planning method, is more respectful of women's autonomy than the English model, which constructs it as a medical decision. The comparative study offered in this chapter is a supplement to the feminist legal analysis of the English and Chinese laws of abortion. This is because the comparative study facilitates the examination of the English and Chinese abortion laws' lack of respect for women's autonomy and the assessment of their weak and strong points in terms of promoting women's decision-making.

Second, by comparing women's experience under the two regulatory models, women's lack of power to act on their freely held desires in abortion decisions can be more clearly observed and the underlying cause of their powerlessness can be analysed in depth. As Linders and Lee have respectively claimed, analysing more than one case has the potential to offer useful insights into reasons for the phenomenon studied and into its possible limits and various effects on women.[11] As has been discussed in chapter 3, under the medical-centred model, health professionals' discretion to change women's decision-making can make access to abortion unnecessarily difficult and stressful. The discussion offered in chapter 4 also suggests that under the state-centred model, women's basic needs for health and for control over their daily lives are violated by the state's intervention, which uses abortion as a coercive means of reducing the population. While England and China adopt very different methods of governing abortion services, they both

[11] Annulla Linders (1998) p.491 and Ellie Lee (2003) *Abortion, Motherhood and Mental Health* (New York: Aldine de Gruyter) p.16

fail to work within the framework of promoting autonomy. English law's and Chinese law's entrenchment of medical and state control over women's agency reminds national feminists to be aware that law's embrace of the compulsory cultural assumption of womanhood as maternal[12] is not just a phenomenon in a particular jurisdiction, but exists globally.

Given that law's lack of respect for women's procreative autonomy exists in many legal contexts, I suggest that in order to eliminate this sexist phenomenon at the global level, the experience of feminists from different nations in engaging with law and fighting for procreative rights should be shared. As Pine and Law have clearly observed, women should continue to help their sisters fight for reproductive rights by providing inspiration and determination, 'even when they had won these rights for themselves', because a real success in gender equality should be beyond a local level and gained globally.[13] Moreover, comparing the English and Chinese models of the regulation of abortion allows English and Chinese legal scholars to view a regulatory method which is distinct from their national one. By learning of each other's experiences in regulating abortion services, they can formulate alternative visions of how abortion should be constructed and provided.

Furthermore, from contrasting women's experiences under the English and Chinese abortion regulatory models, it can be seen that drawing up proposals for law reform should take account of the extent to which women's awareness of reproductive rights is raised and feminism is accepted in these two contexts. With these contextual differences in mind, law reform does not pursue the promotion of English and Chinese women's decision-making in abortion decisions to the same level. As has been discussed in chapter 4, Chinese women's rights consciousness has historically proven to be weaker than their English sisters'; they do not experience strong

[12] For an analysis of the compulsory cultural assumption of womanhood as maternal, see section 3.2 of chapter 2
[13] Rachael Pine and Sylvia Law (1992) 'Envisioning a Future for Reproductive Liberty: Strategies for Making the Rights real' 27(2) *Harvard Civil Rights-Civil Liberties Law Review* 407-463 p.463

feelings on the issues of 'control', 'power' and 'choice' in their daily lives.[14] For example, when the concept of 'feminist' was first introduced into China, it was translated as *nüquan zhuyizhe* (literally, people who believe in the ideology of women's power-ism). As Ko and Zheng have clearly observed, this powerful version of translation has not been accepted by Chinese women, including those who are highly educated. The powerful version of translation is similar to the stereotype of 'a man-hating he-woman hungry for power',[15] so this makes the term 'feminism' sound like the idea of 'advocating too aggressively for the improvement of Chinese women's conditions'.[16] This strong vision detaches feminism from Chinese women's daily language and life experience. Thus, it even aroused women's resistance because they refused to claim to be feminists.[17] The term 'feminism' maintained its linguistic ambivalence and conceptual controversy in China until a softer version of translation of the term 'feminist': *nüxing zhuyizhe* (literally, the ideology of feminine-ism and also meaning to refer to people who value feminine characteristics) was created; this version has been accepted by many white-collar and educated women in China.[18] Given that feminism is less accepted and people's consciousness for gender equality in the context of procreation is comparatively weaker in China,[19] I argue that raising women's awareness of reproductive rights in China is a more difficult and longer process than that in England. Moreover, from the analysis of the characteristics of human rights thinking in China in chapter 4, it can be seen that citizen rights in the Chinese legal context are different from human rights in the English context.[20] Citizen rights can be changed by successive

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[14] For a discussion of Chinese women's awareness of human rights and reproductive liberty, see section 3.1 of chapter 4

[15] Dorotby Ko and Wang Zheng (2007) *Translating Feminisms in China* (Australia: Blackwell Publishing)

[16] Jingbao Nie (2004) p.73

[17] Susan Brownell and Jeffrey Wasserstrom (2002) 'Theorizing Femininities and Masculinities' in Susan Brownell and Jeffrey Wasserstrom (ed) *Chinese Femininities/ Chinese Masculinities* (London: University of California Press) pp.28-31

[18] Ko and Zheng (2007) p.1

[19] Jingbao Nie (2004) pp.75-78

[20] For an analysis of human rights thinking in China, see section 4 of chapter 4 and also Randle Edwards, Louis Henkin and Andrew Nathan (1986) (eds) *Human Rights in Contemporary China* (New York: Columbia University Press) pp.126-128

governments amending the Constitution and they are significantly reliant on the fulfilment of citizens' relevant constitutional duties.

Considering these contextual differences between England and China, reconstructing the medical-centred and state-centred regulatory models according to the principle of respect for autonomy requires different strategies. Because of the characteristics of the rights thinking in China, rights-based strategies to argue or fight for accessible abortion services will be not productive. As has been discussed in chapter 4, the right to funded abortion services cannot be guaranteed by the Chinese jurisdiction, particularly when women fail to fulfil their duty to obey the state's population policies.[21] The analysis of the importance of autonomy in the context of abortion offered in chapter 2 suggests that it is essential to satisfy women's basic needs for health and for control over lives.[22] Therefore, I argue that using need-based language or strategies to argue for law's respect for autonomy will be more productive in China because they are closer to women's life experience. In England, both feminism and gender equality in the context of reproduction are more accepted. Furthermore, while the Abortion Act 1967 appears to be more restrictive, in practice both abortions and financial support in England are more accessible than in China. As a result, the number of back-street terminations of pregnancy is smaller in England.[23] This indicates that English women are more able to act on their autonomously held procreative desires by comparison with their Chinese sisters. Thus, in England stronger and radical language and strategies can help feminists argue for having women's autonomy respected, such as defining women's autonomy in abortion decisions as their right to control their lives. According to the analysis in section 2.3 of chapter 3, having this right

[21] For a discussion of the reasons why law fails to secure access to family planning services, see section 4.1 of chapter 4

[22] For a discussion of the importance of autonomy in abortion decisions to women's health and control of everyday lives, see section 2.3.1 of chapter 4

[23] For a discussion of legal and illegal abortions in England and China, see section 3.2.1 of chapter 3 and section 3.4 of chapter 4 respectively

means that women should be trusted and allowed to pass their own moral judgments on whether their pregnancies should be discontinued.

In addition, the comparative study of English and Chinese laws of abortion in this thesis contributes to the feminist literature on abortion and the principle of respect for autonomy. From the analysis provided in chapter 4, it can be seen that feminism, both as a political movement and an academic subject, is not adequately developed in China.[24] The comparative study not only highlights the problem that feminist studies of reproductive rights are comparatively lacking in China, but also, and more importantly, serves to improve on the studies made previously. Furthermore, it also contributes to the English feminist literature on the principle of respect for autonomy. While feminism has a longer history in England, the relationship between feminism and autonomy is still not very clear, particularly in the context of abortion.[25] The values stemming from the concept of autonomy have not been accepted by and have even attracted strong criticism from some feminists. They argue that using the language of autonomy and autonomy-related strategies in campaigns for women's reproductive rights is actually to embrace exclusively male-dominated values, such as independence, self-interest and isolation, which deny and exclude women's experiences.[26] Nevertheless, the comparative study of the English and Chinese abortion regulatory models suggests that the principle of respect for autonomy does not need to be understood in the way that privileges male-dominated values. The discussion of Chinese and English laws' lack of respect for autonomy offered in chapters 3 and 4 shows that this principle can be strategically used as a theoretical ground for procreative self-determination

[24] For a discussion of feminism in China, see section 4 of chapter 4, also Jing Bao Nie (2004) and Dorotby Ko and Wang Zheng (2007)

[25] For a discussion of the relationship between feminism and the term of autonomy, see section 3.2 of chapter 2 and John Christman (1995) 'Feminist and Autonomy' in Dana Bushnell (ed) *'Naggin' Questions* (London: Rowman & Littlefield)

[26] Anne Donchin (2001) 'Understanding Autonomy Relationally: Toward a Reconfiguration of Bioethics Principles' 26(4) *Journal of Medical and Philosophy* 365-386 p.371 and Robin West (1992) 'The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory' in Mary Joe Frug (ed.) *Women and the Law* (Westbury: The Foundation Press) p.823

in abortion decisions. In sections 3 and 4 of this chapter, I will raise the possibility of applying the principle of respect for autonomy to reforms of the English and Chinese laws of abortion and then assess this application.

Last but not least, by comparing the English and Chinese means of governing abortion services, alternatives can be formulated to challenge the current thinking about termination of pregnancy. Law is often an inconsistent and gendered institution; the solutions produced by it seem, superficially, gender-neutral, but in practice may be not respectful of women's interests.[27] Messages which are conveyed by law are often considered by the public as 'authorised truth and discourse' even when they are discriminatory and sexist.[28] From the analysis of how abortion is constructed under the medical-centred and state-centred models, it can be seen that English and Chinese law makers attempted to persuade people to accept the fact that abortion, as a medical decision or a means of facilitating the national policy of population, should be left in the hands of health professionals or the state respectively. Contrasting these two methods of regulating abortion can help English and Chinese reformers to highlight the problems with their national law's construction of abortion. It also provides them with a chance to rethink what role health professionals and the state should undertake in providing abortion services. For example, challenging English law defining abortion as a medical decision by introducing the Chinese state-centred model of regulating abortion will encourage legal scholars and reformers to explore the positive influences of state involvement on women's abortion decision-making. In the meantime, challenging Chinese law constructing abortion as a method of implementing the state's population policy by introducing the medical-centred model will boost the thinking about how the medical profession can enhance women's control of reproductive choices in China. In

[27] For a discussion of the nature of law, see section 2.4 of chapter 2 and Nicola Lacey (1998) *Unspeakable Subjects: Feminist Essays in Legal and Social Theory* (Oxford: Hart Publishing) p.34
[28] Carol Smart (1989) *Feminism and the Power of Law* (London: Routledge) p.160

sections 3 and 4 of this chapter, I will scrutinise what lessons English and Chinese legal scholars and reformers can learn from each other's experiences of having a different regulatory model.

2. Some Further Observations: Differences and Similarities

In this section, I will make some further observations on some differences and similarities between the English and Chinese regulatory models of abortion. To do so, first, I will briefly revisit the main problems with the medical-centred and state-centred models that were analysed in chapters 3 and 4 respectively. Second, since the discussion provided in chapters 3 and 4 shows how abortion is differently regulated under the two models, discussing their differences in this section will focus on addressing the question of why Chinese women's reproductive autonomy is not respected in practice compared to their English sisters', although the Chinese 'law in the books' appears to be less restrictive. Third, by contrasting the images of 'irrational women' and 'glorious mothers' that are constructed under the English and Chinese models respectively, I will scrutinise how these two models are similar in the way in which they treat women's decision-making and I will also explore the underlying cause of this similarity. Through analysing how differently and similarly women's autonomy is treated under these two models, two objectives will be achieved: first, to assess their strengths and weaknesses in promoting women's reproductive decision-making, and second, to examine how these two models should change according to the principle of respect for autonomy.

2.1. The Medical-centred Model and the State-centred Model

As has been discussed in chapter 3, since the beginning of the nineteenth century, the regulation of abortion has worked within the framework of 'doctor knows best' in England. Thus, for

example, 'quickening' was no longer used to distinguish between criminal and non-criminal abortions, creating statutory grounds for abortion and adopting a cut-off point for legal abortions on social grounds. Through the lens of gender, these changes show that the medical and legal professions were motivated by their desire to maintain the existing gender relations by placing a closer control over women's fertility. Moreover, the discussion of abortion in practice provided in section 3.2 of chapter 3 indicates that the medical-centred model results in social class discrimination against women from socioeconomically disadvantaged backgrounds. Before 1967, when abortion was legalised in England, thousands of working class women died from unreliable back-street abortions, whilst termination services offered by medical professionals were still open to middle and upper class women. Even since the decriminalisation of abortion in 1967, women whose doctors are not supportive and who cannot afford a private service have to bear more strains and stresses.[29] The analysis of the state-centred model offered in chapter 4 shows that since 1949, when the communist state was founded, the state has replaced the individual male head of households and become women's reproductive decision maker. Because successive governments have used family planning services as a tool to facilitate the implementation of their population policies, some women were forced to continue unwanted gestation, to resort to back-street abortionists or to end their wanted pregnancies. Thus, under the state-centred model, the provision of abortion services became a strategic and intrusive state agenda to achieve national population goals.

The discussion of the large number of abortions performed by unauthorised providers in China in section 3.4 of chapter 4 indicates that the argument that the Chinese regulation of abortion is 'one of the least restrictive laws in the world'[30] should be treated more critically. Focusing solely on the 'law in the books' without considering the reality in practice leads to ill-considered

[29] For a discussion of service-related delays, see section 3.2.2 of chapter 3

[30] Susan Rigdon (1996) 'Abortion Law and Practice in China: An Overview with Comparisons to the United States' 42(4) *Social Science & Medicine* 543-560 p.546

conclusions like this. Moreover, this also overlooks women's need to be empowered to act on their autonomously held desires in the regions where abortion is legalised, but in practice law is not respectful of their autonomy. In order to further compare how women's decision-making is treated under the English medical-centred and Chinese state-centred regulatory models of abortion, the rest of this subsection will discuss the reasons why, despite the fact that the Chinese model places less restrictions on the statutory grounds on which and the time when abortion can be lawfully performed, in practice it is less respectful of women's autonomy.

First, in the Chinese family planning context the state-centred method of regulating abortion services is significantly reliant on the state's policy-making on population figures.[31] Women have to subject their decision-making to the state's population policies. Currently, the government's imposition of comparatively few limits on abortion aims to facilitate its use of abortion as a method of avoiding 'unauthorised' births. For Chinese women, termination of pregnancy can be a compulsory duty if they cannot afford fines for having 'out-of-quota' births.[32] Because of this duty, under the state-centred regulatory model women are more pressurised in comparison with their English sisters. Nonetheless, I should emphasise that I do not intend to make a sweeping generalisation. Obviously, the stresses imposed by law on different Chinese women are not identical and not all women are more pressurised than English women. This is quite similar to the influences of implementing the birth control policy on women from different socioeconomic backgrounds. Women from comparatively advantaged backgrounds often bear a lighter burden than those who are more socioeconomically disadvantaged. For example, if they want more children, they can do so by paying fines. Nonetheless, women who fail to get permission for their pregnancies from local family planning

[31] For an analysis of the Chinese family planning context, see section 3.2 of chapter 4
[32] For a discussion of 'out-of-quota' births see section 3.3 of chapter 4 and also Edwin Winckler (2002) 'Chinese Reproductive Policy at Turn of the Millennium: Dynamic Stability' 28(3) *Population and Development Review* 379-418

centres and who cannot afford the fines will be persuaded or even forced to have an abortion. Thus, compared to English women, apart from childbearing and childrearing, Chinese women have to undertake another duty, that is, to ensure that their fertility meets the state's needs for fewer and healthy citizens.

While the state-centred model of the regulation of abortion allows women who want to end their pregnancies to do so, it may also force those women who desire to continue wanted pregnancies to abort. The analysis offered in section 4 of chapter 4 shows that in China one's citizenship and citizen rights are heavily dependent on whether one can fulfil the duties of a citizen imposed by successive communist governments. Moreover, while both male and female citizens are required, according to the Constitution, to take responsibility for birth control, in practice it is mainly undertaken by women.[33] Since a 'woman-friendly polity'[34] is lacking and feminism is less accepted in China, both the state's legislation on abortion and its population policies are derived from 'a set of values, experiences, modes of discourse, rituals, and practices' that privilege men and the 'masculine' and exclude women and the 'female'.[35] To be recognised as 'glorious' citizens and as eligible for citizen rights, in the Chinese family planning context women have to undertake more duties and bear more strains than their male peers. They are not only required to undertake traditional maternal duties of childbearing and childrearing, but are also obliged to avoid extra births.

