ABORTION POLITICS IN THE UK: FEMINISM, MEDICINE AND THE STATE

by

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ABSTRACT

Abortion rights are often used as a litmus test for how well women's interests are represented by the state. However, feminist accounts of British abortion legislation have been conflicting, either presenting the law as fundamentally anti-feminist, or noting that feminist actors have played an active role in its construction and defence. This thesis makes sense of this tension through coding and a chronological discourse analysis of Parliamentary debates on abortion legislation from the 1967 Abortion Act onwards, supplemented by analysis of interview data and commentary.

The thesis finds that the gendered assumptions encoded in the Act have constrained the debate. Due to a desire to protect access to abortion, feminists have been forced to defend a law which constructs women as vulnerable and irrational. While feminists have used the discursive resources available to them in creative ways, they have also perpetuated problematic ideas about gender. Difficulties have also been present for anti-abortion politicians, who oppose an Act widely regarded as protecting the vulnerable. These actors have attempted to borrow elements of a liberal, 'pro-woman' discourse on abortion, appropriating feminist language. Nonetheless, alongside this rhetoric are elements of a conservative backlash politics which identifies feminism as the cause of women's problems.

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LIST OF ACRONYMS AND ABBREVIATIONS

ALRA	Abortion Law Reform Association
BMA	British Medical Association
BMJ	British Medical Journal
BPAS	British Pregnancy Advisory Association
CAC	Campaign Against Corrie
CQC	Care Quality Commission
D&X	dilation and extraction, also known as ‘partial-birth abortion’
EMA	early medical abortion
FI	feminist institutionalism
HFEA	Human Fertilisation and Embryology Authority
HFE Bill/Act	Human Fertilisation and Embryology Bill/Act
MP	Member of Parliament
MWF	Medical Women’s Federation
NAC	National Abortion Campaign
NARAL	National Abortion Rights Action League
NHS	National Health Service
RCOG	Royal College of Obstetricians and Gynaecologists
RMPA	Royal Medico-Psychological Association
RNGS	Research Network on Gender and the State
SPUC	Society for the Protection of the Unborn Child
SRA	strategic-relational approach
WPA	women’s policy agency

CHAPTER ONE. INTRODUCTION

1.1 Background and overview

Abortion rights are often used as a litmus test for how well 'women's interests' are represented at the level of 'the state' (e.g. Outshoorn and Lovenduski, 1986; McBride Stetson, 1996; McBride Stetson, 2001c). In the UK, however, feminists wishing to defend access to abortion are placed in the difficult position of defending a law which disempowers women in principle. The academic literature is also divided on the significance of abortion politics for feminism: either it is bluntly pessimistic, depicting the regulation of abortion as thoroughly dictated by the agenda of 'the state' with little room for feminist politics (Fyfe, 1991; Sheldon, 1997), or it is more celebratory, emphasising the successes of feminist politicians and activists in defending the 1967 Act from anti-abortion attacks (McBride Stetson, 2001b; McBride and Mazur, 2010).

This thesis contains a feminist analysis of abortion politics in the UK Parliament from the passage of the 1967 Abortion Act, which greatly increased women's access to safe and legal abortion, to 2013. The 1967 Act has been criticised by feminists for its medicalisation of abortion (Fyfe, 1991; Petersen, 1993; Sheldon, 1997): the Act did not grant women a right to abortion but rather provided a legal defence to doctors performing abortions in certain defined circumstances. Due to the medical profession's increasingly liberal attitude towards abortion and the prevalence of not-for-profit abortion clinics, accessing abortion has become relatively easy in practice. Nonetheless, the law has changed very little: doctors who are opposed to abortion may still place obstacles in the way of women seeking it. However, an arguably greater problem is the symbolic implications of the law, which constructs women as people

who need paternalistic control and cannot make big decisions unassisted, and validates medical interpretations of women's experiences over women's own interpretations, requiring:

> that the woman open herself to the medical gaze and reveal quite intimate details of her personal life in order to justify her request and convince the doctor, as it is the doctor's interpretation of her life experiences which will be valid and recognised for all official purposes (Sheldon, 1997: 68).

While the literature is divided on the implications of the current law for UK feminism, it is indisputable that abortion *is* signification for feminist politics. The issue of abortion brings to mind several feminist 'problem areas'. First and foremost among these are the sex/gender division and the meaning of biological sex, especially the meaning of reproduction and pregnancy for women, but questions are also raised concerning the place of feminist activism and engagement with the state. Generally, feminism has been associated with the 'pro-choice' movement; however, the ability to choose to have an abortion has not always been the most pressing matter of reproductive rights for the many women who have faced forced sterilisation and pressure *not* to have children (e.g. Silliman *et al.*, 2004; Smith, 2005; West, 2009). For example, as Andrea Smith notes:

> Planned Parenthood and NARAL [National Abortion Rights Action League] opposed restrictions against sterilization abuse, despite the thousands of women of color who were being sterilized without their consent, because they saw such policies as interfering with a women's 'right to choose' (2005: 130).

More recently, in a British context, politicians in favour of further restrictions on legal abortion have styled themselves as 'modern feminists' with an interest in protecting women from abortion's harmful effects (Dorries in Hansard, 2011a; Miller in Newman, 2012). Nonetheless, the ability to reject pregnancy and motherhood has far-reaching implications for

gender politics, disturbing the construction of the female body as fundamentally a reproductive body and of women as primarily child-bearers. For this reason, this thesis is underpinned by a pro-choice ethos. These normative underpinnings allow, for example, 'modern feminists' such as Women and Equalities Minister Maria Miller who favour a reduction in the upper time limit for legal abortion (Newman, 2012) to be distinguished from pro-choice feminists who favour further liberalisation of the law. Such a distinction is a necessary tool in evaluating feminist politics when these two completely opposing political goals can both be broadly described as feminist, in that they aim to 'identify with women; … represent women; improve the status of women; challenge gender hierarchies' (Lovenduski, 2008: 189n1).

Feminist political scientists have recently stressed the diversity of feminist political actors and others who claim to act 'for women' and their differing strategies and ideologies (Mackay, 2008; Childs and Krook, 2009). This thesis has a clear normative position and is critical of arguments such as Dorries' and Miller's. I agree with Karen Celis and Sarah Childs that conservative feminists and other conservatives who act 'for women' should not be pre-emptively dismissed 'on the grounds that this is either false consciousness or that these women are but "a wolf in sheep's clothing"' (Celis and Childs, 2012: 214); analysis of women's substantive representation would not be complete without consideration of the diversity of those who claim to act on behalf of women (Celis *et al.*, 2008; Celis, 2009). However, my aim is not to account for the substantive representation of women but to make sense of the tension between the avowedly feminist claims of some Conservative women and the fact that these claims are strongly resisted by other self-professed feminists. The historical approach of this thesis is useful here as it sheds light on 'pro-woman' claims by situating them in context, and asks what it is that they resist or reinforce.

Accordingly, this thesis is a feminist *critique* of abortion politics rather than, for example, an analysis of women's substantive representation or an attempt to model the circumstances in which strategies for 'gendering' (Eveline and Bacchi, 2005) or inserting 'feminist frames' (McBride and Mazur, 2010) into the policy process are successful. Despite different aims, I share some of the concerns of the 'institutional turn' (Kenny, 2007) in feminist political science, namely that context matters (Mackay *et al*., 2010) and history matters (Waylen, 2009) in the creation of public policy. However, my focus is not on the ways in which the institution of Parliament is gendered but on how the regime of abortion regulation is constituted by ideas about gender and the extent to which this is contested. The discourses mapped here form the prelude to a broader project dealing with reproductive rights, the state, and contemporary feminism in the UK, as explained in Section 1.2.

