

Legality of Disability Selective Abortion: Discrimination and Privacy Laws Under the ECHR

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Abstract

Disability Selective Abortion (“DSA”) is a contested issue in disability studies. Most countries that allow a right to abortion also permit selective abortion on grounds of foetal disablement. In the United Kingdom (UK), s.1(1)(d) of the Abortion Act 1967 allows for the termination of pregnancies where the foetus is likely to be disabled. Section 1(1)(d) was challenged in R. (Crowter) v Secretary of State for Health and Social Care as being in violation of the ECHR. The challenges were dismissed. This article discusses some of the issues relating to s.1(1)(d) and DSA to question some of the explicit and implicit assumptions involved in its justification. A general right to abortion is important, but DSA does have an impact on disabled people in violation of rights under the ECHR that needs to be acknowledged and addressed. The article concludes with a discussion of changes that need to be made in law and society to ensure greater reproductive justice.

Introduction

The recent case of *Dobbs v Jackson*¹ in the Supreme Court of the United States has brought discussions on abortion rights to the front and centre of political debates. Arguments about women’s rights (and, indeed, rights of other marginalised groups) often ignore the interests and rights of disabled people. The issue of abortion affects disabled people in many ways. Many disabled people need to access abortions as a life-saving treatment in case of pregnancies, as many conditions make it dangerous to carry a pregnancy to term. However, another aspect of abortion touches on disability: disability-selective abortion (“DSA”). Jurisdictions that allow abortions also permit DSA, sometimes extending the time allowance for DSA. The Abortion Act 1967 (Abortion Act) in the UK is an example of this type of legislation.

The Abortion Act provides for the medical termination of pregnancy in Great Britain. Section 1(1)(d) of the Abortion Act allows for the termination of pregnancies for foetuses with specific abnormalities. This allowance is not time-bound. While the law restricts other terminations² to the first 24 weeks of pregnancy, foetuses with abnormalities may be aborted until birth. Medical practitioners do (and encourage people to)³ terminate pregnancies if the foetus shows signs of severe disablement, regardless of the foetus’s viability after birth. The ethics of DSA and the legality of extended timelines for DSA, not available to other forms of abortion are subjects of many debates and cases. Most recently, s.1(1)(d) was challenged

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¹ *Dobbs v Jackson Women’s Health Organisation* 597 U.S. (2022) (*Dobbs*).

² Except where there is a risk to the gestator’s life.

³ D. C. Wertz, “Eugenics Is Alive and Well: A Survey of Genetic Professionals around the World” (1998) 11 *Science in Context* 493.

in *R. (Crowter) v Secretary of State for Health and Social Care*.⁴ The *Crowter* cases exemplify much of the discourse on DSA. As such, it is an ideal case to highlight ongoing problems in the discourse. In this paper, I consider the legality of DSA, including s.1(1)(d) in the context of discrimination and privacy laws under the European Convention on Human Rights (ECHR).⁵

In any discussion on disability, it is essential to clarify which model of disability is used. The Social Model of disability frames environmental barriers excluding disabled people as the cause of disability in society.⁶ This contrasts with the Medical Model which sources disability entirely in bodily impairments. While medical sciences still use the Medical Model, disability rights legislation depend on the Social Model of disablement.⁷ Where the Medical Model treats disablement as tragic happenstance, the Social Model highlights the ways in which society oppresses disabled people, highlighting the need for environmental accommodations for disabled people. Since disability rights primarily deal with access and accommodations to include disabled people in society, Social Models are better suited to analyse legislation impacting disabled people. Arguably, the Abortion Act does not reference disabled people. Foetuses are not people, nor do I claim this. Defining disability in legislation nonetheless impacts how courts interpret and understand disability. Moreover, the Abortion Act also impacts disabled people (rather than foetuses) in other ways, which must be acknowledged.

This article commences with analysis of the definition of disability in s.1(1)(d). It argues that s.1(1)(d) defines disability in ways that are incompatible with Social Models of disability and that this is a glaring problem in the Abortion Act. Moreover, I argue that DSA and s.1(1)(d) violate the ECHR because of their impact on disabled people. Specifically, DSA and s.1(1)(d) violate the rights to anti-discrimination under art.14 and the right to respect for private life under art.8 of the ECHR.

I. Definition of Serious Handicap

Section 1(1)(d) exempts medical practitioners from any criminal liability for terminating a pregnancy where “there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped”. The phrase “seriously handicapped” is not clearly defined by the Abortion Act, nor is the phrase “substantial risk”. Since neither term was circumscribed, medical practitioners’ opinions are afforded a wide ambit of interpretation. This makes it nearly impossible to evidence bad faith in the decision to terminate the pregnancy if any potential for disablement was present. The clause itself appears to be cumulative in that the practitioner needs to believe both that the risk is substantial and that the risk is that of serious handicap.

The Royal College of Obstetricians and Gynaecologists (“RCOG”) has issued guidelines on the use of s.1(1)(d).⁸ The Guidelines highlight the difficulty in proving bad faith in these decisions; but state that the clause only protects a good faith judgement on the extent of risk (e.g. whether the risk is 25% or 50%) rather than on what risk counts as “substantial”. There has been only one successful prosecution of a doctor under s.1(1)(d), namely *R. v Smith*.⁹ In this case, the conviction of a doctor for causing a miscarriage was upheld; the court ruled that it was for the jury to decide whether the doctor had acted in good faith to avail of the exemption under s.1(1)(d) but does not provide details of the specific facts or the jury’s

⁴ *R. (Crowter) v Secretary of State for Health and Social Care* [2021] EWHC 2536 (Admin); [2022] 1 W.L.R. 2513. This decision was appealed, and was decided against the appellants in *R. (Crowter) v Secretary of State for Health and Social Care* [2022] EWCA Civ 1559; [2023] 1 W.L.R. 989.

⁵ Convention for the Protection of Human Rights and Fundamental Freedoms of 1953.

⁶ See generally, The Union of the Physically Impaired Against Segregation and The Disability Alliance, “The Fundamental Principles of Disability” (1975) *The Disability Archive: Centre for Disability Studies, University of Leeds*, <https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPLAS-fundamental-principles.pdf> [Accessed 29 August 2020]; M. Oliver, *Social Work with Disabled People* (Macmillan Education, 1983).

⁷ There are critiques of the Social Model (for instance, see generally, T. Shakespeare, *Disability Rights and Wrongs Revisited* (Routledge, 2014)), and other models (interactionist, human rights, postmodern) exist. For the sake of brevity, I use the phrase “Social Models” in this paper to mean models that source disablement (wholly or partially) in environmental barriers.

⁸ Royal College of Obstetricians and Gynaecologists, “Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales” (May 2010) (Guidelines).

⁹ *R. v Smith* [1973] 1 W.L.R. 1510; (1974) 58 Cr. App. R. 106 CA (Crim Div).

reasoning in the case. The only other case involving an assessment of the risk of disablement appears to be the case of *Jepson v The Chief Constable of West Mercia Police Constabulary*.¹⁰ In *Jepson*, an abortion had been performed because the foetus had a cleft palate, which was reviewed and sent for reinvestigation by the court. The claimant was a curate with a congenital facial impairment seeking to prevent late-term abortions for trivial reasons and concerned about the eugenic application of the exemption under s.1(1)(d).¹¹ The prosecutor reinvestigated the case; the fact that two doctors had concluded that there were sufficient grounds under s.1(1)(d) was deemed evidence of good faith. The doctors were not charged.

The fact that s.1(1)(d) justified the termination of a pregnancy where the foetus had a cleft palate, which was then deemed in good faith by enforcement authorities, is evidence of ambiguity in s.1(1)(d). Absence of case law does not necessarily demonstrate an absence of bad faith decisions. Instead, it may denote the difficulty in providing evidence for bad faith beyond reasonable doubt given the wide ambit provided to healthcare professionals on the matter.

The general understanding of the threshold at which termination is considered (according to the Guidelines) is that the child is likely to have physical or mental disablement causing “significant suffering or long-term impairment of their ability to function in society”. This definition, like that of disability under s.6(1)(b) of the Equality Act 2010, requires the person to have an impairment that “has a substantial and long-term adverse effect on [the person’s] ability to carry out normal day-to-day activities”. Whether “ability to function” is the same as “ability to carry out normal day-to-day activities” becomes a matter of subjective opinion. The ambit of “serious handicap”, therefore, may extend to any disability under the Equality Act.¹² This would essentially allow all disabilities under the Equality Act to fall within the terms of s.1(1)(d), if the medical authority subjectively understands it as such.

Considerations for such a decision under the Guidelines include treatment potential, self-awareness and communication capacity, potential suffering, and capacity for independence. Most of these considerations are still rooted in presumptions of disability based on the Medical Model. As such, it is relevant here to investigate the contrapositions of the Medical Model and Social Models on these points.

A. “Serious Handicap” Criteria Under Social Models of Disablement

The process of inclusion or exclusion of conditions within diagnostic manuals is politically fraught. The Medical Model prescribes a “normal” level of human functioning; anyone performing below this line is disabled. Medical science identifies bodily sources of conditions deemed abnormal, with the intention of eliminating them.¹³ The history of homosexuality’s inclusion in the Diagnostic and Statistical Manual of Mental Disorders demonstrates how any condition can be pathologised.

¹⁰ *Jepson v Chief Constable of West Mercia* [2003] EWHC 3318 (QB).

¹¹ C. Blackstock, “Curate’s Court Action over Abortion” (19 November 2003), *The Guardian*, <https://www.theguardian.com/society/2003/nov/19/health.healthandwellbeing1> [Accessed 14 June 2023].

¹² As an additional note, the necessity for criminal sanctions may be questioned; illegality does not necessitate criminality (e.g. discrimination is often illegal, but not criminal). However, a more detailed discussion of this is beyond the scope of this paper.

¹³ The historical drive of society and medical science to eliminate traits of disablement/disabled people is best evidenced by Aktion-T4 of the Third Reich, which saw the Reich authorising and medical professionals carrying out the systemic euthanasia of disabled people of various stripes (see generally, H. G. Gallagher, *By Trust Betrayed: Patients, Physicians, and the License to Kill in the Third Reich* (Vandamere Press, 1995)). Physicians formed the largest group of graduate members of the Nazi Party, with very few raising objections to the program (H. Hanauske-Abel, “From Nazi Holocaust to Nuclear Holocaust: A Lesson to Learn?” (1986) 328 *The Lancet* 271, 272; Gallagher 137–38). Disabled people were considered the first victims of the holocaust (see K. Fries, “The Nazis’ First Victims Were the Disabled” (13 September 2017), *The New York Times*, <https://www.nytimes.com/2017/09/13/opinion/nazis-holocaust-disabled.html> [Accessed 25 June 2023]) and Aktion-T4 was itself an extension of sterilisation programs to prevent disabled people from reproducing and passing their disabilities to future populations, modelled on the sterilisation programs of the US (see D. Ummel, “Dream or Nightmare? The Impact of American Eugenics, Past and Present” (2016) 66 *CrossCurrents* 389, 392).

While there is ample historical evidence of medical science seeking to both eliminate disabilities and disabled people, modern medical science continues to harbour the desire to solve disablement through elimination of abnormalities. The case that validated sterilisation programmes in the US, *Buck v Bell*, has not yet been overruled. While the term “eugenics” has largely gone out of use, the reduction of undesirable populations continues (for instance, see Rachel Iredale, “Eugenics and Its Relevance to Contemporary Health Care” (000) 7 *Nursing Ethics* 205; the author claims that the intentions behind positive and negative eugenics are still valid). Forced sterilisation has continued in detention centres (“CREW, NIPNLG and Project South Sue ICE over Forced Sterilization Records”, *Citizens for Responsibility and Ethics in Washington*, <https://www.citizensforethics.org/legal-action/lawsuits/ice-forced-sterilization-records-crew-nipnlg-project-south/> [Accessed 16 August 2021]). Bioethicists have argued that it is moral for disabled

Social Models shift focus onto the environmental barriers. Disability under the Social Model is “the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities.”¹⁴ Social Models separate “impairment” and “disability” to focus on how society creates the latter, leaving the definition of impairment to medical science. Social Models thus depend on the Medical Model to identify those classified as impaired, but frame disablement as being additional burdens imposed by society on people with impairments. Disability rights movements sought civil rights for disabled people, comprising immediate needs such as access and accommodation. Most disability legislation today results from this activism.

