Comparing the Management of Early Medical Abortions in the USA and UK: A New Institutionalist Perspective

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Paper presented for the International Political Science Association
23rd World Congress of Political Science
‘Challenges of Contemporary Governance’, 19 - 24 July 2014
Montreal, Quebec - Canada

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Abstract

Abortion is a procedure littered with cultural and societal considerations, and countries display disparate approaches to treatment. This is particularly true of EMAs (Early Medical Abortions) and the home administration of misoprostal. Far from the sole product of evidence-based policy making, and despite World Health Organisation (WHO) guidelines endorsing its use in settings other than medical facilities, global management of the abortion pill varies substantially. In the USA, for example, its application away from clinics is common practice, while the UK recently witnessed an unsuccessful court case to allow women such an option. This paper engages the theoretical lenses of new institutionalism to explore the factors that have shaped this contrasting regulation. The analysis reveals that the UK displays a strong path dependency and actors in the policy process are reluctant to depart from strict medical control. Normative discussions are yet to successfully move beyond a woman's right to choose, and demand optimal care within the parameters of the law. Conversely, the innovative healthcare domain in the US does not suffer the same constraints, and the consumer is at the heart of regulation. Thus a divide in societal and political discussions has evidenced, and two separate frames run parallel: the pro-choice/pro-life debate, and the delivery of abortion as a service. It is submitted that this comparison highlights the UK's dated position, and the possibility of further legal challenge is forwarded on the basis of the protection of social inclusion.

Introduction

The termination of pregnancy is undoubtedly a frequently practiced procedure across the contemporary world, and has become a significant feature of modern reproductive healthcare for women. Interestingly, however, the action has also been a regularly occurring phenomenon throughout recorded history, and studies claim that techniques of terminating an unwanted fetus were widely available in antiquity. Certainly classical and medieval documents have uncovered specific reference to such methods, and detail countless women transferring their knowledge, and a 'pharmacopoeia' of effective herbal abortifacients, down through the generations.¹ Whereas the dangers of physically induced abortion in the ancient world were considerable, the innovation in the discipline over the centuries has, unsurprisingly, been extensive, and clinical evidence now suggests that the variety of modern techniques are amongst the safest medical treatments in industrialized countries, with only a negligible risk of morbidity.² Studies of the use of RU486, or the colloquially term ‘abortion pill’, in particular, indicate that it is does in fact harbor fewer dangerous side affects than an

array of over-the-counter drugs such as Tylenol and Aspirin. In spite of these scientific developments, however, legislation globally still lacks continuity and the rate of female deaths resulting from procedures performed illegally, or in unsuitable environments, contribute substantially to a maternal mortality pandemic. According to figures published by the World Health Organization in 2013, an estimated 289,000 such deaths occurred, with the number of unsafe abortions reaching a high of 21.6 million in 2008. A worldwide standard of access to safe abortion is consequently a major concern and is promoted by a number of international bodies such as the UN and the EU; indeed a reduction in the maternal mortality ratio featured significantly in the Millennium Development Goals (MDGs), and is set to further be a concern of the post-2015 agenda. Despite these measures, however, attitudes towards the deliberate ending of pregnancy continue to vary, and even developed countries display markedly disparate approaches and, although in 2009 it was recorded that 97% permit abortion to save the woman’s life, this amounts to a very stringent pre-requisite that rarely arises. In reality, the additional regulatory demands and procedural requirements peculiar to nation states, including gestational limits, spousal consent and third party authorization, dictate that policy is far from standardized across the world, and is instead a field littered with an array of cultural, religious and societal considerations.

Two such examples of this diverging approach to management of abortion are evidenced in the UK and USA. In the former, the introduction of the Abortion Act 1967 permits women living in the UK to access medical abortions in situations in which their health is considered to be at risk. This legislation serves to create one of the most liberal schemes in Europe, in principle permitting abortion up until 24 weeks of gestation, double the limits in France and Germany, and six weeks later that in Sweden and Norway. Conversely, the latter statutory field appears domestically disjointed, and despite the seminal case of Roe v. Wade paving the way for the decriminalization of abortion across the country, individual states are free to impose their own criteria upon access, save creating an ‘undue burden’ for women, due to the ruling in Planned Parenthood v. Casey. As a result, limits on termination range from mandatory ultrasounds and counseling, to the informing of the parents of pregnant

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minors. Contrary to initial assumptions of a largely liberal UK, and an internally conflicted US, however, examination of the use of the abortion pill in both regions uncovers a new angle to the debate and unveils a somewhat surprising twist in the abortion narrative; challenging the seemingly lenient approach housed in the UK’s law, it appears that women in the US actually receive a more comprehensive level of treatment, and patient centered approach, to this specific aspect of reproductive technology.

The term early medical abortion (EMA) refers to the use of medication to induce an abortion within the first trimester of pregnancy and is most commonly associated with the phrase ‘abortion pill’. The discovery of the clinically termed RU-486 – a steroid synthesized by Dr Etienne-Emile in the 1980s – indeed allows for a non-surgical method of inducing abortion at up to 63 days gestation. Dating back almost three decades, the drug is by no means a new innovation and was actually introduced into the UK back in 1991, and medical abortions now account for almost half the total number of terminations carried out in the country. In comparison, the USA’s relationship with the treatment is far less mature and the pill was neglected approval by the Food and Drug Administration (FDA) refused to approve the drug until 2000. Since that time, however, the use of this abortive technique has become commonplace and, in 2011, similarly accounted for 36% of all abortions performed before nine weeks gestation. Furthermore, despite the greater experience of the UK in dealing with the medication, the home administration of the second stage of the process through the prostaglandin misoprostal has been at the centre of much debate and discourse, and remains prohibited in the country. The choice to receive the final tablet at a place of their choosing, other than solely a medical facility, is thus not a reality for British women, greatly restricting their level of access in comparison to their transatlantic counterparts; 23% of whom, in 2011, received nonhospital medical abortions. Thus, despite the USA’s late start with the method, on average the statutory scheme now appears to provide women with a wider range of therapeutic choice. Much has been made of this seemingly insignificant detail of accessing EMAs, indeed, at the bottom line, it is available in both countries, however delving below this statutory field reveals a different array of both respected and restricted rights for women in the UK and USA alike.