The thesis could, in this sense, be described as an analysis of encounters between feminism and 'the state', rather than an analysis of women's substantive representation, which may or may not be overtly feminist. However, the key contention of Chapters Two and Three is that regulatory regimes cannot be conceptualised as the products of a unified 'state' with clear motives and goals. Instead, I draw upon the Foucauldian concept of *governmentality* to encapsulate the extent to which the formation of such regimes relies on dispersed governance among a variety of institutions and practices. It is particularly necessary to conceptualise the regulation of abortion in this way. Abortion legislation is not generally pioneered by the executive but often by backbench MPs; moreover, its enactment relies heavily on the capacity of the medical profession to monitor and adjudicate the decision to abort, meaning abortion provision is very much governmentalised (Sheldon, 1997). The place of feminist politics in such a regime will necessarily be complex, and the use of a Foucauldian framework entails an awareness that parliamentary feminist discourses will be neither wholly 'subservient to

power' nor 'raised up against it' (Foucault, 1981: 100-1). Hence, a guiding question of the research is: to what extent are governmental feminist discourses subservient to or raised up against dominant governmental rationalities?

This thesis contends that feminist politics has been incorporated into governmental networks and actively plays a role in shaping attitudes and regulations concerning abortion, but that this cannot be straightforwardly evaluated in terms of either the success or 'appropriation' of feminism. It does so by exploring the *specific* ideas about gender relations constituting abortion politics (Eveline and Bacchi, 2005; Squires, 2008) rather than simply asking *whether* gendered or feminist 'frames' have been inserted into the policy process. It finds that since the Parliamentary debates over the 1967 Abortion Act, political debate on abortion has been divided into two camps, not so much in terms of a 'right to choose' versus a 'right to life' as in terms of a *logic of medicalisation* (which also underpins the Act) versus a *logic of medical purity*. The logic of medicalisation establishes abortion as a predominantly medical matter, and doctors as socially responsible agents who are capable of deciding whether an abortion should be carried out. The logic of medical purity, in contrast, sees abortion as primarily a 'social' matter which has the capacity to pollute and corrupt the profession.

Crucially, both of these competing logics are gendered. The logic of medicalisation, as articulated by reformists in the 1960s, construed women seeking abortion as virtuous but vulnerable 'tired housewives' (Sheldon, 1997: 32) in need of paternalistic care. The logic of medical purity, meanwhile, constructed women who have abortions as irrational, selfish and frivolous 'girls', complicit in the corruption of the medical profession. These gendered assumptions, encoded in the debate in the 1960s, have channelled debates over legal abortion in certain directions. They have presented problems for both pro-choice feminists, who feel

compelled to defend the Abortion Act in spite of its shortcomings, and anti-abortion actors, whom the Act situated as the enemies of vulnerable women.

The thesis charts the various ways in which actors have attempted to deal with the gendering of the Act. It argues that while feminist actors have often used the discursive resources available to them in creative ways, they have also been complicit in an 'awful-isation' of abortion (Hadley, 1997: 249) by continuing to represent women who have abortions as essentially vulnerable and abortion itself as necessarily traumatic. These actors have also relied heavily on ideas about female virtue in constructing their arguments, running the risk of implying that access to abortion is (or should be) conditional on a woman having behaved rationally and done nothing 'wrong', rather than a matter of human rights and bodily autonomy. Meanwhile, the logic of medicalisation underpinning the Act has been challenged little.

On the other hand, medicalisation has presented problems for anti-abortionists. The constitution of the Act as a measure to help vulnerable women had the effect of situating its opponents as *women's* opponents. Anti-abortion strategies since the Act can therefore be explained as attempts to grapple with this 'woman problem', depicting the relationship between women and the medical profession in different ways. From the 1970s onwards, anti-abortion MPs and peers have depicted their interventions as attempts to act on behalf of women portrayed as somehow harmed or exploited, whether by profit-hungry abortion clinics or by men who know that legal abortion means they can 'get away with it'. Increasingly, these strategies have involved a conscious appropriation and subversion of feminist arguments concerning rights and entitlements. Yet at the same time, analysis reveals their convergence with the backlash *against* feminism: their tendency to blame social progress and feminism itself for the problems facing women and to call for a return to traditional values.

1.2 Research design

Some explanation of the decision to analyse parliamentary politics is required. According to Nikolas Rose, analyses of governmentality:

> are not studies of the actual organization and operation of systems of rule … They are studies of a particular 'stratum' of knowing and acting. Of the emergence of particular 'regimes of truth' concerning the conduct of conduct, ways of speaking truth, persons authorized to speak truths, ways of enacting truths and the costs of so doing. Of the invention and assemblage of particular apparatuses and devices for exercising power and intervening upon particular problems (1999: 19).

The particular apparatuses and devices for intervening in abortion were negotiated and developed in Parliament, particularly during the controversy over the 'social clause' of the Abortion Act and the change in the role of the medical profession it seemed to imply. Parliament continues to be the principal site in which this regime is contested, as demonstrated by the 31 Private Members Bills introduced since 1967 which have attempted to amend the Act, plus the various amendments to items of government legislation tabled by backbenchers. As Paul Bayley observes, parliamentary debates may not always succeed in persuading MPs to change their stance on an issue, but:

> it does provide the semantic as well as the symbolic framework within which important social and political questions can be represented. It stakes out the boundaries which demarcate which meanings can and cannot be made at the symbolic centre of representative democracies (2004: 12-13).

The British Parliament is not to be privileged over, say, the medical profession in analyses of governmentality – both are actors in governmental networks, and it is not necessarily helpful to distinguish between 'state' and 'non-state' actors in this context. However, Parliament is a

key site in which processes of *translation* (see Chapter Three) between the goals of these disparate actors take place, perhaps particularly so where abortion is concerned. While its capacity to create legislation is generally limited (Norton, 2005), this is less true in the case of abortion. As abortion is a 'conscience issue', voting on abortion bills is unwhipped and there is no 'party line'. In addition, the executive does not introduce abortion legislation, although it may help or hinder the progress of a bill through the scheduling of parliamentary debates (Marsh and Chambers, 1981). Women's policy agencies, an important focus of much recent feminist analysis, also tend to remain quiet on the issue of abortion (McBride Stetson, 2001b; Lovenduski, 2007: 160). Of course, meaning-construction among the medical profession and among women who have abortions is also a crucial aspect of abortion provision, and this is being researched elsewhere (see for example Beynon-Jones, 2012; 2013; Hoggart, 2012).

Subsequently, the method employed here is discourse analysis of parliamentary debates, bolstered by analysis of relevant documents produced by members of the medical profession and prominent campaigners, and interviews with MPs and former MPs. The existing literature on abortion politics indicated which Bills and debates were most significant to the development of abortion politics (Marsh and Chambers, 1981; Sheldon, 1997; McBride Stetson, 2001b). Gaps were filled in using a list compiled by the Department of Information Services (2008) and by subject searches on Hansard, the database of parliamentary debates. 52 documents were analysed in total, including parliamentary debates, Committee reports, Department of Health documents and commentary from the medical profession.

The debates selected for analysis were primarily the Second Reading debates of the relevant Bills, where parliamentarians have the first chance to discuss the general principles of a Bill. Also included were adjournment debates, where general principles are discussed but a vote is

not taken, and the First Reading debates of Ten Minute Rule Bills. Ten Minute Rule Bills rarely make it to Second Reading, but at First Reading the Bill's sponsor is allowed to talk for ten minutes in support of her Bill, and an opponent of the Bill may also take ten minutes to speak against it. These Bills are generally regarded as a useful way of airing a particular issue in Parliament. Not considered are debates from the Committee and Report stages, where Bills are scrutinised in more detail. Analysis of these debates would have added little as new ideas or concerns about a Bill are rarely introduced at this stage; in other words, saturation had already been reached (Strauss and Corbin, 1990). The exceptions to this rule are the debates over the Abortion Act itself, as the controversial 'social clause' evolved considerably over the course of the Standing Committee and Report stages, with important implications both for abortion law and for subsequent debates.