Second, compared to their English sisters, Chinese women who need abortion, particularly unmarried ones, have less financial support from the government. The analysis in section 3.2.2 of chapter 3 shows that under the English medical-centred regulatory model, some women have

[33] See section 3.2 of chapter 4
[34] For the definition of woman-friendly polity, see Kathleen Jones (1990) 'Citizenship in A Woman-Friendly Polity' 15(4) *Signs* 781-812
[35] Ibid p.811

to pay for private abortions because of service-related delays or their doctors' unsympathetic attitudes towards unwanted fertility. Nevertheless, in practice there has been a steady increase in the NHS-funded abortion rate since the beginning of the twenty-first century. Although there was a decrease in the total number of abortions in some years, such as a fall of 3.2 per cent between 2008 and 2009 and 1.6 per cent from 2007 to 2008, the funded abortions account for an increasing proportion. In 2009, 94 per cent of 189,100 abortions were NHS funded.[36] These statistics suggest that funded services under the English regulatory model are more accessible than those under the Chinese model. In China the provision of public funding for abortion services is also reliant on the government's birth control programme, which currently is mainly targeted at married women.[37] As a result, unmarried women who cannot afford legal abortion services are left no choice but to resort to back-street abortions. While abortion services are legalised and available on demand in China, the inadequate financial support from the state leads to the fact that a large number of women have abortions performed unlawfully every year.[38] Article 3 of the Code on Population and Family Planning 2002 (the 2002 Code) says:

> The provision of family planning services shall aim to promote women's health and social status.

According to article 336 of the Criminal Law 1979 (amended in 1997), unlawfully performing birth control surgery (including abortion) constitutes a criminal offence against public health.[39] Since unsafe family planning services are considered by law makers as a threat to the state's public health, the availability of safe abortions should be essential to promoting women's health. Moreover, in accordance with Article 21 of the Constitution, the state is under the obligation to

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[36] 78% of 175,900 abortions were funded by the NHS in 2002; 80% of 181,600 in 2003; 82% of 185,400 in 2004; 84% of 186,400 in 2005; 87% of 193,700 in 2006; 89% of 198,500 in 2007 and 91% of 195,296 in 2008, see England and Wales Abortion Statistics 2009, Department of Health

[37] See section 3.5 of chapter 4

[38] For a discussion of illegal abortions in China, see section 3.4 of chapter 4

[39] Article 336 of the Criminal Law: Whoever unlawfully supply unauthorised birth control surgery, including abortion and taking IUDs out without permission, shall be imprisoned for up to three years.

protect citizens' health.[40] Since citizens' marital status does not make their right to health less important, the government should enhance funded abortion services and make them equally available to married and unmarried women.

Third, from the discussion offered in chapters 3 and 4, it can be seen that under the Chinese regulatory model of abortion, women who need abortion can find it more difficult to request support from the medical profession.[41] As has been argued in chapter 2, law's respect for autonomy not only requires protecting women's decision-making by eliminating coercive medical influences, but also, and more importantly, involves enhancing supportive involvement from health professionals.[42] While I was critical in chapter 3 of how English abortion law entrenches medical power, thereby restricting women's decision-making, I suggest that supportive medical participation, such as providing accurate treatment information, can enhance women's exercise of autonomy over reproductive decisions. Therefore, to bring the provision of abortions into line with the principle of respect for autonomy is to avoid health professionals' paternalistic intervention and to maintain a cooperative relationship with women who need abortion. While not all women will need health professionals' support for having an abortion,[43] women who need abortion should be given the right to require health professionals to offer accurate information and competent advice. As Brazier and Cave have argued, doctors prescribing contraception have to be 'properly informed about the current stage of research and knowledge about different types and brands and their risks' to women.[44] Similarly, in the context of abortion, health professionals first owe women an obligation not to impose their personal beliefs on women's decision-making, and second owe them a duty to supply support on request.

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[40] Article 21 of the Constitution: The state shall develop health care services, modern and alternative medicine...protect citizens' health

[41] For a discussion of medical control over access to abortion in China, see section 3.4 of chapter 4

[42] See section 4.2 of chapter 2

[43] For a discussion of home abortions, see section 2.3 of chapter 3 and BBC Online News (15 February 2006) 'Study Find Home Abortion Safe' available at http://news.bbc.co.uk/1/hi/health/4717786.stm (last accessed 8 April 2011)

[44] Margaret Brazier and Emma Cave (2011) *Medicine, Patients and the Law* (London: Penguin Books) p.309

Although the medical-centred regulatory model does not endorse women's ultimate authority to decide whether they are eligible for abortion, the statistics on abortions mentioned above show that both the safety and availability of termination services are promoted under this model. As Sheldon has observed, by treating abortion as a decision between women and their doctors, the English law of abortion to some extent improves legal abortion services.[45] Compared to the Chinese state-centred method, the upside of law constructing abortion as a medical decision is that it prevents any third party, such as the state, from exerting a more coercive influence on women's decision-making.

Furthermore, the analysis of the reasons for having an abortion, provided in section 2.3 of chapter 3, indicates that nowadays in England the justification for terminating pregnancies does not necessarily need to be strictly therapeutic, since childbirth was proven to be clinically more dangerous than termination of pregnancy. While I discussed some cases about unsympathetic doctors in chapter 3,[46] there are also some doctors who are keen on maintaining a cooperative relationship with their abortion-seeking patients. For example, according to *Scientific Developments Relating to the Abortion Act 1967* issued by the Science and Technology Committee in 2007, in practice many doctors agreed that it would be best for the right to make the decision about whether to continue a pregnancy to be taken away from them and left to women. This report says,

> We were not presented with any good evidence that, at least in the first trimester, the requirement for two doctors' signatures serves to safeguard women or doctors in any meaningful way, or serves any other useful purpose. We are concerned that the requirement for two signatures may be causing delays in access to abortion services. If a goal of public policy is to encourage early as opposed to later abortion, we believe

[45] Sally Sheldon (2006) 'Subject Only to the Attitude of the Surgeon Concerned: the Judicial Protection of Medical discretion' *Social and Legal Studies* 5(1) 95-112 and p.96
[46] For a discussion of unsympathetic GPs, see section 3.2.2 of chapter 3

there is a strong case for removing the requirement for two doctors' signatures. We would like see the requirement for two doctors' signatures removed.[47]

Additionally, the medical-centred model guarantees health professionals legal safety from prosecution and also keeps their practice independent of the state's coercive intervention. This effectively prevents a problem caused by the state-centred model, which is that the medical profession is used as the state's agent to implement its population policies. What could be worse about the Chinese regulatory model is that in the process of using medical practice to carry out the population polices, the state's power becomes an engine of medicalising abortion. The analysis offered in section 3.4 of chapter 4 shows that under the state-centred model, medical controls were imposed by successive governments over the provision of abortion services in order to ensure that women's fertility is under the state's control. When the pro-natalist policy was advocated in the Maoist era, doctors were required by the Ministry of Health to emphasise the side effects of abortion in order to persuade women to continue their unwanted pregnancies. Nevertheless, in the post-Maoist era, physicians have to obey the birth control policy and treat abortion as a method of practising family planning. Thus, compared to their English sisters, Chinese women have to bear double pressures under the state-centred model.[48] To access abortion services, they first have to ensure that their requests are consistent with the state's population policy, and second, they must prove this consistency to health professionals.

While the law of abortion in England looks less liberal than the law of abortion in China, in practice both abortion services and government funding are more accessible in England. According to the statistics released by the Department of Health in 2009, 91 per cent of 195,296 abortions performed in 2008 were funded by the NHS and 99 per cent were undertaken on the

[47] Science and Technology Committee (2007) *Scientific Developments Relating to the Abortion Act 1967* available at http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf (last accessed 26 December 2011)

[48] For a discussion of the influence of the state's policy-making on population figures, see section 3 of chapter 4

grounds in s. 1(1)a, namely the 'social grounds'.[49] These statistics suggest that in practice the medical-centred model serves to encourage health professionals to safeguard access to abortion. However, the situation under the Chinese state-centred model is very different. Since the performance of abortions has to obey the state's population policies, health professionals are required to practise within successive governments' guidelines. For instance, when the Maoist government advocated a large population, doctors had to treat termination of pregnancy as a threat to the collective good. Although currently Chinese health professionals normally offer termination services on demand, their practice is not motivated by the desire to promote women's autonomy. After carrying out the birth control policy at the beginning of the 1980s, Chinese doctors and nurses started to view providing abortion services as the state's requirement rather than a critical method of satisfying women's needs for health and for control over their lives.[50] In other words, health professionals' attitudes towards unwanted pregnancies heavily depend on the state's strategies to manage the population. As a result, they can become very unsympathetic when the state tightens access to abortion. While in chapter 3 I argued that the performance of abortions, particularly early medical abortions, should not be limited to health professionals, medical support should be available on demand. Women's lack of information about termination treatment limits their capacity to act on their autonomously held desires for abortion. This is particularly true in China where women's sex education and access to information about family planning are less developed than those in England. This is why, in section 4.2 of chapter 2, I suggested that to enhance women's reproductive decision-making, abortion law should clearly define health professionals' obligations. For example, according to a study conducted in 2004 by the National Research Institute for Family Planning, of about 13

[49] Department of Health (2011) 'Abortion Statistics, England and Wale 2009' available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_116336.pdf (last accessed 29 August 2011)

[50] For a discussion of the law of abortion and birth control policy in the post-Maoist era, see section 3 of chapter 4 and also Thomas Scharping (2003) *Birth Control in China 1949-2000: Population policy and demographic development* (London: Routledge)

million legal surgical abortions performed in China, repeat abortions account for a large proportion and most abortion 'repeaters' are teenagers or unmarried young women.[51] This group of women are most likely to lack proper knowledge about how to end unwanted pregnancies and how to avoid becoming accidentally pregnant again. While the Chinese state-centred model does not stop them from ending their unwanted pregnancies if they know how to access abortion and can afford it, it does not ensure that medical and financial support is available if they do not. As I have argued in section 5.1 of chapter 4, the problem of the high rate of repeat abortions among teenagers and unmarried young women is avoidable if the provision of pre- and post-abortion information provision is improved.

The analysis of the Chinese family planning services discussed in section 3.2 of chapter 4 shows that, compared to staff members in local family planning centres who work for the state to keep the birth control policy running smoothly, health professionals are suitable for the role of offering women who need abortion relevant information. Nonetheless, the state-centred model fails to require health professionals to fulfil both their negative and positive obligations to respect women's autonomy in abortion decisions. Moreover, the analysis in section 3.4 of chapter 4 indicates that in order to facilitate its exercise of control over women's fertility, in order to use the medical profession as the gatekeeper of termination services, the state pass regulations to ensure that medical and surgical abortions can only be prescribed and performed by registered physicians in public hospitals and authorised medical sector units. Although these restrictions also exist in England, they can cause even more stresses to women in China. This is because the uneven distribution of medical resources leads to the unavailability of registered physicians in some undeveloped rural regions.

[51]Yuan Cheng, Xuan Guo, Sun Qu and Bang Kang (2004) 'Repeat induced Abortions and Contraceptive Practices among Unmarried Young Women Seeking An Abortion in China' 87(2) *International Journal of Gynaecology and Obstetrics* 199-202

Nevertheless, as has been discussed in section 3.3 of chapter 4, the upside of the state-centred model is that it constructs abortion as a back-up family planning method and also provides abortion as a family planning service. This enhances the provision of termination services in public hospitals and private medical sector units.[52] Moreover, since abortion is defined by the state as a family planning means, doctors are not given the right to judge women's requests for termination services or to refuse to take part in providing them. This ensures that health professionals only undertake a role as service providers rather than moral arbiters. As health professionals' personal attitudes towards abortion do not affect their obligation to provide treatment under the state-centred model, the service-related delays discussed in section 3.2.2 of chapter 3, which were caused by the medical-centred model, can be avoided. Since the birth control policy is currently being carried out in China, the government adopts a less restrictive attitude to the use of abortion to avoid unwanted fertility. Accordingly, the situation in Maoist China, when termination services were poor, expensive and only available in public hospitals, has been significantly improved because authorised private medical sector units are allowed to provide abortions. This also strongly challenges Maoist law's construction of abortion as a dangerous medical procedure and one which ought to be limited in some extreme cases. I therefore suggest that possible proposals for redefining abortion in the English jurisdiction can be derived from the Chinese experience of considering abortion as a back-up family planning means of avoiding unwanted pregnancies. The definition of abortion as a back-up family planning method suggests that medical limits on termination services should be removed because they should be viewed as essential for women to managing their fertility.

The post-Maoist state-centred model also gives more freedom to public and private hospitals, allowing them to offer medical and surgical termination of pregnancy as an economic service.

[52] See section 4.1 of chapter 4

Consequently, in Chinese urban areas, particularly in those which are relatively economically developed, the quality of abortion services is greatly improved and women's control over their procreative decision-making is also increased. Nevertheless, I concede that although the attempt to promote abortion services by treating them as a medical commodity was successful in the Chinese urban regions, such as Shanghai and Beijing, this is still very controversial. According to Fletcher's observation on the advantages and disadvantages of defining abortion as an economic service in Irish society, the possibility of using a customer-based approach to abortion may be an 'innovative and creative' feminist legal strategy because law's construction of abortion as an economic service can provide 'a welcome legal tool for pro-choice activists struggling to gain some legitimisation of women's reproductive rights'.[53] This strategy will be particularly productive in a society where women's rights consciousness is relatively weak, but 'economic expansion ... has seen a rise in consumer practice'.[54] The commercialisation of abortion services is not new in China: it started in the early 1980s. Fletcher's argument can provide an explanation of why this strategy works well in Chinese cities. As has been indicated in chapter 4, in order to increase their competitiveness and attract more customers, many private medical sector units reduced the prices for termination services and improved information provision before and after actual treatments. For example, before having an actual termination treatment, some private suppliers offer women online or phone chat services and encourage them to discuss possible options and effects with their staff members.[55]

Fletcher has also pointed out that the downside of treating abortion as an economic service is that women may lose the formal recognition of their interest as women in reproductive autonomy and

[53] Ruth Fletcher (2000) 'National Crisis, Supranational Opportunity: The Irish Construction of Abortion as a European Service' 8(16) *Reproductive Health Matters* 35-44 p.37
[54] Ruth Fletcher (2000) p.37
[55] An example is Shanghai Fukeyanjiu Private Hospital, which provides detailed information about surgical abortion services, staff members who will carry out these services and online chat support on their website available at http://www.shxycm.com (last access 27 December 2011)

the government may be discouraged from improving access to funded terminations. However, the Chinese experience of applying a customer-based approach to the provision of abortion services suggests that this approach can be applied flexibly. The commercialisation of abortion services does not need to be all or nothing. This means that the customer-based approach can be applied and exist together with other methods of providing abortion, such as treating abortion as a health-centred service. This is similar to the provision of condoms: the fact that condoms are available in Boots as a commodity does not stop NHS health centres from supplying free condoms or give the government an excuse not to protect people's access to free contraception. On the contrary, applying both the customer-based and the NHS-based approaches can enhance condom users' autonomy by increasing choice and flexibility. Nonetheless, I accept that the term 'commodification' does not usually appear to be feminist-friendly. For example, the commodification of sex, and surrogate and assisted procreation has been strongly criticised by many feminist scholars because arguably, it is caused by the penetration of male-dominated values and therefore unavoidably brings more exploitation and oppression to women.[56] On the one hand, I suggest that establishing a necessary connection between the term 'commodification' and female victimhood can narrow feminists' insight and stop them from exploring the strategies to empower women from the viewpoint of the idea of commodification. For example, women's procreative decision-making can be promoted by providing abortion in a customer-based way because this can effectively deprofessionalise termination of pregnancy. On the other hand, feminists' criticisms of 'commodification' can serve as a reminder that constructing abortion as a completely economic service could pressurise the women who are socioeconomically disadvantaged into seeking unsafe back-street services. Therefore, applying the customer-based approach to enhance women's control over abortion decisions ought to take account of the

[56] Sheila Jeffreys (1997) *The Idea of Prostitution* (Melbourne: Spinifex Press); Kari Kesler (2002) 'Is a Feminist Stance in Support of Prostitution Possible? An Exploration of Current Trends' 5(2) *Sexuality* 219-235 and Julia Po-Wah (2004) 'Right-Making and Wrong-Making in Surrogate Motherhoood' in Rosemarie Tong Anne Donchin and Susan Dodds (eds) *Linking Visions* (Oxford: Rowman & Littlefifield)

state's obligation to promote public health and gender equality by providing funded abortion services. In section 3 of this chapter, based on the analysis of the Chinese experience of providing customer-based abortions services, I will suggest some proposals for reforms of the English law of abortion in order to demedicalise abortion services.

2.2. 'Irrational Women'[57] and 'Glorious Mothers'[58]

Since the images of 'irrational women' and 'glorious mothers' have been discussed in chapters 3 and 4 respectively, in this subsection I put these two methods of constructing womanhood together for a comparative study of the English and Chinese models of the regulation of abortion. I will discuss how law constructs these two images under the two models in order to achieve two objectives: first, to assess how similar the y are in treating women's autonomy in abortion decisions, and second, to explore the underlying cause of this similarity.

