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Love as a Journey in the Informed Consent Context: Legal Abortion in England and Wales as a Case Study

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The right to informed consent (IC), as established in the Supreme Court judgment in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, I claim involves a ‘journey of love’ between clinicians and patients. The latter entails a process of dialogue and support between the parties, concerning disclosure of risks, benefits and alternatives to medical treatment(s). In this paper, I first claim that IC, in the light of the spirit of *Montgomery*, is predicated upon two pillars, namely patients’ autonomy and medical partnership. I will then explore a case study: the case of legal abortion in England and Wales. Regarding this case, the progressive reduction of medical involvement has meant that little opportunity has been provided for this ‘journey’ to be unpacked in a medical context. I will ultimately claim that more needs to be done to safeguard IC as a ‘journey of love’ through valuing both patients’ autonomy and medical partnership.

KEYWORDS Informed consent, love, autonomy, medical partnership, abortion

I. Introduction

It might seem *prima facie* out of context to speak about love in a health law context.

What this paper will propose is that love, understood as an ongoing journey of care for the patient, is on the contrary very suitable. This is particularly true for the right of informed consent (IC). The latter, in the light of the Supreme Court judgment in *Montgomery*, is best expressed not as a one-off event, but as an ongoing process, where the disclosure of information concerning risks, benefits and alternative to a medical treatment is unpacked. IC in this sense is here proposed as a valid expression of what a ‘journey of love’ can look like. Love, indeed, would best show its potential when respect for both the individuality of the patient (i.e. respect for autonomy) and opportunities of support, through dialogue with clinicians (i.e. medical partnership), are also offered. However, whenever these opportunities for doctor–patient encounters are significantly reduced, such a ‘journey’

is at risk of being jeopardized. In this respect, this paper will propose abortion in England and Wales, before, during and in the immediate aftermath of the COVID-19 pandemic, as a relevant case study. It will claim that the risk of jeopardizing a ‘journey of love’ is made evident in the context of abortion through a process of progressive reduction of medical involvement. While not advocating for a return to a doctor-centred approach, this case study aims to point out that the reduction of the number of opportunities to meet with a clinician can fail to safeguard IC in its fullness. IC, as a ‘journey of love’, entails that opportunities for an open, truthful and respectful dialogue are offered, while leaving to the patient to voice the desire to engage or disengage with it. Both patients’ autonomy and medical partnership are hence key for a ‘journey of love’ to be safeguarded. Love is and indeed should be more clearly at the heart of IC.

II. Love as a journey: definition

Love is never something ready-made, something merely given to men and women, it is always at the same time a ‘task’ which they are set. Love should be seen as something which in a sense never is, but is always ‘becoming’ and what it becomes depends up on the contribution of both persons and the depth of their commitment. (Wojtyla 1981, p. 139)

Love, building upon this definition formulated by Wojtyla (1981), is indeed crucially a ‘journey’. An ongoing process where every moment is a new opportunity to learn about each other, to grow in the relationship. Such a ‘journey’ is dependent upon the contribution and the desire of both parties to make a daily ‘step further’ in the relationship. Imagine this like a series of brushstrokes, all with a potential to build up towards the creation of a masterpiece, which is the fruit of daily hard work from the artists.

Such a definition of love might still leave the reader with a question: what is the significance of this definition in the medical context? On a closer look, ethics of love¹ can be framed as a desire to walk hand-in-hand with patients, placing their care at the heart of the medical relationship. Informed consent, as it will be clarified later, is an expression of a desire to journey with the patient in the information disclosure ‘process’, giving relevance to dialogue and communication. To act otherwise about IC would mean ignoring patients’ needs and to reinstate a doctor-centred approach. Ultimately, to speak of a journey of love, as shall be seen later, will not mean ‘patronizing’ patients, but giving voice to both, medical expertise and advice together with respecting patients’ autonomy and wellbeing.