Moving beyond prevalent studies concerning the construction of pro-life and pro-choice arguments in the regions, therefore, it becomes pertinent to explore the range of influences and actors in this critical case study of the regulation of EMAs.

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14 Opie.
Certainly, examining this contrasting aspect of policymaking within two liberal western democracies will shed further light on the importance of institutions in the day-to-day regulation of a value-laden, and emotive topic, such as abortion and the paper progresses as follows. First, the efficacy of new-institutionalism (NI) as a conceptual framework for a study of this nature is discussed, and the key institutions under investigation, in addition to the mechanisms for change, are identified. The data collection is then preempted by an outline of the present regulatory field surrounding EMAs and, in particular, the home administration of misoprostal in the UK and US. The remaining sub-sections will then address an arm of NI in turn, and will begin with the historical aspect and the possibility of policy inheritance, move through rational choice institutionalism and the constraints placed on policymakers, and end with discussions concerning the normative position and societal ‘code of conduct’ in both regions.¹⁶ The study reveals an unyielding path dependency of both the UK government and medical profession on the criminal nature of abortion that creates a neo-functionalist type of spillover into the administration of the procedure, and dictates its strict control in approved medical settings only.¹⁷ The elite discourse that surrounds this small, but significant, facet of access to abortion has failed to engage the mass public and a solid rhetoric around the rights of the patient is yet to galvanize support. In comparison, the US has successfully brought RU-486 into mainstream medical practice and clinicians, not facing the same binding constraints as those in the UK, continue to preserve its position in light of consumer demands. In this vein, the possibility of home administration of misoprostal in cases of legal abortion is seen as appropriate behavior, and runs alongside, rather than within, the pro choice/pro life debate. The successful positioning of the patient, and their rights, at the heart of this contentious issue in the US sheds light on the outdated situation in the UK, and creates problems for the British statutory regime in terms of social inclusion.

**Applying Theoretical Lenses: The Utility of New Institutionalism**

Abortion has always occupied a significant position in both public and political consciousness in the UK and USA alike. The procedure is certainly not a nineteenth century construct, with reference to a British statutory scheme governing the termination of pregnancy appearing as far back as the ecclesiastical courts of the thirteenth century, and debates over its status and function featuring heavily in American political discourse throughout the twentieth century.¹⁸ When analyzing the history of abortion in the two countries, however, attention should not be focused solely upon the aggregate consequences of personal utilitarianism and moral individualism, thereby excluding any causal exogenous influences; the procedure is instead informed by a number of wider religious, medical and ethical considerations, and it’s governance can largely be seen as the culmination of the shared ‘morality’ of

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a given society. Indeed the contentious nature of the procedure and the complexity of this policy area, playing host as it does to the three interrelated domains of legislation, regulation and cognition, suggests that outcomes in this field may be attributed to the shaping of collective behavior through organizational structures, and rules of appropriate behavior, perpetuated by a range of formal and informal bodies.

In order to ascertain the reasons for the aforementioned disparity in abortion governance in these two countries, it is therefore essential that a full investigation of the autonomous role of domestic institutions, and the effects of their structures, rules and norms upon key actors in the policy process, is conducted. In this vein, the theoretical lenses of new-institutionalism offer explanatory merit to the development of the procedure in society, and it is of surprise that, although an institutionalist perspective of social policy generally is galvanizing academic attention, abortion has not yet been subject to the same rigor.

Certainly, new institutionalism, and the very idea that institutions do indeed matter, has come to occupy a vast array of political science literature, but the theory around these actors has not always been so fashionable. Having largely been replaced by the behavioral movement in the mid-twentieth century, old institutionalism failed to offer little more than an empirical account of such bodies, and largely evaded any casual hypotheses. In the 1980s, however, this so-called ‘new institutionalism’ reignited the line of inquiry with deep explanations on how institutions actually matter in political organization and new strands of institutionalism, taking into account both formal and informal interactions, were born. Thus, although heavily criticized as providing limited theoretical insight, and failing to answer the pertinent question of ‘how’, the sentiments of even traditional institutionalism that a number of seemingly insignificant details can have a pervasive impact on the actions of institutions, and thereby the individuals within them, finds truth with an emotively charged and opinion based subject such as the termination of pregnancy. Furthermore, largely remediying these deficiencies, but conveniently retaining the notion that institutions do matter, the strands of new institutionalism presented by March and Olsen in the 1980s, submitting that the strategies and goals of actors in the policy process are shaped by the beliefs, paradigms, codes, culture and knowledge embedded in a range of institutions, form an important line of inquiry in the governance of abortion.

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21 Existing empirical studies largely trace the development of abortion attitudes over time, but are limited in their attempt to highlight the causal position of institutions.


Opening with the assumption that institutions do indeed assume a causal position in governing the termination of pregnancy, therefore, and adhering to Katzenstein's popular formulation that the state is not only affected by society, but in turn affects it, the legislature, medical profession and a range of norm entrepreneurs are all identified as significant actors, and their influence in the regulation of RU-486 is considered worthy of further investigation.  