One of the most significant issues in the treatment of disabled people has been society’s obsession with eliminating impairments. Disabled people have a range of attitudes towards our “impairments”. Some do not view disabilities as “defects” but as a part of human variability. It is solely societal treatment that is the source of disability here: we¹⁵ would not be disabled if society were perfectly accessible. Others are more ambivalent about impairment: some aspects are perfectly fine or include positive experiences, while others are troublesome and need management. Others view their disability wholly along the lines of the Medical Model: they experience distress at the condition and desire cures. Regardless of individual experiences of impairment, all disabled people face societal barriers to access and inclusion.

1. Potential Suffering

The first criterion of “serious handicap” under the Guidelines is the likelihood of significant suffering. While it is true that impairments can cause suffering, it is impossible to pre-judge the disabled person’s experiences. Many disabled people experience suffering primarily due to oppression rather than impairment. Intersecting experiences of marginalisation make it impossible to isolate and measure the impact of impairment. For instance, insufficient access to healthcare can increase suffering. If distress at a condition is created/worsened by inadequate healthcare, is the cause of oppression society or the condition? How does one measure/apportion suffering between the two? At most, we might be able to review individual experiences of people currently living with the condition and estimate the chances of what conditions are more or less likely to result in suffering, but this criterion does not address variability and oppression.

2. Functioning in Society and Capacity for Independence

“Ability to function in society” appears rooted in biological functioning/capacity but ignores the “society” aspect. Society dictates norms of proper functioning and is responsible for enabling or disabling various forms of functioning. Society conditions us to believe that certain forms of existence are unworthy, and that non-existence is preferable to them. Likewise, independence is a relatively new societal standard for humans, a concept uniquely valued in western, educated, industrialised, rich and democratic (“WEIRD”)

new-borns to be euthanised, going to the extent of calling it “after-birth abortion”; the killing of disabled infants is relabelled “abortion” to minimise the moral impact of calling it murder (A. Giubilini and F. Minerva, “After-Birth Abortion: Why Should the Baby Live?” (2013) 39 *Journal of Medical Ethics* 261; See also Ummel 396–398 describing modern eugenics). Increasingly, medical science is moving towards genetic selection through embryo screening, to reduce, if not eliminate, the chance of having undesirable traits in children (P.Ball, “Imagine You Could Select Your Future Child Based on Likely Intelligence. Would You?” (6 March 2023), <https://www.prospectmagazine.co.uk/ideas/technology/60592/imagine-you-could-select-your-future-child-based-on-likely-intelligence-would-you> [Accessed 31 May 2023]). It is no exaggeration to say, as Brown puts it, the world is “literally out to kill us” (L.X. Z. Brown et al. “Radical Disability Politics” in A.J. Withers et al (eds), *Routledge Handbook of Radical Politics* (Routledge, 2019), p.183; see also P. S. Miller and R. Leah Levine, “Avoiding Genetic Genocide: Understanding Good Intentions and Eugenics in the Complex Dialogue between the Medical and Disability Communities” (2013) 15 *Genetics in Medicine* 2, 95 on the risk of disabled genocide through genetics).

¹⁴ The Union of the Physically Impaired Against Segregation and The Disability Alliance, “The Fundamental Principles of Disability” (1975) *The Disability Archive: Centre for Disability Studies, University of Leeds*, <https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPIAS-fundamental-principles.pdf> [Accessed 29 August 2020], as cited in Michael Oliver and Colin Barnes, *The New Politics of Disablement*. (Palgrave Macmillan, 2012) 21.

¹⁵ Experiences of disability (or lack thereof) impact research into disability (see C. Barnes, “Disability and the Myth of the Independent Researcher” (1996) 11 *Disability & Society* 107). I use personal pronouns where appropriate to reflect my own inclusion in relevant experiences of disablement.

countries.¹⁶ Disability advocacy has highlighted the contribution of industrialisation and capitalist economies in creating norms of individualism and independence that did not otherwise exist.¹⁷

Mainstream narratives around disability devalue dependence. These narratives paint the requirement of assistance as humiliating and undignified for disabled people and burdensome for providers. Early disability activism and independent living movements reframed independence as implying autonomy and decision-making capacity rather than the ability to act without assistance. Some disabled people can live independently, given environmental accommodations. Others require assistance for many daily activities. Many disabled people only need assistants to gain independence under this definition. The direction and control over services would belong entirely to the disabled person, whereas earlier, the service provider had control over assistance to disabled people. This gave many disabled people agency. While previously subject to the control of institutions that dictated how disabled people under their care would live, independent living afforded disabled people control over their own lives.

However, this narrative is still under-inclusive: many disabled people do not have the decision-making capacity to achieve such agency successfully. Independent living still excludes some forms of cognitive disablement. Reframing independence as agency does not challenge autonomy as essential for a worthwhile life. Disabled people incapable of autonomous agency may still lead worthwhile lives; lives of varied experiences and ranges of human emotions: joy, sorrow, pain, delight, surprise, anger, and many others. For many people, disabled and enabled, this may be sufficient for personal fulfilment. When we assume that a life without material/societally approved achievements and functions is not worthwhile, we substitute other people's life experiences for our own, conditioned with societal biases. Instead, we ought to provide space for acknowledgement of different ways of being as worthwhile in and of themselves while expanding all people's capacities by providing support systems and accommodations.

3. Potential for Treatment

Of the criteria listed in the guidelines, this is perhaps the most rooted in the Medical Model. The Medical Model provides the narrative that every disabled person must prefer cures/treatments as their priority; all other claims (accommodation/non-discrimination) are only required while treatments are unavailable. "Potential for treatment" ignores Social Models entirely. Many Social Models acknowledge treatment as a possibility. However, the Medical Model places treatment as the most/only valuable option for a disabled person. This places human life on a hierarchical scale where life with an impairment is always deemed worse than life without an impairment, regardless of all other factors that might affect the person.

The Social Model has been considered paradoxical for this reason. If barriers to access cause disability, providing such access means the person is no longer "disabled"; yet many people would still identify as "disabled".¹⁸ However, this is also true of many other forms of oppression: if we magically reconstruct society, undoing past and current racism, "race" may cease to exist; yet people will still identify with different ethnicities/cultures. Likewise, converting everyone into the same skin tone may erase some forms of racism, but not all; nor would it erase the effects of historical racism. Placeholders in lieu of visible markers of race (e.g. language/name/behaviour) would become more recognised. Indeed, the Indian

¹⁶ See generally, J. Henrich, *The Weirdest People in the World: How the West Became Psychologically Peculiar and Particularly Prosperous* (Penguin, 2020), pp.23–24; G. Hofstede, *Culture's Consequences: Comparing Values, Behaviors, Institutions and Organizations Across Nations* (SAGE Publications, 2001). Scholars hypothesised that people in WEIRD countries today are psychological outliers, both chronologically and geographically; most people in non-WEIRD countries demonstrated tendencies that didn't match those of WEIRD countries along certain moral values including individualism. Where people in WEIRD countries are more likely to see themselves as self-contained and independent individuals, most people in other places tend to see themselves as being interdependent parts of collective tribes/groups (see J. Henrich et al., "The Weirdest People in the World?" (2010) 33 *Behavioral and Brain Sciences* 61, 10–11).

¹⁷ See generally, Oliver and Barnes, *The New Politics of Disablement* (2012), Ch.3; T. MacVeigh, "Roddy Slorach, A Very Capitalist Condition-a History and Politics of Disability" (2016) 5 *Irish Marxist Review* 73; M. Russell, "Capitalism & Disability: Selected Writings by Marta Russell" (Haymarket Books, 2019), p.269.

¹⁸ A. Gregory, "Disability as Inability" (2020) 18 *Journal of Ethics & Social Philosophy* 23, 42.

practice of caste was arguably once based on visible ethnic differences¹⁹ but continues to operate without visible markers.²⁰ Caste discrimination is perpetrated through cultural traits, linguistic differences, behaviour, and identifiers (such as names). Likewise, past disability status is often included in anti-discrimination law because disablement can occur with past medical diagnoses or cured conditions. People are denied employment because of previous illnesses/institutionalisation; being “cured” of disability does not guarantee enablement.²¹

Racial erasure/assimilation is not an ethical way to end racism; likewise, not every disabled person seeks cures/treatments. To understand this, we first must divest ourselves of the notion that ability/capacity is a valid form of hierarchy.²² Disabled people’s lives are worthwhile regardless of capacity or interest in treatment. Reducing the incidence of conditions by pre-empting the birth of people with that condition reduces the incentive for research into treatment.²³ Decreased numbers of disabled people will reduce disabled people’s capacity to mobilise for resources, treatments, or rights. Reducing the number of disabled people will negatively impact disability rights. Accessibility and accommodations exist thanks to disability mobilisation over the last five decades, just as LGBT+ rights exist because of pride and queer rights movements.

4. Self-Awareness and Communication Capacity

Self-awareness and communication capacity are criteria that primarily affect cognitively disabled people. They are premised on beliefs that life without self-awareness or communication is necessarily worse than with such capacities. A caveat: self-awareness is not the same as a capacity to experience life. A person may not be self-aware and yet experience life (e.g. babies up to a certain age and most animals). Additionally, these must be acknowledged as hypothetical since it is impossible to communicate self-awareness without communication capacities. It is certainly possible that the first-person experience of someone without self-awareness and communication capacity is worse than someone with both. Nevertheless, possibility does not imply likelihood; it is equally possible that the reverse is true in some cases. Someone who is self-aware and able to communicate may have worse first-person experiences than someone without these abilities. First-person experiences do not require self-awareness, only sentience. This is also impossible to estimate externally: there is no known way of identifying if a person is experiencing things.

If there is a possibility of experiencing something, our only question ought to be whether (and how) we can facilitate positive experiences. First-person experiences are possible without self-awareness and communication; using this as a criterion for termination is more likely based on parents’ experiences. I will address whether parental distress is a sufficient cause for extended termination allowance in Section II. Another objection to this criterion is that we sometimes underestimate self-awareness and communication capacity. As a case in point, studies on disabled people with Rett Syndrome have recently shown that many of them may have the capacity to communicate effectively, given the right tools, training, and interventions.²⁴ However, impaired motor skills and a lack of adequate accommodations and training to

¹⁹ See generally, T. Joseph, *Early Indians: The Story of Our Ancestors and Where We Came From* (Juggernaut Publication, 2018).

²⁰ While skin tone is correlated to caste status, caste itself is not identifiable through skin tone.

²¹ *School Board of Nassau County, Florida v Arline* 480 U.S. 273 (1987).

²² It may be worthwhile to divest ourselves of hierarchies altogether, but that is beyond the scope of this paper.

²³ See section A.1.b below on the Resource Allocation Hypothesis. See also C. Gyngell and T. Douglas, “Selecting Against Disability: The Liberal Eugenic Challenge and the Argument from Cognitive Diversity” (2018) 35 *Journal of Applied Philosophy* 319; K. Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (Oxford: Oxford University Press, 2017), p.236.