However, this approach might still be deemed to ‘lack realism’ and to be at odds with medical practice. Though the focus of this paper is on the theoretical framework, namely ethical and legal principles upon which medical practice can be built, these challenges are worth a brief exploration. It is true, especially in a post-COVID-19 timeframe, that the practice of medicine is more often than not, marked by a lack of opportunities to build relationships of care and trust

¹ For a wider reflection on meaning and relevance of an ethics of care, see Herring (2013, pp.46–85); Herring (2019, pp. 99–140), particularly on the importance of relationality.

between clinicians and patients. Time constraints might risk framing the medical encounter as a ‘rushed’ one, rather than an expression of love. It might also seem that the medical consultation can be the expression of often abusive doctor-patient relationships, and pervasive power-dynamics,² which still perceive the patient as subordinate to clinicians. Yet, such realities are in many ways unacceptable, if patients’ care is to be taken seriously. A call to embark in a ‘journey of love’, during practical challenges, entails the desire to strive to go beyond unbalanced relationships and/or practical constraints. In this respect, the Supreme Court judgment in *Montgomery* ([2015] UKSC 11 at 92–93), which will be unpacked in more detail in following sections, clearly expresses the desire, to work on the ‘relational’ components of the medical encounter, highlighting the importance of tackling, as far as possible, the practical challenges of everyday medical practice. Love, in this vein, can and should find a place when a genuine desire to care for the patient is placed at the heart of the encounter.

III. The journey of love and the right to informed consent: the spirit of *Montgomery* and its two pillars³

The ‘journey of love’ can find a remarkable expression in patients’ rights to IC. In 2015, the Supreme Court judgment in *Montgomery* established that patients hold such a right to IC ([2015] UKSC 11 at 75). They are no longer to be regarded as passive recipients of medical advice, but as persons holding a right to have disclosed material information from clinicians. As will be clarified in this section, I argue that IC is based upon two mutually necessary components: patients’ autonomy (*Montgomery* [2015] UKSC 11 at [80] (Lords Reed and Kerr), at [108] (Lady Hale), at [77]–[78]) and medical partnership (*Montgomery* [2015] UKSC 11 at [77]–[78]). I frame these as the two pillars that encapsulate the spirit of *Montgomery* and hence also a ‘journey of love’. Patients’ voice (autonomy) and medical expertise ‘meet’ during a process of dialogue and communication (medical partnership) around material information. IC hence, is more than a mere one-off event, but is a process, here expressed as a ‘journey of love’ which values both clinicians’ and patients’ contribution.

In clinical negligence cases, the Supreme Court laid down a new test of information disclosure, the materiality test (*Montgomery* [2015] UKSC 11 at 87).⁴ According to this test of information disclosure, clinicians should adopt a ‘patient-sensitive and fact-sensitive approach’ (*Montgomery* [2015] UKSC 11 at

² This also recalls MacIntyre’s question concerning the existence of a medical power and wondering how to use it: ‘The crucial question concerns the use of this [medical] power, the competence of the profession to judge how this power should be used, and the knowledge base upon which decisions are made’. This reflection has also relevance for the context of analysis e.g. abortion (MacIntyre 1973, p.132).

³ With this term, this paper means ‘legal’ pillars or principles behind the Supreme Court judgment in *Montgomery*, as opposed to pure ethical pillars.

⁴ The materiality test is structured around two limbs. The first limb focuses on the disclosure of what a reasonable person in the patients’ position would want to know and implies the relevance of an objective medical component. The second limb focusing on the particular patients’ needs and hence calling for the disclosure of more subjective information. The materiality test, in its two limbs, hence implies that both an objective medical component and a more subjective and hence patient-oriented aspect should be taken into account when disclosing information.

89). Information should not be disclosed taking into account solely medical advice, but this should be tailored also in light of the circumstances which patients are in, their relevant needs, and medical background.⁵ It is hence the case that *Montgomery* underlined that patients' voices should be heard and that their autonomy matters. On a closer analysis, this judgment also tied the fulfillment of IC not only to right of patients' autonomy to be respected but also to a dialogical and collaborative approach between patients and clinicians, that is to say to a medical partnership (*Montgomery* [2015] UKSC 11 at 90). The spirit of *Montgomery*, rightly interpreted, did not consider clinicians and patients as antagonists, but as partners working on the best outcome possible for the patient. Clinicians, building upon the General Medical Council (GMC) guidelines on consent at the time (GMC 2008) also have a clear advisory role that is not fulfilled 'by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form' (*Montgomery* [2015] UKSC 11 at 90). IC entails a collaborative and dialogical approach. IC, which in the light of the spirit *Montgomery* clearly stands on two-mutually necessary pillars⁶: patients' autonomy and medical partnership.