Interviews were conducted in order to triangulate the conclusions drawn from analysis of debates. Interview invites were sent to 42 MPs, former MPs and peers identified during documentary analysis as having been highly active on the issue of abortion, on all sides of the debate (many of those identified who were active in debates in the 1960s and 1970s are now deceased). Unfortunately, only five responded in the affirmative. In some cases, parliamentary aides and advisers acted as gatekeepers, rejecting a request for an interview before the MP in question had seen it. The low response rate may also have been related to the participant information sheet sent out with interview requests, which was upfront about the normative aims of the project – it is worth noting that only pro-choice participants responded.

MPs and former MPs who participated include Alice Mahon, former Labour MP for Halifax, Julie Morgan, former Labour MP for Cardiff North, Brian Iddon and Des Turner, both former Labour MPs and members of the Commons Science and Technology Committee, and Kate

Green, currently Shadow Equalities Minister[1]. Where possible, the data was bolstered by interviews conducted by the British Pregnancy Advisory Service in 1997 with MPs and peers who helped to bring the Act through Parliament (Furedi and Hume, 2007 [1997]). As the chief purpose of the interviews was to help confirm and triangulate the conclusions drawn from the documentary analysis, it was not felt that the low response rate was severely detrimental to the study.

Once collected, the data was coded using the qualitative analysis software package QSR NVivo[2]. Coding is a method for categorising and labelling sections of data and hence for recognising patterns (and quickly finding sections of data which conform to a particular pattern later for closer analysis). Codes assist in the application of a *logics* approach to discourse analysis. A logic captures the aspects of a practice or regime of practices 'which make it tick' (Glynos and Howarth, 2007: 135). It sets out objects, subject positions and the systems of relations and meanings with connect them. Coding helps to identify elements of such logics, such as the vulnerable woman and the socially responsible doctor[3].

As well as providing a rich source of material for analysis, parliaments are, as Johanna Kantola observes, 'privileged discursive sites, and the discourses stemming from these sites attain particular authority' (2006: 44). However, analysis of parliamentary debates is limited in that it only takes a single institutional site into account. While, as I have argued, the institutional site of Parliament is the most important to the development of abortion legislation, such an analysis is still not reflective of the multiplicity of sites and diversity of actors involved in policy processes more generally (Annesley, 2010). Additionally, my

[1] It was judged impossible to obscure participants' identities fully, as their involvement in abortion politics is a matter of public record. Consent was secured to use their names in the text.
[2] While NVivo may be used for automated analysis and comparison of texts, in this case it was merely used to manually code sections of data for later analysis. This proved more efficient for the management and analysis of long texts than 'pen and paper' methods.
[3] A full explanation of the logics approach may be found in Chapter Three.

analysis is restricted to the single policy issue of abortion. For these reasons, this thesis cannot stand on its own as a commentary on contemporary feminist politics and encounters with the state. Rather, the mapping of discourses in the thesis forms the prelude to further research which will connect these discourses to broader feminist and non-feminist 'meso-discourses' (Brodie, 1997) about the state, citizenship and reproductive rights. This future project will assist in understanding where policy ideas come from and how they are gendered, and will move beyond a single focus on the institution of Parliament and the issue of abortion.

Finally, a note on how 'feminist discourses' were identified. Attempts to define feminism are not without controversy. However, some working definition of feminism was required in order to identify it in debates. Following the Research Network on Gender and the State (RNGS), this thesis identifies feminist arguments as those which 'identify with women; [are] explicitly gendered; represent women; improve the status of women; challenge gender hierarchies' (Lovenduski, 2008: 189n1). While this definition is contested and does not capture all of the complexities of contemporary feminist politics, it is used here as a purely heuristic device which can be used to help identify arguments which contain elements of feminist rhetoric, before subjecting them to closer scrutiny and critique.

1.3 Structure of the thesis

This thesis is formed of two conceptual chapters, which establish the theoretical and analytical framework, and four empirical chapters tracing the development of abortion politics from the debate over the 1967 Abortion Act to 2013. Chapter Two contains an overview and critique of the literature concerning feminism and abortion. Its first half stresses the significance of abortion for feminist politics by reviewing the feminist literature on

reproduction and the body. It argues that access to abortion has potentially radical implications which may be perceived as a threat by those who hold an interest in the reproduction of gendered social relations.

The second half of Chapter Two considers the feminist literature on abortion politics in the UK. This literature is comprised of two very different strands: the 'medicalisation critique', which sees the medicalised regime established by the Abortion Act as foreclosing the radical implications of abortion, and the 'state feminism' approach, which is more positive, emphasising feminists' success in defending access to abortion. The chapter argues that there is a need to steer a course between these two approaches. The medicalisation critique is clumsy in its treatment of 'the state' as a unitary actor with clear aims. The state feminism literature is more conceptually refined in this regard as it sees the state as a non-unitary entity which feminists may succeed in influencing. However, its account of abortion politics is ahistorical and fails to recognise the significance of medicalisation in mitigating the radical implications of abortion. As an alternative, I argue for an analytical framework which does not treat the state as a monolith but allows room for the implications of medicalisation to be discussed.

Chapter Three sets out such a framework. It introduces the notion of governmentality and key concepts from discourse theory such as articulation, equivalence and difference, and explores the implications of these for governmental feminisms. Drawing on literature on feminist movement strategies when engaging the state (Cooper, 1995; Kantola, 2006; Squires, 2008), it argues that feminist involvement in the activities of government risks the exclusion of particular discourses, because feminists translate their aims into formats which resonate with the *status quo*. Feminist discourses which achieve cultural resonance also run the risk of appropriation by forces antithetical to feminism. Hence, there is a need for an analytical

framework that accommodates such complexities without assuming that feminism is simply 'co-opted' upon entering the governmental arena. I develop such a framework by drawing on Dean's (2010) reformulated understanding of feminist 'radicalism' and Glynos and Howarth's (2007) 'logics of critical explanation'.

Chapters Four to Seven contain the results of the analysis. The history of UK abortion politics can be divided into distinct 'epochs' which generally culminated either in a successful attempt to change the law, or a failed attempt after which the issue went relatively quiet for a number of years; the structure of the empirical chapters reflects this. These epochs can also be characterised by the development of certain ideas. The period of 1966-7, during which the Abortion Act was negotiated, is primarily characterised by debates over the 'social' role of doctors. The period of 1969-80, by contrast, saw the entry of distinctly feminist ideas into parliamentary debate, in opposition to anti-abortion attempts to restrict the activities of private abortion clinics which culminated in the failed Corrie Bill. The period of 1981-90 witnessed the development of the concept of 'late' abortion which was crucial to the 1990 Human Fertilisation and Embryology (HFE) Act which lowered the time limit for legal abortion from 28 to 24 weeks' gestation. After the HFE Act, parliamentary activity on abortion went quiet for several years until reviving in the mid-2000s, with debates which are still ongoing.

Chapter Four develops existing accounts of the passage of the 1967 Abortion Act and the establishment of a logic of medicalisation in abortion regulation. It argues that this logic did not draw upon a ready-made affinity between the state and the medical profession (as implied by some feminist critiques of medicine) – rather, it involved a protracted negotiation of the role of the profession and its relationship with the state, made most evident in the controversy over the so-called social clause, which allowed abortion for 'social' reasons. The 'social' role of doctors in providing abortions was justified in part by the portrayal of women as vulnerable

and in need of paternalistic care, and of abortion as a means by which to allow women to carry out their maternal function in relation to existing children. However, it was resisted by those who saw abortion as potentially polluting and corrupting the profession.

Chapter Five deals with parliamentary debates between 1969 and 1980, during which time explicitly feminist ideas entered the parliamentary arena. It argues that feminist contributions in Parliament during this time could be described as 'radical' in Dean's sense, in that they articulated an extensive feminist agenda and thoroughgoing critique of parliamentary norms. However, these women were less radical when it came to the Act itself, declining to critique the logic of medicalisation or even employing arguments that served to reinforce it. This 'woman problem' was also present for their opponents, who made various attempts to present their anti-abortion interventions as 'woman-friendly' in spite of occasionally depicting women who seek abortions as 'brazen' and immoral. In this way, the initial gendering of the Act channelled later debates in a particular direction.