²⁴ J. Ahonniska-Assa et al, “Assessing Cognitive Functioning in Females with Rett Syndrome by Eye-Tracking Methodology” (2018) 22 *European Journal of Paediatric Neurology* 39, 44.

test communication without the use of motor skills may have led researchers to underestimate cognitive ability.²⁵

It is vital, however, to retain the exception allowed for late-term abortions in the case of fatal foetal abnormalities (FFAs). There is scope for a distinction between foetal abnormalities where there is no chance of survival and where the foetus is very likely to survive at birth and be disabled (whether severely or not). In some cases, it may even be that the anomaly may cause the parent pain through gestation or cause the child severe pain (if born) prior to death shortly after birth. Where viability is impossible, or the child is very likely to die shortly after birth, a late-term abortion may spare the families the pain of dealing with a certain death of a child after birth. It affords families some dignity in how best to deal with the loss of a child.

Many congenital abnormalities do not result in death at birth and are perfectly compatible with a happy life. Distinguishing between FFAs and other congenital abnormalities makes sense for late-term terminations, given the foetus' incompatibility with life. Equating FFA with all congenital disabilities equates disability and death, implicitly devaluing disabled peoples' lives. DSA in this paper refers solely to anomalies identified in utero that are compatible with life, excluding FFAs.

In conclusion, the criteria for "serious handicap" are unsupportable as reasons to distinguish between viable foetuses on their potential disabilities. The wide ambit afforded to medical practitioners creates room for bad-faith decisions, even assuming most practitioners eschew such decisions.

II. Prohibition of Discrimination: ECHR Article 14

Article 14 of the ECHR prohibits discrimination in the enjoyment of rights and freedoms under the Convention on protected grounds. Because disability is often stigmatised, medical professionals often use negative messaging when informing prospective parents of potential disability in their child, making DSA more likely. Disability rights advocates seek neutral messaging on conditions to educate prospective parents. Others suggest that DSA ought to be banned either temporally or outright.²⁶ On the other hand, women's rights advocates resist restrictions on abortions, regardless of the reasons.²⁷ On legality, most analyses conclude that DSA cannot be discriminatory as anti-discrimination law only applies to persons.

The *Crowter* decision exemplifies the legal discourse on the subject. The court investigates whether "persons" in art.14 includes foetuses. Based on *Re Northern Ireland Human Rights Commission's Application for Judicial Review*,²⁸ *Vo v France*,²⁹ *Re MB (Medical Treatment)*,³⁰ and *RR v Poland*,³¹ the court (rightly)³² concludes that a foetus is not a "person" for rights under the ECHR.³³ No law in the UK grants personhood to the foetus. However, this neither means that the foetus has no protections nor automatically rules out discrimination. I will not investigate the issue of foetal personhood in this paper.

²⁵ J. Ahonniska-Assa et al., "Assessing Cognitive Functioning in Females with Rett Syndrome by Eye-Tracking Methodology" (2018) 22 *European Journal of Paediatric Neurology* 43–44.

²⁶ T. Shakespeare, "Choices and Rights: Eugenics, Genetics and Disability Equality" (1998) 13 *Disability & Society* 665; A. Asch, "Disability Equality and Prenatal Testing: Contradictory or Compatible?" (2002) 30 *Florida State University Law Review* 315; M. Saxton, "Disability Rights and Selective Abortion" in L. J. Davis (ed.), *The Disability Studies Reader*, 4th edn, (Taylor & Francis Group, 2013); S. Nizar, *The Contradiction in Disability Law: Selective Abortion and Rights* (Oxford: Oxford University Press, 2016); K. Ramaswamy, "Addressing Ableism: Lessons from the Problem of Female Feticide in India" (2017) 27 *Transnational Law and Contemporary Problems* 1; Gyngell and Douglas, "Selecting Against Disability: The Liberal Eugenic Challenge and the Argument from Cognitive Diversity" (2018) 35 *Journal of Applied Philosophy* 319.

²⁷ S. Sheldon and S. Wilkinson, "Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law?" (2001) 9 *Medical Law Review* 85, 106–109; D. R. Williams and P. B. Jackson, "Social Sources of Racial Disparities In Health" [2017] *Health Affairs* 147; Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), pp.235–238.

²⁸ *Re Northern Ireland Human Rights Commission's Application for Judicial Review* [2018] UKSC 27; [2018] N.I. 228.

²⁹ *Vo v France* [GC] (App. No.53924/00), judgment of 8 July 2004.

³⁰ *Re MB (Medical Treatment)* [1997] EWCA Civ 3093.

³¹ *R v Poland* (App. No.27617/04), judgement of 26 May 2011.

³² Regarding foetal personhood, I agree with Kate Greasley's arguments that personhood arises at birth (see Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), Ch.8).

³³ *Crowter* [2022] 1 W.L.R. 2513 at [38], [39], [49], [50], [62], [67], [71].

If evidence proves foetal personhood, DSA is automatically discriminatory. I instead assume that personhood arises at birth and argue that DSA is nonetheless discriminatory, which is the higher threshold.

Discrimination law deals with acts of discrimination against persons on account of their membership to a protected class.³⁴ Since discrimination law does not apply to entities that do not have personhood, discrimination law cannot apply directly to DSA. However, DSA and s.1(1)(d) may still violate anti-discrimination law by negatively impacting disabled people (who are not foetuses) and by permitting certain distinctions based on prohibited grounds, *viz* disability. Differential treatment of non-persons based on protected grounds can (and often does) result in discrimination of people belonging to the same class. As an ancillary right, art.14 guarantees the right to non-discrimination, but this must fall within the ambit of the rights set out in the ECHR. The substantive rights impacted by DSA are the Right to Life under art.2 and the right to Privacy and Non-Interference under art.8 (which I deal with in Section III of the paper).

A. Impact of Class-Selective Abortion on the Selected Class

There are currently no studies on the impact of DSA on the real lives and experiences of disabled persons. While many have hypothesised possible positive and negative results, there has been little research (qualitative or quantitative) on the potential impact on disabled people. A part of the problem is the lack of control groups: DSA is widely available, practised, and often justified as an allowable exemption by some who otherwise oppose abortion rights.³⁵ No comparator exists to examine relative differences in the impact of DSA/prohibitions of DSA on disabled people. The other problem is that much research on disabled people focuses on the well-being, subjective experiences, and opinions of (enabled) parents, family members of disabled people, and the opinions of healthcare professionals while ignoring the experiences of disabled people themselves in considering policy on DSA.³⁶ In the absence/impossibility of direct research on the impact of DSA on disabled people, analogous situations will have to suffice to understand the impact of selective abortion on the selected class. In this section, I analyse the possible impacts (positive and negative) of DSA on disabled people.

1. Positive Impacts of DSA

Hypothesised positive outcomes of DSA include (a) more enabled children being born in place of the terminated foetuses, resulting in a net positive outcome of welfare (“replacement hypothesis”); (b) reduced numbers of disabled people in society may increase resources available to remaining disabled people, increasing their welfare (“resource allocation hypothesis”); (c) parents choosing DSA may have a better quality of life with enabled children (“parental welfare hypothesis”); and (d) it is in the interests of all people to ensure that they do not needlessly suffer; since disabled people suffer, it is in the interests of the foetus to avoid suffering by not being born (“foetal interest hypothesis”).

A fifth and often implicit argument for DSA is eugenics. Eugenics is the eradication of undesirable traits in a population by controlling reproduction. Since World War II, medical science has largely sought to distance itself from labels of eugenics due to the atrocities of the Nazi Regime. However, some professionals in the medical community retain eugenic aspirations.³⁷ To that end, medical professionals avoid claiming that DSA is eugenic. Professionals distinguish DSA from other forms of eugenics (such as genetic engineering) by emphasising that DSA is preventative/passive. However, the (hypothetical) positive impacts of DSA are inherently eugenic. The replacement hypothesis differentially values disabled

³⁴ See generally, T. Khaitan, *A Theory of Discrimination Law* (Oxford: Oxford University Press, 2015).

³⁵ Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), p.223.

³⁶ D. Kaplan, “Prenatal Screening and Its Impact on Persons with Disabilities” (1993) 8 F.D.T. 64, 67.

³⁷ See generally, Wertz, “Eugenics Is Alive and Well: A Survey of Genetic Professionals around the World” (1998) 11 *Science in Context* 493.

and enabled persons (couched in terms of experienced welfare). It seeks to reduce disability (the undesirable trait) in the population, replacing them with enabled people by preventing the birth of disabled people (controlling reproduction). The parental welfare and foetal interest hypotheses again seek to decrease pain and suffering (undesirable traits) by preventing the birth (controlling reproduction) of people assumed to be the source of the suffering. While I will be dealing with the four identified hypotheses, I will not criticise eugenics separately since various scholars have already done so adequately.³⁸

a. Replacement Hypothesis Many unfounded and implicit claims build up the replacement hypothesis. First, that replacing people for welfare gains is ethical. While dealing with the act of abortion itself, we are not considering “people” but foetuses. The replacement hypothesis refers to the resulting *people*, thus referring entirely to individuals with full personhood. Sheldon and Wilkinson highlight that it is based on the belief that there will be replacements from the same parents or from other parents in society.³⁹ In any case, even if one can depend on such replacement to occur, Sheldon and Wilkinson argue that it still does not justify s.1(1)(d), which makes no mention of replacement nor allowances for other replacements;⁴⁰ if, for example, genetic engineering became available, s.1(1)(d) does not entitle a person to opt for abortion of a foetus to replace it with a genetically enhanced foetus for increased welfare.⁴¹ The replacement hypothesis, therefore, cannot be the basis of s.1(1)(d).

Second, the replacement hypothesis endorses a belief that *every* disabled person is necessarily worse off in welfare/overall utility than *every* enabled person. It may be true that to a disabled person (or to each disabled person), being enabled (on account of increasing societal enablement rather than through a magical “cure”) is better than being disabled. It does not follow that the quality of life of *each* enabled person is necessarily better than the quality of life of *every* disabled one. This idea fails even to consider Social Models and the extent to which society influences experiences of disablement. For instance, disabled people born into wealth may have significantly better and happier lives than enabled people born into abject poverty.⁴² Even without considering intersecting oppressions, it is possible for an enabled person to feel less joy than a disabled person throughout a lifetime. Societal treatment significantly impacts disabled people’s welfare. A better way to improve overall welfare would be to augment societal inclusion of disabled people.

Third, it assumes that all disability-related experiences are negative. People’s experiences of disability are as vast and varied as experiences generally tend to be. Even experiences of bodily pain, while generally believed to be negative, can become sources of positive changes/attitudes/experiences for some disabled people.⁴³ Our physical differences may result in joy, pain, discomfort, indifference, surprise, curiosity, and other combinations of positive and negative experiences, much like enabled people’s bodies. Deaf people, for example, speak of “Deaf Gain”: the counterpoint to “hearing loss” that enables deaf people to

³⁸ See generally, D. Pfeiffer, “Eugenics and Disability Discrimination” (1994) 9 *Disability & Society* 481; D. J. Kevles, “Eugenics and Human Rights” (1999) 319 *B.M.J.* 435; P. A. Lombardo, *Three Generations, No Imbeciles: Eugenics, the Supreme Court, and Buck v Bell* (Kindle edition, The John Hopkins University Press, 2008); B. A. Fischer, “Maltreatment of People With Serious Mental Illness in the Early 20th Century: A Focus on Nazi Germany and Eugenics in America” (2012) 200 *The Journal of Nervous and Mental Disease* 1096; P. S. Miller and R. Leah Levine, “Avoiding Genetic Genocide: Understanding Good Intentions and Eugenics in the Complex Dialogue between the Medical and Disability Communities” (2013) 15 *Genetics in Medicine* 2, 95; D. Ummel, “Dream or Nightmare? The Impact of American Eugenics, Past and Present” (2016) 66 *CrossCurrents* 389; A. Suuberg, “Buck v. Bell, American Eugenics, and the Bad Man Test: Putting Limits on Newgenics in the 21st Century” (2020) 38 *Law & Inequality* 115.

³⁹ Sheldon and Wilkinson, “Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law” (2001) 9 *Medical Law Review* 85, 96.