This is not to say that *Montgomery* was a panacea. Wider challenges, as I have already argued elsewhere together with Cave (Cave and Milo 2020), remain. This is because the balance between these two pillars, autonomy and medical partnership, is often left unclear within the judgment and risks putting too much on one side (doctor) or the other (patient). In this sense, one crucial risk is the return to a medical deferential approach. I have phrased elsewhere this as the *Bolam* legacy, where I considered, together with Cave (Cave and Milo 2020) the ongoing relevance of the previous test of disclosure as laid down in *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582. This is especially true in matters related to the identification of treatment options and subsequent disclosure of risks, the former being still in the remit of *Bolam*, the latter in the remit of a more patient-centred approach as laid down in *Montgomery*. The tension between the two tests is still pervasive and one that cannot be easily resolved.

An additional and related risk is that of a focus on patients alone, in a 'consumerist approach'. Lords Kerr and Reed recognize in *Montgomery* that patients are 'widely treated as consumers exercising choices' (*Montgomery* [2015] UKSC 11 at 75). Consumerism in a medical context rightly emphasizes that patients' voices need to be heard, not silenced by clinicians. However, consumerism, as McMahon and Arvind (Arvind and McMahon 2020, p. 445, 462) have pointed out, can end up devoting undue weight to patients' unilateral decisions over a collaborative and dialogical approach with clinicians. What is crucially undermined by a 'consumerist approach' here is medical partnership, particularly the relevance of dialogue with clinicians which should underpin IC and a 'journey of love'.

A way to minimize the challenges outlined above, and to promote a more balanced view of IC and its two pillars, is to look at relevant GMC guidelines.

⁵ The importance of both 'objective' and more 'subjective' elements to be disclosed in the IC process in light of *Montgomery* has been stressed also in a 2017 article by Herring, Fullford, *et al.* (2017, p. 582)

⁶ This is also built on the assumption that the patient can provide a legally valid consent, under the Mental Capacity Act 2005 ss.1–3.

Montgomery was based upon the 2008 GMC guidelines on consent (GMC 2008, p. 9, p.31)⁷ where the relevance of both these two pillars was already clearly included. The *Montgomery* approach has been further explored and expanded firstly in the 2018 draft guidelines on consent (GMC (October 2018), pp. 8, 9), and then in the latest definitive guidelines on consent 2020 (GMC 2020). It is the case that the GMC has widened the implications of *Montgomery* giving relevance to both patients' autonomy *and* medical partnership. This is particularly evident when the GMC emphasizes the role of clinicians in supporting patients' decision-making. The 2018 draft GMC guidelines already highlighted that:

For a relationship between doctor and patient to be effective, it should be a partnership based on openness, honesty, trust and good communication. You must listen to patients' concerns, ask for and respect their views and values, and encourage them to ask questions. You should not make assumptions about the information they might want or the factors they might consider significant. (GMC, October 2018, p. 9 at 11)

This approach has been also clearly reiterated in the 2020 GMC guideline on consent where the GMC has further endorsed clinicians' role in supporting patients during the decision-making process (GMC 2020, p.17). In its enunciation of the seven principles of decision-making and consent, a particular weight is given to a 'meaningful dialogue' with patients (GMC 2020, p.7, principle two), and patients' 'right to be listened'(GMC 2020, p.7, principle three), which are key elements of the medical partnership. There is no partnership, and hence no 'journey of love', without a 'bridge' of dialogue and communication between the parties.

What we, therefore, can and should derive from this interpretation of the spirit of *Montgomery* is that: (1) IC matters as a key patients' right and (2) IC is not a one-off event, but a process that is not merely fulfilled with 'a paper work' approach, nor with bombarding patients with information. Rightly framed, it entails time and space for both patients and clinicians to engage in dialogue and support around material information concerning risks, benefits and alternatives to the proposed medical treatment. From this consideration, it follows that any approach which unilaterally reduces clinical involvement and focuses on patients' autonomy *per se* does not capture the whole picture of IC. IC is based upon two pillars, medical partnership *and* patients' autonomy.