Chapter Six considers debates between 1981 and 1990, which saw a heightened 'technicisation' of abortion with the advent of new reproductive and foetal imaging technologies. It finds that feminist actors in this period continued to situate their defence of legal abortion within a counter-hegemonic chain of demands and critique of contemporary politics. However, their arguments relied more than ever on problematic assumptions about female virtue and vice, and represented women primarily as *patients*, thus reinforcing rather than challenging the logic of medicalisation. Meanwhile, opponents of abortion continued to depict themselves as acting 'for women' and appropriating elements of feminist arguments. Nevertheless, their arguments simultaneously drew upon a conservative morality which situated feminism itself as the cause of women's problems rather than, say, patriarchal norms. This period also saw the emergence of the 'foetal subject' as a patient in its own right, able to

make the same demands of the medical profession that women can and potentially threatened by female vice.

Chapter Seven covers parliamentary activity from 1991 to 2013. These debates took place against a fragmentation of medicalisation in practice, due to the prevalence of charitable abortion clinics and the increasingly liberal attitudes of doctors. However, the law did not change in this period. The chapter finds that there was again a strong pro-choice feminist showing in Parliament during this time. Nonetheless, feminists again avoided strong critique of medicalisation, in spite of private concerns – although such critique is perhaps less urgent now than in previous decades. Feminist contributions also became less 'radical' in Dean's sense in the 2000s, but there are signs of a reinvigorated critical feminism re-emerging since the 2010 general election. At the same time, there have been important shifts in anti-abortion strategy in this period. Chief among these are counselling amendments, which now situate doctors in a caring, socially responsible role, as opposed to older anti-abortion discourse which saw such a role as antithetical to the proper function of doctors. However, 2012 and 2013 have seen the rise of concern about 'sex-selective' abortion and claims that the female foetus is particularly threatened by abortion. While such claims are new, they resonate with earlier anti-abortion strategies which depict women as harmed by abortion, and hence attempt to decouple the issue of abortion from the issue of women's rights.

In summary, this thesis is a case study of the entry of feminist ideas into a policy debate, and of how these interacted with the other ways in which actors have gendered, or attempted to gender, the debate. The findings have several consequences. First, there are consequences for feminist strategy in abortion debates, which, I argue, has been overly cautious. Secondly, there are consequences for feminist political science: I stress that conceptualising feminist politics is about more than the insertion of feminist 'frames' into public debate. Finally, there

are consequences for feminism more generally, in particular the prospects for feminist engagement with the state. Political arenas may favour the translation of feminist demands into 'governance friendly' formats, resulting in the exclusion of certain ideas and demands. These consequences are discussed in Chapter Eight, which also sketches out the foundations of a future research project.

CHAPTER TWO. ABORTION, FEMINISM AND 'THE STATE'

Introduction

As abortion rights are often seen as a litmus test for how well women's interests and concerns are represented at the level of the state, the case of abortion politics has been used to draw conclusions about the state of feminism (or anti-feminist backlash) in a given country. This chapter offers an overview and critique of the literature concerning feminism and abortion. The existing feminist literature dealing with abortion politics in the UK tends to focus either on the role of the medical profession in regulating abortion (Fyfe, 1991; Petersen, 1993; Sheldon, 1997), or on the role of so-called 'state feminism' in the creation of abortion policy (McBride Stetson, 2001a; 2001b; McBride and Mazur, 2010). The former strand is rather pessimistic, offering a monolithic account of the state in which there is seemingly no place for feminist intervention. The latter, in contrast, is more celebratory, offering an assessment of feminist 'success' in defending abortion law which overlooks continuing feminist critique of British abortion policy and fails to ask why feminists have not been successful in achieving desired reforms.

To shed some light on these two currents of thought, it is first necessary to provide an overview of feminist writing on reproduction in order to discern the significance of abortion for feminist politics. The chapter argues that the potentially radical implications of access to abortion mean that it may be considered a threat by government actors and others with a vested interest in, for example, maintaining population trends or the reproduction of gendered social relations (although such motives may be numerous and contradictory). Section 2.1 assesses feminist ideas about reproduction. It is common in feminist writing to describe pregnancy and motherhood as alienating, 'emptying' women of subjectivity and

subordinating them to the reproductive imperative. Importantly, this is not a *necessary* meaning of pregnancy; however, it is a potential symptom of circumstances in which women are not able to reject reproduction or decide when to become pregnant. Subsequently, as Section 2.2 argues, access to abortion has far-reaching implications both for how women relate to their own bodies and for the structuring of society. Abortion signifies a departure from dominant ideas about gender roles and narratives of women's life course, most significantly 'the particular and inevitable attachment of women to domesticity and child raising' (Gordon 1986: 25). This argument will be returned to in later chapters, which argue that participants in debates over legalised abortion are aware of these implications, even if this is not always explicitly stated.

Abortion may thus be perceived as threatening by those invested in the *status quo*. Hence, Section 2.3 summarises some ways in which governments have responded to this threat, with a particular focus on the recent history of abortion law in the UK. Finally, the chapter turns to the ways in which feminist analyses have made sense of this history. Section 2.4 focuses on the feminist critique of the 'medicalisation' of abortion. This critique recognises abortion's potentially radical implications, and hence the potential motivation for state actors to try to 'contain' abortion. This, these critics argue, was achieved by medicalising abortion: in other words, by handing the final abortion decision to doctors, not to pregnant women.

While an incisive analysis in some ways, the medicalisation critique tends to assume the existence of a unitary state with clear and coherent motives. Section 2.5 argues that, in this sense, the 'state feminism' approach to analysis is more conceptually refined, drawing on literature demonstrating that the state is an amorphous and fragmented entity. However, this approach yields an ahistorical account which fails to recognise the significance of medicalisation in mitigating the radical implications of abortion, or to ask why feminists have

not managed to achieve liberalising reforms. My critique of these strands offers some guidance in how to proceed: future research requires a framework which does not treat the state as a monolith but manages to account for the continuing grip of medicalised abortion regulation. This framework is elaborated in Chapter Three.

2.1 Pregnancy, motherhood and feminist politics

That lack of control over one's ability to reproduce might be experienced as alienating has long been argued by feminists. Shulamith Firestone (1971) and Simone de Beauvoir (2011) are the authors of perhaps some of the most radical and influential feminist writing on the reproductive body. This section explores their concerns but critiques their tendency towards essentialism. From here, it moves from these more general theorisations of the female reproductive body towards feminist commentary on liberal political and legal systems' (in)ability to accommodate pregnancy (e.g. Ruhl, 2002; Bordo, 2003), as a springboard for a discussion of the social and political implications of pregnancy.

Firestone advanced 'a materialist view of history based on sex itself' (1971: 6) in which women's reproductive capacity is the origin of their oppression:

> women throughout history before the advent of birth control were at the continual mercy of their biology – menstruation, menopause, and "female ills," constant painful childbirth, wetnursing and care of infants, all of which made them dependent on males (1971: 8-9).

For Firestone, the aim of feminists should therefore be to question 'the very organization of nature' (1971: 2), by utilising reproductive technology to detach procreation from women's bodies. For Firestone, the female reproductive body is therefore necessarily oppressive, and is indeed the *origin* of oppression. While my argument departs from Firestone's – my aim is not

to search for the 'origin' of oppression – as I will argue below, this classic feminist concern with sexual difference may be reactivated without essentialising the female reproductive function as oppressive.