The analysis of the images of 'rational women' and 'glorious mothers' provided in section 3.1 of chapter 3 and section 4.1 of chapter 4 respectively suggests that English and Chinese laws of abortion do not respect women's decision-making adequately. Under the medical-centred model, women who need abortion are described as irrational people who need medical discretion in order to make responsible decisions. Under the state-centred model, women of reproductive age are encouraged and even forced by law to become 'glorious' citizens, and their agency is subject

[57] For a discussion of how the medical-centred model construct the image of 'irrational women', see section 3.1 of chapter 3

[58] For a discussion of how the state-centred model construct the image of 'glorious others', see section 4.2 of chapter 4

See Yinhe Li (2003) *Shengyu yu Cunluo Wenhuai* (Beijing: Wenhuayishu Publisher) p.166 for further information about the term 'Guangrong Muqin' (literally, glorious mothers)

to successive governments' population policies. More specifically, decriminalising abortion in the era of medicalisation did not result from law makers' desire to enhance women's control of their reproductive choices. The parliamentary discussion of the 1967 reform by pro-choice MPs noted in section 2.2.1 of chapter 3 indicated that abortion should be legalised because in some special circumstances it can save tired and desperate housewives' maternal capacities. The four statutory grounds in the Abortion Act 1967 (the 1967 Act) imply that women who request abortion on these grounds are in need of medical help, so that they can maintain their normal womanhood as motherhood. The enactment of the 1967 Act shows that in parliament reformers' means of creating a victimhood of abortion-seeking women gained more support than the anti-abortion conservatives' method of constructing women who need abortion as selfish. Either way, women who request abortion are not treated as rational decision-makers. As Thomson has observed, in parliamentary narratives by opponents of and proponents of the abortion law reform, 'tarts' and 'tired housewives' represent women who need abortion, and constructing these two figures justified the regulatory situation in which 'women could only seek abortions through *medical men*'.[59]

While the reformers' strategy to construct abortion-seeking women as 'victims' led to the decriminalisation of abortion in England, it did not grant women the ultimate right to decide whether they could end their unwanted pregnancies. In successive governments' amendments to the regulation of abortion, the reformers' strategy continued to play a significant role. For example, according to the discussion in section 3.1 of chapter 3, this strategy was used to maintain the 24-week time limit. In parliament, the reformers who supported the 24-week cut-off point argued that both teenage victims of accidental pregnancies and desperate mothers of multiple children should be allowed to access late abortion because they needed medical help in

[59] Michael Thomson (1998) *Reproducing Narrative* (Aldershot: Ashgate Publishing Limited) pp.12 and 68

order to maintain their normal womanhood. The statutory grounds conveyed a message to the public that although abortion is generally undesirable, it may be acceptable in some extreme circumstances when it is the only method of saving women's maternity.

From the analysis in chapter 4 of how law constructs the image of 'glorious mothers' under the Chinese state-centred model, it can be seen that although the English and Chinese methods of regulating abortion are distinct from each other, they are both built on the compulsory cultural assumption of womanhood as motherhood discussed in section 3.2 of chapter 2. Since the Maoist government takeover in 1949, female citizens' fertility has become the state's concern. The party state's attitudes towards demographic development, rather than women's decision-making, decide whether women can access abortion services. Since the Maoist government preferred a larger population, women were encouraged and even forced to lead a 'glorious' maternal life by producing more children for the state. Women who sought to terminate their pregnancies were considered inglorious according to the pro-natalist policy because they tried to escape the citizens' duty to reproduce. At the beginning of the 1980s, the post-Maoist state's implementation of the birth control programme significantly changed the legislation on abortion, which became defined as a necessary and even a compulsory method of avoiding extra births when contraception fails. As a consequence, women are persuaded and even forced to have an abortion if they fail to gain birth permission from their local family planning centres.

As has been discussed in chapter 4, while the current Chinese government emphasises that nowadays implementing the birth control policy is becoming more reliant on incentive-orientated measures rather than punishment, this change did not grant women any right to make reproductive decisions. For example, *jihuashengyu guangrongzheng* (literally, the glorious

certificate for one-child families)[60] is issued by the Population and Family Planning Committee as an incentive to encourage couples to have only one child. Both awarding mothers of multiple children the designation of *guangrong muqin* (literally, glorious mother) in the Maoist era and issuing *jihuashengyu guangrongzheng* are also means of exerting control over women's lives, adopted by the party state in order to achieve its demographic goals. In addition, the current government financially penalises couples who breach the birth control policy. Such a 'carrot and stick' strategy implies that Chinese women not only have to undertake a duty to bear and rear children, but also have to do so in a 'glorious' way according to the party state's requirements.

Both the decriminalisation of abortion and the use of abortion law to facilitate the implementation of population policy in the post-Maoist era serve to require women to fulfil two duties in order to maintain their 'maternal glory'. First, they are required by the party state to keep their maternal capacity of bearing and rearing children. To do so, successive governments have encouraged women to be glorious mothers who can take good care of their single-child families. Second, they are also under the obligation to help the state reduce the pressure caused by having a large population. The analysis of the legislation on abortion in the post-Maoist era in section 3 of chapter 4 suggests that there are two important reasons why the party state seeks to exert coercive influences over female citizens' fertility. Women's reproduction is treated by the party state as a necessity for producing labour and taxpayers. While post-Maoist governments repealed the pro-natalist policy, it does not change the spirit of the law, which is that female citizens have to play a maternal role. Moreover, women's fertility is also regarded as a potential threat to the good of the nation since it symbolises their resistance to the state's power. The state

[60] Instead of using financial punishment or coerced abortions, the existing government adopts some soft incentive-orientated methods in order to encourage couples to have a smaller family. Women who have 'Jihuashengyu Guangrong Zheng' can apply for a small account of allowance of ¥10-50 per month (£1-5), get 30 days more than the statutory maternal leave (90 days) and get better maternal care.

therefore legislates to construe itself as an arbiter that is entitled to regulate women's behaviour to ensure that it is appropriate and to punish 'inglorious' procreative activities.

From the discussion of the concept of 'autonomy' offered in chapter 2, it can be seen that a competent person is able to form second-order desires according to her own convictions, so she ought to be allowed to act on her autonomously held desires.[61] The decision of whether or not to reproduce, as one of the most intimate choices, determines whether a person can have her basic needs for health and for control over her everyday life satisfied. Nevertheless, the extent to which a person can act on her freely held desires concerning procreation is not completely dependent on her internal capability to critically form high-level desires. According to the principle of respect for autonomy, as a minimum a person should have her decision-making free of violent interference. Moreover, this principle suggests that she should be able to access proper support when it is necessary for her to act on her high-level desires. The availability of medical and state support can facilitate women's exercise of control over meaningful procreative choices. As Riley and Furedi have observed, autonomy is not respected unless offered in a healthcare environment which respects self-determination and offers support for autonomous decision-making. They note:

> Facilitating this environment in abortion care requires (for example) accurate, appropriate and timely non-directive information for healthcare professionals to enable each individual to fully explore their options, with a commitment to appropriate confidentiality, and for a choice of appropriate treatment methods to be offered in order to maximise the acceptability and accessibility of each option.[62]

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[61] See section 2.1 of chapter 2

[62] Laura Riley and Ann Furedi (2009) 'Autonomy and the UK's Law on Abortion' in Shelley Day Sclater, Fatemeh Ebtehaj, Emily Jackson and Martin Richards (2009) (eds) *Regulating Autonomy: sex, reproduction and Family* (Oxford: Hart Publishing) p.241

Accordingly, to empower women to act on their freely held procreative desires, law should ensure that a cooperative rather than paternalistic relationship is established between them and health professionals. Law should also protect women against the state's abuse of power and require the state to take a supportive role in supplying family planning services and funding. However, the above analysis of how English and Chinese laws construct the images of irrational women and glorious mothers shows that the two regulatory models both fail to regulate the provision of abortion services in accordance with the principle of respect for autonomy. Under the English model, women are required to have their normal womanhood, which is to take maternal responsibilities. To justify this requirement, law constructs abortion as an undesirable choice unless it is made on certain grounds. In China, the use of abortion as a compulsory means of avoiding extra births shows that women must obey the national birth control policy in order to be considered as glorious citizens. Thus, under the state-centred model, having those births which are not authorised by the state is thought of as a political wrong caused by women's failure to act gloriously. Law's construction of the above two images suggests that while abortion has been legalised for a half century, women are still not recognised by law as autonomous decision makers.

To gain a thorough understanding of the spirit of English and Chinese law-making on abortion, I suggest that their national population policies deserve a mention. I use Yuval-Davis' main discourses to summarise the main principles applied by various states to their policy-making on population figures: 'people as power', 'eugenics' and 'Malthusianism'.[63] In brief, when a state's population policy is based on the principle of 'people as power', its government has a strong need for people for a wide range of nationalist purposes, civil and military; when a state advocates the eugenicist discourse, its government's concern is the 'quality' of the nation and it

[63] Yuval-Davis Nira (1997) *Gender & Nation* (London: Sage Publication Ltd) pp.29-35

does not require more citizens but healthy citizens; when a state's population policy is Malthusian, its government tends to use various means to reduce both its national birth rate and population.[64] From the discussion in chapters 3 and 4, it can be seen that English and Chinese law-making on abortion was influenced by their governments' population policies to different degrees. For example, the analysis in chapter 4 shows that the legislation on abortion in China changed dramatically after the state implemented the birth control policy. While the English law of abortion works within a medical-centred framework, the state's population policy also plays a role in legislating and regulating abortion. After the Second World War, the fear of national population decline was intensified in parliament. For example, the Beveridge Report warned that 'with its present rate of reproduction, the British race cannot continue'.[65] Winston Churchill therefore argued that British people must be encouraged by 'every means to have larger families', so that the state was able to maintain the leadership of the world and survive as a great power.[66] However, from the 1960s on, the problems of over-population became the government's concern, which in turn produced 'a new climate of opinion' in support of abortion reform.[67] Although the English state's involvement in providing abortion services is much less coercive compared to the state's role in China, the entrenchment of medical discretion suggests that it also has an interest in controlling women's reproductive bodies. This explains why women's abortion decision-making was left in the hands of health professionals intentionally by successive English governments.

To justify their entrenchment of medical and state controlling involvement in abortion provision, the English and Chinese regulatory models construct the figures of medical professionals and that of the state in a way which is in sharp contrast to how women are portrayed. As has been

[64] Ibid.
[65] William Beveridge (1942) cited by Barbara Brooks (1988) *Abortion in England, 1900-1967* (London: Croom Helm) p.134
[66] Ibid.
[67] Anthony Hordern (1971) *Legal Abortion: the English Experience* (Oxford: Pergamon Press)

analysed in chapter 3, under the English model doctors are treated as parallel judges and gatekeepers who are entitled to scrutinise women's abortion requests. According to the analysis of Chinese abortion law in chapter 4, each successive government is construed as a figure that protects the national good and its population policies are defined by the Constitution as beneficial to the collective interest.[68] The state's population policies are used to judge whether women's procreative behaviour is proper. To be viewed as glorious citizens, women had to produce more 'people as power' in the pro-natal era, but had to avoid extra births when the state advocated Malthusianism in the post-Maoist era.

From the analysis of the compulsory cultural assumption of womanhood as motherhood provided in section 3.2 of chapter 2, it can be seen that the medical-centred and state-centred models are built on this compulsory assumption. The English model implies that women should produce a proper number of healthy children, so it allows abortion when it is requested by women in order to maintain their maternal capacities or avoid the birth of a child with disabilities. Chinese law requires women to produce fewer but better citizens, so abortion is treated as a rational and glorious choice when women's pregnancies are not authorised by local family planning centres. Law's embrace of the gendered assumption blurs the importance of its respect for autonomy that is essential to satisfying women's needs for health and for control over their lives. In sections 3 and 4 of this chapter, I will suggest feasible proposals that challenge and change how the current two models construct women who need abortion. By doing so, the power imbalance in women's relationships with health professionals and with the state will also be redressed.

[68] Article 25 of the Constitution: the state shall carry out the birth control policy in order to promote the national economy and social stability.

3. Law Reform in England: Proposals and Problems

In this section, I will examine what role English law ought to play in promoting women's autonomy and suggest proposals for law reform that are targeted at addressing women's lack of power in abortion decisions. Further, the problems that may be caused by these proposals will also be analysed. After discussing the possible proposals for reforming the Chinese law of abortion and regulating controversial abortions in sections 4 and 5 of this chapter respectively, in section 6 I will return to the limits to all suggested reforms, including their chance of success in the English and Chinese political climate and their effectiveness in enhancing women's control of abortion choices in practice.

According to the analysis of the medical-centred model in section 2 of chapter 3, it can be seen that this model defines abortion as a medical decision and grounds the relationship between women who seek abortion and health professionals on the principle of 'doctor knows best'. In practice this model causes service-related delays that make accessing abortion more difficult and stressful than it needs to be. For example, women have to wait longer or travel to another county in order to have an abortion if their GPs are not cooperative. Moreover, for women in disadvantaged situations, such as those who do not have the knowledge to convince their doctors that their requests for abortion are genuine or those who are not entitled to access NHS-funded services, the current medical-centred model cannot ensure that they can access adequate medical and state support. To solve problems caused by the medicalisation of abortion discussed in chapter 3, I suggest the following reforms that can post a challenge to law defining abortion as a medical decision and can redress the power imbalance within the paternalistic relationship between women who request abortion and health professionals.

3.1. Reshaping Law's Construction of Abortion

From the discussion of the medical-centred model in section 2 of chapter 3, it can be seen that after 1967 the conditional decriminalisation of abortion does not change the fact that termination of pregnancy is treated by law as a highly skilled procedure that must be left in the hands of doctors. While the four statutory grounds in the 1967 Act allow some women to access abortion services in certain circumstances, they put all women's reproductive autonomy in an uncertain situation. The medical-centred model serves to maintain the gendered assumption of womanhood as motherhood because 'the only women who are allowed to terminate are those who can do so without rejecting maternity/familial norms per se'.[69] Reconstructing the medical-centred model of the regulation of abortion according to the principle of respect for autonomy involves changing how law constructs abortion services. To do so, I suggest that the Chinese experience of defining abortion as a back-up family planning means is helpful in formulating an alternative to the definition of abortion as a medical decision.

While I have been critical of the party state's use of abortion to facilitate the implementation of its population policies, technically law's construction of abortion as a family planning method is not problematic. The discussion of the Chinese family planning context in section 3.2 of chapter 4 suggests that because of the party state's coercive involvement, this definition is misused as a tool to reduce the national birth rate. In the English context, where state involvement is much less coercive and women's awareness of procreative rights is comparatively strong, treating abortion as a back-up family planning means can enhance women's exercise of control over decision-making. Moreover, by comparison with defining abortion as a medical decision or procedure, constructing abortion as a back-up family planning method is more accurate because this represents the reality whereby, as discussed in section 2.3 of chapter 3, medical and surgical

[69] Sally Sheldon (1993) 'Who is the Mother to Make the Judgment? The Constructions of Woman in English Abortion law' 1(1) *Feminist Legal Studies* 15-21 p.18

means of terminating have proven to be clinically safer than continuing pregnancy and giving birth. The development of reproductive medicine means that medical termination of early pregnancy can be safely administered by lay women at places other than hospitals or authorised private medical sector units, such as at their or their friends' homes or at their university accommodation. According to the Royal College of Obstetricians and Gynaecologists' (RCOG) recent evidence-based report, lay women should be able to carry out their termination of pregnancies at home.[70] The safety of early medical home abortions carried out by lay women has also been confirmed by many scholars' studies.[71] Additionally, the analysis of the global abortion pills market in the introduction to this thesis shows that early medical termination drugs, such as RU486, can be readily accessible from online shops or back-street clinics. These illegal purchases are very difficult to detect. Therefore, defining abortion, particularly early medical termination, as a medical decision or a highly skilled procedure which must be made and carried out by health professionals is clinically groundless and legally undesirable. Last but not least, law constructing abortion as a family planning method can demedicalise termination of pregnancy and emphasise its importance to women's health. The latest finding published by the National Collaborating Centre for Mental Health suggests that an unwanted pregnancy that is carried to full term can double women's risk of mental health problems, but that having an abortion does not have negative impacts.[72] Since unwanted fertility is a serious threat to women's health, the state has an obligation to enhance their access to family planning services.

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[70] RCOG (2011) 'The Care for Women Requesting Induced Abortion' published on' available at http://www.rcog.org.uk/files/rcog-corp/uploaded-files/NEBInducedAbortionfull.pdf (last accessed 8 April 2011)

[71] Beverly Winikoff (1995) 'Acceptability of Medical Abortion in Early Pregnancy' *Family Planning Perspectives* 27(4) 142-148; Beverly Winikoff, Irving Sivin, Kurus Coyaji, Evelio Cabezas, Xiao Bilian, Gu Sujuan, du Ming-Kun, Usha Krishna, Andrea Eschen, Charlotte Ellertson (1997) 'Safety, efficacy, and acceptability of medical abortion in China, Cuba, and India: A comparative trial of mifepristone-misoprostol versus surgical abortion' 10(6) *International family Planning Perspectives* 73-89; Christian Fiala, Beverly Winikoff, Lotti Helstrfm, Margareta Hellborg and Kristina Gemzell-Danielsson (2004) 'Acceptability of home-use of misoprostol in medical abortion' 70(5) *Contraception* 387-392 and Williams Clarks (2005) 'Home use of two doses of misoprostol after mifepristone for medical abortion: A pilot study in Sweden and France' *The European Journal of Contraception and Reproductive Health Care* 10(3) 184-191

[72] The National Collaborating Centre for Mental Health (09 December 2011) 'Induced Abortion and Mental Health ' available at http://aomrc.org.uk/publications/reports-guidance.html (last assessed 09 December 2011)

Thus, if law defined abortion as a back-up means of practising family planning, this would encourage the state to take an active role in enhancing the provision of abortion services. To ensure that law embraces the construction of abortion as a back-up family planning means, I suggest the following proposals.