It should be also clearly said that IC, framed as such, should never be an excuse, or worse an obstacle, to delay or impede access to medical treatment. On the contrary, IC can and should represent a valid opportunity for patients to be supported before deciding to undertake a medical treatment or not. This is all the more so because patients have the right to refuse IC, as clearly expressed in *Montgomery* (*Montgomery* [2015] UKSC 11 at [85]).

It is hence the case that for a relationship between doctors and patients to effectively encapsulate IC, it should ultimately be a 'journey of love' based on openness, honesty, trust and good communication.

⁷In this guideline, the relevance of the principle of partnership is explored, and where the importance of treating patients as individuals and respecting their dignity is also clarified.

IV. Abortion in England and Wales as a case study: the challenge of de-medicalization and IC

This interpretation of IC as a ‘journey of love’ clearly goes beyond the mainstream medicine context, to which *Montgomery* refers to, and has relevant consequences also in other healthcare branches. This section will consider abortion in England and Wales as a case study. It might *prima facie* seem that abortion does not fit squarely in the proposed analysis of a ‘journey of love’, a different type of medical intervention involving more long-term and ongoing medical care might be a better fit (e.g. in case of a critical or chronic health condition). On a closer analysis, the reason behind this choice does not stand on the nature of the medical intervention and hence on the long or short term relevance of medical care, but on the challenges connected to the safeguard of IC as a ‘journey of love’ per se in the context of abortion. Despite the crucial relevance given by post-*Montgomery* professional guidelines to IC (e.g. Nice 2019), it remains all too possible in the context of abortion⁸ that such a ‘journey of love’ can risk being jeopardized. This paper supports this claim through reference to what I argue to be a key challenge: the recent reduction of medical involvement (below referred to as de-medicalization) in abortion provision. Such a challenge is shown by the risks of missing at least one of the two IC pillars, namely medical partnership. I will claim that abortion in England and Wales has embraced a narrow understanding of IC, devoting a major weight to patient’s autonomy, while undermining the concurrent relevance of medical partnership. I will then argue that both pillars are relevant for the full safeguard of IC as a ‘journey of love’. Legal and policy change should hence consider new ways to address this challenge.

The reduction of medical involvement and the role of clinicians in abortion in England and Wales

Abortion in England, Wales is regulated by the Abortion Act 1967. Abortion is only lawful under the Act when two registered-medical-practitioners are of the opinion, formed in good faith, that the legal defenses listed in s.1(1) are satisfied. This presents a legal model where a strong medical intervention is included, at least in theory, though the ‘law on paper’ often strongly differs from the ‘law in practice’ (Lee 2004, p. 290).⁹ The latter often shows a more flexible approach and leans towards an assumed existence of a right to abortion (Lee 2004, pp. 287–289).

⁸ The tie between abortion and IC has been widely explored in the USA. It should, however, be clarified that the model of IC legislation implemented in the USA provides a different approach from the one proposed by *Montgomery*. The former offers a more stringent approach of mandatory disclosure, with the latter offering a more flexible and patient-oriented approach. For an overview of the USA regulations on this topic, see Guttmacher Institute (2020). This report highlights that 29 USA States’ legislations provide a list of information a woman must be given by clinicians; National Right to life committee (2018). This report also highlights that, as of June 2018, 28 USA States enacted forms of IC legislations (Benson *et al.* 2007). The proposal of a state-mandated regulation was also recommended in 2007 by the House of Commons Science and Technology Committee, but never implemented. See: House of Commons Science and Technology Committee, ‘Scientific Developments relating to the Abortion Act 1967, twelfth report of session 2006–2007’.

⁹ See also: Manson arguing that this is only a façade, and that the law in practice is more relaxed (Mason 2009, pp. 29–30).

The issue of an essential involvement of clinicians remains controversial and has been strongly challenged in recent years as it is seen as a tool that undermines women's autonomy (Lee 2004, p.290).¹⁰ Significant changes in this respect started in 2018 and were aimed at reducing medical involvement and enhancing self-administration of an early-term medical abortion (EMA). These reforms allowed the home use of the second pill, mifepristone, whereas the use of misoprostol, the first pill, was still to be taken under medical supervision in a licensed facility. In 2018, first in Wales (Welsh Minister for Health and Social Services, 20th June 2018) and then in England (Department of Health and Social Care, (14 January 2019)),¹¹ this approach was adopted. Before this legal change, an EMA should have taken place only in an NHS-funded abortion clinic or, more rarely,¹² an NHS facility, under the supervision of medical staff. These legal and policy changes were also prompted¹³ not only by the desire to enhance access to early term medical abortion but also to challenge the medicalization of abortion.