Beauvoir's (2011) own account of the female reproductive body is overwhelmingly negative. She does not view reproductive capacity as an essential meaning of women's bodies; nonetheless, it is a capacity with devastating consequences. The menstrual cycle itself seems to inhibit the potential for agency, bringing home to women that their bodies are 'the prey of a stubborn and foreign life', 'alienated and opaque thing[s]' beyond their control (2011: 42). This alienation, however, is intensified during pregnancy. Beauvoir describes pregnancy as a 'servitude' which places women in 'the grip of the species' (2011: 43). Reproductive capacity, for Beauvoir, eats away at both women's bodies and women's freedom in a way that it cannot for men. She writes:

> [Woman] is the most deeply alienated of all the female mammals, and she is the one that refuses this alienation most violently; in no other is the subordination of the organism to the reproductive function more imperious nor accepted with greater difficulty. Crises of puberty and of the menopause, monthly 'curse', long and often troubled pregnancy, illnesses and accidents are characteristic of the human female: her destiny appears more fraught the more she rebels against it by affirming herself as an individual. The male, by comparison, is infinitely more privileged: his genital life does not thwart his personal existence; it unfolds seamlessly, without crises and generally without accident (2011:44).

There are well-documented tensions in this discussion of the female reproductive body. Despite arguing that bodies 'do not carry their meaning in themselves' (2011: 47), Beauvoir seems to say that pregnancy must necessarily, on some level, be an alienating experience. Several commentators have interpreted these passages on reproduction and alienation as

suggesting that, in order to be truly free, women must deny the reproductive body. For example, Catriona Mackenzie argues that Beauvoir vacillates between an account of the female body as constructed and an account of the female body as inherently oppressive. Women's lack of freedom, in this interpretation, is a result of patriarchal oppression, but this oppression is structured on features of the female body which somehow inhibit women's quest for subjectivity (Mackenzie, 1986: 147). Mackenzie suggests that the constructed female body, to Beauvoir, has been overdetermined by its reproductive capacity such that it has come to signify reproduction to the exclusion of any other possible meanings (1986: 151). Beauvoir's argument hence suggests that reproduction is not the *only possible* meaning of the female body. However, Beauvoir still seems to understand female reproduction itself as necessarily oppressive, enslaving women to the species. Women's subjectivity thus requires a denial of the female reproductive body.

This is not to argue that Beauvoir and Firestone's accounts are of no use to feminists trying to rethink the meaning of maternity. Some feminists have attempted to interpret them in ways which do not require an essentialist understanding of the female body. As Sara Heinämaa (1997) notes, passages in Beauvoir concerning reproduction can be read as phenomenological portrayals of women's experiences of reproduction in a patriarchal social system, even if it is not always clear that this is the author's original meaning. Indeed, when read in this way, these accounts of maternity are extremely powerful – having, as Linda Zerilli (1992) argues, the ability to subvert the construction of reproduction as women's destiny, to be accepted passively and calmly. Read in this way, Beauvoir and Firestone's accounts chime with later feminist discussions of pregnancy and motherhood.

The poet and essayist Adrienne Rich also attempted to describe the potentially oppressive experience of motherhood without resorting to essentialism. In *Of Woman Born* (1986), Rich

chronicled the loss of subjectivity she experienced bearing and bringing up her three sons. Pregnancy itself she experienced as a loss of control and fostering of dependency: towards the end of her first pregnancy and hospitalisation two days prior to giving birth, she felt entirely reliant upon her obstetrician (1986: 26); her third and final pregnancy taught her 'that my body was not under my control' (1986: 28). Once born, her children seemed to make unfair and unreasonable demands on her time and independence, yet at the same time she felt great guilt at being unable to love them unconditionally. The experience radicalised her: *Of Woman Born* is not a critique of the activity of mothering, but of the (patriarchal) institution of mother*hood* which 'has withheld over one-half of the human species from the decisions affecting their lives' (1986: 13). Echoing Beauvoir, Rich argues that motherhood as an institution 'has alienated women from our bodies by incarcerating us in them' (1986: 13).

The idea that motherhood as an institution involves women's subordination to the reproductive imperative, and corresponding loss of subjectivity, has been taken up in analyses of liberal legal and political systems. Rather than giving an account of women's experiences, Susan Bordo (2003) discusses the status of women as subjects in the culture and legal tradition of the United States. She demonstrates that the liberal legal tradition which claims to establish equal individual rights in fact fails to treat women as full subjects, instead treating women 'as mere bodies despite an official rhetoric that vehemently forswears such treatment of human beings' (2003: 72). Bodily integrity, under this system, is normally legally inviolable, even when to violate this right would save the life of another[1]. However, in practice this dictum does not seem to apply to pregnant women. As evidence, Bordo cites the

[1] Bordo cites the case of *McFall v. Shimp*, in which it was ruled that David Shimp could not legally be forced to donate bone marrow to his cousin, Robert McFall, despite the unlikelihood that the latter would find another compatible donor. The court decision stated that to infringe upon Shimp's 'absolute right to his "bodily security"' would 'change every concept and principle upon which our society is founded.' (Bordo, 2003: 73; McFall v. Shimp, 1978)

1987 court decision to force Angela Carder to undergo caesarian section. At 25 weeks' gestation, Carder was diagnosed with a lung tumour, which she opted to treat with chemotherapy and radiation (surgery being ruled out). At this stage of pregnancy, the foetus was unlikely to survive long after birth; nonetheless, when Carder's condition rapidly deteriorated, the hospital administration – alarmed by the decision not to attempt delivery – requested that a court intervene on the foetus' behalf. The court ordered that Carder undergo caesarian section, despite the low likelihood of her survival and her own protests. The foetus survived for two hours after the operation; Carder died two days later (2003: 76-77).

As Bordo points out, 'a woman whom *no court in the country would force to undergo a blood transfusion for a dying relative* had come to be legally regarded, when pregnant, as a mere life-support system for a fetus' (2003: 77; emphasis in original). The case emphasises the inconsistency and the gendered nature of legal and cultural understandings of subjectivity – pregnant women, it seems, are not considered embodied subjects. Rather, the subjectivity of the foetus seems to detract from the pregnant woman's, resulting in a culture where

> pregnant women are not subjects at all (neither under the law nor in the zeitgeist) while fetuses are *super*-subjects. It is as though the subjectivity of the pregnant body were siphoned from it and emptied into fetal life (Bordo, 2003: 88).

For Lealle Ruhl, this is a failing of the liberal conception of the individual, which she argues 'is inherently unable to accommodate pregnancy, either on a philosophical level or on the level of lived reality' (2002: 38). This is because conception and pregnancy lie 'outside the realm of self-willed activities' (2002: 38) – particularly when reliable contraception is not widely available – and because the pregnant subject is 'bifurcated'. Ruhl notes that in court decisions in the US and Canada, the foetus is accorded a status beyond normal subjectivity, entitled to demand sacrifices from its parent that no other liberal subject could. In this sense,

the liberal subject with rights and obligations is split in two: the foetus has rights, while the pregnant woman has obligations – woman and foetus are 'not two liberal subjects in one body, but rather *one* liberal subject in two bodies' (2002: 39). This description of legal understandings of pregnancy has obvious resonance with Bordo's observation that pregnant women's subjectivity is 'siphoned off and emptied' into the foetus.

Bordo and Ruhl's observations concern case law, but as Ruhl notes, legal tradition is rooted in a cultural and philosophical tradition with a certain conception of subjectivity – a conception which seems to exclude pregnant women, if not all bodies with the capacity for pregnancy. At the heart of this is the notion that pregnancy is not 'self-willed'. Classical liberal theory conceptualises the individual as rational, and as exercising a rational function over his[1] body (which is thought of as property, subordinate to the mind). Pregnancy seems to lie outside the scope of this rational management of the body, hence the insistence of classical liberal thinkers such as John Locke that women could not be full citizens (Ruhl, 2002: 38).