First, I suggest that challenges should be posed to law defining abortion as criminal or an undesirable choice. To do so, I argue that instead of only decriminalising abortion services in some extreme situations, abortion ought to be fully decriminalised. As has been argued in chapter 3, criminalising women seeking abortion causes gender and social class inequalities because this pressurises only women, particularly those who are comparatively socioeconomically disadvantaged and are unable to avoid the ban. Accordingly, section 58 of the 1861 Act, passed in the era of criminalisation, should be repealed. Access to termination services is still not treated as part of women's basic need for control over their daily lives according to the 1967 Act. To reconstruct abortion as a family planning method, women's requests for abortion services should not be regulated by criminal law. From the Chinese experience of governing abortion services discussed in chapter 4, it can be seen that the regulation of abortion provision is included in the Code on Maternal and Infant Health 1994 (the 1994 Code)[73] and the 2002 Code, which both belong to administrative law.[74] Furthermore, the Constitution also states that citizens have the right to family planning services.[75] Currently, the English law of abortion is included in the 1861 Act and the 1967 Act, which are classified as criminal law and medical law respectively. This can cause uncertainty about the situations under which abortion is regarded as criminal and those under which it is not. Even in the era of criminalisation, law's enforcement was not

[73] It was passed at the Tenth Meeting of the Standing Committee of the Eighth National People's Congress in 1994. It belongs to national basic law and its legal status is equivalent to an Act of Parliament in the UK

[74] See section 3.3 of chapter 4

[75] Article 49 of the Constitution: citizens have the right and duty to practise family planning.

effective because detecting criminal abortions could be difficult.[76] Additionally, although abortion is still kept as part of the criminal law after the enactment of the 1967 Act, as discussed in chapter 3 it has become defined and used as a medical decision in practice.

To completely decriminalise abortion and define it as a means of avoiding unwanted fertility, I suggest that public law can replace criminal law and regulate abortion provision. Both constitutional and administrative law belong to public law in the English legal system, which is 'the collection of rules which establish and regulate or govern the government'.[77] More specifically, constitutional law deals with 'the legal foundations of the institutional hierarchy through which the state is governed' and seeks to 'delineate individual rights'.[78] Administrative law aims to regulate government power and prevent 'maladministration in the public services and the execution of public policy'.[79] Thus, public law mainly serves to promote citizens' rights and regulate the activities of the government and any other public bodies. One of its legal sources is the Human Rights Act 1998, which prohibits discrimination on any ground such as sex.[80] According to this prohibition of sex discrimination, women's access to abortion services should be enhanced because termination of pregnancy is a crucial method which women can use to manage their fertility. As Fox has argued, criminalising abortion is a form of sex discrimination since men do not experience pregnancy and 'any forced pregnancy will always deprive and hurt one sex only as a member of her gender'.[81] Therefore, apart from eliminating the uncertainty mentioned above, including abortion within the ambit of public law has another two merits. Since the state is under an obligation to eliminate sex inequality, it should also

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[76] See section 1.1.1 of chapter 3
[77] KC Wheare (1966) *Modern Constitutions* (Oxford: Oxford University Press) p.10
[78] Alex Corrall (2009) *Constitutional and Administrative Law* (London: Pearson) p.5
[79] Barnett Hilaire (2010) *Understanding Public Law* (London: Routledge-Cavendish) p.2
[80] Full statutes are available at http://www.legislation.gov.uk/ukpga/1998/42/schedule/1 (last accessed 27 December 2011)
[81] Marie Fox (2012) 'The Case for Decriminalising Abortion in Northern Ireland' in Amel Alghrani and Rebecca Bennett *The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge: Cambridge University Press) (forthcoming) (the chapter on file with author)

undertake the duty to remove limits on abortion services that, as has been discussed in chapter 2, is essential to satisfying women's basic needs for health and for control over daily lives. Therefore, regulating abortion under the public law model requires the state to act more positively in enhancing women's abortion choices. Moreover, including provision for abortion in administrative law can redress the paternalistic relationship between women who plan to have an abortion and health professionals by allowing the state to prevent the medical profession's abuse of power.

The second proposal is that an autonomy-based regulatory model under which abortion is treated as a family planning method should not limit the legal reasons for having an abortion on the therapeutic grounds. The analysis of the four statutory grounds in the 1967 Act in chapter 3 shows that the abortion grounds are ill-considered. This is because they cannot represent the reality where most women's reasons for termination of unwanted pregnancies are not therapeutic or health-related. Furthermore, they wrongly assume that abortion is a complex and complicated medical procedure which ought to be restricted to some extreme circumstances. As has been discussed earlier in this section, both medical and surgical termination of pregnancy are clinically safer than giving birth, and termination of unwanted pregnancies can prevent women's mental health problems. The limits on the legal reasons for having abortion make access to abortion unnecessarily difficult and stressful and also violate women's fundamental human right to health. Thus, to treat abortion as a back-up family planning method, law ought to ensure that abortion services are available on demand.

The third proposal is that the time limit for seeking abortions on the social grounds should be removed. The discussion of abortion in practice in section 3.2.1 of chapter 3 shows that women do not opt to access abortion at late stages of pregnancies, so abortions are rarely performed after

24 weeks. Furthermore, the existence of the cut-off point for legal abortions on the social grounds creates uncertainty as regards the legal status of foetuses. This leads to endless debates on why a 24-week healthy foetus deserves legal protection but not a 23-week foetus or a 25-week foetus with a disability. While it is better that abortion is performed at earlier stages, having a time limit is not an effective method of reducing late terminations.[82] Instead, the government should promote the provision of contraception and access to early abortion.

Moreover, as has been discussed in chapter 3, the 24-week cut-off point strengthens the medicalisation of abortion services and puts women's autonomy in danger by providing a new platform for anti-choice campaigns. Although in practice abortion after 24 weeks is rarely requested on the social grounds, I argue that as a family planning means, abortion should be allowed by law until birth, which legally distinguishes unborn human lives from existing human beings. Nevertheless, I agree with Ronald Dworkin, who has argued that human embryos and foetuses have their values and termination of pregnancy wastes these values.[83] Moreover, human embryos and foetuses can have some interests which should be protected by law, such as inheritance. Nonetheless, as has been analysed in section 5.1 of chapter 2, this does not mean that they have a legal personhood or have all of the rights which can be claimed by established persons. Therefore, wasting the values of embryos and foetuses can be justified in some circumstances. Given that the risk of unwanted pregnancy to women's health is serious and taking parenting responsibility for supporting a child through to adulthood after birth should be voluntary, termination of pregnancies, even when they are at a late term, should be treated as a family planning means which is essential to women's needs for health and control over their lives.

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[82] Ellie Lee (2004) *Why Women Have Late Abortion in Late Abortion: A Review of the Evidence, A Briefing Compiled* available at www.prochoceforum.org.uk (last accessed 13 April 2011)
[83] Ronald Dworkin (1993) *Life's Dominion* (New York: Alfred Knopf) p.60

Apart from their limited usefulness in practice and their low possibility of success in the current political climate, which I shall discuss in section 6 of this chapter, the above proposals have at least another two problems. First, if law constructs medical and surgical termination of pregnancy as a back-up family planning method, the boundary between contraception and abortion can be blurred. Considering the current situation, in which the necessity of enhancing contraceptive advice and treatment has been generally accepted and is legally less contentious than abortion in the UK,[84] erasing the line between preventing conception and ending gestation could put access to contraception, particularly the use of emergency contraceptive pills, under the attack of the pro-life lobby. For example, in the case of *R (John Smeaton on Behalf of Society for the Protection of Unborn Children) v The Secretary of State for Health*, the Society for the Protection of Unborn Children (SPUC) argued that selling emergency contraceptive pills breaches the terms of the 1861 Offences Against the Person Act that criminalises an attempt to procure a miscarriage.[85] While the SPUC's attempt to blur preventing conception and terminating pregnancy was not successful in the court, this case suggests that regulating abortion in a way which is similar to the regulation of contraception can provoke strong criticisms.

Furthermore, the removal of the specifications regarding where, when and in what circumstances abortion can be lawfully performed will receive criticisms from the anti-choice group. This may even be criticised by people who are happy with the existing regime, in which abortion is not generally desirable, but is acceptable in some extreme circumstances or before a certain moment during gestation. According to a poll on whose right it is to make abortion decisions, conducted by Ipsos MORI in 1997, only 34 per cent of respondents believed that the law should be changed to give pregnant women the right to an abortion in any circumstances, but 51 per cent disagreed

[84] Jean McHale and Marie Fox (2007) *Health Care Law: Text and Materials* (London: Sweet & Maxwell) p.86
[85] [2002] EWHC 610

that the law should be so changed.[86] Clearly, any attempt to challenge an established knowledge provokes considerable controversies. While many studies suggest that oral contraceptives should be readily accessible as a reliable and convenient method of avoiding accident pregnancies,[87] allowing women to obtain them as easily as aspirins without prescription can be contentious.[88] I shall reiterate the argument made in section 5.2 of chapter 2 that individuals are able to pass their own judgements on whether termination of pregnancy is a moral, right or responsible choice. However, the real question is to what extent law should be used as a method of enforcing the morality of abortion. As Freeman has observed, law is not some neutral tool wielded in an apolitical way; it is 'very much a social product, a reflection of the power of particular interest groups...'.[89] As discussed in section 3.1 of chapter 2, the fact that the regulation of abortion accepts women's normal role as motherhood indicates that the medical-centred model enforces the brief that abortion is not a rational and desirable decision. With this in mind, a permissive abortion law is required because it is respectful of different views on the morality of abortion. As Brazier has argued, 'a liberal democracy should respect divergent moral views'.[90] A permissive jurisdiction does not force people who believe that abortion is immoral to have one, but restrictive law forces women to continue unwanted pregnancies.[91] People who are generally happy with the current regulatory situation, where women should only be allowed to have an abortion in some special circumstances or before a certain moment during gestation, accept that women should normally take the maternal responsibility to continue their pregnancies unless in some extreme circumstances where they become too irrational to do so. Essentially, they

[86] More information is available at http://www.ipsos-mori.com/researchpublications/researcharchive/2117/Abortion-Whose-Choice.aspx (last accessed 27 December 2011)
[87] For example, see Ronald Burkman (2006) 'Safety concerns and health benefits associated with oral contraception' *American Journal of Obstetrics and Gynaecology* 190(4) 5-22
[88] Daniel Grossman (2008) 'Should the contraceptive pill be available without prescription?' available at http://www.bmj.com/content/337/bmj.a3044.full (last accessed 27 December 2011)
[89] Michael Freeman (1988) 'Legal and Philosophical Frameworks for Medical Decision Making' in Michael Freeman (ed) *Medicine, Ethics and the Law* (London: Stevens & Son Ltd.) p.3
[90] Margaret Brazier and Emma Cave (2011) p.395
[91] Sheila McLean (1990) 'Abortion Law: Is Consensual Reform Possible?' 17(1) *Journal of Law and Society* 106-123 p.110

advocate law's embrace of the compulsory cultural assumption of womanhood as motherhood. Therefore, reconstructing abortion as a family planning means not only challenges the medical-centred model, but also serves to change people's current thinking about termination of pregnancy and about women who need it. Given that using contraception cannot always guarantee success,[92] termination of pregnancy should be supplemental. Defining abortion as a family planning means also challenges the stereotype about practising family planning.

3.2. Reshaping the Relationship between Women Who Need Abortion and Health Professionals

According to the analysis of the medical obligations to respect the autonomy of women who need abortion in chapter 2, as a minimum health professionals are obliged to impose controlling influences on women's reproductive decision-making; moreover, they have a professional obligation to provide women with adequate support. Nevertheless, the medical-centred model does not maintain a supportive relationship between health professionals and women who need abortion.

As has been discussed in chapter 4, registered physicians in the Chinese family panning context have much less control of their relationship with women who need abortion by comparison with their English peers. They are not entitled to decide whether women are eligible for abortion services or to claim the right to conscientious objection. To reform the medical-centred model according to the principle of respect for autonomy, doctors' rights and obligations in the context of abortion should be reframed. To do so, I suggest that the Chinese experience of limiting doctors' power is helpful in developing possible law reform proposals.

[92] James Trussell (2004) 'Contraceptive Failure in the United States' 70(2) *Contraception* 89-96

First, in seeking to redress the power imbalance between women who need abortion and health professionals, the requirement of two doctors' approval in s. 1(1) of the 1967 Act should be removed. The analysis of the 1967 Act in chapter 3 suggests that women who decide to end their pregnancies could be vulnerable to the exercise of medical discretion as a result of being dependent on their doctors for a referral. Since abortion is treated as a family planning method under an autonomy-based model, access to termination services under this model should only be subject to women's informed consent rather than doctors' judgement. Instead of advocating health professionals' right to exert controlling influences on women's decision-making, law ought to require them to fulfil the positive obligation to provide women who request terminations with proper information about possible treatment options.

Second, law should secure a balance between protecting health professionals' right to claim conscientious objection and promoting their fulfilment of professional obligations. The discussion of the case of *Royal College of Nursing of the United Kingdom Respondent v Department of Health and Social Security Appellant* (*RCN*) in section 2.3 of chapter 3 suggests that since the scope of abortion-related treatment where a doctor can claim this right is not clearly defined, their right to refuse to participate in abortion treatments is comparatively unregulated. This therefore has a negative influence on fulfilling the professional obligations they owe to women who need abortion. In accordance with s. 4(1) of the 1967 Act, doctors are allowed to claim this right 'in any treatment'[93] relating to abortion services. As a result, even if GPs do not participate in any actual termination processes, they can still block women's requests by refusing to sign the form to refer her to a specialist. This puts women who need abortion in a

[93] Sections 4(1) of the Abortion Act 1967: Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this Act to which he has a conscientious objection: provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

disadvantaged situation where they can be denied the fundamental right to reproductive health and the fulfilment of their basic needs for controlling their fertility. Furthermore, according to the 1967 Act, GPs do not have to publicise their conscientious objection in advance, so women are unable to know whether their GPs object to abortion until they actually go to discuss their requests. This also makes requesting abortion stressful and difficult, particularly when GPs are hostile to abortion.[94]

The question of to what extent doctors have a right to refuse to participate in abortion treatments is a complex one. Given contextual differences discussed earlier in section 1 of this chapter, distinct from the Chinese legal system, the total removal of doctors' right to claim a conscientious objection will not be productive and perhaps also not realistic in the English legal context where the role of doctors in the provision of abortion has, historically, proven to be crucial. From the discussion of the figures of medical professionals in section 3.1 of chapter 3, it can be seen that in English society they embody justice, rationality and trustworthiness. Thus, in the current political and cultural climate, completely denying them the right to conscientious objection has very little possibility of success. Instead of a total removal, I suggest that there are two feasible solutions to the problem of law currently overemphasising health professionals' right to conscientious objection but failing to highlight their obligations: first, to restrict this right to actual treatment, and second, to require GPs to publicise their conscientious objection to abortion in advance. More specifically, the scope of treatments in which a doctor can refuse to participate should be narrowly defined as actual terminating procedures, so GPs' participation in preliminary steps, such as providing relevant information and signing a referral form, should not be included in 'authorised treatments' where doctors are eligible for conscientious objection. Furthermore, women should be informed when they register at local health centres if any of the

[94] *Barr v Matthews* [2000] 52 BMLR 217

GPs are conscientious objectors. The General Medical Council should have information about GPs' conscientious objection on their list of registered medical practitioners and allow female patients to check it online.

Third, redressing the power imbalance between women who need abortion and health professionals can be achieved by removing the limits on who is eligible to perform abortions and where terminations can be carried out. More specifically, the discussion of the case of RCN in section 2.3 of chapter 3 shows that given that in practice nurses carry out surgical abortions in doctors' presence in practice, the law should allow nursing staff to take greater responsibility for providing abortion services, such as prescribing medical abortions and performing surgical terminations. Furthermore, doctors should also relinquish some control to women who are clinically suitable for early medical abortions. The analysis of the case of *British Pregnancy Advisory Service v Secretary of State for Health*[95] offered in section 2.3 of chapter 3 suggests that if women are allowed to administer their early medical abortions at home after being given misoprostol pills, their experience of ending unwanted pregnancies would be less stressful because travelling time could be saved, the risk that they may start to bleed on their multiple journeys between hospitals and home could be reduced, more respect could be given to their privacy and support from their partner, family members or friends could be more accessible. Women should be able to gain early medical abortion pills from family planning clinics, private abortion providers and NHS health centres after nursing staff have confirmed that their pregnancies are of less than 9 weeks' duration and are suitable for medical termination.