⁴⁰ Sheldon and Wilkinson, “Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law” (2001) 9 *Medical Law Review* 85, 98.

⁴¹ Sheldon and Wilkinson, “Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law” (2001) 9 *Medical Law Review* 85, 98.

⁴² A ready example exists in President Franklin D Roosevelt (See generally, D. J. Wilson, “Passing in the Shadow of FDR: Polio Survivors, Passing, and the Negotiation of Disability” in J. A. Brune and D. J. Wilson (eds), *Disability and passing: Blurring the Lines of identity* (Temple University Press, 2013)).

⁴³ For example, Wendell describes how chronic pain transformed and enhanced her understanding of both her body and pain itself (see S. Wendell, *The Rejected Body: Feminist Philosophical Reflections on Disability* (Routledge 2013), p.103, pp.171–172).

enjoy aspects of being deaf that are inaccessible to hearing people.⁴⁴ Some of us with noticeable disabilities enjoy freedom from fear of difference and worrying about our appearances. When conformity is impossible, the pressure to conform can lose its power.

Fourth, it imposes enabled perspectives of disablement, particularly existential anxiety,⁴⁵ onto disabled people. The underlying belief is, “I am afraid of disablement because I cannot imagine being happy as a disabled person; therefore, disabled people must be unhappy”. While existential anxiety is very real, it does not stem as much from the fear of loss of specific functions as from the resulting devaluation of life. The analogy of race can demonstrate the distinction between the two. People do not generally worry about becoming another race (since it is impossible), but many have anxieties about becoming *minorities*. There is a growing fear among some white people in the United States (US), for instance, of their proportion in the country’s population falling below 50%. The fact that white people will still be the largest single ethnic group in the US even if they fall below 50% does not mitigate this fear. They fear a (mythically united) non-white majority treating them as (they implicitly understand) minorities are currently treated. This fear is deeply existential as well. Many conservatives speak of “white genocide”, indicating their fear of being killed/exterminated as a race, even though whiteness is not a target of systemic oppression or violence.⁴⁶

Existential anxiety operates in general terms: people do not fear the loss of specific functions as much as they fear the idea of being labelled “disabled”. This is exemplified by deaf people who sometimes distance themselves from disability:⁴⁷ the inability to hear is not existentially threatening, unlike the devaluation attached to being disabled. Parallely, most sighted people do not actively fear moderate sight deterioration from ageing, despite it being a loss of function that most people use regularly. This is because there are adequate accommodations (whether through corrective lenses or surgical interventions) and more importantly, no significant cultural devaluation is attached to being bespectacled. The fear of disablement may include fear of trauma involved in becoming disabled; however, this may be separated from existential anxiety because trauma is generally frightening and harmful to most people irrespective of whether it involves disablement. My argument is not that the fear of disablement is either *always* or *only* about devaluation, but that fear of devaluation better explains existential anxiety, and as such parallels the existential fear of racial minoritisation.

Disabled people all experience disablement differently. Some of us experience it as purely societal, others experience it as a mix of societal and bodily problems, and others experience it as solely sourced in the body.⁴⁸ These are all valid perspectives of disablement. They demonstrate that no single perspective of disablement is universal, nor can such perspectives be used to support the replacement hypothesis. Thus, we see that the replacement hypothesis fails as a justification for DSA and s.1(1)(d).

b. Resource Allocation Hypothesis The resource allocation hypothesis claims that DSA benefits disabled people by reducing the number of disabled people. If states have a fixed amount of money to spend on disabled people, fewer disabled people mean more money spent on each disabled person. Scholars have also made a similar claim about sex-selective abortion (“SSA”): that wanted girls would have better outcomes (explicitly claimed in terms of infant mortality) if SSA is permitted. Those who do not want

⁴⁴ H. Dirksen Bauman and J. Murray, “Reframing: From Hearing Loss to Deaf Gain” (2009) 1 *Deaf Studies Digital Journal* 1; H. Dirksen, L. Bauman and J. J. Murray, *Deaf Gain: Raising the Stakes for Human Diversity* (University of Minnesota Press, 2014).

⁴⁵ This is a phrase coined by Harlan Hahn to describe the fear of disablement triggered in the minds of enabled people when considering or interacting with disabled people (see H. Hahn, “The Politics of Physical Differences: Disability and Discrimination” [1988] 44 *Journal of Social Issues* 39, 43).

⁴⁶ For a discussion on the use and understanding of the phrase “white genocide” and the lack of evidence to support it, see A. Dirk Moses, “‘White Genocide’ and the Ethics of Public Analysis” (2019) 21 *Journal of Genocide Research* 201. Ironically, similar fears of white eradication fuelled eugenic policies throughout the twentieth century, despite no coercion, intention, or systemic action targeting white people for their race: A. Moses, “‘White Genocide’ and the Ethics of Public Analysis” (2019) 21 *Journal of Genocide Research* 207–09.

⁴⁷ E. Dolnick, “Deafness as Culture” (September 1993), *The Atlantic*, <https://www.theatlantic.com/magazine/archive/1993/09/deafness-as-culture/668630/> [Accessed 14 June 2023]; M. Scott-Hill, “Deafness/Disability-Problematising Notions of Identity, Culture and Structure” in S. Riddell and N. Watson (eds), *Disability, culture and identity* (Routledge, 2003), p.89.

⁴⁸ It is arguable that society nevertheless contributes to the oppression of the disabled person even if they believe that their problems are solely a result of bodily defects. However, this only refers to first-person experiences of disabled people.

daughters (and are therefore likely to mistreat them) do not have them.⁴⁹ However, studies have indicated that this hypothesis is false; SSA is associated with increased or no change in gender discrimination.⁵⁰ Further, many people advocate DSA as a way to defund disability support.

Disabled groups are generally allocated fewer (rather than more) resources with decreases in the population of the group.⁵¹ There are examples of this happening in practice: vaccinations against polio reduced the amount of research and support for those who acquired disabilities after contracting polio.⁵² Those who needed medical support lost access to experts who knew how to treat them. Under this hypothesis, widespread polio immunity ought to have freed up resources to support those who had contracted it. Instead, interest in and resources for polio reduced to the point where nobody bothered with it anymore. This is not to say that vaccinations should be stopped; they serve a vital function in preventing death.⁵³ Instead, it shows that the resource allocation hypothesis fails. Political ideologies may exacerbate the problem; austerity in the UK has had a devastating impact on disabled people.⁵⁴

c. Paternal Welfare Hypothesis Like the replacement hypothesis, the paternal welfare hypothesis is also premised on a universalised notion that *every* disabled child is necessarily a greater burden to the parents than *every* enabled one. This is not true: many families of disabled people are perfectly happy with their situation and relationships with each other. In contrast, many families with no disabled members are terribly unhappy. Again, we have an analogy in gender: studies indicate that daughters may cause more distress in familial relationships than sons,⁵⁵ yet this does not justify SSA.

Scholars have argued that Parental Welfare Hypothesis succeeds in justifying DSA because disablement is unlike other societal oppressions such as sex and race.⁵⁶ I have previously debunked this claim, and the objection to the broad scope of “disablement” under the Social Model in my work: disability, in as much as one understands it through Social Models, is not significantly different from race, sex, or sexuality.⁵⁷ Like disability, other forms of oppression have been seen as “inherently” negative in the past, and many continue to harbour beliefs of gender/racial hierarchies. A number of positive and negative traits can be attributed to one’s gender/ethnicity, as indicative of the inherent inferiority/superiority of the group. Like disability, gender and race have been the focal points of systemic violence, oppression, and exclusion.⁵⁸ One can claim (and many do) that sex differences are not socially constructed but a necessary consequence of biological reality. The claim may be that since only biological females can bear children, it is logical

⁴⁹ D. Goodkind, “On Substituting Sex Preference Strategies in East Asia: Does Prenatal Sex Selection Reduce Postnatal Discrimination?” (1996) 22 *Population and Development Review* 111, 112.

⁵⁰ M. E. Shepherd, *Sex-Selective Abortion in India: The Impact on Child Mortality / Mary Elizabeth Shepherd* (Cambria Press, 2008); S. Dasgupta, “Is Sex-Selective Abortion Associated With a Reduction in Gender Differentials in Child Health Investments? Evidence from India” (SSRN Scholarly Paper, 5 November 2011).

⁵¹ Gyngell and Douglas, “Selecting Against Disability: The Liberal Eugenic Challenge and the Argument from Cognitive Diversity” (2018) 35 *Journal of Applied Philosophy* 319; Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), p.236.

⁵² P. L. Kaufert and J. M. Kaufert, “Methodological and Conceptual Issues in Measuring the Long Term Impact of Disability: The Experience of Poliomyelitis Patients in Manitoba” (1984) 19 *Social Science & Medicine* 609, 616.

⁵³ This is not to say that since prevention of death/disease is good, disability is always bad. For disabled people’s perspectives on the subject, see S. Wendell, *The Rejected Body: Feminist Philosophical Reflections on Disability* (Routledge, 2013); E. Barnes, *The Minority Body: A Theory of Disability* (Oxford: Oxford University Press, 2016).

⁵⁴ F. Ryan, *Crippled: Austerity and the Demonization of Disabled People* (Verso, 2019); M. Bluman, “More than 17,000 Sick and Disabled People Die While Waiting for Welfare Benefits, Figures Show” (14 January 2019), *The Independent*, <https://www.independent.co.uk/news/uk/home-news/pip-waiting-time-deaths-disabled-people-die-disability-benefits-personal-independence-payment-dwp-a8727296.html> [Accessed 29 August 2020]; F. Ryan, “Disabled People Are Going Hungry. Tears Are Not Enough” (29 January 2019), *The Guardian*, <https://www.theguardian.com/society/2019/jan/29/disabled-people-hungry-thatcher-social-fabric> [Accessed 1 June 2020].

⁵⁵ S. P. Morgan et al., “Sons, Daughters, and the Risk of Marital Disruption” (1988) 94 *American Journal of Sociology* 110; K. Bedard and O. Deschênes, “Sex Preferences, Marital Dissolution, and the Economic Status of Women” (2005) XL J Human Resources 411; J. Kabátek and D. C. Ribar, “Daughters and Divorce” (2021) 131 *The Economic Journal* 2144.

⁵⁶ Sheldon and Wilkinson, “Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law” (2001) 9 *Medical Law Review* 85, 104.

⁵⁷ Ramaswamy, “Addressing Ableism: Lessons from the Problem of Female Feticide in India” (2017) 27 *Transnational Law and Contemporary Problems* 1, 9–15.

⁵⁸ Ramaswamy, “Addressing Ableism: Lessons from the Problem of Female Feticide in India” (2017) 27 *Transnational Law and Contemporary Problems* 1, 11–15.

(and not oppressive) that childcare falls upon women.⁵⁹ People have claimed that gender disparities in specific fields occur not because of oppression but because of innate preferences governed by sex hormones.⁶⁰ These are ways in which gender has been treated as being a “natural” superiority/inferiority; race has also been historically treated as a “inherent” hierarchy backed by science.⁶¹ The treatment of disablement as a “natural” inferiority parallels the treatment of gender and race.

Sheldon and Wilkinson have argued that comparing disability to sex and race may lead people to pathologise sex and race.⁶² Instead, they draw distinctions between disabilities caused by impairment and those caused by society; for example, they say that reductions in functioning that disabled people often experience cannot be attributed to society. This claim ignores the history of disablement and oppression. Drawing parallels between disability and sex/race does not increase pathologisation. Conversely, separation of disability from other forms of oppression (which happens in *Crowter*) can exacerbate the pathologisation of disabled people.

Marginalisation has always been accompanied and supported by the pathologisation of the oppressed class. For example, claims of women being “hysterical” to devalue and delegitimise women’s ideas, experiences, or perspectives, and ethnic differences in facial/bodily appearance evidencing “white superiority”. The pathologisation of sex and race is not a result of the use of Social Models; instead, it further demonstrates the parallels between sex and race with disability. Pathologisation continues to be considered legitimate for disabled people but illegitimate⁶³ for race, sex, gender, and sexuality. The idea that disability is a distinct category from other forms of oppression (which are implicitly similar to each other but different from disability) separates those “deserving” pathologisation (disabled people) from those who do not.