These observations do not necessarily entail that pregnancy always precludes full subjectivity. An understanding of pregnancy as something other than immanence and enslavement to the species has been articulated in a number of feminist works. Iris Marion Young takes issue with the immanence/transcendence dichotomy expressed by existentialists such as Beauvoir. Young describes the experience of pregnancy as a sense of the 'splitting' or 'doubling' of the subject – yet questions the assumption that this must automatically entail alienation from the pregnant body (1984: 48-9; see also Tyler, 2000; Lundquist, 2008; Oliver, 2010). The pregnant body, she argues, may also be experienced aesthetically. In a similar fashion, Rich draws attention to the possibility of seeing pregnancy and childbirth 'as one way of knowing

[1] I use the male pronoun because, as the failure of liberal theory to accommodate the pregnant body demonstrates, this individual is implicitly male (for further discussions of this, see Pateman, 1988; Brown, 1992).

and coming to terms with our bodies, of discovering our physical and psychic resources' (1986: 157).

2.2 The significance of abortion

The above commentary should indicate how much is at stake in struggles over legal abortion. The full significance of these understandings of pregnancy for abortion politics will be elaborated in this section through a discussion of feminist literature on abortion outside of the UK political context. As an intervention into the workings of the female reproductive body, abortion is deeply entwined with questions of women's liberation: this much was intuited by early feminist activists. Margaret Sanger, a prominent sex educator and birth control activist in the early 20th century, wrote at length on reproductive rights and responsibilities in the essays in her book *Woman and the New Race* (1920). In an essay titled 'Contraceptives or abortion?' she asserts that while abortion is just as 'abhorrent' as child abandonment or infanticide, it is merely symptomatic of women's lack of freedom. Abortion, she argues, occurs when the 'feminine spirit' – women's natural desire to be free – is constrained by social circumstances and unwanted pregnancy; women will always be driven to desperate measures when preferable alternatives such as birth control and sex education are lacking. Elements of this analysis echo throughout more recent feminist writing – compare Sanger's assessment of abortion as symptomatic of a lack of freedom with Catharine MacKinnon's assertion that abortion 'provides a moment of power in a life otherwise led under unequal conditions that preclude choice in ways [women] cannot control ... a window of relief in an unequal situation from which there is no exit' (2005: 141).

However, abortion can have wider-ranging effects than those identified by Sanger and MacKinnon. If the capacity for pregnancy renders women vulnerable to exploitation – not *necessarily* 'emptying' women of subjectivity, but making such an emptying possible – legal, safe and accessible[1] abortion has radical implications both for how women relate to their own bodies and for the structuring of society. Female subjectivity is 'siphoned off' in situations where pregnancy cannot be rejected; hence, the female body is coded as passive and as inevitably becoming pregnant. The capacity to deny the reproductive body thus destabilises dominant constructions of gender and narratives of women's life course. Of course, the significance of abortion will not be experienced in the same way by every woman, and my intention is not to erase the experiences of trans*, lesbian, post-menopausal or infertile women who are unable or unlikely to become pregnant. However, as Christine Battersby notes, even these women are likely to find themselves 'assigned a subject-position linked to a body that has perceived potentialities for birth' (1998: 16).

Beauvoir depicts abortion as traumatic, not because it is a form of violence to the female body, but because it represents a rupture of feminine values:

> from childhood woman is repeatedly told she is made to bear children, and the praises of motherhood are sung; the disadvantages of her condition – periods, illness, and such – the boredom of household tasks, all this is justified by this marvellous privilege she holds, that of bringing children into the world ... Even consenting to and wanting an abortion, woman feels her femininity sacrificed (2011: 545).

Abortion, as a rejection of the childbearing capacity, calls feminine values into question – right down to the meaning of the female body. This chimes with Valerie Hartouni's (1991) discussion of abortion and reproductive discourses. Hartouni notes that dominant images of

[1] The importance of accessibility should not be underestimated. As Petchesky has forcefully argued, legal abortion makes little difference for many women without the ability to access abortion in practice (1980; 1986).

motherhood portray it as a passive, biological process. This is evident in headlines calling a woman kept on life support for the sake of the gestating foetus a 'brain-dead mother', a usage of the word 'mother' which would not be intelligible were motherhood primarily considered an active, social role. Gestation, moreover, has been considered 'the natural fact of female bodies' (1991: 43) – the female body is a 'natural-familial-maternal body' (1991: 33), a body which passively, inevitably becomes pregnant. Abortion thus fundamentally disturbs how female bodies are understood, indicating that pregnancy and motherhood can be a conscious and active choice rather than an inevitable consequence of engaging in sexual activity while having a female body.

If the reproductive function can be denied, the female body cannot be overdetermined by this it. As Hartouni notes and I have already hinted, if motherhood does not emerge passively as a natural condition of female embodiment, it must instead be figured as an active and social role and as a *choice*. The implications of this are broad. While Kristin Luker avoids any normative assessment of the implications of women's reproductive rights, the findings of interviews she conducts with both pro-life and pro-choice women activists in the US seem to confirm that abortion has broad implications for what it means to be a woman. She argues that while the debate between the 'pro-life' and 'pro-choice' movements is, on the surface, about the 'status' of the embryo – incorporating questions about whether, how and when the foetus can be considered a 'person' or a 'human life' – on a deeper level it is also about the status of women. The debate is 'about women's contrasting obligations to themselves and others' and is subsequently '*a referendum on the place and meaning of motherhood*' (1984: 193; emphasis in original).

Through her interviews with activists, Luker identifies the differing 'social worlds' and worldviews of female pro-choice and pro-life activists. The latter, she finds, were unlikely to

work in the paid labour force, especially after marriage. They were generally housewives or, if they did work, were in traditionally female occupations such as social work and nursing. Pro-choice women, on the other hand, were generally more highly-educated, working women, often with large salaries (1984: 195). To Luker, the activists' views on abortion result from these differences, and stem from vested interests in the legal and cultural status of abortion. The pro-life women interviewed were heavily invested in traditional gender roles and family structure, which were 'satisfying, rewarding, and meaningful' (1984: 201) for them. In contrast, pro-choice women, who generally made use of the traditionally 'male' resources of paid employment and participation in the public sphere, typically experienced an unplanned pregnancy as highly disruptive, threatening their access to these resources.

The normative implications of abortion's connection to gender roles and women's participation in the labour force have been drawn out by feminists. The historian Linda Gordon points out that if childbearing and childrearing are no longer imperatives, the 'basic organization of society' is called into question. She identifies this as the source of New Right opposition to reproductive rights:

> Our opposition sometimes appears to know better than we do how radical are the implications of reproductive rights for women. We are talking about undoing the basic gender organization of society, traditional 'femininity' as we have known it, the particular and inevitable attachment of women to domesticity and child raising … We are talking about reconstructing not only femininity but masculinity, and in the process, altering the bases of our culture (1986: 25).

Some feminists argue accordingly that that the right to abortion is a fundamental women's right. Early 20th century socialist feminist Stella Browne, for example, saw free access to abortion as an imperative, freedom of choice being essential for 'the full right of free

motherhood' (Riley, 1981: 191-192). Much more recently, Rosemary Nossiff has argued that women's right to control their reproductive function must be paramount if full citizenship is to be achieved (2007). All this is not to argue, like Beauvoir, that the reproductive body must be denied if liberation is to be achieved. Rather, the ability to *choose* whether or not to be pregnant has cultural consequences, disturbing as it does the construction of the female body as fundamentally a reproductive body and therefore disrupting the link between female embodiment and the social institution of motherhood. Access to abortion, along with access to birth control, makes a host of activities and social arrangements more thinkable and achievable for women than they would otherwise be: sex outside marriage, sex without procreative intent, and uninterrupted participation in the workforce, to name a few.

These potentially radical implications suggest that women's access to abortion may be highly unsettling for those invested in a sexist social order. Indeed, analyses of abortion provision globally demonstrate that this is often the case. The Soviet case yields one such example. While abortion was (re-)legalised in the Soviet Union in 1955 to prevent deaths from illegal and unsafe practices, it was still seen as a highly undesirable practice. Abortions often took place in large wards without privacy – and sometimes without anaesthesia – with the aim of punishing women for their refusal of motherhood (Rivkin-Fish, 1994; 2013). As the following section demonstrates, strategies for 'containing' abortion have also developed in the UK, albeit in a very different way.