After being prescribed abortion pills and taking the first dose of the pills, women should decide whether they return to hospitals or authorised health clinics to complete their second-stage

[95] [2011] EWHC 235

medical terminations with the nursing staff's assistance or go home or to other places which they find more comfortable for self-administration. The promotion of early medical abortions by removing medical limits on the performance of abortions has at least two advantages. First, since early medical terminations are clinically less complicated and morally less contentious than late surgical abortions, enhancing their provision can avoid both the complications caused by surgical abortions and the provocation of too much criticism, which late abortions give rise to. Second, the discussion of abortion in practice in section 3.2 of chapter 3 indicates that around 75 per cent of terminations were performed before 9 weeks and that there is a steady increase in the early medical abortion rate.[96] Thus, enhancing access to medical terminations will effectively take pressure off the inadequate number of doctors who are willing to perform abortions and also reduce costs for the NHS.

The above proposals to reduce doctors' control of the provision of abortion services also have two general problems which other reforms suggested in this section face: limited usefulness in practice and little chance of success. I shall return to these two points in section 6 of this chapter. Furthermore, the above proposals have another two shortcomings. First, as has been discussed in section 2.3 of chapter 3, under the medical-centred model abortion is constructed as a health-related decision between pregnant women and their doctors, so it rules out the possibility that other parties, such as women's sexual partners, claim their interests in abortion decisions. Thus, the above proposals to demedicalise abortion mean that women's decision-making may be challenged by the exercise of their sexual partners' alleged right to be a father. From the analysis of the interests of putative fathers in abortion decisions offered in section 5.1 of chapter 2, it can be seen that promoting women's reproductive autonomy should not exclude their sexual partners' say. In practice, women often take their partners' suggestions and their relationships into account

[96] Department of Health (2001-2009) *Abortion Statistics for England and Wale* available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/index.htm (last accessed 27 December 2011)

in abortion or other reproductive decisions. Nevertheless, when there is a conflict between pregnant women's and putative fathers' interests in abortion decisions, legally women's basic needs for health should be given priority over men's desire to become a father because the harm caused by involuntary fertility and coerced motherhood to women is more serious than that caused by losing a chance to be a father to men.

One more minor worry about these suggested reforms is that deprofessionalising the performance of abortions may increase unsafe abortions. Nevertheless, I argue that this is very unlikely. As has been analysed in section 2 of chapter 3, restricting the performance of terminations to health professionals does not eliminate, but increases illegal abortions because this makes access to legal services less available. Women do not opt to use unreliable abortion providers if legal services are readily accessible. According to the World Health Organization's definition, unsafe abortion is a procedure for terminating an unwanted pregnancy carried out by persons who may lack the necessary skills or conducted in an environment that lacks the minimal medical standards.[97] This means that the performance of safe abortion does not need highly specialised skills or to take place in medical institutions with high professional standards. As has been discussed earlier in this section, given that home medical abortions have proven to be clinically safe, termination of pregnancy can be carried out by lay persons with proper guidance in places other than hospitals and authorised medical sector units. Since there is no necessary link between the safety of abortion and professional skills or knowledge, deprofessionalising the performance of abortions does not increase unsafe abortions.

[97] World Health Organisation (2003) 'Safe Abortion: Technical and Policy Guidance for Health System' available at http://whqlibdoc.who.int/publications/2003/9241590343.pdf (last accessed 11 December 2011)

4. Law Reform in China: Proposals and Problems

The analysis of abortion in practice in China in section 3 of chapter 4 suggests that in the Chinese family planning context, law's respect for autonomy in abortion decisions not only involves protecting women's access to safe abortion services, but also requires protection of their right to refuse to have an abortion. Therefore, under an autonomy-centred model, women should be allowed to decide whether to continue their pregnancies. Moreover, given that in the Chinese family planning context women may be persuaded or forced to have abortions because of the state's birth control policy, respecting autonomy in the context of abortion means that the provision of abortion services is based on women's informed consent, namely women should be given the right to reject abortions 'by order'. Before examining my proposals to establish an autonomy-centred regulatory model of abortion in China, I will first look at an event: Marie Stopes International's (MSI) setting up of a chain of abortion clinics in China.[98] The discussion of this event will suggest why the proposals suggested in this section are helpful in building an autonomy-centred regulatory model and protecting women's rights to choose and to informed consent in the context of procreation.

In 2000, MSI started to develop its services, including abortion, post-abortion care and young people's family planning, in China. Because the current government advocates a birth control policy and treats abortion as a back-up means of avoiding extra births, it adopts a supportive attitude towards MSI's provision of abortion services. Therefore, MSI worked in partnership with five provincial population and family planning commissions to open a clinic in each province. These provincial population and family planning commissions also provide MSI

[98] Marie Stopes International (MSI) is an International Non-Governmental Organisation working on Sexual and Reproductive Health with headquarters in London, UK. It is named after Marie Stopes a Scottish author, campaigner for women's rights, and a pioneer in the field of family planning. Marie Stopes is a pro-choice organisation, and provides a variety of sexual and reproductive healthcare services including advice, vasectomies, and abortions in the UK. MSI works in 42 countries worldwide. The organisation operates through its own clinics (known as Marie Stopes Centres). In 2008 there were 560 centres. See further in *MSI* available http://www.mariestopes.org/Home.aspx (last accessed 29 August 2011)

clinics with some funds to develop family planning services. One of these services offered in these centres is to provide women under the age of 24 who have financial difficulties with free surgical abortions (awake under local anaesthetic)[99] and discounted fees for early medical abortions and surgical abortions (asleep under general anaesthetic, also known as painless abortion treatment in China). Nonetheless, these services raised doubts in both England and China. For example, the *Sunday Times* cited MP Kate Hoey, who comments:

> I don't see why British taxpayers' money via the NHS should in any way be supporting Chinese government policies ... It's very sad that an organisation like Marie Stopes doesn't reflect more on the grotesque human rights abuses that take place there.[100]

In the meantime, MSI's provision of free and more affordable abortion services for unmarried young women also provoked criticisms from some Chinese citizens. In 2008, when MSI opened its branch in the province of Nanjing and started to offer free surgical abortions carried out under local anaesthetic for pregnancies of less than 10 weeks' gestation for women under the age of 24, many local people worried that this would encourage unmarried young women to have premarital sex and give them an excuse to 'make moral mistakes'.[101]

The above criticisms are not well-founded for the following two reasons. First, as has been discussed in chapter 4, while the problem of coerced abortions performed 'by order' in China receives considerable international attention, the problem that safe and legal termination services are not available to those young unmarried women who either lack accurate knowledge or financial support to manage their unwanted pregnancies is not taken seriously. Although abortion

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[99] These include one in the city of Xi-an, one in Nanjing, one in Zhengzhou, one in Nanning and one in Qingdao. See MSIC website http://www.mariestopes.org.cn/index.php?act=about&lang=en# (last accessed 29 August 2011)
[100] Lois Rogers (30 May 2010) 'Sex health charity opens abortion clinics in China' *The Sunday Times* available at http://www.timesonline.co.uk/tol/news/world/asia/article7140260.ece (last accessed 29 August 2011)
[101] Zhang Xiao (22 November 2008) 'Mianfei liuchan re zhengyi' available at http://www.js.chinanews.com.cn/news/2008/1017/2431.html (last accessed 29 August 2011)

is used as a means by successive post-Maoist governments of avoiding 'unauthorised' births, not all women are eligible for funded termination services. Moreover, limiting the performance of abortions to registered physicians means that women in comparatively undeveloped rural areas are not able to access legal services because of the shortage of registered practitioners. As a study conducted by the Guttmacher institute in 2009 shows, even in countries where abortion is legal, the lack of availability and the cost force women to resort to unlawful providers.[102] The analysis of the Chinese family planning context offered in chapter 4 suggests that since the rate of involuntary sex and accidental pregnancy is high among unmarried, young and rural women who are from socioeconomically disadvantaged backgrounds, there is an urgent need for making safe termination services more accessible to them.[103] Thus, I argue that while MSI's provision of charitable abortion services is consistent with the state's birth control policy, it mainly serves to reduce the rate of illegal abortions among young women who have financial difficulties.

Second, the argument that MSI's termination services increase premarital sex is built on an assumption: women need regulation, and for limits to be imposed on their sexual and reproductive activities in order to act rationally and responsibly. According to the analysis of the high rate of repeat abortions among unmarried young women in chapter 4, although premarital sex was thought of as a social taboo in Chinese Confucian culture, the increasing number of unmarried termination seekers indicates that it has become a common phenomenon.[104] The decision of whether to have sex before marriage or not, similar to that of whether to reproduce or not, is closely related to people's lifestyle and should be determined by their personal preferences and beliefs. Imposing limits on abortion services cannot change people's preferences and beliefs. Moreover, restricting abortion funding to married women can force unmarried

[102] Guttmacher (2009) 'Abortion Worldwide' available at http://www.guttmacher.org/pubs/summaries/Abortion-Worldwide-summary.pdf (last accessed 27 December 2011)
[103] See section 2.3 of chapter 4
[104] See section 3.2 of chapter 4

women who are unable to afford legal termination services to resort to unreliable providers. A study conducted in 2006 by a medical centre in the province of Yunnan, which offers free surgical abortion services to young women, demonstrates that in 2006 there were around 1,000 cases of women seeking premarital terminations in the centre; two main reasons for this that were mentioned by the abortion seekers were unprotected sex due to lack of contraceptive knowledge and involuntary sex.[105] In addition, because of the shortage of financial support from the government in China, unmarried young girls will generally find it difficult to raise a child alone. Therefore, the government should advocate free or special rates of abortion services offered by reliable providers, such as MSI, which effectively meet women's basic needs for health and for control over their lives. Apart from MSI, some Chinese public hospitals in several big cities, such as Shanghai, Beijing and Guangzhou also work in partnership with the city population and family planning commissions and offer discounted rates for termination services. Nevertheless, hospitals which provide free services and offer lower rates for young women who have financial difficulties are very limited in number and only available in a few big cities. Moreover, the abortion funds available in these hospitals, offered by local population and family planning commissions, are completely inadequate for meeting the high demand among unmarried women. For example, the hospital which offers special rates to unmarried young women in the city of Shanghai only has ¥10 million (£1 million) per year from the Shanghai population and family planning commission. Therefore, only women who are under the age of 18 and in an extremely difficult financial situation are eligible for reduced rates for abortion services.[106] Considering these limitations, I suggest that only providing non-profit terminations in some hospitals cannot eradicate the problem of a lack of affordable abortion services nationwide. As will be discussed in section 4.1 of this chapter, the government should extend its

[105] Yingjie Xu (05 February 2006) 'Shaonv yiwai huaiyun jiezhu zhongxin zhounian huigu' *Xinhua News* available at http://news.xinhuanet.com/focus/2006-02/05/content_4112197_3.htm (last accessed 29 August 2011)
[106] See http://baike.baidu.com/view/6966416.html?fromTaglist for more information about how special rates of abortion services are provided in Shanghai (last accessed 12 December 2012)

family planning funding scheme to unmarried women and make abortion funds equally available to all female citizens.

While MSI is not the only organisation which offers affordable terminations to young girls in China, it was the first one that publicised its termination-related services, such as pre-abortion information giving, post-abortion care and young people's confidential abortion. These services provided by MSI are what the state should promote, but it fails to do so. As has been discussed in chapter 4, the party state is under an obligation to promote citizens' health according to the Constitution, so it should enhance access to safe abortions, which are essential to satisfy female citizens' basic needs for health. MSI's strategy for carrying out termination services in China suggests that one weakness of the current Chinese abortion regulatory mode is that it fails to make abortion services accessible to women from socioeconomically disadvantaged backgrounds. According to the information on the website of 'You and Me', a brand founded by MSI in 2001 to carry out family planning services in China, it provides women under the age of 24 who have financial difficulties with free surgical abortions under local anaesthetic and discounted rates for early medical abortions and surgical abortions under general anaesthetic.[107] Both charity-based and market-orientated strategies are adopted by 'You and Me' to develop its family planning services in China. The analysis of abortion in practice in chapter 4 shows that although about 30 million abortions are estimated to be performed in China every year, the availability of safe and affordable services cannot meet the demand. Apart from providing actual terminating treatments, MSI encourages its staff members, who do not need to be medical professionals, to offer non-directive information about contraception and termination options online and by phone. This can promote women's health and enhance their control over everyday life by improving their lack of proper knowledge about contraception and abortion. Therefore, I

[107] For more information about how abortions are provided by You and Me, see its website http://www.youandme.net.cn (last accessed 27 December 2011)

suggest that to bring the provision of abortion services into line with the principle of respect for autonomy, law should require abortion providers to take an active role in offering adequate information about possible contraceptive and termination options before and after actual abortion treatments. It is not necessary that the people who undertake the task of offering information are health professionals; they can be administrative staff members in abortion providers or local family planning centres. For example, recently, a private hospital in Shanghai started to publicise detailed information on its website about how medical and surgical information is spread widely and who performs this service in the hospital. Moreover, its website has 24-hour online chat software that allows women who need abortion to ask any questions about it and to make appointments via the internet to have abortion treatments.[108] This enhances women's control over abortion choices by providing abortion-seeking women with more privacy and convenience.

The proposals for law reform suggested below can achieve at least two objectives: first, to redress the power imbalance between female citizens of reproductive age and the party state, and second, to reframe the role of abortion providers according to the analysis of the positive and negative obligations offered in chapter 2. Similar to the suggested reforms of the English regulatory model of abortion, the proposals made below also face two general problems: limited usefulness in practice and only a small chance of being passed by politicians, which will be analysed in section 6 of this chapter. In this section, I will also discuss other risks which could be posed by these proposals.

[108] For more information, see its website http://www.shxycm.com (last access 27 December 2011)

4.1. Redressing the Power Imbalance between the State and Female Citizens

As has been discussed in chapter 4, while law defines abortion as a family planning method, in practice it is often used by the party state as a tool to facilitate the implementation of the birth control policy. Because of the state's controlling intervention, the provision of abortion services serves to subject women's procreative decision-making to the state's policy-making concerning population. As a result, law fails to protect women's right to informed consent in abortion decisions. Although the 1994 Code states that health professionals have to obtain pregnant women's signatures before terminating their pregnancies, it does not clearly state that women's signatures ought to be based on their informed consent. Such an unclear legislative situation is likely to be intentional by law makers in order to create space for the state to exert its discretion over women's fertility. For example, women can be persuaded or even forced to sign a termination agreement if their pregnancies are not authorised by local family planning centres. The analysis of how the state constructs the image of glorious mothers suggests that by using abortion services to control women's fertility, the state becomes defined by law as the procreative decision maker for female citizens.

Therefore, restricting the state's coercive involvement in abortion decisions is essential to establish a regulatory model in accordance with the principle of respect for autonomy. The discussion of the English method of regulating abortion in chapter 3 suggests that an initial step in achieving the above tasks can be separating the legislation on abortion from the state's population policies. As has been discussed in chapter 4, family planning services and the state's population policy are both regulated in the 2002 Code. Blurring the line between abortion law and population policy serves to enhance the state's use of family planning services to accomplish its population objectives. This unclear boundary puts women in a disadvantaged situation from which they are disempowered to act on their autonomously held desires concerning procreation.

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As has been discussed in chapter 4, while law defines abortion as a family planning method, in practice it is often used by the party state as a tool to facilitate the implementation of the birth control policy. Because of the state's controlling intervention, the provision of abortion services serves to subject women's procreative decision-making to the state's policy-making concerning population. As a result, law fails to protect women's right to informed consent in abortion decisions. Although the 1994 Code states that health professionals have to obtain pregnant women's signatures before terminating their pregnancies, it does not clearly state that women's signatures ought to be based on their informed consent. Such an unclear legislative situation is likely to be intentional by law makers in order to create space for the state to exert its discretion over women's fertility. For example, women can be persuaded or even forced to sign a termination agreement if their pregnancies are not authorised by local family planning centres. The analysis of how the state constructs the image of glorious mothers suggests that by using abortion services to control women's fertility, the state becomes defined by law as the procreative decision maker for female citizens.

Therefore, restricting the state's coercive involvement in abortion decisions is essential to establish a regulatory model in accordance with the principle of respect for autonomy. The discussion of the English method of regulating abortion in chapter 3 suggests that an initial step in achieving the above tasks can be separating the legislation on abortion from the state's population policies. As has been discussed in chapter 4, family planning services and the state's population policy are both regulated in the 2002 Code. Blurring the line between abortion law and population policy serves to enhance the state's use of family planning services to accomplish its population objectives. This unclear boundary puts women in a disadvantaged situation from which they are disempowered to act on their autonomously held desires concerning procreation.