The multifaceted nature of abortion management, inciting as it does legal, regulatory and societal demands, requires several angles of investigation and its is submitted that a range of perspectives falling under the NI umbrella – namely the historical, rational choice and normative branches – will provide rich insight into this policy domain. A considerable criticism raised against the development of the multi-variant conceptual approach, however, is its failure to provide a unified body of thought and thus the efficacy of using all three strains together is rightly questioned. It is posited from the outset, however, that this study does not fall foul of similar criticism as the termination of pregnancy, embodying as it does a criminal activity shrouded in questions of morality, but firmly rooted in the healthcare field, has ramifications at the macro, meso and micro levels of analysis. It is therefore instead contended that the range of dimensions offered by NI are of particular merit in this respect and can be helpful in three ways.

First, although historical intuitionalists are themselves eclectic, much can be borrowed from this school of thought when investigating the statutory regime in both countries. Immergut, for example, proffers that the institutional structure of the political system affects expectations around the likelihood of successful challenges to the legislature, whereas other authors cite an asymmetry of power and a disparity in attention to different social groups. In both senses, a hierarchical policy community is assumed that provides little recourse for ‘outside actors’. This strain is thus heavily focused upon historical development, and greatly accentuates a path dependency and encouragement of social forces to organize along particular lines. Historical events, they claim, are characterized by long periods of continuity punctuated by ‘critical junctures’. Of perhaps greatest pertinence to this study, and the aforementioned interrelated realms however, is the idea heavily espoused by historical institutionalists that institutions are located in a complicated casual chain that has deep appreciated of other factors. Second, and although developed in isolation from the other strains of NI, rational choice institutionalism provides alternative insights into the regulation of abortions deemed lawful within the parameters of the law. Assuming that an actor’s behavior is driven by strategic calculation, it claims that institutions structure interactions between various actors and thereby set the rules of the game. This operational environment is of much interest when investigating, as previously cited, a criminal activity seated firmly within the healthcare realm. Finally, finding

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28 Ibid.


commonality with the first, historical strain, normative institutionalism is invaluable when examining the societal behavior towards the issue of termination of pregnancy and, specifically, the use of RU-486. Rather than concerning themselves with ideas of ‘rationality’, normative institutionalists stress culturally specific practices and look for the social scripts that guide human action. To their minds, institutions can affect human behavior by outlining what is appropriate in a given situation and thereby finds support in the idea of social constructivism. Thus the various angles of the debate around the abortion pill can only be comprehensively investigated by deploying the mechanisms of path dependency, a logic of calculation and a logic of appropriateness in the legal, regulatory and cognitive realms respectively.

### Early Medical Abortions (EMAs)

The use of medication, as opposed to more evasive, surgical techniques, is common practice in terminations under 9 weeks, or 63 days, gestation. For this purpose, three treatment regimens currently exist in the US: RU-486 (also known as mifepristone) with misoprostol, methotrexate combined with misoprostol, and solely misoprostol. This first technique of combining the a dose of mifepristone with a second misoprostol tablet is mirrored in the UK and is highly effective at ending early pregnancies; in a study conducted in 1993, 96.9% of 505 women under 50 days gestation, and receiving misoprostol 48 hours after mifepristone, had their pregnancy terminated. Furthermore, abortion occurred in 2.9% of the women within 48 hours of administration of mifepristone, and 60.9% within 4 hours of the misoprostol.

According to US statistics, the method similarly carries a low associated death rate that is comparable to surgical abortion, and less than pregnancy to full term with delivery. RU-496, or the colloquially termed ‘abortion pill’, is thus widely viewed as a clinically safe method of terminating an unwanted or harmful pregnancy and, to the uninitiated; it would appear that little controversy surrounds its use. Indeed, if used within the parameters of the law in terms of gestational limits and conditions for granting an abortion, it could easily be assumed that the therapeutic process would only be of professional interest to practitioners in charge of its use. Far from merely an issue of prescription, however, the pill is at the heart of medical and societal debate for two reasons: both its close association with contraception and the possibility of its use in setting other than medical facilities.

The possibility of inadvertently promoting the abortion pill as a mode of contraception, and the subsequent impact this would have on abortion rates globally, has long been a fear of policymakers. This potential confusion is born from the role

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of the drug Mifepristone which blocks the action of the female hormone, causing the membrane of the uterus to be shed, and can be used in separate circumstances, with differing effects. When taken a short time after sexual intercourse as an emergency method, it prevents the implantation of a fertilized egg and acts a contragestive. Importantly, when the pill is ingested at this stage, no abortifacient act takes place. Within a time frame of nine weeks of gestation, however, Mifepristone can alternatively be taken to act to dislodge a fertilized egg that has been implanted, thus causing the termination of pregnancy.\textsuperscript{37} Conversely, this is an abortive process and concern is rife that it should be viewed as such by patients. Second to this problematic conflation of terms, the setting for this treatment is also the source of much contention. As a requirement of the Medicines Act 1968, the accompanying Data Sheet states that this form of medicinal abortion does not require the hospitalization of the pregnant woman as an in-patient. Rather, observation should be conducted for at least two hours, following which the she can be discharged home and return between 36-48 hours later for the second round of treatment in the form of Misoprostal.\textsuperscript{38} This original explanation of care is the source of much contention, and will feature heavily in the succeeding empirical sub-sections; suffice to say at this juncture, however, that the absence of a need for hospital care creates a marked difference between surgical and medical abortions, and a more complex management issue for national governments.