It is impossible to separate problems caused by impairment and those caused by society for many categories of disablement. Am I more societally impaired because I need help lifting heavy objects, or is that a function of my limb difference? Is this *more* or *less* medical disablement than a petite (enabled) person who cannot lift things any more than I can? Here I am in the same position as the enabled petite person, in that I cannot carry things without help, whereas only one of us is “deemed” disabled. Other examples demonstrate this. Consider countries that make it illegal for homosexual couples to adopt a child or choose surrogacy while legalising this (and perhaps providing financial support) for infertile heterosexual couples. The two couples start in similar positions: wanting children while being in sexually exclusive relationships where pregnancy is less likely/impossible. Does their biology oppress the homosexual couple? Or are they legally oppressed because the state *disables* them from choosing surrogacy while enabling heterosexual couples? Likewise, is a trans person societally or biologically oppressed if the state will not fund gender affirmation surgery? If they experience bodily dysphoria manifesting as pain, is it different from an amputee experiencing phantom pain?⁶⁴ There are reasons for some things requiring medical attention for both enabled and disabled people. Medicalisation becomes an issue when a condition is

⁵⁹ While not all people who get pregnant are women and not all women can give birth, I use “women” in this context as the placeholder for patriarchal ideas that equate sex and gender, considering them both as biological mandates rather than social constructs.

⁶⁰ For a discussion of this argument in relation to the tech industry, see E. Chang, *Brotopia: Breaking up the Boys’ Club of Silicon Valley* (Portfolio, 2019).

⁶¹ See generally, R. W. Sussman, *The Myth of Race: The Troubling Persistence of an Unscientific Idea* (Harvard University Press, 2014); A. Saini, *Inferior: How Science Got Women Wrong and the New Research That’s Rewriting the Story* (Beacon Press, 2017); A. Saini, *Superior: The Return of Race Science* (Beacon Press, 2019).

⁶² Sheldon and Wilkinson, “Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law” (2001) 9 *Medical Law Review* 85, 103.

⁶³ This is not to say pathologisation has ceased entirely, or that *medicalisation* of a condition is always illegitimate. Many disabilities require medical attention/care, and it is neither illegitimate or ableist to seek or provide such attention/care. Similarly, many conditions tied to sex require medical care (enlarged prostates, pregnancy, menopause, dysphoria) and again, it is not sexist to seek or provide such care. The problem is that all these categories are often over-medicalised leaving societal aspects entirely ignored (pathologisation). While there has been a steady push in scientific literature against pathologizing sex, gender identity, race, and sexuality, the same is not true for disability.

⁶⁴ This highlights an important aspect of disability and enablement: on some measures, being medically recognised as disabled renders legitimacy to accommodation claims; a lack of legitimacy for one’s condition as disabling can lead to a dismissal of accommodation claims. Gender dysphoria is sometimes, but not always, recognised as a disability (for instance, see *Kesha Williams v Stacey Kincaid* No.21-2030 [4th Cir. 2022]).

pathologised as being *inherently problematic*. We must recognise that disability continues to be pathologised by society, and this pathologisation is often built into laws that treat disabled people's lives as less valuable.

This is not to argue that oppression along the lines of race, gender, and disability status are all *exactly* alike. There are material differences in how different forms of oppression manifest, and there are differences in how those at the intersections of these oppressions experience them. Rather, it is to say that they share similarities in form and structure, and these are relevant to understanding how oppression operates in society. Social Models reframe the pathologisation of disabled people as oppressive. Claims of similarities between disability and sex/race do not lead to the pathologisation of sex and race. However, the converse may be true: denying parallels between the oppression of disabled people and oppression along the lines of sex/race reinforce the continued pathologisation of disabled people. The judges in *Crowter* do precisely this: they distinguish disability from ethnicity to deny disabled people protections under art.8.

d. Foetal Interest Hypothesis Of the four, the foetal interest hypothesis is the most heavily criticised in scholarly discourse on the subject.⁶⁵ At its base is a belief that every disabled person would, given a choice, prefer to have never existed over existing as a disabled person. It further assumes once again that the overall experience of a disabled person is always negative. Further, this belief is often informed by people who are not themselves disabled in the ways the foetus will be, but by enabled people's subjective opinions of their own interests.⁶⁶ As with the Replacement Hypothesis, such beliefs are presumptuous and often wrong. They centre medicalised notions of disablement while ignoring variability in experience.

Greasley has additionally argued that the foetal interests argument is incoherent. Justifications of abortion presume that the foetus has no interest in not being terminated (based on non-personhood), allowing overriding interests of a person (the gestator) in choosing abortion.⁶⁷ It is of higher value to be a person than not; disabled people are persons in the same sense as enabled people. Therefore, it cannot be in the interests of a disabled person whose value as an existing person is higher than if they did not exist not to exist. Since the foetus is not a person, it has no interest in either existing or not existing. It is, therefore, incoherent to argue that it is in the interest of the foetus not to exist.⁶⁸ Even if we assume that disabled people have a lower quality of life than non-disabled people, most disabled people prefer to exist as disabled people than not existing at all.⁶⁹ Thus, the Foetal interest hypothesis also does not justify DSA.

2. Negative Impacts of DSA

a. Devaluation of Disabled People: Healthcare Outcomes and Attitudes of Medical Professionals The attitudes of healthcare providers toward oppressed groups can impact healthcare outcomes for such groups.⁷⁰ Studies have shown that most healthcare providers implicitly/explicitly espouse negative attitudes towards disabled patients.⁷¹ These include believing that disabled people are undeserving of healthcare, burdens on society, less worthy of attention/care, or incapable of making healthcare decisions. To elucidate this issue, consider the usual recommendations of amniocentesis. Obstetricians usually recommend an amniocentesis to pregnant people above the age of 40. At this age, the risk of miscarriage due to

⁶⁵ Sheldon and Wilkinson, "Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law" (2001) 9 *Medical Law Review* 85, 88–93; Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), pp.239–240.

⁶⁶ Kaplan, "Prenatal Screening and Its Impact on Persons with Disabilities" (1993) 8 *F.D.T.* 64, 67.

⁶⁷ Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), pp.239–240.

⁶⁸ Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), pp.239–240.

⁶⁹ Most disabled people report having a higher quality of life than enabled people expect of them (see G. L. Albrecht and P. J. Devlieger, "The Disability Paradox: High Quality of Life against All Odds" (1999) 48 *Social Science & Medicine* 977).

⁷⁰ See A. Nelson, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (2002) 94 *Journal of the National Medical Association* 666, p.667, confirming that stereotypes and biases against racial minorities can contribute to racial and ethnic disparities in healthcare outcomes.

⁷¹ For example, one implicit bias study of over 25,000 healthcare professionals, over 82% showed an implicit bias (with 44% showing a strong bias) against disabled people, and nearly 32% explicitly preferred nondisabled people: see L. VanPuymbrouck et al, "Explicit and Implicit Disability Attitudes of Healthcare Providers" [2020] 65 *Rehabilitation Psychology* 101, 104–106.

amniocentesis is less than the risk of the child having Down's Syndrome.⁷² While this may seem reasonable, people often miss that the two things compared are (1) the foetus becoming a disabled child and (2) the foetus not surviving. A greater risk of disablement is considered *worse* than a smaller risk of death/non-existence. The implication is that it is better not to exist than to be disabled. This is clear in the Marteau study: the obstetricians speak solely of the risk of Down's Syndrome in recommending the amniocentesis to women, rather than any other conditions (including FFAs)⁷³ that might be tested for using the same procedure, meaning the effort is in aid of preventing the existence of disabled people, rather than identifying FFAs. Recent studies also report that genetic counsellors provide solely negative information about Down's Syndrome to patients; patients are often not making fully informed prenatal testing decisions.⁷⁴

Attitudes of healthcare professionals towards disabled people tend to be more positive if the individual has had more frequent contact with disabled people in personal capacities, either as a friend or a family member as equals rather than in professional capacities.⁷⁵ Most people interact with healthcare professionals in a professional setting only when there is a problem/issue. Thus, if the only interaction a person has with disabled people is in the context of professional healthcare, interactions are likely to induce negative biases of disabled people among such professionals.⁷⁶ This implies that DSA could create a feedback loop of negative attitudes towards disabled people. By recommending and choosing DSA, healthcare professionals reduce the number of disabled people they are likely to interact with personally, increasing the incidence and impact of negative attitudes.

Disabled people, like other classes of oppressed people, have worse health status, access to healthcare and healthcare outcomes than enabled people.⁷⁷ Many of these disparities arise from preventable causes, sometimes unrelated to the primary disablement.⁷⁸ The attitudes of healthcare providers impact the healthcare received; biases and negative attitudes of healthcare providers—including towards disabled people—negatively impact the healthcare outcomes of the relevant groups.⁷⁹ Disabled people are particularly susceptible to discrimination in healthcare, given that impairment can be exacerbated by negligent or

⁷² T. M. Marteau et al, "Obstetricians Presenting Amniocentesis to Pregnant Women: Practice Observed" (1993) 11 *Journal of Reproductive and Infant Psychology* 3, 4–5. The risks of Down's Syndrome with a pregnancy at the age of 40 is 1 in 100, and at age 41 is 1 in 88. The risk of miscarriage from amniocentesis is 1 in 150 (according to the obstetricians in the Marteau study) and 1 in 100 as per the NHS website (see NHS, "Amniocentesis" (17 April 2019), <https://www.nhs.uk/conditions/amniocentesis/> [Accessed 6 July 2022]).

⁷³ Marteau et al, "Obstetricians Presenting Amniocentesis to Pregnant Women: Practice Observed" (1993) 11 *Journal of Reproductive and Infant Psychology* 3, 4–5.

⁷⁴ J. M. Hodgson et al, "'Testing Times, Challenging Choices': An Australian Study of Prenatal Genetic Counseling" (2010) 19 *Journal of Genetic Counseling* 22, 34–35; J. Hodgson and J. Weil, "Talking about Disability in Prenatal Genetic Counseling: A Report of Two Interactive Workshops" (2012) 21 *Journal of Genetic Counseling* 17, 18–19.

⁷⁵ M. Lyons, "Enabling or Disabling? Students' Attitudes Toward Persons With Disabilities" (1991) 45 *American Journal of Occupational Therapy* 311, 314; S. French, "Attitudes of Health Professionals towards Disabled People: A Discussion and Review of the Literature" (1994) 80 *Physiotherapy* 687, 691; R. C. Tervo and G. Palmer, "Health Professional Student Attitudes towards People with Disability" [2016] *Clinical Rehabilitation* 913. It is interesting to note that this effect appears to have remained true for these studies over nearly three decades, suggesting that little has changed in the attitudes of healthcare professionals towards disabled people over this time period.

⁷⁶ Tervo and Palmer, "Health Professional Student Attitudes towards People with Disability" [2016] *Clinical Rehabilitation* 913, 913–914.

⁷⁷ See generally, P. N. Walsh et al, "Healthy Ageing—Adults with Intellectual Disabilities: Women's Health and Related Issues" (2001) 14 *Journal of Applied Research in Intellectual Disabilities* 195; C. P. Coyle and M. C. Santiago, "Healthcare Utilization among Women with Physical Disabilities" (2002) 7 *Medscape Womens Health* 2; M. A. Nosek et al, "National Study of Women with Physical Disabilities: Final Report" (2001) 19 *Sexuality and Disability* 5; N. R. Mudrick and M. A. Schwartz, "Health Care under the ADA: A Vision or a Mirage?" (2010) 3 *Disability and Health Journal* 233; L. I. Iezzoni, "Eliminating Health And Health Care Disparities Among The Growing Population Of People With Disabilities" (2011) 30 *Health Affairs* 1947.