The analysis of the state-centred model in chapter 4 shows that abortion is currently regulated by the 1994 Code and the 2002 Code. Nonetheless, these two codes were not passed because of the government's desire to enhance women's control of reproductive choices. They were enacted for two main reasons: avoiding births with so-called undesirable traits and reducing the population growth. Therefore, I suggest that to build the regulatory model on the principle of respect for autonomy, a new code is required to protect women from coerced abortions. This would restrict the state's abuse of power and also promote women's access to termination services by making government funding available to all female citizens of reproductive age. More specifically, the new code should ensure that the provision of abortion services is subject to women's informed consent and that unmarried women are covered by the family planning funding scheme. Furthermore, to empower women to exert autonomy over reproductive decisions, law's construction of women whose reproductive decisions are not consistent with the state's population policy should change. As has been discussed in section 2 of this chapter, under the state-centred model, to be considered as glorious citizens, women have to obey the national birth control policy. By constructing the image of glorious citizens, successive governments can justify their failure to fulfil the negative and positive obligations to promote women's reproductive autonomy. Therefore, the existing limits on unmarried women's access to funded abortion services should be removed. The comparative analysis offered in section 1 of this chapter shows that one of the reasons why women's autonomy is comparatively respected under the medical-centred model is that it does not consider women's marital status as a necessary condition for accessing funded services.

As has been argued earlier in this section, similar to the suggested reforms of the English regulatory model, the above proposals for reform of Chinese abortion law also carry a real risk,

that is, it will be difficult to convince the current Chinese polity to accept these reforms and relinquish some control to women. This problem is more serious in the Chinese political climate which, as has been discussed in section 1 of this chapter, is less woman-friendly than the English one. This risk will be further discussed in section 6 of this chapter. In addition, the above proposals for law reform have at least two shortcomings. First, removing the limits on unmarried women's access to abortion funding can alienate people who are not against the idea of promoting abortion services, but have a conservative attitude to premarital sex. As has been discussed in chapter 4, although abortion is morally and legally less contentious in China, premarital sex is a traditional social taboo. The analysis of MSI's abortion services in China shows that many people do not have a supportive attitude towards giving financial support to unmarried women who need abortion because they believe that this can encourage premarital sex. To address this problem, I shall return to the discussion provided earlier in this section about the decision whether or not to have sex before marriage and how it should be made according to individual preferences. Moreover, considering the legal age for first-time marriage is comparatively high (20 for women and 22 for men) and the steady rise in citizens' average age for first-time marriage in China, the amount of premarital sex and the number of premarital abortions will further increase in future. For instance, according to a study conducted by Li and Yang in 2009, in Shanghai females' average age for first-time marriage was 30 and the male average was 32.[109] Thus, limiting abortion funding to married women can force unmarried women who are from socioeconomically disadvantaged backgrounds to resort to unreliable providers.

Another risk is that reducing the state's control over the provision of abortion can allow health professionals to control women's decision-making. The analysis of the current role taken by

[109] Xing Li and Yang Yang (2010) 'Shanghai Nanxing 09 Pingjun Jiehun Nianling Chaoguo 30' *Dongbei* available at http://internal.dbw.cn/system/2010/01/12/052305602.shtml (last accessed 10 August 2011)

Chinese doctors of gynaecology and obstetrics in section 3.4 of this chapter suggests that they are not entitled to judge women's abortion requests because of the state's use of abortion as a method of avoiding extra births. Therefore, for the women who are covered by the national family planning scheme or those who can afford private services, the state-centred model enhances their control over abortion decisions. Removing the controlling influences of the state's policy-making concerning population over the regulation of abortion can cause changes to the current role of the medical profession in providing termination services. Nevertheless, these changes do not lead to increasing medical discretion over women's procreative decision-making if law reframes the role of abortion providers according to the principle of respect for autonomy. To do so, I suggest the following proposals.

4.2. Reframing the Role of Health Professionals

As discussed in section 1.2 of chapter 4, currently in China legal abortion providers are authorised public and private hospitals. The comparative analysis offered in section 1 of this chapter suggests that although health professionals who work in these hospitals do not have the power to decide whether women are legally eligible for abortion, they fail to perform the positive obligation to enhance women's procreative decision-making. The main reason why abortion providers normally do not refuse women's abortion requests under the state-centred model is the state's implementation of the population control policy.[110] In other words, the performance of abortions is subject to successive governments' population plans. This puts women's access to abortion services in danger because these abortion providers will reject women's termination requests when the state changes its population strategy. The discussion of health professionals' response to the ban on abortion imposed by the Maoist government in section 2.2 of chapter 4 shows that this risk is high in China.

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[110] For a discussion of the role of health professionals in the context of abortion in China, see section 3.4 of chapter 4 and Jingbao Nie (2005) *Behind the Silence* (Oxford: Rowman & Littlefield Publishers) pp.40-44

Since, in the Chinese family planning context, health professionals' provision of abortion is decided by the state's population policy more than by law, space is created by law makers for successive governments to use the medical profession as the gatekeeper of abortion services in order to control female citizens' fertility. To reframe health professionals' role according to the principle of respect for autonomy, I argue that an initial step is that abortion law should clearly define their role and obligations. The analysis of medical limits on abortion services offered in section 3.4 of chapter 4 suggests that health professionals in the Chinese family planning context act as the state's agents, so they are not keen to know whether women's abortion decisions are made autonomously. In other words, their performance of abortions is respectful of the state's population policy rather than women's right to informed consent.

To give valid consent to medical treatments, as has been discussed in chapter 2, patients should be able to obtain and understand information about their possible benefits or side effects. Due to the lack of proper information before having actual termination treatments, women can experience difficulty in giving informed consent. As Winikoff et al have observed, many Chinese women who had a surgical abortion did not even know that they could have chosen medical abortions because they either misunderstood medical abortions or were not told about them.[111] Additionally, the analysis offered in section 3.4 of chapter 4 shows that the main cause of the high rate of repeat abortions among teenagers and unmarried young women is that they often lack knowledge about how to avoid accidental pregnancies. Thus, their control over their fertility will be increased if they are able to gain relevant contraception information from abortion providers after their first abortions.

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[111] Beverly Winikoff, Irving Sivin, Kurus Coyaji, Evelio Cabezas, Xiao Bilian, Gu Sujuan, du Ming-Kun, Usha Krishna, Andrea Eschen and Charlotte Ellertson (1997) 'Safety, efficacy, and acceptability of medical abortion in China, Cuba, and India: A comparative trial of mifepristone-misoprostol versus surgical abortion' 10(6) *International family Planning Perspectives* 73-89

As has been discussed in section 3.2 of chapter 2, being respected as an autonomous decision maker should be considered as a right, not a duty for women.[112] Women who need abortion have the right to keep their decision-making independent from health professionals' controlling influence, but they also have the right to request medical support, such as obtaining information about the side effects of treatment and contraceptive options after treatments, from termination service providers. The discussion of MIS's termination services indicates that women's capacity to act on their autonomously held abortion decisions can be promoted when non-directive information is offered before and after having actual treatments. In chapter 3 I argued that given that in England women's awareness of procreative rights and their access to information about family planning and funded abortion services are much more developed compared to women in China, law's respect for autonomy should ensure that their decision-making concerning reproduction is free of manipulation by health professionals. Nevertheless, in Chinese family planning, where the state's intervention blocks unmarried women's access to contraceptive and abortion information, abortion providers can play a role in reducing the disadvantages for unmarried women that are caused by the state's population policy.

To change the role of health professionals as the state's agents, I suggest that an abortion code that is separate from the regulation of population figures should first require health professionals to offer actual treatments according to women's informed consent; second, it should ensure that they offer non-directive information about family planning before and after actual treatments on demand. However, the provision of information should be non-directive and optional, so it helps women who need abortion to better understand termination procedures and suitable contraceptive options rather than manipulating their decision-making. In addition, when women

[112] See JK Mason (2006) *Law and Medical Ethics* (seventh edition) (Oxford: Oxford University Press) pp.8-10 Marson has argued that 'respect for autonomy' should be regarded as a right but not a duty for patients.

understand relevant treatment information and make up their mind to have an abortion, termination of pregnancy should be carried out as soon as possible.

While the proposal discussed above aims to ensure that health professionals' performance of abortions enhances women's decision-making, I emphasise the argument made in chapters 3 and 4 that abortions should not necessarily be prescribed or performed by health professionals in hospitals.[113] Reframing the role of health professionals also involves challenging law limiting the provision of abortions to registered physicians and hospitals. The analysis in section 3.4 of chapter 4 indicates that medical limits were imposed by the state to facilitate using abortion services to control women's fertility. Thus, challenging these limits on the performance of abortion will reduce the controlling influences of the state's population policy on women's decision-making concerning procreation. Therefore, I suggest that the medical limits discussed in section 3.4 of chapter 4 should be removed. Under the state-centred model, surgical abortion must be performed by registered physicians and in public hospitals or authorised private sector units and medical abortions must be prescribed by registered physicians and administered in public hospitals or authorised private sector units. Because of the limited number of registered physicians in comparatively undeveloped rural regions,[114] law should permit *chijiao yisheng* (literally, barefoot doctors) to carry out abortion services.[115] As has been discussed in chapter 4, barefoot doctors emerged in the Maoist era. They were not health professionals in the real sense and were often lay persons who were rural residents. Barefoot doctors were paid by the Maoist government to practise in those undeveloped rural areas where registered physicians were lacking after attending some short medical training courses and spending some time practising as registered physicians' assistants in public hospitals. The Maoist programme of training barefoot

[113] See section 3.2.1 of chapter 3 and section 3.4 of chapter 4
[114] *China Health Care Year Book 2008* (2009) (Beijing: Xiehe Medical University Press) p.40
[115] For more information about barefoot doctors, see section 3.4 of chapter 4 or Daqing Zhang and Paul Unshuld (2008) 'China's Barefoot Doctors: Past, Present, and Future' 327(9653) *Lancet* 1865-1867

doctors was successful in promoting basic medical services, such as delivery, in comparatively undeveloped areas where professionally trained medical practitioners were not available.[116] In order to make medical practice more formal and professional, the barefoot doctor regime was repealed in 1985.[117] As a result, their performance of abortions was also criminalised. To remove the limits mentioned above, I suggest that a new barefoot-doctor programme is required, particularly in rural areas where registered physicians are not available. More specifically, the government should encourage nursing staff and lay persons who are keen to offer reproductive services in rural areas and provide them with financial support to receive proper training. Additionally, the proposal to remove the limit on where abortion can be lawfully performed, analysed in section 3 of this chapter, is also applicable to reforming the Chinese law of abortion. Permitting and promoting the administration of early medical abortions at home rather than in registered public and private hospitals can significantly enhance the procreative decision-making of women in comparatively undeveloped areas where authorised medical institutions are not available.

The above proposals have at least two disadvantages. First, even if law reframes health professionals' obligations in the context of abortion according to the principle of respect for autonomy, it cannot guarantee their fulfilment in practice. What could be worse is that health professionals' obligation to enhance women's decision-making by giving non-directive information may turn into their exercise of medical discretion. To solve this problem, I suggest that although the government should not manipulate health professionals into obeying its birth control policy, it can play a role in supervising their performance of negative and obligation obligations. Since the government ought to protect citizens' health in accordance with the Constitution, it should ensure health professionals' effective fulfilment of their professional

[116] See section 3.4 of chapter 4
[117] Sydney White (1998) 'From "Barefoot Doctor" to "Village Doctor" in Tiger Springs Village: A Case Study of Rural Health Care Transformations in Socialist China' 57(4) *Human Organization* 480-490 p.480

obligations to enhance women's reproductive autonomy, which, as has been discussed in chapter 2, is essential to satisfy women's basic needs for health. Furthermore, I stress that the session of information-giving should not be compulsory. It is not a necessary condition for having abortion; and it is not necessarily carried out by health professionals in the form of face-to-face conversations. As has been analysed in an earlier part of this section, information can be given on abortion suppliers' websites or provided by lay persons, such as administrative staff members, on the internet.

Second, there is a risk that encouraging nursing staff, barefoot doctors and even lay persons to provide abortions may become the government's excuse not to improve the low quality of family planning services in rural areas by promoting the existing uneven health care development. Nevertheless, the application of this proposal would fulfil urgent practical needs. Moreover, to prevent the government from using medical limits to keep closer control over women's fertility, deprofessionalising abortion is required. Additionally, as has been discussed in section 3.4 of chapter 4, under the state-centred model, the government's controlling involvement also medicalises abortion. Removing the limits on the performance of abortions will therefore avoid the problems caused by the medicalisation of abortion discussed in chapter 3.

5. How to Regulate Controversial Abortions

In chapters 3 and 4 I have discussed three special types of abortions in England and China: late abortion, termination of foetuses with a disability and sex-selective abortions with no medical needs. Another type of abortion that recently triggered considerable controversy in England is post-IVF abortion. The Human Fertilisation and Embryology Authority Statistics released in

2010 reveal that about 80 out of 22,856 assisted conceptions end in abortion.[118] This has generated intense media interest and caused consternation among medical professionals. The majority of responses from the media and medical professionals are negative.[119] The emergence of knowledge about these controversial abortions raises the question of to what extent law should endorse women's autonomy to access abortion in these circumstances. In section 3.1 of chapter 3 and section 2.2.2 of this chapter, I examined how law having a time limit for the performance of abortions is problematic and scrutinised why law should not ban abortion after 24 weeks (although in practice it is rarely performed respectively). In this section, I focus on abortions of foetuses with a disability and 'social' sex-selective abortions and post-IVF abortions and address the question of why the regulation of these abortions should work within the framework of respect for autonomy.

The methods of regulating these special types of abortions in England and China are quite similar. For example, abortions on the grounds of foetal disability are allowed in England and China. Under the English medical-centred model, the authority to assess women's eligibility for abortion of disabled foetuses is left in the hands of doctors. In China, because of the government's support for eugenics, putative mothers are even encouraged by health professionals to terminate their pregnancies if the foetuses are diagnosed with an abnormality. According to the Act on the Prohibition of Prenatal Sex Diagnosis and Sex-Selective Abortion with No Medical Needs 2002, 'social' sex-selective abortions are banned in China. Similarly, they are also prohibited in England as sex-selection with no medical needs is not included in any

[118] BBC Online News (07 June 2010) '80 IVF fetuses are aborted a year, figures show' available at http://news.bbc.co.uk/1/hi/health/10254133.stm (last accessed 28 December 2011)

[119] The Mail (07 June 2010) 'Dozens of IVF babies aborted 'after women change their minds about becoming a mother' available at http://www.dailymail.co.uk/health/article-1284384/IVF-babies-aborted-women-change-minds.html (last accessed 28 December 2011); Time Online News (06 June 2010) 'IVF babies aborted as mothers lose in love' available at http://www.thesundaytimes.co.uk/sto/news/uk_news/Health/article310151.ece (last accessed 28 December 2011) and the Sun (07 June 2010) 'Test-tube women change minds' available at http://www.thesun.co.uk/sol/homepage/woman/health/health/3002225/80-IVF-mums-a-year-have-abortions.html (last accessed 28 December 2011)

of the four statutory grounds. In relation to post-IVF termination, while currently its regulation is not different from that of abortion of a naturally conceived pregnancy, there is a possibility that women's access to abortions after assisted reproduction will be limited in future. Given that post-IVF abortion provoked strong criticisms from both health professionals and medical scientists, it is likely to be used as a new platform for the anti-choice lobby to argue for more restrictions on women's procreative decision-making. In China, as IVF services are mainly self-funded, terminating assisted reproduction is comparatively unregulated.

From the above discussion of the existing means of regulating abortions of disabled foetuses and sex-selective abortions with no medical needs, it can be seen that they do not aim to promote women's autonomy, but to maintain medical and state-controlling influences on the provision of abortion services. For example, in England, women's requests for abortion on the grounds of foetal abnormality must be subject to health professionals' opinions on whether the disabilities can be viewed as serious or not.[120] Nevertheless, as has been discussed in section 2.2.1 of chapter 3, the decision of whether or not to continue a pregnancy when foetuses are diagnosed with a potential disability would better be made by putative parents, particularly mothers, because they are better placed than doctors to judge whether they are capable of dealing with the difficulties of raising a child with an so-called undesirable trait. When women make the decision to end reproduction when foetuses are diagnosed with a disability, this decision can be treated as a judgement about their personal ability to deal with the stresses caused by raising a child with undesirable trait(s). This does not necessarily mean that they have any discriminatory views on existing disabled persons. Thus, women's decision-making rather than medical discretion should be treated seriously in the context of termination of pregnancy on the disability grounds.

[120] See section 2.2.1 of chapter 3

Furthermore, imposing a ban on sex-selective abortions on social grounds is not descriptively and normatively desirable. As has been discussed in section 3.1 of chapter 4, before the widespread use of prenatal screening and abortion in China, the phenomena of female infanticide and abandoning female newborns were not unusual, although they were criminalised. Rather than prohibiting and criminalising sex-selective abortion, which is a product of people's sexist belief, the state should improve sex equality and women's social status. Moreover, from the analysis of the seeking of sex-selective abortions on social grounds by circumventing the ban, set out in section 3.2.3 of chapter 3 and section 5.1 of chapter 4, it can be seen that the enforcement of the ban is unlikely to be effective and would also deepen the inequality against women who are socioeconomically disadvantaged.