In view of these neighboring considerations, RU-486’s introduction into the pharmaceutical market, from the outset, has attracted much distain and disapproval to the extent that the company marketing the drug initially wavered on whether to sell it. Rather it was the intervention by the French government, who owned 36% of the French subsidiary of the German company in question – Hoescht, and firm order to sell the pill, that brought the measure into medical practice in the late 1980s.\textsuperscript{39} As previously mentioned, the drug was granted a product license in the UK in 1991 under the brand name ‘Mifegyne’, and became a feature of clinical practice in 1995. The US followed with FDA approval in 2000 but, in the years since its arrival, the drug has received different treatment in the to countries. By virtue of section 1(3) of the 1967 Act, and reaffirmed in a recent legal challenge, both aspects of which will be discussed in greater length below, the two stages of the abortion pill must be administered in a healthcare setting in the UK. In practice, this means two trips for women to their local clinic, with a gap of 48 hours between first and second consultation. In the USA, however, 59% of abortion providers offer EMAs, and it is common practice at the majority of these establishments for misoprostal to be given to the woman to take home after her first visit.\textsuperscript{40} This apparent discrepancy in patient autonomy is somewhat surprising, not only for the previously mentioned reason that the UK is largely perceived as a liberal nation on the matter of abortion, but, in addition, an abundance of studies highlighting the safety and efficacy of home administration appear to shed an outdated light on Britain’s current situation.\textsuperscript{41}

\textsuperscript{38} 08 DSF 91 UK; see also, Kennedy, I. and Grubb, A. (2000) \textit{Medical Law} (Butterworths: London).
\textsuperscript{40} Jones R. and Jerman J, (2014), \textit{Opicit}.
Consequently, the regulatory field is plagued with similar controversies in the two countries alike, yet the domestic interaction between the legislature, medical profession and a range of norm entrepreneurs on this matter has clearly resulted in contrasting situations. It is thus the focus of the next three sub-sections to explore the nature of these interactions and why they have served to constrain the UK’s administration of the pill, and liberalize the USA’s.

**Hanging Onto the Old: Legislative Constraints in a Stagnating Field?**

Reproductive healthcare in the UK experienced radical transformation in the latter half of the twentieth century. Abortion was legalized for the first time in the country, and a list of health-based defenses for the crime of terminating a pregnancy under the Offences Against the Persons statute were implemented by the 1967 Abortion Act. Unlike other European member states such as France, Italy and Spain, however, where abortion is available upon request within the first trimester, the termination of unwanted pregnancies in the UK in the absence of legally defined justification remains illegal.42 In practice the law now ensures the procedure is treated solely as a public health matter, creating no *de jure* choice for women, and providing strict health-based mitigations that serve only to protect the well being of mothers and fetuses in cases of potentially harmful pregnancies. This strong medical control of the issue has ramifications for the use of RU-486 and presently the two stages of the drug must both be administered in preapproved healthcare settings, thereby preventing women from taking the second misoprostal tablet in the comfort of their own homes. This strong element of policy inheritance, and dogged retention of the criminal aspect of abortion, is similarly mirrored in the USA. Despite the landmark decision in *Roe v Wade*, arguably mirroring sweeping liberalization across the Western states, federal legislation on the matter is lacking, and Congress has evaded much activity in the field. This harmony of status on the matter provides the context, or indeed backdrop, in which decisions regarding the administration of medical abortions are made and investigation of this fundamental legal domain is vital for assessing the influential role of the legislature in both countries.

The development of the law on abortion at common and early statutory law in the UK indicates an entrenched element of misdemeanour that has preserved the crime of abortion and permitted only incremental changes to the regulatory scheme. Indeed, even prior to the drafting of any codified law, the termination of pregnancy in the UK was always considered an offence with the period of statutory prohibition over abortion, and the recognition of the offence in the criminal law, beginning in the nineteenth century with Lord Ellenborough’s 1803 Act. In 1967, the situation radically changed, however, and the Abortion Act was created to provide several health-based clauses. Bound by the strong historical and normative ties to the criminal law, however, this liberalization was the culmination of a range of pressures exerted upon the UK government, which served to punctuate the status quo of path dependency for that moment alone; such radical change has indeed not been evidenced before and after the act. Providing the initial push for reform, an

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42 Abortion is available on demand in these states by virtue of the Veil Law of 1975 in France, Law no.194 of 1978 in Italy and Article 417 of the Penal Code in Spain.
exploration of the approach to the treatment amongst certain sections of the medical profession reveals that, in reality, by the early twentieth century, the procedure was often endorsed by clinicians if performed for health-based reasons: a questionnaire sent out to London doctors in 1965 received 751 replies, 69% of which approved of reforms to the law set out in the survey, 84% indicated belief in the safety of the operation and 75% supported its availability on the NHS.43

Indeed, by adhering rigidly to the time-honoured principles on the issue of abortion, the existing statutory regime was believed not only to compromise the status of women, but prevented doctors from acting in the best interest of their patients, and clinicians consequently demanded appropriate protection from criminal liability. Certainly, although Bourne was sufficiently courageous to risk a ‘cause celebre’ to highlight the need for reform, many doctors feared the legal backlash and damage to their reputation performing an abortion might incite. This alone, however, was not felt sufficient by the government to warrant legislative action, and the fact that the critical decision in the Bourne case was submitted almost three decades before the introduction of the Abortion Act pays testament to this. Furthermore, this event provides a strong indicator that history really does bind the legislature on this matter and, in addition, sets the tone for the rest of society; the general public more generally was not fully engaged with the need for reform and the pressure on the government was alone insufficient to negate the risks involved in overturning an ethically infused topic such as abortion.44 In this sense, logic can be borrowed from the study of economics and the government, as the ultimate risk manager, required additional motivation to abscond from the entrenched arrangement.45