2.3 The recent history of abortion law

Before the early 19th century, intent to procure an abortion was only illegal after 'quickening', the point at which a pregnant woman starts to feel foetal movement. However, abortion before

quickening was criminalised in an 1803 Act, although the distinction between pre- and post-quickening was maintained for the purpose of administering punishment. In 1828, abortion was brought under the banner of 'offences against the person' along with a number of other statutes dealing with crimes such as murder, rape and assault. The next Offences against the Person Act, in 1837, removed the distinction between pre- and post-quickening from the statute book entirely, along with the term itself – now, any 'intent' to procure abortion was simply illegal. The 1861 Offences against the Person Act included women themselves in the crime of 'intent' to procure an abortion, separating from those found to be 'aiding and abetting' them, who were subject to a lesser punishment (Fyfe, 1991: 162).

The 1929 Infant Life (Preservation) Act introduced the notion of foetal viability – the length of gestation at which a foetus is assumed to be 'capable of being born alive' – and set this at 28 weeks. For the first time, abortion post-viability came to be legally regarded as murder. However, abortions after 28 weeks were legalised where they were necessary in order to save the life of the pregnant woman (Fyfe, 1991: 163). Nonetheless, this barely changed the situation in practice until the Bourne case of 1938 (Hindell and Simms, 1971: 13). In 1938, a 14-year-old girl was raped by a group of off-duty soldiers. After a hospital refused to terminate her pregnancy, the case was taken up by the Abortion Law Reform Association (ALRA), who wrote to Aleck Bourne (at the time, Consultant Obstetrician at St Mary's hospital) and asked him to terminate (Hindell and Simms, 1971: 69-70).

Bourne agreed to carry out the termination after noting the girl's severe distress, later writing that 'in her there was nothing of the cold indifference of the prostitute'[1] (cited in Hindell and Simms, 1971: 70). In order to force a court ruling that would clarify the legal situation, he

[1] The idea that access to abortion should be conditional on the virtue of the woman involved continues to feature in abortion debates (see Chapters Five to Seven).

informed the police and was charged with a criminal offence. However, Bourne was acquitted on the grounds that it was impossible to distinguish between a woman's life being in danger and her health being in danger. As Justice Macnaghten told the jury: 'Life depends on health, and it may be that if health is gravely impaired, death results' (cited in Hindell and Simms, 1971: 71). If the pregnancy was likely to turn the woman into a 'physical or mental wreck', he added, the doctor who carried out the termination might well be viewed as acting to save the life of the woman. In establishing *health* as a legal ground for abortion, this ruling was extremely liberalising.

By the mid-1960s, however, it had become clear that existing restrictions on abortion were not functioning to contain it. Illegal abortions were on the rise as women became increasingly determined to flout the law to obtain abortions (Hindell and Simms, 1971: 32-33; Petchesky, 1986: 115). Abortion, in other words, was becoming unmanageable as the law became increasingly ineffective. Women with access to the right resources could have 'discretely legal' abortions in the private sector, and only women poor enough to consult untrained abortionists using dangerous methods felt the full force of the law (Hindell and Simms, 1971: 39-41). As well as drawing public outrage over the existence of a so-called 'law for the rich', this situation rendered the law unenforceable – it 'was obvious to anyone who examined the problem that both illegal and quasi-legal operations were being carried out on so large a scale that the law had little public support' (1971: 42).

As I have explained, authors have described abortion as at once a signifier, cause and consequence of social change and upheaval, thoroughly linked to gender relations and women's life courses and potentially disrupting the prevailing social order. For Rosalind Petchesky (1986: 116-7), states intervene in reproduction for a number of reasons: firstly, for population control; secondly, in order to regulate sexual behaviour and norms; thirdly, due to

a need to maintain the social order and its own legitimacy. The legalisation of abortion in the United States under *Roe v. Wade* parallels the UK case in that it was a response to social changes that meant existing abortion laws no longer had credibility. Critical to these changes was women's increasing labour force participation: 'the capitalist economy required reliable means of fertility control to support a growing demand for female labor power' (1986: 115). Women themselves were determined to defy the law, having abortions no matter what, and abortion was slowly becoming accepted as an element of family planning. The state, in order to maintain legitimacy, was forced to respond by changing the law.

The UK state's response to mounting illegitimacy came in 1967 in the form of the Abortion Act. The Act did not 'legalise' abortions for women who sought them so much as decriminalise the doctors who carried them out. It stipulated that abortion could legally be carried out by a registered medical practitioner before the 28th week of pregnancy (later reduced to the 24th week), if two doctors agreed that the abortion if the pregnancy posed 'a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman' or there was 'a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped' (Abortion Act 1967, s1(1)(a-d)). Rather than granting women a right to abortion on demand, the Act gave doctors the final say over whether an abortion could be carried out. While different countries have dealt with the abortion 'problem' in different ways, this 'medicalisation' of abortion is hardly unique to the UK. As McBride Stetson notes, the medical profession forms one corner of an 'abortion policy triad' in abortion debates globally, along with the state and women (1996: 97). Since the professionalisation of health care, she argues, the interests of the medical profession have always been taken into account when constructing abortion policy.

In the UK, however, the law continues to be contested. In the 1970s, several anti-abortion Bills were introduced – most notably by James White (Labour), William Benyon (Conservative) and John Corrie (Conservative) – aimed at curtailing apparent 'abuses' of the 1967 Act by circumscribing the circumstances in which abortions could legally be carried out. The debate reignited in 1988 with the introduction of the Alton Bill, which aimed to lower the upper time limit for legal abortion to 18 weeks' gestation. While the Alton Bill did not complete its passage through Parliament, it inspired several attempts to amend the 1990 HFE Act. The HFE Act eventually lowered the time limit to 24 weeks (a limit which had already been achieved in clinical practice), and more restrictive amendments were defeated.

Since then, further attempts to change the law have been unsuccessful. However, the issue has not abated. The 2008 update to the HFE Act renewed the debate on abortion law and more attempts were made to reduce the upper time limit, although none were successful. In 2011, Conservative MP Nadine Dorries, along with her Labour co-sponsor Frank Field, sponsored an amendment to the coalition government's Health and Social Care Bill which would have stripped abortion providers of their right to provide independent counselling, instead requiring that this counselling be provided by independent organisations. This amendment was widely regarded as an attempt to slowly erode access to legal abortion (Henebury, undated). In early 2012, the *Daily Telegraph* exposed three doctors offering to arrange abortions on the grounds that the foetuses were female (Newell and Watt, 2012), prompting an investigation by health officials. Not long afterwards, the then Health Secretary, Andrew Lansley, launched a wave of unannounced inspections on abortion clinics following claims that doctors were 'pre-signing' abortion paperwork without seeing patients. Attempts to reform the law have not all been anti-abortion. In 2011, for example, the British Pregnancy Advisory Service (BPAS) made a bid to allow women to undergo early medical abortions in their own home. However, this was

unsuccessful (see Chapter Seven). Likewise, attempts to liberalise abortion law by attaching amendments to the two HFE Acts have failed.

An overview of the feminist literature reveals two very different ways of making sense of this history. The first, which I term the *medicalisation critique* due to its roots in Marxist and feminist writings about the medical profession, depicts the 1967 Act as the outcome of entrenched medical control over female reproduction. The second is rooted in analyses of 'state feminism' and is more optimistic, noting the success of feminists in defending the Act from anti-abortion attacks. The rest of the chapter outlines and critiques these approaches, and draws out some implications of this critique for the thesis: most importantly, the need to work with a conception of 'the state' which neither treats it as an anti-feminist monolith nor uncritically celebrates the achievements of 'state feminism'.