⁷⁸ C. P. Coyle and M. C. Santiago, "Healthcare Utilization among Women with Physical Disabilities" (2002) 7 *Medscape Womens Health* 2; M. A. Nosek et al, "National Study of Women with Physical Disabilities: Final Report" (2001) 19 *Sexuality and Disability* 5; US Department of Health and Human Services, "The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities" (2005) *Way Back Machine*, <https://web.archive.org/web/20051110083430/http://www.surgeongeneral.gov/library/disabilities/calltoaction/calltoaction.pdf> [Accessed 25 June 2023].

⁷⁹ G. Thornicroft et al, "Discrimination in Health Care against People with Mental Illness" (2007) 19 *International Review of Psychiatry* 113; S. Akhavan and P. Tillgren, "Client/Patient Perceptions of Achieving Equity in Primary Health Care: A Mixed Methods Study" (2015) 14 *International Journal for Equity in Health* 8. See also W. Dressler et al, "Race and Ethnicity in Public Health Research: Models to Explain Health Disparities" (2005) 34 *Annual Review of Anthropology* 231; J. Banks et al, "Disease and Disadvantage in the United States and in England" (2006) 295 *Journal of the American Medical Association* 2037; L. A. Penner et al, "Health and Health Care Disparities" in J. F. Dovidio et al (eds), *The Sage handbook of prejudice, stereotyping and discrimination* (Sage Thousand Oaks, 2010); J. F. Dovidio and S. T. Fiske, "Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Can Contribute to Health Care Disparities" (2012) 102 *American Journal of Public Health* 945; Williams and Jackson, "Social Sources of Racial Disparities In Health" [2017] *Health Affairs* 147.

inadequate access to healthcare. Those likely to face barriers to healthcare for other reasons (race, gender, ethnicity, or financial difficulty) are at greater risk of disablement, making them susceptible to more significant barriers to healthcare access. A recent study showed that physicians generally had negative attitudes towards disabled people and refused to provide them with adequate treatment. The study confirms that negative attitudes and biases worsened healthcare disparities for disabled people.⁸⁰

A recent example of disabled people facing discriminatory healthcare has been the COVID-19 pandemic: disabled people across several countries were systematically refused essential healthcare by medical professionals for no other reason than their disability.⁸¹ Medical professionals consistently deprioritised disabled people of all stripes. This was done because disabled people's lives were deemed less valuable and worthy of protection than their enabled counterparts.⁸² Disability (regardless of COVID-19 survivability) was used as an indicator to deprioritise treatment due to lower quality of life and social utility.⁸³ Here we have the devaluation of disabled people's lives among healthcare providers directly impacting healthcare received by disabled people. Disability status, rather than specific health conditions, has been used as a placeholder for automatic devaluation and denial of healthcare services.

DSA both contributes to and is emblematic of discrimination against disabled people. Section 1(1)(d), to the extent that it allows for extended timelines to terminate pregnancies on the grounds of foetal abnormalities that are not fatal, is patently endorsing the devaluation of the lives of disabled people and contributes to the oppression, stigma and discrimination that disabled people face. If a protected characteristic is considered a valid reason for preventing a person's birth, the implication is that people with that characteristic are legitimately considered unworthy of existence.

The European Court of Human Rights ("ECtHR") has recognised the right to health, despite it not being explicitly listed in the ECHR. The ECtHR has recognised that the right to health impacts enjoyment of art.2 of the ECHR; art.2 requires states to "take appropriate steps to safeguard the lives of those within its jurisdiction"⁸⁴, which may give rise to issues in case of denial of healthcare made available to the population more generally.⁸⁵ There is evidence of disability discrimination in healthcare in the UK as well, particularly for cognitive disablement; from neglect, lack of treatment, to excessive preventable deaths of disabled patients.⁸⁶ In as much as the state contributes to this devaluation of disabled people through the maintenance of s.1(1)(d), it is responsible for the discriminatory impact on the lives of disabled people.

⁸⁰ T. Lagu et al, "I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities" (2022) 41 *Health Affairs* 1387; G. Kolata, "These Doctors Admit They Don't Want Patients With Disabilities" (19 October 2022), *The New York Times*, <https://www.nytimes.com/2022/10/19/health/doctors-patients-disabilities.html> [Accessed 27 December 2022].

⁸¹ S.R. Bagenstos, "Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols" (2020–21) 130 *Yale Law Journal Forum* 1; B. Chen and D. M. McNamara, "Disability Discrimination, Medical Rationing and COVID-19" (2020) 12 A.B.R. 511; T. Shakespeare et al, "Triple Jeopardy: Disabled People and the COVID-19 Pandemic" (2021) 397 *The Lancet* 1331; J. Tapper, "Fury at 'Do Not Resuscitate' Notices given to Covid Patients with Learning Disabilities" (13 February 2021), *The Guardian*, <https://www.theguardian.com/world/2021/feb/13/new-do-not-resuscitate-orders-imposed-on-covid-19-patients-with-learning-difficulties> [Accessed 8 March 2023].

⁸² E. M. Lund and K. B. Ayers, "Raising Awareness of Disabled Lives and Health Care Rationing during the COVID-19 Pandemic" (2020) 12 *Psychological Trauma: Theory, Research, Practice, and Policy* S210; N. Panocchia et al, "COVID-19 Pandemic, the Scarcity of Medical Resources, Community-Centred Medicine and Discrimination against Persons with Disabilities" (2021) 47 *Journal of Medical Ethics* 362; J. Leach Scully, "Disability, Disablism, and COVID-19 Pandemic Triage" (2020) 17 *Bioethical Inquiry* 601; T. Shakespeare et al, "Triple Jeopardy: Disabled People and the COVID-19 Pandemic" (2021) 397 *The Lancet* 1331; N. Brusseleers et al, "Evaluation of Science Advice during the COVID-19 Pandemic in Sweden" (2022) 9 *Humanities and Social Sciences Communications* 1, 6.

⁸³ Leach Scully, "Disability, Disablism, and COVID-19 Pandemic Triage" (2020) 17 *Bioethical Inquiry* 601, 602.

⁸⁴ *L.c.b v the United Kingdom* (App. No.23413/94), judgment of September 1998 at [36]; *Powell v the United Kingdom* (App. No.45305/99), decision of 4 May 2000 at [17]; see also I. Koch, *Human Rights As Indivisible Rights: The Protection of Socio-Economic Demands under the European Convention on Human Rights* (Brill, 2009) Ch.5.

⁸⁵ *Cyprus v Turkey [GC]* (App. No.25781/94), judgment of 5 October 2001 at [219].

⁸⁶ A. White et al, "Learning from Lives and Deaths-People with a Learning Disability and Autistic People (LeDeR) Report for 2021" (King's College London 2022), pp.3–72; J. Lee, "Tommy Jessop: Why I Investigated Hospital Care for People like Me" (10 September 2022), *BBC News*, <https://www.bbc.com/news/uk-63179063> [Accessed 12 January 2023]; L. Nicolle, "NHS England Reminds Staff to Make Appropriate DNR Decisions" (19 April 2023), *Learning Disability Today*, <https://www.learningdisabilitytoday.co.uk/nhs-england-issues-statement-reminding-healthcare-professionals-to-make-appropriate-dnacpr-decisions> [Accessed 30 May 2023].

b. Devaluation of Disabled People: Differential Valuation of Lives DSA and s.1(1)(d) do not mention disabled people. Many have claimed that this fact implies that they do not devalue the lives of disabled people, and that DSA is separable from valuation of the lives of disabled people. However, nobody makes such a claim in case of SSA; it is understood that SSA is both created by and feeds into the devaluation of women in society. The notional separation of DSA from devaluing disabled people's lives is sleight-of-hand: it seeks to retain a convenient and unethical practice while distancing itself from the harmful beliefs it espouses. As Greasley argues, it is impossible to argue that no negative valuation is placed on people with disabilities if disablement is the attribute that is used to justify preventing the birth of new disabled people.⁸⁷ Moreover, what is often ignored is that DSA devalues the protected characteristic of disability; if the foetus is terminated because it is deemed to be disabled, this devalues the characteristic of being disabled for disabled people as well.

Further, differential treatment of disabled people in healthcare facilities is often the result of explicit or implicit biases among healthcare professionals. Sometimes, legislation and government policies codify this devaluation. The COVID-19 pandemic once again demonstrated this. Sweden has been severely criticised for having the infrastructure to protect vulnerable people from COVID-19 infection and death and failing to do so by implementing policies that instead put them at risk.⁸⁸ For example, compulsory school attendance was not relaxed for children living with vulnerable family members or those who tested positive for COVID-19. Masking was actively discouraged in places, taking an ethically dubious individualistic approach to the pandemic.⁸⁹ In the US, many states adopted “crisis standards of care”, explicitly encouraging the denial of services to disabled people.⁹⁰

These policies reflect society's endorsement of the devaluation of disabled people. The COVID-19 pandemic has disproportionately affected many oppressed classes: mortality rates have been significantly higher for racial minorities, essential workers, and healthcare workers.⁹¹ No government published guidelines recommending that such classes be denied treatment because of their higher mortality rates. Doing so would be discriminatory; most decision-makers understood such discrimination as illegal and unethical. However, disability is still considered a *legitimate reason for discrimination*. Policymakers will often believe that discriminatory policies against disabled people (such as the ones mentioned above) either do not meet the legal threshold for being considered discriminatory or are otherwise justifiable forms of discrimination.⁹² Legislative permissiveness of disability discrimination such as s.1(1)(d) perpetuates the belief that disability discrimination is justifiable.

⁸⁷ Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017), p.240.

⁸⁸ Brusselsaers et al., “Evaluation of Science Advice during the COVID-19 Pandemic in Sweden” (2022) 9 *Humanities and Social Sciences Communications* 1, 10–11.

⁸⁹ Brusselsaers et al., “Evaluation of Science Advice during the COVID-19 Pandemic in Sweden” (2022) 9 *Humanities and Social Sciences Communications* 1, 6–13.

⁹⁰ Washington State Department of Health issued a policy on Scarce Resource Management and Crisis Standards of Care recommended using “Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)” to screen and de-prioritise such patients and reallocate resources to treat “healthier” patients, separately from any connection to reduced survivability (see Washington State Department of Health, “Scarce Resource Management & Crisis Standards of Care”, *Way Back Machine*, 2 April 2020, 3–4). Similarly, the Kansas Department of Health and Environment and the Alabama Department of Public Health recommended chronic disease and intellectual disability exclusion criteria to deny or take away ventilators from patients (see Kansas Department of Health and Environment, “Toolkit for COVID-19”, *Way Back Machine*, 25 March 2020; Letter from Roger Severino, “Complaint of Disability Discrimination Filed by the Disability Rights Center of Kansas, the Topeka Independent Living Center, and Tessa Goupil” (27 March 2020); US Department of Health and Human Services, “OCR Reaches Early Case Resolution With Alabama After It Removes Discriminatory Ventilator Triaging Guidelines” (4 August 2020)). See also S. R. Bagenstos, “Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols” [2020–21] 130 *Yale Law Journal Forum* 1; B. Chen and D. M. McNamara, “Disability Discrimination, Medical Rationing and COVID-19” [2020] 12 *Asian Bioethics Review* 511.

⁹¹ A. Rimmer, “Covid-19: Disproportionate Impact on Ethnic Minority Healthcare Workers Will Be Explored by Government” (2020) 369 *British Medical Journal*; D. Bambino Geno Tai et al., “The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States” (2021) 72 *Clinical Infectious Diseases* 703.