Pressure on the government to partially remove the sanctions attached to abortion instead undeniably exploited the tolerant atmosphere of the 1960s, in addition to the mounting recognition of the procedure as a vital medical treatment. A departure from the longstanding criminal law on abortion would certainly require the conflation of several matters amounting to a crisis, and a growing public health epidemic at this time provided this final push. Indeed, first building upon the successful framing of contraception in scientific terms by the family planning pioneer Marie Stopes in the 1920s, the push for reform represented much more than a decline in moral standards amongst practitioners and was instead perceived by many as a vital step in the development of healthcare.46 The number of women dying from backstreet abortions, or indeed attempts to self-abort, contributed substantially to female ill health and the need to reduce the incidence of criminal activity, through the creation of a legal

framework of services in which the procedure could be conducted in clinically safer conditions, became pressing and was at the centre of advocacy work conducted by the ALRA.\footnote{47} Adopting a multiple streams model to explain the policy decision around abortion that occurred in the 1960s, the growing healthcare frame further coalesced with an acute medical crisis, and a window of opportunity arose in parliament to successfully introduce a new piece of legislation.\footnote{48} In the wake of the much publicised thalidomide tragedy, society’s attention was drawn to the inadequacies of the existing statute and public support for a change to the law was galvanised.\footnote{49} The epidemic concerned a sedative drug popularly used in the late 1950s to cure morning sickness, but, by 1962, was widely known to cause severe deformities in many children.\footnote{50} Victims of the tragedy inevitably argued their right to abort the potentially disabled foetuses and, aware of the increasingly liberal climate, the government feared that any refusal to do so would gain negative publicity.\footnote{51} The experience of the American actress Sherri Finkbine, for example, who was administered the drug during her fifth pregnancy, caused widespread controversy. When she was made aware of the possible damage that had been done to the foetus she was carrying, she sought an abortion and, on refusal, was eventually forced to fly to Sweden and received much sympathy for her situation.\footnote{52} Such events clearly aided the introduction of Lord David Steel’s private members bill; in the fifteen years prior to the disaster, no fewer than five parliamentary initiatives with the aim of reform were unsuccessfully introduced. A large and favourable Labour majority, however, supported the proposal and the Abortion Act was carried at the third reading by 167 votes to 83.\footnote{53}

\footnote{47} As noted by Hall to the House of Commons Science and Technology Select Committee Enquiry, the large number of ‘backstreet abortionists’ only came to the attention of the police and the courts if a woman died or became seriously ill as a result of their treatment. Access to the memorandum is available via \url{www.historyandpolicy.org/docs/abortion_act_1967.pdf} (accessed 13/05/2011). Even in acceptance of the low disclosure rate, according to figures collated from Reports on Confidential Enquiries into Maternal Deaths in England Wales by the Royal College of Obstetricians and Gynaecologists between 1958 and 1963, of 50 fatal cases of abortion each year, in approximately 60% of those cases there was reason to believe the abortion was criminally induced. The College unanimously voted in the report that, irrespective of the debates surrounding concrete numbers, it was clearly desirable to eliminate them if possible. For the full report see ‘Legalized Abortion: Report by the Council of the Royal College of Obstetricians and Gynaecologists’, \textit{British Medical Journal} 1966(1): 850-854. For further discussion of the different indices employed by commentators to assess the incidence of illegal abortions, see Cavadino, P. (1976) ‘Illegal Abortions and the Abortion Act 1967’, \textit{British Journal of Criminology} 16(1): 63-67; for framing effects see Rein, M. and Schon, D. (1993) \textit{Opit}; for an account of the ALRA, see Isaac, J. (1994) ‘The politics of morality in the UK’, \textit{Parliamentary Affairs} 47(2): 175-189.


\footnote{50} For a medical account of the thalidomide tragedy, see Dally, A. (1998) ‘Thalidomide: was the tragedy preventable?’ \textit{Lancet}, 18: 1197-9; an interpretation of the events is also supplied at \url{http://www.guardian.co.uk/society/2010/jan/14/thalidomide-apology-government} (accessed 20/05/2014).


\footnote{53} For more of the passage of the bill, see Buxton, R. (1973) ‘Criminal Law Reform: England’,
The demand for an appropriate healthcare scheme was clearly a principal driver in the introduction of legalised abortion, and the government was mindful in the drafting of the legislation that this fact would be the overriding sentiment. As such, the new statute did not allow room for women to have reproductive choice, but instead perpetuated the ‘pubic health frame’. The ‘medicalisation’ of the crime of abortion reflected a strategic action by the government to satisfy the immediate demands for a better level of protection for women, but also remain sympathetic to the long historical and normative association abortion had with the criminal law. Although action was required to improve healthcare, the morality of the topic continued to polarise opinion and vote-maximising politicians avoided costly ethical debates by legislating only for therapeutic abortion.

A similar situation has progressed in the US throughout the twentieth century and the criminality of abortion has been a feature of the legal and political landscape throughout this time, and in the centuries before. In actuality, a commonality between the transatlantic counterparts can be traced back to the time of impendence and the applicability of English common law across many of the domestic states. As detailed previously, under this regime abortion was not permitted after quickening and this provided the legal backdrop for many years to come. Indeed, prior to the landmark ruling in Roe v Wade, abortion was prohibited across 30 federal states and it was not until this court deliberation in 1973, and further qualification in 1992 through Planned Parenthood v Casey, that a threshold was put into place to prevent a state’s right to override a woman’s autonomy. Initially established as up until the first trimester, the latter court case replaced this with the ‘point of viability’ clause. Of pertinence to an examination of the behavior of the legislature in this section, however, is the absence, both before and after this time, of federal legislation. Despite the unconstitutional ruling announced by the court in 1973, arguably ushered in by the notable death of Gerri Santaro and sweeping liberalization at a state level, this was not the punctuation to the policy equilibrium, and continual inheritance, witnessed in the UK.

It must therefore be postulated that the US legislature actually displays far stronger historical constraints and path dependency than the UK on the matter and has evaded comprehensive statutory deliberation.

The legislatures in the two countries alike have thus illustrated a strong path dependency upon the criminality of abortion and an unwillingness to completely abandon this position. Previous studies into the development of healthcare

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54 For further discussion on the frames used by elites, and the affect on public opinion, see Druckman, J. (2001) Op cit.
have strongly alluded to the influential position of past events and, from a comparative perspective, the UK and US both appear to remain dependent upon this illegal status. Whether this situation can entirely be attributed to a reluctance to change the status quo, however, must be questioned when viewed in such two-dimensional terms. Indeed, in contexts of complex social interdependence, new policies are costly to create but, if they result in change such as the 1967 Act, they must require the consideration of a range of factors beyond merely what has gone before. The next sub-section therefore principally concentrates on the introduction of the abortion pill, and its corresponding regulatory scheme, to uncover the incentive structure of those pivotal in the decision to introduce the drug, and the inducements offered by their institutions.