In March 2020,¹⁴ the COVID-19 outbreak prompted a further legal change in the direction of reduction of medical involvement. 'Home' was temporarily licensed as a class of places for the use of *both* abortifacients in case of an early-term abortion in England and Wales. This meant that the use of both mifepristone and misoprostol for early-term medical abortion was introduced in England and Wales. These 2020 changes were also coupled with the widespread use of forms of self-referral and the use of telemedicine (phone and video consultations). This approach has then been made permanent in March 2022, with the formal inclusion within the Abortion Act of 'home' as a registered class of places (Health and Care Bill 2022). In a nutshell, the Abortion Act 1967 had been often criticized because it initially figured a strongly medicalized legal model which had long been deemed in need of legal¹⁵ and policy changes. Since 2018, a process of reduction of medical involvement had been seen as increasingly necessary.

De-medicalization has long been perceived as a way forward for abortion provision. Particularly, for EMA, it is the safety and acceptability of medical abortion,¹⁶ which *prima facie* justifies the reduction of medical involvement and the widespread use of telemedicine. This also echoes the understanding that abortion should be framed as a private concern¹⁷ of women, to which clinicians cannot

¹⁰ See also Sheldon (2016a, p. 283).

¹¹ This was also subject to further conditions as set by the UK Secretary of State for Health and Social care in Secretary of State for Health and Social Care (27th December 2018).

¹² See on this point 2017 abortion statistics, supporting the claim that prior to this legal change only 28% of abortions were performed in NHS hospitals: Department of Health and Social Care (June 2018, p. 9).

¹³ An additional reason concerned the risk of miscarriage on the way from the clinic to home. See news coverage on this topic: Brown (2018). Also see on this point: Greasley (2011, p. 314). She critically commented on the judgment in *BPAS v the Secretary of State for Health* [2011] EWCH 235, calling for a change in approach which allowed the home use of the second abortion pill to avoid miscarriage occurring on the way and also unnecessary trip back to the clinic.

¹⁴ The measure was then approved on 30th March 2020 in England and 31st March 2020 in Wales and Scotland. See Department of Health and Social Care (30th March 2020), Welsh Government (31st March 2020), Scottish (31st March 2020).

¹⁵ A key feature here is the calling to de-criminalize abortion. See on this point: Sheldon (2016a, p. 283); Sheldon (2016b, p.334), Lee (2003, p. 532), Greasley (2017, pp. 203–221), Sheldon and Wellings (2020, pp. 1–16), Amery (2020, p.145).

¹⁶ See Aiken, Lohr, Lord (2021a).

¹⁷ See Sheldon (2016a, pp. 307–312).

and should not have any say. To do otherwise would mean reiterating a paternalistic view of abortion, whereby it is the ‘doctor’, generally a male, that ‘knows best’ what the course of treatment should be for a woman. Safety and acceptability of an EMA, coupled with an understanding that abortion is a question for women alone to be answered, *prima facie* renders the involvement of clinicians progressively irrelevant with a few exceptions.

However, there is a risk here that has gone unnoticed: the impact of these changes upon the safeguarding of the medical-partnership-pillar, and hence on IC broadly understood as a ‘journey of love’. The legal and policy changes brought forward since 2018, clearly figured a further reduction of medical involvement which was coupled with changes to the setting and nature of the medical consultation. The number of opportunities for medical encounters was significantly reduced, and face-to-face encounters were often substituted by telemedicine. This captured and responded to access-related concerns,¹⁸ and hence provided a safeguard of patients’ autonomy, in what was, at least in March 2020, the context of a strict lockdown. It is also true though, that professional guidelines issued during the COVID-19 pandemic, still recognized the relevance of IC. For instance, the Royal College of Obstetricians and Gynecologist and (RCOG) 2020 specifically recognized that a pandemic should not be an exception to the safeguarding of IC, when it states that: ‘A woman must be given enough information and time, including the opportunity to ask any questions she may have, so that she can give informed consent to proceed with the abortion’.¹⁹ Yet, this statement of principle contrasts with the progressive reduction of opportunities for medical consultations. It is the case that de-medicalization, looked at more closely, challenges first the advisory role of clinicians and second, undermines the safeguarding of IC. This is because it reduces the opportunities for a meaningful encounter between patients and clinicians. This is not irrelevant for IC, quite the opposite. IC is crucially predicated on the existence of a meaningful encounter with a clinician, if its medical partnership pillar is to be taken into proper consideration.