Currently, the gender rate is comparatively less skewed in big cities, such as Shanghai, where women's education and employment rates are higher than in rural areas. This means that instead of conditionally limiting women's a ccess to abortion, challenging people's sexist belief by increasing women's well-being and reducing gender inequalities can more effectively redress the sex imbalance in the national population. More specifically, I suggest that in the areas where the sex rate is skewed and abortion of female foetuses is common, the state should increase female student enrolments. For example, girls from families with financial difficulties should be eligible for free school books, buses, meals and uniforms and their parents should be given an annual allowance until they finish compulsory state education. These financial incentives to some extent could prevent these girls from being forced to quit school earlier by their parents in order to relinquish educational opportunities to their brothers or become low-paid workers in cities. In the meantime, to promote women's employment rate, the state should seek effective machinery for

the enforcement of the statutes relating to gender equality in the Labour Protection Code 1995,[121] such as promoting women's right to sue and to claim compensation from employers who fail to offer maternity benefits or to obey the principle of gender equality in recruitment and payment.

Currently, the number of assisted conceptions that end in abortion, as has been mentioned above, is very small. Furedi has claimed that the fact that only 0.7 per cent of 22,856 pregnancies following assisted conception were terminated does not 'flag up a warning about poor quality care, or flippant consumerism'.[122] Nonetheless, my concern is that given the growing popularity of assisted reproduction,[123] an increase in post-IVF abortions may drive law makers to restrict access to abortion services. As has been discussed in section 3.2 of chapter 2, the decision to carry pregnancy to term not only affects women's physical status, but also, and more importantly, affects their daily lives significantly by bringing forthcoming maternal responsibility. Women are not likely to accurately predict the strains and stresses brought about by reproduction even if conception was planned. Assisted reproduction cannot guarantee women the ability to cope with the future strains and stresses or help them fulfil the duty to support a child through to adulthood. Thus, the autonomy of women whose pregnancies were conceived by IVF should not be diminished.

Thus, my suggestion is that termination of pregnancy in these special circumstances should be regulated according to the principle of respect for autonomy. To do so, law should keep medical and state controlling interference to a minimum. However, similar to the proposals for law reform made in sections 3 and 4 of this chapter, bringing the regulation of these types of

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[121] The Labour Protection Code was passed at the Eighth Meeting of the Standing Committee of the Eighth National People's Congress in 1994 and came into force in 1995. It belongs to national basic law.

[122] Ann Furedi (2010) 'Keeping abortion decisions in context' 562 *BioNews* available at http://www.bionews.org.uk/page_64319.asp (last accessed 28 December 2011)

[123] *Kiddicare News* (18 May 2010) 'IVF will be main method of conception within 10 years' available at http://www.kiddicare.com/webapp/wcs/stores/servlet/newsarticle0_109924_10751_-1_10001 (last accessed 28 December 2011)

abortions into line with the principle of respect for autonomy also faces two problems that will be discussed in section 6 of this chapter: limited effectiveness in practice and a low possibility of success in the English and Chinese political climates. While abortions in the above circumstances provoked more controversy, they should still be regulated according to the principle of respect for autonomy. Imposing legal limits on the reasons for seeking abortions will lead to deeper inequality for and more oppression of women, particularly those who are socioeconomically disadvantaged. Because 'reproduction is an experience full of meaning and importance for the identity of an individual and her physical and social flourishing',[124] any legal involvement in prohibiting or regulating would be wrong unless there were sound reasons for doing so.[125]

6. Other Limits to Law Reform

While the discussion of the above proposals accepts that law reform can be an effective method of enhancing women's control of reproductive choices, law reform has its limits. In sections 3, 4 and 5, I discussed the problems that may be caused by the suggested reforms. Additionally, these proposals have two other limits. In this section, I discuss these two limits and examine how to reduce them. Then I scrutinise why feminists should be active in engaging with law reform whilst being wary of its limits.

First, the proposed law reforms have very little chance of success in the existing English and Chinese political climates. The analysis of the changes to the legislation of abortion made by successive English and Chinese governments in chapters 3 and 4 shows that neither of these two

[124] John Robertson (2003) 'Procreative Liberty in the Era of Genomics' 29(2003) *American Journal of Law & Medicine* 229-487 p.450
[125] Stephen Wilkinson (2010) *Choosing Tomorrow's Children: the Ethics of Selective Reproduction* (Oxford: Clarendon Press) p.12

polities is keen to follow the principle of respect for autonomy because they are afraid of losing either votes or control. Their political unpopularity also weakens the hope of having the above proposals discussed in parliament and the people's congress. As has been discussed earlier in this chapter, the current English and Chinese means of governing abortion are accepted by people from the middle ground who are not strongly against abortion, but advocate restricting the availability of abortion and financial support to certain women in some limited circumstances. Even in China, where abortion is generally less contentious, people generally do not find the limits on unmarried women's access to funded abortions problematic because premarital sex is a taboo subject.[126] Therefore, both governments are not strongly motivated by the desire to enhance women's control over procreative decisions to bring their regulatory model of abortion into line with the principle of respect for autonomy. Considering these practical and political realities, an alternative to the above proposals for law reform in England is to apply them to abortions in the first trimester, namely before 13 weeks' gestation. This would make reform of English abortion law consistent with other western European jurisdictions where termination of early pregnancy is comparatively 'elective',[127] such as in France where the regulation of abortions before 12 weeks is more permissive[128] and the self-administration of abortifacient drugs was legalised in 1998.[129] In China, an alternative to extending the family planning funding scheme to all unmarried women is to provide women who have financial difficulties, such as teenagers, college students, unemployed or low-paid women, with free or discounted rates for abortion services.

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[126] For a discussion of people's attitudes towards premarital fertility in China, see section 3.2 of chapter 4 and section 4 of this chapter

[127] Sally Sheldon (1997) *Beyond Control: Medical Power and Abortion Law* (London: Pluto) p.158

[128] Melanie Latham (2002) *Regulating reproduction: A century of conflict in Britain and France* (Manchester: Manchester University Press) p.102

[129] Rebecca Cook and Bernard Dickens (2003) 'Human rights dynamics of abortion law reform' 25(1) *Human rights quarterly* 1-59 p.32

The second unanswered question that the proposed law reforms could face is to what extent they can be effective in facilitating women's reproductive decision-making in practice. As Carol Smart has observed, the usefulness of any law reform may be limited because '...once enacted, legislation is in the hands of individuals and agencies far removed from the values and politics of the women's movement'.[130] For example, although the current regulation of abortion in China imposes less restrictions by comparison with that in England, Chinese women's procreative autonomy is treated with less respect in practice. Furthermore, law reform can have different effects on women from different backgrounds or in different circumstances. For instance, under the state-centred model, the experience for women from comparatively socioeconomically disadvantaged backgrounds of accessing abortion can be very different. Similarly, under the medical-centred model, accessing abortion for women who have a supportive GP is experiencing a 'choice'; but for women whose GP states a conscientious objection, requesting abortion is a stressful experience.

As has been discussed in section 1 of this chapter, law reform targeted at empowering women to act on autonomously held desires concerning reproduction can eventually turn into 'lip service' or at least fail to achieve its original goals in societies where women's awareness of human rights is comparatively weak, such as China. The large number of women who have abortions of female foetuses does not suggest that they are empowered by the state-centred regulatory model to exert autonomy over their abortion decision-making. It is similar to the amputation decision discussed in chapter 2, which was made by the mother who voluntarily cut off her hand in order to save her daughter, who was suffering from leukaemia, effectively begging for money. In some circumstances when choices are very limited, people can only choose an option which is not likely to make them worse off. For instance, in the amputation case, the mother chose to use

[130] Carol Smart (1989) *Feminism and the Power of Law* (London: Routledge) p.164

amputation to try to obtain more money from begging rather than to let her daughter die. Similarly, some women choose to abort female foetuses so they can be less pressurised or violated by their husbands or families-in-law. Nevertheless, law, as has been argued in section 5 of this chapter, should not prohibit women from accessing sex-selective abortions on the social grounds unless it can ensure that women will not receive unwanted harmful consequences caused by making procreative decisions which are inconsistent with traditional beliefs.

These limits to law reform can remind feminists to beware of the 'siren call of law', which is defined by Carol Smart as being that although feminists try to be critical of existing regulations, they can also be seduced by law and also attempt to use new or more laws to improve old laws.[131] Feminists may not just be seduced by law, but may also be deceived by the neutral and powerful image of law. Because of this image, when problems occur, feminists often seek alternatives to current regulatory methods. However, the existence of law itself can hardly be described as a woman-friendly phenomenon. As has been discussed in chapter 2, law in practice is not what its traditional image depicts: a neutral and dispassionate institution which always resolves disputes justly and regulates social relations fairly. According to the analysis of Naffine's three 'phrases' in chapter 2,[132] laws are built on and serve to maintain the social orders that often privilege men.

While I argue that feminists should not overestimate the usefulness of replacing 'old' and 'bad' laws with 'new' and 'good' ones in solving problems and establishing an ideal regulatory system, this does not lead to the conclusion that law should be left unchallenged by feminists. The analysis in chapter 2 suggests that since law is also a system of knowledge rather than just a system of rules, it can formulate and disqualify certain truths and discourses. By actively

[131] Ibid. p.160
[132] For a discussion of Naffine's three 'phrases', see section 3.2 of chapter 2 and also Ngaire Naffine (1990) *Law and the Sexes: Explorations in Feminist Jurisprudence* (London: Allen&Unwin) pp.4-7

engaging with law, feminists are able to shape alternative understandings and visions of those authorised truths and discourses which are in fact 'deeply antithetical to the myriad concerns and interests of women'.[133] Thus, the crucial question is not how much political possibility of success these proposed reforms have, but to what extent they can challenge the current thinking of abortion and women's autonomy in the English and Chinese jurisdictions, such as how abortion is defined and how the images for women, health professionals and the state are constructed. In this respect, the proposals in this chapter that are derived from the comparative study of the English and Chinese regulatory experiences are particularly helpful because, as discussed in section 1 of this chapter, they offer a different angle from which national feminists who live in their own legal context long enough can more clearly view and analyse the problems of their national abortion laws in depth.

Conclusion

In this chapter, I have focused on two main questions: first, what lessons English and Chinese law makers can learn from comparing and contrasting their regulatory models of abortion and second, what proposals can be derived from these lessons to build a regulatory model according to the principle of respect for autonomy. To address the first question, I have discussed the value of comparative methods in sections 1 and assessed the strengths and weaknesses of the English medical-centred and Chinese state-centred models in how they treat women's autonomy in section 2. In England, the medical-centred model causes the power imbalance in the relationship between women who need abortion and their doctors. In China, access to abortion is reliant on the party state's policy-making on population, so abortion is used to facilitate its population goal. Thus, the power imbalance in the relationship between women who decide to end their

[133] Carol Smart (1989) p.164

pregnancies and their doctors in England and that in the relationship between female citizens and the state can be redressed under an autonomy-based model. Furthermore, by contrasting these two regulatory models, I have argued that there is a paradox that while the Chinese law of abortion superficially looks more respectful of autonomy than the English law of abortion, in practice it is less so.

To highlight the significance of establishing an autonomy-based model in England and China, in section 2 I have examined the images of 'irrational women' and 'glorious mothers', which are constructed by the two models because of their embrace of the gendered assumption of normal womanhood as motherhood. Although in practice women's procreative autonomy is treated with less respect in China, the English and Chinese regulatory models of abortion are both grounded in this sexist assumption. Moreover, the English and Chinese abortion regulatory models are both built on the assumption that women need regulations and restrictions to act 'rationally' or 'gloriously' in the context of procreation. In seeking to challenge how English and Chinese laws construct the images of women who need abortion, possible proposals for reform of English and Chinese abortion laws have been drawn up in sections 2 and 3 respectively. In England, the establishment of an autonomy-based model should achieve the following objectives: completely decriminalising seeking termination of pregnancies, removing the limits on the statutory reasons and the restrictions on the time when women can request abortion on the social grounds, removing the requirement for two doctors' approval and the restrictions on who can lawfully carry out terminations and where they can take place, requiring health professionals to publicise their conscientious objection in advance and restricting the range of abortion treatment to which they can claim the right to conscientiously object to surgical procedures. In China, building an autonomy-based model requires redressing the power imbalance between female citizens of reproductive age and the state and reframing health professionals' role in the provision of

abortions. In section 4, I have discussed why the special types of abortions should still be regulated according to the principle of respect for autonomy although they caused more moral and legal controversies. While the proposed law reforms could be effective in achieving changes, they will face problems and may even lead to backlashes. Therefore, in sections 3, 4 and 5, I have examined risks which are likely to be posed by these proposals.

Based on the observation that law is often not a dispassionate institution which always provides just and fair solutions to social problems, I have further discussed the limits to the proposals for law reform in section 6. Nonetheless, feminists should not have blind faith in law's usefulness and effectiveness in promoting women's procreative autonomy. These limits do not only exist in English and Chinese jurisdictions. For example, the recent multiple infanticide case in France, where abortion is already legalised, shocked the public in Europe.[134] While it may be too early to blame Dominique Cottrez's infanticide on the French law of abortion, this case may raise two questions: why this 45-year-old mother and grandmother was fully aware of her unwanted pregnancies but said that she found it difficult to seek support from doctors in a country where abortion is legalised and why at least a dozen similar cases 'have come to light since 1984' [135] in a country where law permits women to have abortion. These questions can be a reminder for feminists that laws concerning reproduction which appear to be gender-neutral often disappoint their hopes in practice. Whilst stressing the problems of the proposals for reforms, I have scrutinised how to reduce the risks posed by these problems and sought alternatives which have a good chance of success in the current English and Chinese political climates.

While the effectiveness of law reform in enhancing women's reproductive decision-making is limited, I have argued that feminist engagement with law reform is important because it helps in

[134] BBC News (29 July 2010) 'Frenchwoman 'admits smothering eight newborn babies' available at http://www.bbc.co.uk/news/world-europe-10799539 (last accessed 29 August 2011)
[135] Ibid.

reframing the current approach adopted by law to construct abortion and women who need abortion in a woman-friendly way. The proposals suggested in this chapter are particularly useful in this respect because they were derived from the comparative study of two jurisdictions. They therefore offer a chance for national reformers who have been used to their domestic regulatory model to explore its problems from a different standpoint. Although I suggested drawing up reform strategies and that rhetoric should take account of the differences between the English and Chinese cultural and historical contexts, this does not rule out the possibility of directly transplanting some of each jurisdiction's successful regulatory experiences. Each jurisdiction, as discussed in section 1, has its own advantages in enhancing women's control over abortion choices. This chapter will end with an attempt to exemplify some specific lessons that the two jurisdictions could directly learn from each other.

In England, private abortion providers, such as BPAS and MSI, should be allowed more freedom to widely publicise their termination services on the internet and TV, and in newspapers and magazines.[136] Moreover, health centres, family planning clinics, local councils and student unions should be encouraged to offer information about where and how to gain an abortion on demand, so women do not have to access this information from their GPs. In China, although abortion pills are prescribed by registered physicians and available in hospitals and authorised private medical sector units, women only have to visit hospitals once. On the same day that a woman requests a medical abortion and a registered physician believes that she is clinically suitable, she will be prescribed both mifepristone and misoprostol and take the former in the

[136] In May 2010, an advertisement for abortion services by Marie Stopes was screened for the first time on UK television. However, because of the limits imposed by the Broadcast Committee of Advertising Practice on post-conception advice services adverts, instead of mentioning the word of 'abortion', the advertisement only asked the question 'Are you late?' The advert was in the form of giving information rather than providing services. For more information, see the Christian Institute (19 May 2010) 'First ever abortion ad to air on national TV' available at http://www.christian.org.uk/news/first-ever-abortion-ad-to-air-on-national-tv (last accessed 28 December 2011); The Telegraph (20 May 2010) 'Britain's first abortion television advert in spite of ban' available at http://www.telegraph.co.uk/health/healthnews/7741365/Britains-first-abortion-television-advert-in-spite-of-ban.html (last accessed 28 December 2011) and BBC News (20 May 2010) 'Abortion advice organisation Marie Stopes to air TV ad' available at http://news.bbc.co.uk/1/hi/uk/8693732.stm (last accessed 28 December 2011)

hospital. Then she can go home to administer the second part of the termination procedure. After the abortion is completed, she can return to the hospital to have an ultrasound scan in order to make sure the treatment has worked. Law makers in England can learn from this experience and allow women to administer the second dose of abortifacient drugs, namely misoprostol at home. In China, the state-centred model discourages medical professionals from performing an active role in providing abortion seekers with non-directive information before and after actual termination treatments. To improve this situation, I suggest that lessons can be learnt from English charity providers' experiences of carrying out abortion services. Instead of only supplying actual termination treatments, staff members in public hospitals, private medical sector units and family planning centres ought to be active in giving free information and advice about how to use reliable contraception after abortion. In England, free and confidential contraception and abortion advice and services are designed to enhance young people's control over procreative decisions, such as the sexual and reproductive services which are available in 'Brook'[137] and targeted at people under the age of 25. Nonetheless, the current means of regulating abortion in China put unmarried young women in a disadvantaged position. To reduce the high rate of unprotected sex and repeat abortion among young women, similar services for young women should be promoted in public hospitals, authorised abortion providers and local family planning centres.