Rational Decisions: Regulation and the influence of the Public/Private Divide

The strong and unrelenting historical dependence on the criminality of abortion provides the context in which the introduction of the drug RU-486 into medical practice must be seen. Far from an easy process, the adoption of this form of EMA in the UK and USA was plagued with difficulties at the outset, both countries putting the regime at the centre of much discussion, contention and debate. Interestingly, however, a divide in clinical practice has been witnessed between the two regions, and although he UK prohibits the home administration of the second stage of the process, this has come to be habit in the USA. Moving from the historical strain of NI, therefore, the section engages the theoretical merit of rational choice institutionalism in exploring the medical profession’s decision, and the constraints and inducements offered, in these two situations.

The 1967 Abortion Act served to enshrine the growing public health frame on the termination of pregnancy within UK legislation, and ushered the procedure into the field of health policy. Clearly reflected in the regulation of adjacent reproductive methods and contraceptive technology such as IVF, egg donation and surrogacy, the discovery of new medical techniques and the evolutionary nature of clinical practice places demands on any statutory scheme for appropriate amendments. By virtue of the 1967 Act, making abortions safe in the UK became a matter of good public health policy, and a fundamental concept for good public health practice is an evidence-base.
based approach (EBPH). Indeed making decisions founded upon the best available scientific facts, using data and information systems systematically, conducting sound investigation and disseminating what is learned, are all key components of EBPH.\(^{63}\) Regardless of the level of control afforded to the medical profession, however, clinical developments in abortion are severely constrained, and this has resulted in numerous conflicts. In recent years, a specific clash between the 1967 statute and the development of the abortion ‘pill’ has arisen that clearly illustrates the statutory constraints of EBPH, and the context in which the medical profession must operate. Indeed, in addition to the four grounds upon which two registered practitioners can grant a termination of pregnancy, the text of the 1967 Act creates a licensing procedure operated by the Secretary of State, with subsequent monitoring and inspection carried out by medical, nursing and administrative officials from the DoH.\(^{64}\)

The scientific innovation of RU-486, however, created two problems for the smooth running of section 1(3) of the 1967 Act and demonstrated the inability of the current regulatory scheme to meet modern scientific demands. Prior to its development, the techniques employed for the termination of pregnancy required a hospital, or approved clinic, because of the facilities and appropriate staff offered. As the use of Mifepristone does not demand this level of care however, questions first arose as to the appropriateness of its administration in alternative venues. Certainly, it had been contemplated that it could be used in GPs’ surgeries and, as the individual approval of practices by the Secretary of State would be an onerous task, the HFEA 1990 actually added a new clause to allow for the approval of a ‘class’ of places in this manner.\(^{65}\) Second, the Data Sheet for Mifepristone submits that the woman is free to leave the hospital or clinic in between the two stages of medicinal action. Case law states, however, that the termination of pregnancy is a process of treatment, therefore the entire period of time between the two rounds of medication that a drug constitutes treatment within the meaning of section 3(1).\(^{66}\) Within the parameters of the statute, therefore, the woman should technically stay in hospital for the duration of the procedure, unless the Secretary of State is to approve ‘every place under the sun where a woman would go’ which, of course, it is not a logical or feasible step.\(^{67}\) Although to retain the patient in hospital would have been the correct interpretation of the act, it would have undermined the advances made by Mifepristone, and, in reality, it is not how the system now operates, with the majority of service providers intending that women accessing EMA are discharged after the first round of treatment.\(^{68}\)

The supervision of this colloquially termed ‘abortion pill’ for EMA thus continues to be at the centre of vast clinical debate. One specific amendment proffered is making


\(^{65}\) Abortion Act 1967, section 1 (3A).

\(^{66}\) Royal College of Nursing of the UK v. DHSS [1981] AC 800.

\(^{67}\) A clear account of these problems is provided by Kennedy, I. and Grubb, A. (2000) Opit, 1437.

available to women the choice of whether to complete their treatment at home. In such circumstances the patient would be administered the first stage of the abortion (Mifepristone) in the clinic, and would be provided with the second (Misoprostol) to take away with her. Those in favour of permitting this method claim unnecessary time is spent by women in a medical setting; this is especially burdensome for patients who already have children and, according to government statistics, this forms half of the demographic that terminate a pregnancy. In addition, the expense of travel and the risk of miscarrying while returning from the clinic may mean women feel forced to choose a surgical abortion instead. Studies have demonstrated that women would welcome being offered the choice of having medical abortion at home or in hospital, many feeling that the home use of Misoprostol was more natural, private and allowed the presence of a partner or friend. Indeed in line with the RCOG’s recommendation that abortion clinics should ideally offer a choice of methods for abortion, a survey was undertaken by BPAS to obtain the opinions of women in the UK on the matter. The results demonstrated that of the 162 participants, the majority of respondents (86%) opted to go home to complete the treatment rather than remain in a clinical setting. To a greater extent, 98% believed home management to be very or, at the least somewhat, acceptable. The results of BPAS’ research concluded with a plea for consideration to be given to the updating of section 1(3).