A further problematic issue is related with the risk of misusing telemedicine and the impact this can have on IC. Telemedicine increases access to abortion, particularly during a pandemic, yet, if misused, can jeopardize the safeguarding of IC as a ‘journey of love’ and it should therefore not be considered as a *panacea*. *Prima facie* it might be argued that there is no substantial difference between a face-to-face medical encounter and a telemedical one, whereby IC can easily be safeguarded even in the latter context. However, the issue is not as straightforward as it might first appear. At present, the use of telemedicine and particularly how the telemedical

¹⁸ The reason for a further step in the direction of a reduction of medical involvement was based upon the importance of safeguarding access to abortion in a strict lockdown context. See RCOG (31st July 2020).

See also: *R v (Christian Concern) v SSHSC* [2020] EWCA Civ 1329. In this case, the appellant sought judicial review of the 2020 legal changes in England and Wales, alleging that the decision was *ultra vires* and contrary to the legislative purpose of the Abortion Act 1967. In rejecting both claims, the Court of Appeal considered the justifications for both the pre-pandemic and 2020 legal changes. In relation to the 2020 change the aim was to ‘broaden the access of a woman to a legal termination of pregnancy’. The 2020 change responded to the difficulty in accessing abortion services due to the extraordinary lockdown measures, forcing both women and doctors to ‘stay at home’.

¹⁹ For a further analysis of RCOG approach on IC, see RCOG (2021a, Question 4). Additionally, RCOG has also developed a decision aid for patient having an early medical abortion without ultrasound, see RCOG (2021b).

encounter is conducted, is largely left to the discretion of clinicians. This leaves open the possible risk of it being misused. Relevant professional guidelines (PG) (e.g. RCOG, (31st July 2020), p.23) are not expressly clear, for instance, on two key aspects for IC: (1) the number and the length of consultations and (2) what information should be disclosed. The former would ensure that IC is not only a statement of principle, but that conditions for its actual safeguarding are in place. An example of the latter is found in current PG in that they lack clarity on the issue of disclosure of unknown or uncertain risks, so-called constructive knowledge of risks (e.g. in the case of maternal-fetus transmission of COVID-19). ‘Constructive knowledge’ refers to those cases of disclosure underpinned by a diagnostic uncertainty.²⁰ It is apparent that the research surrounding COVID-19 is still ongoing, yet the relevance of disclosure of risks whose nature is still unknown/uncertain, is by no means ‘suspended’.²¹ The lack of a clear approach leaves the matter unclear and carries the risk of negatively impacting upon the disclosure process in IC. The effective use of IC in a telemedical consultation would require clinicians to be informed concerning *the state of art*, and for women to be disclosed risks/benefits and alternatives, when this amounts to a material information,²² unless they exercise their right to refuse IC.

That IC has crucial relevance in telemedicine can be further supported by a 2020-quantitative research study on EMA in Canada (La Roche, Foster 2020, pp. 61, 64). This study showed that EMA was associated with both positive and negative experiences. Those participants who described themselves as having a negative experience, shared a feeling of being unprepared and expressed a desire to receive more information about the abortion. The role of clinicians in providing a better informative process was also highlighted, together with the desire to hear more personal stories coming from those who experienced an EMA themselves. Looking at the growing body of literature on telemedicine and abortion,²³ systematic reviews often consider telemedicine generally acceptable, yet telemedicine is often considered to be dependent also upon an effective process of information disclosure. The importance of upholding the right to IC in abortion consultations is hence crucial, and this, I claim, should be also clearly tied with the advisory role exercised by clinical staff.