[137] Brook is the largest young people's sexual health charity in the UK. It provides confidential sexual health services, support and advice to young people under the age of 25. For more information, see its website, available at http://www.brook.org.uk/professionals/about-brook (last accessed 23 January 2012)

Chapter 6

Conclusion

In this thesis, I have explored the role of the English and Chinese models of the regulation of abortion in promoting and respecting women's autonomy in order to achieve four aims. Although I draw two different models of abortion law in this thesis – the medical-centred model and the state-centred model, I do not view them as two totally different regulatory methods. As discussed in chapters 3, 4 and 5, under both models, abortion is subject to the changes made by law makers and is legally provided by the medical profession. Furthermore, in both systems, there is a connection between the population policy and the regulation of abortion; there are medical restrictions on the performance of termination. Moreover, by the lens of gender, the two regulatory models are both motivated by the desire to assert the assumption of womanhood and to maintain the existing social relations. In addition, under the two models, women who need abortion services are not treated as autonomous decision makers. The first objective of this doctorate project was to develop a more defensible feminist approach to understanding the principle of respect for autonomy in the context of abortion. The second goal was to examine the extent to which women's decision-making concerning reproduction is not respected sufficiently under these two models. The third aim was to suggest possible proposals to reform English and Chinese abortion laws by comparing and contrasting these two models. The final aim was to scrutinise the possible limitations to these proposals. In this concluding chapter, I first consider to what extent the above objectives were accomplished in the preceding chapters. In doing so, the main themes and arguments that emerged from the discussion throughout this thesis are revisited.

1. The Principle of Respect for Autonomy in the Context of Abortion

The principle of respect for autonomy has been at the centre of health care ethics and law since the final decades of the twentieth century.[1] To examine what role law ought to play in promoting women's autonomy in abortion decisions, in chapter 2 I first critically discussed the mainstream approach to the term autonomy and then sought to explore it from a feminist perspective. I argued that the values that stem from the hierarchical analysis, such as independence and non-intervention, can help feminists in building solid theoretical grounds for procreative rights. Nonetheless, the traditional analytical approach is less helpful in producing strategies that can empower women to exert control over their abortion decision-making. Moreover, through the lens of gender, access to abortion services should not only be viewed as a health-orientated issue, which prevents 'unnecessary maternal mortality',[2] but ought also to be considered as essential to satisfying women's basic needs for control over their daily lives.

Furthermore, the feminist approach to the concept of autonomy, offered in chapter 2, suggested that since women, particularly those who are socioeconomically disadvantaged, have proven to have less power to act on their autonomously held desires concerning reproduction compared with male peers,[3] promoting women's autonomy in the context of abortion requires the state and the medical profession to provide adequate support. Thus, law's respect for women's autonomy in abortion decisions not only involves recognising their capacity to form high-level desires concerning procreation, but also, and more importantly, should ensure the availability of support from government and the medical profession on demand. More specifically, law should require

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[1] Mary Donnelly (2010) *Healthcare Decision-making and the Law* (Cambridge: The Cambridge University Press) p. 269 and Sheila McLean (2010) *Autonomy, Consent and the Law* (Oxford: Routledge-Cavendish) pp.13-15

[2] Lisa Haddad and Nawal Nour (2009) 'Unsafe Abortion: Unnecessary Maternal Mortality' 2(2) *Reviews in Obstetrics & Gynecology* 122-126 p.122

[3] Catharine MacKinnon (2005) *Women's Lives, Men's Law* (Cambridge: Harvard University Press) and (2006) *Are Women Human? And Other International Dialogues* (Cambridge: Harvard University Press) and Sally Sheldon (2007) 'Reproductive Choice: Men's Freedom and Women's Responsibility?' in John Spencer and Autje Bois-Pedain *Freedom and Responsibility in Reproductive Choice* (eds) (Oxford: Hart Publishing)

the state and abortion providers to fulfil two obligations in accordance with the principle of respect for autonomy. A negative obligation is to keep women's decision-making independent from their controlling influence. For example, a GP should not block her patients' requests for abortion by refusing to refer them to specialists simply because she believes that abortion is morally wrong; and the state should not force women to have an abortion in order to reduce the national birth rate. A more positive obligation for the state and abortion providers is to enhance women's control of reproductive decisions by offering financial and medical assistance. For instance, the state should facilitate access to public funding for women who need abortion; and health professionals ought to provide adequate information about termination treatments on request and help women to understand it.

Whilst emphasising women's procreative autonomy, the analysis in chapter 2 did not bypass other interests in abortion decisions, and examined how the regulation of abortion should respond to the value of the embryo or foetus and the interests of women's sexual partners. In chapter 2 I discussed various perspectives on the moral status of the embryo/foetus in England and China. I argued that instead of focusing on 'the not-proven nature'[4] of embryos or foetuses, law should allow women to be the arbiters of the morality of deciding to terminate their own pregnancies. Furthermore, I suggested that women's autonomy does not necessarily conflict with men's interests in abortion decisions because women tend to consider their relationships with their partners and take their partners' opinions into account before they make a decision to continue or end a pregnancy. Nonetheless, I emphasised that men's desire to be a father should not be satisfied at the expense of women's health and control of their lives. Thus, legally women's right to abortion should be prioritised over men's alleged right to be a father. Finally,

[4] Margaret Brazie and Emma Cave (2011) *Medicine, Patients and the Law* (London: Penguin Books) p.395

in chapter 2 I was critical of the argument against transplanting the principle of respect for autonomy into Confucian societies.

2. The English Medical-centred Regulatory Model

Abortion has been decriminalised in certain special circumstances in England since 1967 when the Abortion Act was enacted. However, the discussion of the medicalisation of abortion offered in chapter 3 showed that the regulatory model of abortion did not aim to enhance women's reproductive decision-making but to place it under closer medical control.

To examine to what extent this model infringes women's right to autonomy, in chapter 3 I first discussed the law of abortion in the era of criminalisation and then scrutinised how the emergence of medical involvement in providing abortions started to play an important role in shaping the English model of the regulation of abortion at the beginning of the nineteenth century. While abortion was decriminalised under the medical-centred model, women who need abortion today are still not treated as rational and responsible decision makers. In accordance with Conrad's observation on the process of medicalising non-medical social problems and its influences on women's everyday lives,[5] I argued that creating the four statutory grounds and the time limit in the 1967 Act serves to construct abortion as a medical decision and blur a wide range of social factors behind unwanted pregnancies.

After exploring the problems caused by the medical-centred method of regulating abortion, such as service-related delays and involuntarily travelling to non-residential areas in order to access abortion, I argued that the current model produces more oppression of and deeper inequality

[5] Peter Conrad (1992) 'Medicalization and Social Control' 18 *Annual Review of Sociology* 209-231 p.209

against women, particularly those from socioeconomically disadvantaged backgrounds. Furthermore, chapter 3 examined different characteristics of the features of women who need abortion and their doctors that were created in parliament and law courts and indicated that the medical-centred model allowing certain groups of women to terminate their pregnancies in some special circumstances is at the expense of all women's reproductive autonomy. Finally, chapter 3 offered an analysis of abortions on the grounds of foetal abnormality and abortions after the second trimester. By doing so, I tried to address the question of why the provision of abortions has to be brought into line with the principle of respect for autonomy.

3. The Chinese State-centred Regulatory Model

Chapter 4 discussed the Chinese model of the regulation of abortion. To give some background information about the legislation on and the provision of abortions in China, I briefly introduced the Chinese legal and health care systems. Due to the significant social and political transitions at the beginning of the 1980s, the current legal and health care systems are newly established and still in progress. Against the background of this transitional history, there was a fundamental change in China's population policy after the Maoist era, which exerted considerable influences over the present Chinese laws on abortion. The analysis of the Chinese state-centred regulatory model was separated into two parts: the first discussed the Maoist abortion policies and the second looked at the post-Maoist abortion laws and policies.

Similar to the regulatory situation in England, abortion was unregulated in China before the twentieth century when the party state started to implement its population policies. The discussion of the Maoist government's pro-natalist policy and its ban on abortion in chapter 4 suggested that they both served to construct the state as female citizens' reproductive decision

maker. As a result, under the state-centred model, abortion was defined and used as a tool for the state to carry out its population programmes. In the post-Maoist era, since the state's population goal changed and became focused on reducing the national birth rate, abortion was accordingly constructed by the first post-Maoist government as a compulsory measure that must be used to remedy contraceptive failures. While abortion is available on demand in accordance with the 'law in the books', in practice law is less respectful of women's autonomy compared with the English law of abortion. Under the state-centred model, women are not only required to take responsibility for childbearing and childrearing, but also have to reproduce according to the state's requirement.

Furthermore, in chapter 4 I discussed medical control over the provision of abortions imposed by the state and argued that state intervention can medicalise abortion. Nonetheless, I also analysed the difference between medical control under the Chinese model and that under the English model. The former is dependent on the state's policy-making on population figures and is mainly targeted at facilitating the state's implementation of population policy. In addition, I analysed law in practice by looking at the ethico-legal problems caused by the controlling influences placed by successive governments on the provision of abortions, such as coerced abortions, repeat abortions and the large numbers of illegal abortions. In doing so, I stressed the necessity of moving law-making on abortion out of the framework of 'the state knows best'. Finally, I raised the possibility of transplanting and contextualising the principle of respect for autonomy into the Chinese jurisdiction by illustrating the autonomy-friendly ideas that stem from Confucianism.

4. An Autonomy-centred Regulatory Model

Chapter 5 first considered what lessons law makers in England and China can possibly learn from each other's experience of having a different model of the regulation of abortion. Then it examined how these lessons can help in drawing up proposals for reforms of the English and Chinese laws of abortion.

To achieve these two objectives, I first assessed the value of the comparative study of the English and Chinese regulatory models of abortion. This broadens English and Chinese legal scholars' insights into their home jurisdictions and contributes to the English and Chinese feminist literature on abortion and the principle of respect for autonomy. Furthermore, by contrasting English and Chinese laws' lack of respect for women's autonomy, the underlying reason why women are less able to act on autonomously held desires concerning reproduction than their male peers can be analysed in depth. Moreover, the comparative study highlighted the importance of understanding the different cultural and historical contexts to suggesting feasible proposals for law reform and helps in formulating alternatives that can pose challenges to the current method of regulating abortion and existing thinking concerning it.

In chapter 5 I also made some further observations on how differently and similarly women's autonomy is treated under the English and Chinese models of regulating abortion. Since chapters 3 and 4 discussed how abortion is regulated in England and China respectively, in chapter 5 I focused on the analysis of these differences by addressing the question of why in practice the Chinese regulatory model is more disrespectful of women's decision-making than the English model despite the Chinese 'law in the books' superficially looking less restrictive. By comparing how the English and Chinese laws on abortion construct 'irrational women' and 'glorious

mothers', I argued that the two regulatory models are both built on the compulsory cultural assumption of womanhood as motherhood.

Based on the analysis of the role which law ought to play in promoting women's autonomy in abortion decisions offered in chapter 2, I suggested proposals for law reform in England and China respectively, which were targeted at redressing the power imbalance in the two relationships: one between women who need abortion and health professionals and the other between female citizens of reproductive age and the state. I also discussed four types of abortions which appear to be particularly controversial: late abortion, termination of foetuses with a disability, sex-selective abortion for non-medical purposes and post-IVF abortion, and approached the question of why the regulation of these abortions should still work within the framework of respecting autonomy. Finally, in chapter 5 I argued that in general, law has its unavoidable limitations,[6] which prevent it from taking women's life experiences seriously, and that specifically, the proposals made in chapter 5 also face problems. For example, the current English and Chinese political climates are likely to discount the possibility that they become law, and enforcement may not be effective in practice even if they become law.

Nonetheless, feminists should still take an active role in engaging with law, though it is not a perfect means of enhancing women's decision-making concerning reproduction. Law, rather than merely reflecting reality, can also contribute to 'constructing our perception of it, lying at the root of some of the most commonplace assumptions which people make in ordering their daily lives'.[7] As has been discussed in chapter 5, the so-called truths and knowledge that are authorised by law may in fact be 'deeply antithetical to the myriad concerns and interests of

[6] Ngaire Naffine (1990) *Law and the Sexes: Explorations in Feminist Jurisprudence* (London: Allen & Unwin);Virginia Held (1993) *Feminist Morality* (Chicago and London: The University of Chicago Press) and Martha Fineman (2005) 'The Social Foundations of Law' vol.54 *Employ Law Journal* 201-237
[7] Sally Sheldon (1997) *Beyond Control: Medical Power and Abortion Law* (London: Pluto) p.166

women'.[8] By examining law in the context of abortion, this thesis has closely scrutinised existing thinking concerning abortion and women who request abortion and has been committed to challenging stereotypes about womanhood and maternity. While the current regulation of abortion is apparently less restrictive in England and China, in comparison with that in the era of criminalisation, it is still based on the compulsory assumption of motherhood which, as discussed in chapter 2, serves to prevent women's exercise of control over reproductive decisions and to maintain the established gender relations.

In general, my investigation of law in this thesis has shown that it is by no means certain that the contemporary regulation of reproduction is gender neutral and will automatically bring equality to women, particularly those who are socioeconomically disadvantaged. More specifically, by employing a broad liberal feminist approach to examining law's role in promoting women's procreative autonomy, this thesis has suggested that law's commitment to autonomy not only requires it to accord recognition to women's inner capacity to critically form high-level desires concerning reproduction, but also, and more importantly, to empower women to act on autonomously held desires by facilitating the availability of medical and state support. In comparison with the models grounded in the principles of 'doctor knows best' and 'state knows best', I have argued that establishing a model in accordance with my discussion of the principle of respect for autonomy can increase gender equality and promote social justice. As has been analysed in chapter 2, in health care practice, promoting people's autonomy can boost other sorts of morality, such as justice and beneficence.

[8] Carol Smart (1989) Feminism and the Power of Law (London: Routledge) p.164

5. Future Directions

This thesis has focused on the regulation of termination of pregnancy in 'normal' cases, although it has also discussed termination in some controversial circumstances. As was suggested in chapter 5, abortions in such cases should also be regulated according to the principle of respect for autonomy. Due to limited space and time, I could not give an in-depth analysis of how to apply this principle to the regulation of abortions in every single difficult case, for instance, reduction of multiple pregnancy, incompetent or underage women's requests for abortion and unsuccessful termination of pregnancy that ends in a living abortus. These are, however, all more or less related to the main theme of 'reproductive autonomy' in this thesis. A detailed discussion of their moral complexity could easily grow into a separate thesis. Briefly, I argue that, apart from pregnant women themselves, it is highly problematic for law to employ any other party to be the decision maker. According to my discussion of autonomy in chapter 2, being autonomous is not all or nothing, but a matter of degree, and being able to act on autonomously held desires is not an innate ability for a person, but something that is reliant on her relationships with relevant parties and needs to be boosted by their cooperation and support. Therefore, the mentally incapacitated or minors are still able to be empowered to express their preferences and exert some degree of autonomy over their preferences.[9] This requires law makers to rethink the 'best interests' principle and take women's preferences into account. Although selective reduction of multiple pregnancies is clinically more complex than complete termination, there is no reason to believe that legally women's autonomy should be accorded less respect in the cases of selective reduction than in the cases of complete abortion. When an unsuccessful termination of the pregnancy ends in a living infant, two established human beings rather than a person and an entity whose nature is 'unprovable'[10] are involved in this situation. While the woman's original

[9] JK Mason and GT Laurie (2006) *Mason and McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press) p.334
[10] Margaret Brazier and Emma Cave (2011) p.395

plan was to relieve herself of the foetus and avoid unwanted motherhood, she cannot kill another person who has the same status as her. However, the woman can still exert autonomy over the decision of whether she will accept this unplanned motherhood. If she refuses to parent the newborn, as Mason and Laurie have suggested, the surviving neonate can be treated as a parentless infant and offered for adoption.[11] I argue that these issues could productively be explored in future work.

My discussion of the principle of respect for autonomy provided in this thesis has suggested that law-making on abortion should enhance women's ability to act on their autonomously held desires concerning procreation by protecting them from controlling influences and facilitating environments that will be instrumental in their exercise of control over reproductive decision-making. This discussion has laid the basis for analysing and solving the complex ethico-legal questions about the issues relating to termination of pregnancy, such as those listed above. Applying the principle of respect for autonomy to the engagement with these questions could be an appropriate progression to this study, which would allow me to thoroughly examine broader questions with regard to the interaction between legal regulation of reproduction and the construction of femininity or humanity in the cultural matrix, as well as the role of state and medicine in the governance and management of gender relations and behaviour.

[11] JK Mason and GT Laurie (2006) p.334

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