Spurred on by this positive data haul, BPAS brought legal proceedings against the Secretary of State for Health in 2011 to forward such argument. The case rested upon a significant interpretation of the law in terms of whether the prescription stage of the medication can be considered to be the termination of pregnancy, rather than the actual consumption. In the course of deliberations, Ann Furedi, Chief Executive of BPAS, reiterated the concerns for social inclusion and consumer welfare held by professionals working in the field, including the time-consuming nature and expense of travel the current scheme demands, and thus submitted that present arrangements are ‘sub-optimal’. Further attached to this argument were the demands produced by public/private collaborations; certainly several incentives are provided by private sector development in healthcare, such as the complementary expansion of services and redistribution of resources, and the terms of the act enables the development of arrangements between the NHS and the abortion providers such as the aforementioned BPAS. In 2010, for example, over half (59%) of publicly subsidized

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69 See, in particular, British Pregnancy Advisory Service v Secretary of State for Health [2011] EWHC 23.
74 Ibid, para 11.
75 Incentives are the focus of Bull, A. (2000) ‘Role of private sector in United Kingdom healthcare system’, British Medical Journal 321: 563; the outsourcing of government functions to private sector
abortions took place in the independent sector under NHS contract.\textsuperscript{76} As a further result, however, abortion is consistently one of the most common patient-funded procedures in the UK, with 4\% (7583) of the 182,574 total abortions conducted last year administered in this manner.\textsuperscript{77}

In these situations, it is difficult to avoid the fact that private healthcare generally promotes the principle of consumer sovereignty, a notion that runs entirely contrary to the strong statutory controls witnessed above. The legislature, at least on the surface, is once again keen to ensure that the law is not circumvented, and has thus issued supplementary controls upon the management of private clinics.\textsuperscript{78} It has been submitted by some abortion providers, however, that there is a growing disparity between law and treatment, and practice is beginning to outpace legislation.\textsuperscript{79} Indeed, by outsourcing the majority of care over abortions to third parties, attention has been focused by these clinics upon the proper running of the system for its patients. Linking back to the stagnating legislative field uncovered in the previous section, the legislature’s actions are significantly shaped by a fear of public backlash, and these competing interpretations would require a potentially harmful moral adjudication. This becomes even more stark when the cost-effectiveness of the procedure is considered; in terms of the NHS, it is indeed cheaper and more expedient for women to have abortion earlier in pregnancy and it therefore appears counterintuitive to oppose them for reasons other than claims of morality.\textsuperscript{80}

Returning once again to the BPAS case, although the judgement refused to redefine the ambit of ‘treatment for abortion’, the conclusion nevertheless placed further pressure upon the stagnating abortion field. A clear division was asserted between the regulatory regime of the termination of pregnancy, and the statutory regime, and by extension the practicalities and moralities of abortion policy, and the power of the Secretary of State to affect a healthcare issue was highlighted. The UK court can therefore be seen to be a key player in the endorsement of an evidence-based approach to regulation but again, reflecting the government’s reluctance to further legislate on the matter, the Court recognized the controversial nature of abortion and indicated that, although the case did not involve a substantial challenge to the law, it’s construction and interpretation staunchly remains a decision for the Secretary of State. Consequently, by extension, this returns the matter to the legislature. Thus the

\begin{thebibliography}{9}
\bibitem{76} Department of Health \textit{Abortion Statistics, England and Wales: 2010}, Opcit.
\end{thebibliography}
independence of the judiciary is of vital importance in challenges to abortion regulation but, ultimately, its competences and abilities fails to circumvent the primacy of the legislature in these matters.

Against the backdrop of reluctance on the part of Congress to fully legislate on the matter of termination of pregnancy, initial assumptions in regard to the introduction of the abortion pill into the US could easily draw the conclusion of federal, and in turn state, resistance, to the method. Certainly this was the case in the infancy of the medication and, unlike the UK’s adoption in 1995, RU-486 did not receive FDA approval until 2000. This decision, and the subsequent, ‘normalization’ of the drug into modern clinical practice, are both indicative of the rational incentive structure shrouding the medical profession, and the inducements offered to clinicians practicing in the field to welcome the method. Operating within a private sphere, and unhindered by ties a welfare state such as the UK inevitably fosters, medical practice in the US continually places customer satisfaction as the heart of its concerns, even when dealing with an essentially criminal activity such as abortion. Here a paradigm shift has been evidenced, and a sharp divide between professionals and the legislature has been drawn; doctors are not politicians, nor vice versa, and therefore, operating alongside the pro-choice/pro-life debate, optimal standards of care when performing legal abortions is of primary importance. This conclusions can easily be drawn of the seminal importance of the medical profession in ensuring this rights based approach to home administration of misprostal, but the private sphere in which they operate alone could not have paved the way for the popular uptake of this drug and the final strain of NI – the normative aspect- which shed further light on the process of wider, societal adoption below.

**Normative Order: Redefining the Paradigm**

The termination of pregnancy remains an emotive and value-laden issue in the UK, and the ideational aspect of domestic abortion policy is inescapable. Unlike the simple yes/no debate presented prior to reform, however, a plethora of clinical and scientific dialogue now ensues on the appropriate administration of the procedure. As a result, the general public is progressively alienated from such elite debates and increasingly discouraged from challenging the existing status quo, even when their needs are not being met. Certainly multiple frames now exist on the role of the practitioner and the implementation of clinical developments, and a disparity is emerging between political knowledge and scientific expertise on the one hand, and civic appreciation of the issue on the other.\(^81\) Although the evolution of the abortion issue in mass consciousness thus originally reflected elite debates around a matter of public health, this has vastly depreciated in the decades since and scientific debates have failed to resonate with the public at the same emotive level with the public.\(^82\) Contrary to the

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82 For the casual connection between party elites and the masses in attitudes on abortions in the USA, see Adams, G. (1997) ‘Abortion: Evidence of an Issue Evolution’, *American Journal of Political*
The overwhelming majority in favor of decriminalization prior to reform, for example, when Social Surveys (Gallup) polled the public in 1967 on amendments to the Abortion Bill, the approval of doctors and the grounds for abortion, there was an abnormally high percentage of ‘Don’t knows’. In the years since this confusion has been a rising trend in opinion statistics relating to the specifics of abortion legislation. MORI, for example, has examined the attitudes of the UK public on the termination of pregnancy for BPAS by virtue of three studies conducted in 1997, 2001 and 2006. Interviews were carried out face to face, at home. Adopting an agency-centered version of sociological institutionalism and ‘logic of appropriateness’, the affect of a top-down process of socialization and learning, encouraging national actors towards what constitutes acceptable behavior, is tracked.