What is ultimately argued here is that if de-medicalization is widened and telemedicine enhanced without clear guidelines, medical partnership risks being silenced and with it the safeguarding of IC. This is because de-medicalization reduces the *number* of opportunities for a meaningful encounter with clinicians to happen,

²⁰ RCOG 2020 is not clear on the association between COVID-19, pregnancy and abortion and connected risks. In an earlier version, it highlighted that the vertical transmission of COVID-19 was still unclear. This risk is however not mentioned in later versions of the same guideline. The risk of vertical transmission is conversely mentioned in another RCOG guideline on pregnancy and COVID-19. RCOG (19th June 2020). In the latter, it is highlighted that vertical transmission is possible, but that evidence on this point is still scarce.

²¹ In the post-*Montgomery* case, in *Duce v Worcester Acute Hospitals NHS Trust* [2018] EWCA Civ. 1307, the issue of constructive knowledge was further explored by the Court of Appeal. Here the court claimed that the question of disclosure sees the interplay of *Bolam* and *Montgomery*. *Bolam* governs the matter of whether the risks were or should have been known; *Montgomery* governs the question of whether the patient should have been informed.

²² This also echoes, what Deveney *et al.* have argued concerning the key relevance in medicine of patients’ right to disclosure of risk in a pandemic context, see, e.g. Deveney *et al.* (2020).

²³ See Aiken *et al.* (2020), Aiken *et al.* (2021b, p. 238). For a further overview on this point, see also Parson and Romanis (2021, p. 10).

telemedicine can also risk impacting the *quality* of the medical encounter, and ending up trivializing IC and the consultation itself when the advisory role of clinicians is reduced or absent. The reluctance expressed here towards widespread use of telemedicine is built on an understanding that doctors in ensuring IC are not merely service providers, but also advisors supporting and listening to each patient in a unique way. It is therefore important that conditions are in place for a ‘meaningful encounter’ (GMC 2020, p.7 principle two), using the GMC expression, between the parties to happen.

However, supporters of de-medicalization and telemedicine, have further argued that this is the only way forward in to ensure access to abortion, which is a priority during a pandemic²⁴ and beyond. In this perspective, if IC calls for a stronger involvement of clinicians, this means placing a barrier to access. I would argue that this view has some validity, especially in a pandemic context, when strict lockdown measures are in place. However, two further observations are relevant here. The first, is that a process of de-medicalization, of which telemedicine is an expression, started well before the COVID-19 outbreak and hence was not necessarily contingent upon strict lockdown measures. This process started in 2018 when the partial home-use of EMA was licensed and was supported within professional guidelines at the time. Both NICE 2019 (Nice 2019, p. 8) and RCOG 2019 (RCOG 2019, pp.144–148) guidance devoted major attention to access-related concerns, encouraging, for instance, the spread of self-referral practices. This process had progressively undermined the relevance of the medical encounter well before the pandemic. RCOG 2020 (RCOG, 31st July 2020) guidance on abortion care and COVID-19, could be possibly exceptionally justified by the unprecedented circumstances of the COVID-19 pandemic, whereby issues of necessity during a strict lockdown and the need to contain the spread of the virus could have affected access to abortion clinics. However this approach, looked at more closely, is not just an ‘exceptional pattern for exceptional circumstances’, since a de-medicalized approach has been given weight already before the pandemic. Beyond the pandemic context, this approach has also been permanently included within the Abortion Act (Health and Care Bill 2022). What this crucially reveals is that IC has been long undermined both before, during and in the immediate aftermath of the COVID-19 pandemic. The second related observation is that a focus on the reduction of medical involvement as a tool to enhance access, risks telling only ‘half of the story’ concerning IC. It risks missing the ‘other half’ concerning medical partnership, which I argue to be one of the two pillars for the safeguard of IC as a ‘journey of love’. This approach particularly can undermine the relevance of the medical encounter as a place where a patient-oriented dialogue around relevant information can and should start.²⁵

Ultimately, what this case study highlights is that de-medicalization can be an obstacle to the full safeguarding of IC as a ‘journey of love’. This is because it risks framing the time spent in an informative process only in a negative sense, namely as an obstacle to the accessibility of the procedure, rather than a potential

²⁴ Parson and Romanis (2021), pp.117–126; Romanis *et al.* (2020).