⁹² For example, see F. Campbell, “Systemic Discrimination against Disabled Justified, N.S. Government Will Argue”, *Saltwire*, <https://www.saltwire.com/halifax/news/systemic-discrimination-against-disabled-justified-province-will-argue-100694373/> [Accessed 8 March 2022].

c. Psychological Impact on Disabled People While there is a dearth of directed research on the impact of DSA on disabled people, there are some reports on the impact of DSA on disabled people's well-being and self-worth.⁹³ This can extend to family and close associates of disabled people, who face stigma, blame and criticism for choosing to have disabled children.⁹⁴ Speaking of cognitively disabled clients in therapy, Sinason elucidates some aspects of this. The extent to which popular discourse extolls DSA significantly impacted her disabled patients. They were acutely aware that the value accorded to *them* by society related to the value accorded to those likely to be like them; DSA was not separable from the value accorded to disabled people living in society. Many felt anxious about their existence, having escaped abortion by chance.⁹⁵ Symington describes similar responses from disabled patients in clinical psychotherapy: patients understood that many people did not want them to exist.⁹⁶

People assume that cognitively disabled people are unaware of society's valuation of them.⁹⁷ On the contrary, they are aware of this and are also often cognizant of the devaluation in DSA.⁹⁸ It is difficult to distinguish between the desire to prevent the birth of a disabled person and the desire to end the lives of disabled people in a world where both are often true.⁹⁹ Katrina Scior provided expert witness on disabled people's stigma.¹⁰⁰ She provides evidence from several studies on the impact of institutional stigma on disabled people's health; discriminatory legislation such as s.1(1)(d) is categorically detrimental to the health and well-being of disabled people.¹⁰¹

d. Impact on Equality Measures As mentioned earlier, empirically measuring the impact of DSA on disability justice is complicated. Once again, however, we have a ready analogy to DSA in SSA¹⁰². SSA,

⁹³ N. Symington, "The Last Lecture" in *The Analytic Experience: Lectures from the Tavistock* (Free Association Books, 1986); V. Sinason, "Gender-Linked Issues in Psychotherapy with Abused and Learning Disabled Female Patients" in J. Raphael-Leff and R. Jozef Perelberg (eds), *Female experience: Three generations of British women psychoanalysts on work with women* (Routledge, 1997); D. Marks, "Dimensions of Oppression: Theorising the Embodied Subject" (1999) 14 *Disability & Society* 611; Saxton, "Disability Rights and Selective Abortion" in Davis (ed.), *The Disability Studies Reader* 4th edn (2013), p. 93.

⁹⁴ E. Goffman, *Stigma: Notes on the Management of Spoiled Identity* (Simon & Schuster, 1963), pp.42–43; French, "Attitudes of Health Professionals towards Disabled People A Discussion and Review of the Literature" (1994) 80 *Physiotherapy* 687; Shakespeare, "Choices and Rights: Eugenics, Genetics and Disability Equality" (1998) 13 *Disability & Society* 665, pp.675–679; M. Ostman and L. Kjellin, "Stigma by Association: Psychological Factors in Relatives of People with Mental Illness" (2002) 181 *The British Journal of Psychiatry* 494; K. L. Kirschner and R. H. Curry, "Educating Health Care Professionals to Care for Patients With Disabilities" (2009) 302 *Journal of American Medical Association* 1334; Tervo and Palmer, "Health Professional Student Attitudes towards People with Disability" [2016] *Clinical Rehabilitation* 913; G.Galli and M. Pazzaglia, "Novel Perspectives on Health Professionals' Attitudes to Disability" (2016) 50 *Medical Education* 804; VanPuymbrouck et al, "Explicit and Implicit Disability Attitudes of Healthcare Providers" [2020] 65 *Rehabilitation Psychology* 101.

⁹⁵ Sinason, "Gender-Linked Issues in Psychotherapy with Abused and Learning Disabled Female Patients" in Raphael-Leff and Jozef Perelberg (eds), *Female experience: Three generations of British women psychoanalysts on work with women* (1997), p.275.

⁹⁶ Symington, "The Last Lecture" in *The Analytic Experience: Lectures from the Tavistock* (Free Association Books, 1986), p.321.

⁹⁷ Marks, "Dimensions of Oppression: Theorising the Embodied Subject" (1999) 14 *Disability & Society* 611, p.618.

⁹⁸ Sinason, "Gender-Linked Issues in Psychotherapy with Abused and Learning Disabled Female Patients" in Raphael-Leff and Jozef Perelberg (eds), *Female experience: Three generations of British women psychoanalysts on work with women* (1997), pp.274–275; S. Logeswaran et al, "How Do People with Intellectual Disabilities Construct Their Social Identity? A Review" (2019) 32 *Journal of Applied Research in Intellectual Disabilities* 533.

⁹⁹ They are both primarily driven by the same goal: to reduce the incidence of disability by eliminating those who are disabled. There are still reports of disabled children being killed by parents in most countries today (for examples of recent cases in the UK, see B. Quinn, "UK Woman Who Killed Disabled Son Detained in Hospital Indefinitely" (2 November 2021), *The Guardian*, <http://www.theguardian.com/uk-news/2021/feb/11/olga-freeman-uk-woman-who-killed-disabled-son-detained-in-hospital-indefinitely> [Accessed 29 July 2022]; A.O'Leary, "Mum Charged with Murdering Disabled Son, 10, after He Dies in Hospital" (27 September 2021), *Mirror*, <https://www.mirror.co.uk/news/uk-news/breaking-mum-charged-murdering-disabled-25081837> [Accessed 29 July 2022]; J. Gant, "Man Who Stabbed Mother and Autistic Boy, Nine, to Death is Convicted" (2 January 2022), *Mail Online*, <https://www.dailymail.co.uk/news/article-10464473/Man-stabbed-mother-26-autistic-son-nine-death-convicted.html> [Accessed 29 July 2022]).

¹⁰⁰ K. Scior, "My Expert Witness Statement in Support of the High Court Legal Challenge by Heidi Crowter and Máire Lea-Wilson" (28 September 2021), *UCL*, <https://blogs.ucl.ac.uk/stigma-research/2021/09/28/my-expert-witness-statement-in-support-of-the-high-court-legal-challenge-by-heidi-crowter-and-maire-lea-wilson-by-katrina-scior/> [Accessed 25 June 2023].

¹⁰¹ Scior, "My Expert Witness Statement in Support of the High Court Legal Challenge by Heidi Crowter and Máire Lea-Wilson" (28 September 2021), *UCL*, <https://blogs.ucl.ac.uk/stigma-research/2021/09/28/my-expert-witness-statement-in-support-of-the-high-court-legal-challenge-by-heidi-crowter-and-maire-lea-wilson-by-katrina-scior/> [Accessed 25 June 2023].

¹⁰² As mentioned previously, there are many reasons that this analogy in the context of abortion is appropriate (see generally, Ramaswamy, "Addressing Ableism: Lessons from the Problem of Female Feticide in India" (2017) 27 *Transnational Law and Contemporary Problems* 1; Greasley, *Arguments About Abortion: Personhood, Morality, and Law* (2017)). International Human Rights Committees have condemned both SSA and DSA as unethical, while recommending that states make only SSA (but not DSA) illegal to "facilitate reproductive choice": see Committee on the Elimination of Discrimination against Women Committee on the Elimination of Discrimination against Women, Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination

where it occurs, usually involves selective abortion to prevent the birth of daughters. Many countries have banned the practice; some, such as India, have made in-utero sex-determination a criminal offence.¹⁰³ This is done explicitly because SSA is understood to be detrimental to sex equality, regardless of the actual impact of the practice itself.¹⁰⁴ That said, there have been studies on the impact of SSA on women's lives; most have concluded that SSA negatively impacts gender equality.¹⁰⁵ Further, the gender ratio is itself often considered an indicator of equality. Since the sex ratio at birth is naturally almost even, disparities in this ratio reflect the persistence of practices and behaviours that prevent females from existing and flourishing, ranging from SSA and infanticide to reduced care and attention given to daughters.¹⁰⁶ Selective abortion is likely to impact the selected groups negatively.

DSA and laws that endorse or allow it both contribute to disparate negative impacts on the lives of disabled people. This is true regardless of foetuses not being persons entitled to anti-discrimination protection. Laws can be considered discriminatory even if the effect of discrimination is not anyone directly concerned with the law but belongs to a protected class of people impacted by its operation. Given the negative impacts of DSA on disabled people, s.1(1)(d) becomes discriminatory. It is essential to reiterate that DSA also violates anti-discrimination laws for the same reasons. Abrogating s.1(1)(d) would merely spur a race to improve prenatal diagnostics of "abnormalities" before the 24th week. However, this would not negate the impact of DSA on disabled people.

III. Article 8 ECHR and the Right to Privacy and Non-Interference

Article 8 of the ECHR primarily deals with the right to privacy and non-interference from the state into a person's private and family life, home, and correspondence. Interference with this right is permitted when done by public authorities in accordance with law and, among other reasons, when such acts are necessary "for the protection of the rights and freedoms of others". The state is generally recognised to have some interest in protecting foetuses. Under the ECHR, States have a wide margin of appreciation in protecting such interests. States are generally free to define life to include only post-natal humans or to define foetuses at different stages of development as qualifying for protection as "life". For this section, I wish to examine how DSA interacts with the right to privacy in reproductive choices.

A. Negative Stereotypes and DSA as a Reproductive Choice under Article 8

The claimants in *Crowter* (two people with Down's Syndrome and the mother of one of the claimants) challenged the validity of s.1(1)(d) as being incompatible with art.8 of the ECHR. The claimants contended (among other claims) that s.1(1)(d) communicates to disabled people that their lives are not worth living, violating the right of disabled people to non-interference in their private lives. The court rejects this contention, claiming that s.1(1)(d) does not itself perpetrate negative stereotypes to the detriment of disabled people since it is focused on pregnancy rather than disabled people. The court further claims that the negative stereotyping of ethnic groups was different than that of disability, making *Aksu* inapplicable.

against Women, CEDAW/C/OP8/GBR/1 (CEDAW Report)). Likewise, in the UK Department of S. C. Davies, "Correspondence on Abortion Act 1967 (As Amended): Termination of Pregnancy by Chief Medical Officer, Professor Dame Sally C Davies" (23 February 2012); Sexual Health Policy Team, Public Health Directorate 10250, "Guidance in Relation to Requirements of the Abortion ACT 1967" (May 2014). This equivocation highlights the continued belief in disability discrimination being justifiable.

¹⁰³ Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 (India) Act No.57 of 1994 (India).

¹⁰⁴ It is arguable that the actual reason for the prohibition is not equality but to ensure marital/procreative parity between the sexes. Popular discourse around sex-selection uses gender ratios rather than on the comparative socio-economic status of genders to demonstrate inequality. This implies an interest in maintaining parity in numbers more than a direct interest in improving gender equality. It is also possible that there is an implicit belief that unequal numbers either indicate or cause unequal status.

¹⁰⁵ Shepherd, *Sex-Selective Abortion in India: The Impact on Child Mortality / Mary Elizabeth Shepherd*. (2008); Dasgupta, "Is Sex-Selective Abortion Associated With a Reduction in Gender Differentials in Child Health Investments? Evidence from India" (SSRN Scholarly Paper, 5 November 2011).

¹⁰⁶ P.Buragohain, "Female Foeticide and Gender Inequality in India: Issue of Attention" (2020) 6 *International Journal of Innovative Science and Modern Engineering* 1.