Conversely, the US situation largely concentrates on the wants and needs of the woman, putting her, as the patient, at the heart of decisions and thus successfully pushing the administration of abortion firmly into the private healthcare system. In particular the fear of the time taken to abort has previously been cited by women, and indeed mirrored in the UK in which the majority of women surveyed admitted that they would rather go home. Away from a welfare system strongly controlled by the government, however, it appears that women in the US are much more ready to assert these views and claims, and patient centered language has become the norm even in the termination of pregnancy. Of particular importance, however, is an exploration of the institutions fundamental to establish this logic of appropriateness and although assumptions could be made that a range of grassroots organizations have galvanized support for this framing of the abortion pill, it can be argued that the medical profession itself in the US ‘normalized’ the RU-486 drug. This influential role is even starker when compared with the immediate post Roe period in which many healthcare officials distanced themselves from providing clinics, residency-training programs or even set standards of care. After FDA approval of RU-486, however, many abortion rights groups within medicine have taken on the task of fully integrating the method into clinical practice and with far greater success than in other countries. In this sense, some authors have gone so far as to suggest the politicization of medical professionals in this realm, which is an intriguing point when contrasted with the


UK’s situation. The political sphere, and in particular the legislature, appear to bind UK doctors on this issue, and their interactions are influenced greatly by the institutions; the opposite appears true in the US, and healthcare professionals appear to ‘want in’ on the political aspect of abortion.

**Conclusion**

The reluctance to depart from the old, and the strong path dependency evidenced by the legislature on the status of abortion dictates the regulation of RU486 in the UK. Although Britain appears to house a seemingly liberal statutory regime around the termination of pregnancy, this has largely been the result of one crucial time in policymaking in the 1960s, and the confluence of a number of factors including the thalidomide tragedy and an overwhelming social movement, that served to punctuate the equilibrium and demand a change to the law. Since that time, amendments have been few and far between, and no crises to the same extent have been evidenced. Thus a system of policy inheritance, which retains strict medical control over the issue, has come to define the UK’s legal landscape and the same is true of the abortion pill. Although welcoming its arrival in the supposed pursuit of evidence based policymaking in the 1990s, the government, and its successors, were keen to preserve its highly technical, and ‘for professional use only’, status, thus, despite attempts by the legal system to update the regulatory system to align with arguably clinical best practice, and the needs and want of patients, this powerful institution has evaded these criticisms and the policy continues to stagnate. As this paper suggest, perhaps crucial in this failure to secure access to administration of misoprostol at home is the lack of galvanized support amongst the wider general public. Indeed, despite the issue being raised in the UK courts by the norm entrepreneur BPAS, it appears that the highly technical nature of the evidence presented has alienated people from the debate, and actors in this sociological realm have not successfully engaged people in a debate that moves beyond the right to an abortion, to a deliberation on the rights of a patient to access legitimate medical treatment, such as clinically approved termination of pregnancy, at an optimal standard.

The notion of a rarely changing legislative landscape in the UK is in fact mirrored in the US and few changes to the law around abortion, subsequent to the procedures decimalization in *Roe v Wade*, have occurred. It is here, however, that the similarities between the two regions end and, in contrast, alternative institutions have successfully removed the regulation of the abortion pill from the clutches of the legislature, and placed it firmly within the healthcare realm. Indeed a successful break had been evidenced, and the status of RU486 as a legitimate therapeutic method has been affirmed, and set aside from the pro-choice/pro-life deliberations. In this sense, the application of the rational choice arm of NI has revealed that the medical profession is of key standing and influence in the regulation and administration of EMAs and thus an innovative healthcare scheme, with respect for best possible care of the patient, to include the fulfillment to a degree of wants and wishes, has flourished. Pivotal to this successful role, however, is the longstanding respect for the patient as a consumer that has enabled clinicians to set the tone in terms of home administration of misoprostol. Indeed, once the legislature had determined the legality of abortion, and within the regional parameters set by federal states, the healthcare climate already fostered in the US empowers women to have a voice in their own treatment and seek the best possible standard of care, irrespective of the ongoing pro-choice/pro-life debate. In
this sense, this final, normative, aspect of NI has uncovered that it is not entrepreneurs operating within the abortion debate specifically that have been of influence in the recognition of rights, but rather it is the longstanding appropriateness that conflates patients and consumers in the US that has provided support for the successful introduction of the abortion pill.

Looking towards the future of regulation in the UK, therefore, the constrained role of the medical profession, as highlighted through application of the lenses of NI, raises concerns in terms of social inclusion. Indeed, the legislature in both regions displays a steadfast retention of abortion as an issue that is seldom touched or amended. Although the US has since successfully divided the matter into one of criminality and one of therapeutic care, the UK continues to allow this path dependency to spillover into the day-to-day healthcare needs of women, and fails to hand over compete control of legal terminations to the medical profession and recognize optimal care for the patient. As previous studies have shown, however, the unwillingness to allow women to administer the second stage of the abortion pill at home causes a myriad of problems for different sectors of the population including single mothers and ethnic groups. Thus, although a complete overhaul of the statutory regime, and a shift in sociological standing to place patients as consumers at the heart of healthcare, appears unlikely in the welfare based system of the UK, it is suggested that future legal challenges on the basis of discrimination may in fact weaken the legislature’s strict control over the issue of abortion.

**Bibliography**