²⁵ For the importance of the doctor-patient relationship in an IC context, see Cave (2020, p. 4).

to concretely safeguard patients' rights to IC. It mostly risks missing a key point behind the 'journey of love', the relevance of *both* medical partnership and patients' autonomy. De-medicalization can serve only the latter and can undermine the relevance of the former.

While it is not the intention of this paper to provide practical and detailed suggestions concerning future legal and policy reforms, I here only highlight some possible general trajectories to better embrace IC as a 'journey of love'. The path ahead needs, I would argue, to be marked by a process of re-medicalization, namely a process of recalibrating medical and patients' expertise. In this respect, the use of telemedicine for possibly the first and only medical encounter during the COVID-19 pandemic should have not been made permanent but should have been considered strictly contingent on strict-lockdown circumstances, since telemedicine can reduce opportunities for a meaningful encounter and with it the possibility of safeguarding IC.

In a post-pandemic context, a more nuanced approach should be proposed. For instance, women could be offered an opportunity of a first medical encounter as a face-to-face encounter, possibly within GP practices. This approach will more clearly safeguard the importance of trust and partnership in a clinical setting as the baseline also for the safeguard of IC. Forms of telemedicine can be tailored at patients' request and can either (a) replace a first face-to-face encounter or (b) used as a form of continuity of care, for subsequent medical encounters, when and if deemed relevant by the patient in line with their circumstances. To achieve a better safeguard of IC, it is also important that relevant PG will more clearly outline the disclosure process within a telemedical encounter(s), reducing the risk of it being misused. Only when clearer PG and professional trainings are in place, can telemedicine be effectively used as a supportive tool to ensure continuity of dialogue and care with medical professionals.²⁶ If IC is to be properly safeguarded, as it should, the relevance of face-to-face encounters should be reconsidered, especially in a post-pandemic context. Also, telemedicine should not be framed as a *panacea*, but as a tool whose use can be better calibrated.²⁷ More widely, ongoing research on the reduction of medical involvement and the impact on the legal safeguarding of IC in abortion is crucially needed.

V. Conclusion

Love as a journey calls for a path of mutual openness, dialogue and respect between clinicians and patients. This definition is particularly relevant for the right to IC. In

²⁶ See also an empirical study conducted in Utah, where IC is mandatory, comparing the characteristics of patients having IC before abortion in-person and telemedicine. Patients who used the latter have been a minority (9%) and were more likely to live far from state and from abortion clinics offering IC visits. 91% of IC were still in person showing that patients still prefer to engage, when no other barriers are in place, with actual meetings with medical professionals, see Daniel *et al.* (2020, p. 56).

²⁷ It should be clarified here that this case study is not saying that IC should be used as a barrier to access abortion, but that issues beyond *pure* access-related concerns should be also given weight. The safeguarding of IC in practice should be looked at carefully and more research on the safeguarding IC in the context of abortion is required.

the light of the spirit of *Montgomery*, I have claimed that IC stands on two pillars: medical partnership and patients' autonomy. It is within the medical encounter where medical expertise and patients' needs and desires can unfold.

However, the *full* safeguarding of IC as a 'journey of love' is often stated in principle, but neglected in practice. This paper has considered abortion in England and Wales as a case study, focusing in particular on a key challenge, namely a process of de-medicalization. It has been claimed that since the progressive reduction of medical involvement is a phenomenon that started well before the COVID-19 pandemic, the latter has exacerbated an already existent and ongoing trend. Considering home as a class of places where an EMA can happen (permanently included also within the Abortion Act since March 2022), has triggered a further process of reduction of medical involvement. This has been coupled with the introduction of wider use of forms of telemedicine.

This paper has argued that these legal and policy changes have the clear potential to safeguard patients' autonomy, in respect of enabling access to abortion services, yet they can jeopardize the overall safeguard of IC, particularly in its medical partnership pillar. It is therefore important that the reduction of medical involvement, together with the wider use of telemedicine are monitored carefully. A process of re-medicalization, namely of recalibration of both medical and patients' expertise, should be instead seen as a possible way forward. Especially post-pandemic and in light of the most recent legal changes, the importance of finding a better balance between telemedicine and face-to-face encounters for the safeguarding IC should be reconsidered. Legal and policy changes should be further brought into place to give greater weight to IC as a 'journey of love'.

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