The ECtHR has previously recognised that negative stereotyping can infringe on the private life (a broad term that cannot be exhaustively defined) of individual members of affected groups in *Aksu v Turkey*.¹⁰⁷ *Crowter* denies that *Aksu* applies to s.1(1)(d). Since *Aksu* dealt with ethnic groups, *Crowter* ruled that it was significantly different from disability.¹⁰⁸ Neither art.8 nor *Aksu* distinguishes different groups for art.8. *Aksu* uses the term “negative stereotyping of a group” (emphasis mine), highlighting that the notion is broad and not subject to arbitrarily narrow definitions. All references to sex and race in anti-discrimination clauses of the ECHR include references to “other status”, implying that protected classes are broad enough to include disability. The Equality Act 2010 also exemplifies this unification of anti-discrimination laws. Race and disability are listed together under s.4 of the Act.¹⁰⁹ The *Crowter* decision demonstrates the problem of ignoring parallels between disability and other forms of oppression: distinctions are used to justify disability discrimination. The *Crowter Appeal* decision accepts that *Aksu* applies to disability as a group but denies that s.1(1)(d) perpetuates negative stereotypes of disablement.¹¹⁰ Both decisions ignore the implicit devaluation of disabled people’s lives and the attribute of being disabled in DSA¹¹¹, claiming that devaluing disabled foetuses is not the same as devaluing disabled people.

On the issue of balancing interests in the right to art.8, it may be argued that the right of pregnant women against forced pregnancy, childbirth and parenting outweighs the right of disabled people under arts 3 and 8 of the ECHR (as the defendants do in *Crowter*). However, this claim equates the right to foetal selection and the right against forced pregnancy, childbirth, and parenting. The ECHR does not endorse any right to trait-selection in foetuses, nor is there any ethical reason to guarantee this within the right to privacy. The right to choose not to be a parent does not entail the right to selectively choose what kind/form of child one parents, just the right to choose whether or not one will take on the responsibilities of parenting generally. This is further evidenced in the prohibition of sex-selective abortion in the UK, and the endorsement of the same by the CEDAW.¹¹² This prohibition does not grant any exemption for parents claiming that the birth of a child of a particular sex would impact the mental health of the parents (which would be relevant in cases of familial/cultural pressure to have a male child). Consider a case where a mistake in sperm donation leads to a person learning in the 26th week of pregnancy that the race of their foetus was different from that they had selected. The right to abortion does not, per law, extend to the right to choose to terminate this pregnancy, regardless of any right to privacy under art.8. I argue instead that the state ought to support the parenting of all children, including disabled children, in addition to recognising that DSA impacts disabled people negatively.

The right to a private life includes reproductive choice; it may be argued that this includes the right to choose not to have a disabled child. Many people exercise reproductive choice at the point of intercourse: some choose partners for their race, height, intelligence, community, caste, health, or appearance, among other things. Egg/sperm donations support this: banks often catalogue the characteristics of their donors,

¹⁰⁷ *Aksu v Turkey* (4149/04) (2013) 56 E.H.R.R. 4 at [58] (*Aksu*).

¹⁰⁸ *Crowter* [2022] 1 W.L.R. 2513 at [101].

¹⁰⁹ Distinctions made for disability under the Equality Act 2010 expand rights available to disabled people (reasonable accommodation/adjustments), rather than to deny disabled people rights available to other protected classes. There are reasons to question such separation as well (see K.Paul-Emile, “Blackness as Disability” [2018] 106 *Georgetown Law Journal* 293).

¹¹⁰ *Crowter* [2023] 1 W.L.R. 989 at [77] and [94]. While Underhill LJ acknowledges that the belief in devaluation by the victim may be genuine, such belief is insufficient for the right, and that the explicit claim by the CEDAW is that it does not perpetuate stereotypes towards disabled people (*Crowter* [2023] 1 W.L.R. 989 at [72] and [73].) However, this argument entitles any government to explicitly claim that their actions do not perpetuate stereotypes, regardless of the act. The fact that there are different perspectives on what count as stereotypes is applicable to any stereotype. While the CEDAW may genuinely believe that their stance does not perpetuate stereotypes, the objective evidence may contradict this claim. I have already argued that DSA has real and evidenced impact on the health and well-being of disabled people in section II.A.2 above on the Negative Impacts of DSA. Likewise, the claimants in the case provided expert evidence on the impact of DSA on disabled people, rather than merely claiming a perception of stereotyping (see *Crowter* [2022] 1 W.L.R. 2513 at [89]–[98]). The defendants do not appear to have provided any evidence to the contrary, relying instead on the right of pregnant women to decide whether or not to continue the pregnancy (see *Crowter* [2022] 1 W.L.R. 2513 at [100]).

¹¹¹ See section II.A.2.b above on Devaluation of Disabled People.

¹¹² Davies, “Correspondence on Abortion Act 1967 (As Amended): Termination of Pregnancy by Chief Medical Officer, Professor Dame Sally C Davies” (23 February 2012); Sexual Health Policy Team, Public Health Directorate 10250, “Guidance in Relation to Requirements of the Abortion ACT 1967” (May 2014) 10; CEDAW Report.

allowing people to maximise the chances of children having specific traits. Since many of these are pre-selected, why do we object to selection post-conception? Surely, that is primarily a matter of technological availability rather than ethics?

However, the persistence of a practice does not imply that it is ethical. Many of these practices stem from evolution: ensuring tribal support for survival. Pre-selecting reproductive partners is not always unproblematic. Feminist scholarship has questioned the valuation of women solely for appearance. While this remains one of the reproductive pre-selection criteria (available to all genders), it behoves us to question what we explicitly and implicitly endorse when we do so. Another glaring example of this problem is the caste issue in India. Caste has, for millennia, privileged the so-called upper castes while restricting the power and freedom of oppressed castes (Dalits). Since caste is inherited, it is maintained through strictly enforced endogamy. Scholars have argued that inter-caste marriage is the only way out of caste hierarchies.¹¹³ While many Indians recognise caste as problematic, they justify and perpetuate caste-endogamy for “cultural similarities” or “traditional values”.

Personal choices are not apolitical and can perpetuate oppression. While politics exercises an oversized influence on personal choices, choices that go against societal pressures can also be sources of influence. This does not mean that we must deliberately change whom we find attractive; indeed, that has some rather unsavoury histories of conversion therapies attached to it. Instead, we must honestly inspect our values and become aware of our implicit biases. We must question how much we wish to identify with and derive self-worth from these values.¹¹⁴ We may not be able to choose/alter attraction, but we can choose what values we explicitly endorse. We can reduce the glorification of oppressive values instead of justifying them as inevitable simply because we have been conditioned into them.

B. The Right to Privacy and Reproductive Choice: What Choices are Endorsed?

Article 8 and reproductive choice have one further interest in the context of DSA: what choices are endorsed and facilitated by the state. In most narratives on abortion and the right to abortion, “choice”, specifically, the pregnant person’s choice, is the focus of abortion rights advocates. They seek to enhance the agency available to people to choose when to carry a pregnancy to term and choose against doing so when they do not wish to have a child. These are fragile rights, as *Dobbs* has demonstrated.

However, abortion rights are *essential* but *insufficient* to protect reproductive choice. Political, economic, and cultural environments shape choices advocated in abortion discourse; many choose to terminate pregnancies not because they do not want the child but because they do not have the means to care for such a child. Their economic disempowerment is re-labelled as autonomy and bodily empowerment, obscuring oppressive forces constraining their choices. People choosing SSA or DSA are not doing so in a vacuum of apolitical personal preference; they do so in contexts of economic hardship, familial and societal pressures, or fear of ridicule/harassment. It is impossible to advocate against DSA and SSA without simultaneously arguing against structures that render these choices inevitable. It is relevant, for example, that in prohibiting SSA, countries like India have simultaneously increased propaganda, education and, most importantly, financial incentives to discourage SSA. While DSA is inherently unethical, it is also unethical to argue against DSA without seeking changes to structural forces that support it. DSA is unethical, and it is the state’s responsibility to push back and facilitate greater enablement and equality for disabled people.

Reproductive rights under art.8 build on the idea of choice: the pregnant person ought to have a choice of whether they wish to carry the pregnancy to term or not. This choice skews toward supporting the

¹¹³ B.R. Ambedkar, *Annihilation of Caste* (Verso Books, 2014) para.20.5; J.Abraham, “Contingent Caste Endogamy and Patriarchy: Lessons for Our Understanding of Caste” (2014) 49 *Economic and Political Weekly* 56, 56.

¹¹⁴ A. Srinivasan, *The Right to Sex* (Bloomsbury Publishing, 2021), pp.85–91.

*choice to terminate*¹¹⁵ pregnancies. The procedure is widely available in Great Britain, healthcare is free of cost with the NHS, and there are nearly no objections to most personal reasons for choosing to terminate a pregnancy in the first 24 weeks. Parents are legally free to decide to terminate or to carry the child to term. However, the choice to carry the foetus to term is largely unsupported: childcare support after the child's birth is dismal. Support for disabled children is grossly inadequate, and austerity has progressively reduced support available to disabled adults.¹¹⁶ Women are often blamed for disablement/associated issues in their children (as also evidenced in *Crowter*).¹¹⁷ Actual choice requires the choices on offer to be equally viable.

The current system affords greater viability to the choice of termination, particularly in case of foetal disablement. Policies need to improve the viability of choosing to carry the pregnancy to term. This is not to say that the choice to terminate should not exist, but that the choice to keep must be equally viable regardless of individual circumstances. The question should not be “can I afford to keep this baby?” or “can I afford to have a child and pursue my career?” or “can I provide for a disabled child?” but instead, “do I wish to have and raise a child?”. Raising children into adult members of society contributes to society's continuance and ought to be supported by society as such. Parents still will have responsibilities: they must be nurturing, provide care, and support the child's growth. Reproductive justice¹¹⁸ is in both options (to carry to term or terminate a pregnancy) being equally viable choices for every person faced with it. This choice includes access to safe abortion and post-abortive support, access to universal healthcare and education, and guarantees of financial, institutional, and social support to care for and raise *any* child.

Conclusion

In analysing the validity of s.1(1)(d), the judges in *Crowter* and *Crowter Appeal* delve into many of the issues surrounding DSA. However, in their ruling, they ignore much of the evidence provided by the claimants. In some instances, the claimants have generally failed to account for the problems arising from s.1(1)(d) and DSA. The legality of s.1(1)(d) is fraught, and circumstances of societal and economic structures render it impossible to isolate this question from the more general issues of disability in society and the state's treatment of disabled people. Given the disparate impact DSA and s.1(1)(d) have on disabled people, it falls foul of guarantees to equality and non-discrimination under the ECHR and the Equality Act 2010. However, to take these guarantees seriously, the state must take measures to mitigate the root cause of DSA: the societal, institutional, economic, and legal devaluation of disabled people in society. To make effective the guarantees to reproductive choice enshrined in art.8, the state must ensure greater guarantees for institutional support for childcare and greater accessibility and enablement guaranteed to disabled people all around.

¹¹⁵ *Dobbs* does not mitigate this; in states that prohibit/curtail abortion, reproductive choice is curtailed entirely (as opposed to leaning towards *choosing* childbirth) as these States provide almost no support for children. Parents aren't choosing childbirth here but forced into childbirth.

¹¹⁶ See generally, F. Ryan, *Crippled: Austerity and the Demonization of Disabled People* (Verso, 2019).

¹¹⁷ See generally, R. Colker, “Blaming Mothers: A Disability Perspective Symposium: The Civil Rights Act of 1964 at 50: Past, Present and Future: Panel VI: The Limits and Future of Antidiscrimination Law” (2015) 95 *Boston University Law Review* 1205.

¹¹⁸ Reproductive Justice was first coined in 1994 by black women, expanding middle-class notions of reproductive rights to include rights to supportive environments in reproduction (D. Roberts, “Reproductive Justice, Not Just Rights” (2015) 62 *Dissent* 79, p.79). Bagenstos argues the need to include disability support while retaining the right to DSA under reproductive justice, as this may have a chilling effect on abortion (see S. R. Bagenstos, “Disability and Reproductive Justice The Politics of Pregnancy” (2020) 14 *Harvard Law & Policy Review* 273, p.286). However, many countries (including India and the UK) implement prohibitions on SSA without any chilling effects on abortion. Bagenstos also does not deal with discrimination law; instead of doing one rather than the other (DSA prohibition or disability support), I argue that states ought to do both.