2.4 The medicalisation critique

This strand of the literature has focused on the role of the medical profession in managing and regulating abortion. Wendy Fyfe (1991) argues that between 1803 and 1967, UK abortion legislation shifted in focus from religion to medicine, a shift which reflected the increasing ability of the medical profession (and decreasing ability of women) to define and control reproduction. Fyfe connects early Acts concerning abortion with the increasing credibility and legitimacy of the medical profession during this period. By the 1929 Infant Life Preservation Act, she argues, the medical profession had begun to consolidate its expertise in the area of reproduction, and abortion had been increasingly redefined in medical terms. This process involved the gradual displacement of definitions used by women in relation to pregnancy, accompanied by a legal shift towards the criminalisation of individual women rather than

doctors. From this shift emerged a distinction between legitimate 'medical' abortions (those authorised and carried out by medical experts) and criminal abortions (those sought outside the clinic and often performed by women) (1991: 163-5). This argument is echoed in the work of Kerry Petersen (1993), who identifies medical control over abortion as an effect of the medical profession's strategy of developing a monopoly over the health care system, particularly through the displacement of midwives from their central role in providing reproductive care.

This historical approach allows Fyfe and Petersen to view the 1967 Abortion Act rather differently to popular wisdom: instead of reversing decades of oppressive or misguided legislation, the Act was actually the culmination of a long process of separation of women from control over reproduction and abortion and legitimisation of medical expertise in this arena. The Act, after all, did not decriminalise or grant a new 'right' to women seeking abortions. Rather, it 'legalised' abortion by granting protection to doctors carrying out abortions in certain medically controlled circumstances. This narrative indicates that the conception of UK abortion law as underpinned by liberal individualism is incorrect – in fact, the 1967 Act was the logical outcome of years of steadily increasing medical control over the sphere of reproduction. The Act succeeded in maintaining the law's legitimacy in the eyes of the public while also ensuring that abortion remained regulated. It dragged abortion from the illegal and invisible 'back streets' and into the visible and legitimate sphere of medical care.

This critique of abortion law is rooted in, and shares some of the failings of, an older critique of medicine. The 'orthodox medicalization critique', as Lupton terms it, has its roots in Marxist perspectives and the social movements which arose in the 1960s and 70s[1]. Supporters

[1] Peter Conrad defines medicalisation as 'a process by which nonmedical problems become defined and treated as medical problems' (1992: 209). This definition is shared by much of the literature, but is problematic in that it

of this critique noted that medicine was amassing power and influence[1] in spite of its apparent lack of effectiveness in treating many conditions. These critics argued that social life was becoming medicalised; in other words, social problems were increasingly being defined using medical terminology and treated medically, as 'diseases'. Further, they argued that medicalisation was a mechanism of social control (Lupton, 1997: 94-5). This charge was taken up by many feminists, who have argued that women in particular have been subject to medical control, especially when it comes to pregnancy and reproductive care (Morgan, 1998; Purdy, 2001).

This is not to say that medicine's 'social' role is new: public health has always aimed to improve sanitation, housing, and other aspects of society, while psychiatry was committed to dealing with and rehabilitating (rather than persecuting or punishing) social 'deviants' (Zola, 1972: 488). Yet for Irving Zola, an influential critic of medicine, it is still possible to identify changes in how sickness and health are perceived, along with an expansion of medicine's role in the mid-twentieth century. Medicine, at first glance, appears to have lifted moral condemnation from individuals by drawing a distinction between illness and crime: criminals are personally responsible for their actions, and therefore can be held accountable whereas sick people cannot be. Nonetheless, the moral condemnation of sick people was not really lifted but displaced:

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assumes that there is a clear-cut distinction between those issues which are 'genuinely' medical and those which are not. The dividing line is more blurred than this, as my discussion of the medicalisation of pregnancy and abortion should indicate.

In addition, much of the literature using the term 'medicalisation' tends to conceptualise it as a highly linear process involving the imposition of medical authority onto all areas of life. This perspective is contested (see for example Rose, 1998: 49-50); however, even authors challenging this account 'tend to present a consonant vision of a world in which individuals' lives are profoundly experienced and understood through the discourses and practices of medicine and its allied professions' (Lupton, 1997: 94). Even if I do not share all of the assumptions made by the literature on medicalisation, the term is useful shorthand for the ways in which abortion has come to be regulated and managed, hence its use here.

[1] These authors are referring to the power of medicine as a 'system' (Ehrenreich and English, 2011 [1973]: 31) or 'institution' (Zola, 1972: 487), rather than simply the status of individual doctors.

> Though [the sick person's] immoral character is not demonstrated in his having a disease, it becomes evident in what he does about it. Without seeming ludicrous, if one listed the traits of people who break appointments, fail to follow treatment regimen, or even delay in seeking medical aid, one finds a long list of 'personal flaws'. Such people seem to be ever ignorant of the consequences of certain diseases, inaccurate as to symptomatology, unable to plan ahead or find time, burdened with shame, guilt, neurotic tendencies, haunted with traumatic medical experiences or members of some lower status minority group – religious, ethnic, racial or socio-economic. In short, they appear to be a sorely troubled if not disreputable group of people (1972: 490-1).

In an explicitly feminist critique of medicalisation, Barbara Ehrenreich and Deirdre English's *Complaints & Disorders* (2011 [1973]) explored how medicine worked in particular to control women in the United States. For these two authors, through the medicalisation of women's lives, medicine became a key contributor to sexist ideology, describing women '*as sick, and as potentially sickening to men*' (2011: 32; emphasis in original) and therefore needing to be brought under medical supervision. Moreover, Ehrenreich and English argue that medical practice in the nineteenth century aimed at controlling or 'taming' women – that it operated as a form of surveillance in which, at the first sign of rebellion, doctors could intervene to 'cure' a 'disease' (2011: 82). A great deal of women's 'unruly' behaviour was diagnosed as some sort of 'nervous disorder' and blamed on the female sexual and reproductive organs. Sometimes these 'disorders' were thought to necessitate surgery, involving removal of the clitoris, or more commonly, of the ovaries – the threat of which was 'enough to bring many women into line' (2011: 81).

Feminist sociologist Ann Oakley also argues that medicalisation has functioned to control women's behaviour. In Britain, the early development of antenatal care occurred at a time when the state's interest in reproduction – along with the legitimacy of state intervention in

this area – was being established, towards the end of the nineteenth century (Oakley, 1984: 34). The notion that public health might be a matter of national interest was established as military men alerted policymakers to the physical 'degeneracy' of army recruits; furthermore, the maladies afflicting the populace were blamed on maternal ignorance (1984: 35-6). Thus, the state and medical profession set about educating women in the proper care of children – and of the pregnant self. Educating mothers was presumably cheaper than providing adequate medical care or housing, 'but the zeal with which it was promoted probably had more to do with perceptions of women's social function' (1984: 38). Moreover, education of new mothers meant education by health-care professionals, not education by other women with experience of motherhood. Crucially, this education took place as a central part of early antenatal care, only splitting off as a separate activity in the 1960s. Antenatal care was therefore, to Oakley, about controlling and altering women's behaviour from its inception (1984: 259; see also Oakley, 1980).

For Oakley, this medical control of women's reproductivity is very clearly a *state* mandate: the state has an interest in controlling populations and public health, and employs the help of the medical profession in order to do so (Oakley, 1984: 2). This perception of the state's interest in managing reproductivity has been carried over into feminist critiques of the 1967 Abortion Act. Sally Sheldon's *Beyond Control* (1997) draws upon Foucault in order to make sense of the Act. She understands the medicalisation of abortion as a form of biopolitical control – in other words, as 'part of a set of strategies for the administration of bodies and the calculated management of life' (Foucault, 1981: 138-9), involving the supervision and regulation of the domains of health, mortality and reproduction. As Rose notes, biopolitics

may be seen in governmental[1] terms, as it seeks, 'with some notable exceptions, to act upon these domains by reshaping the conduct of those who inhabit them without interdicting their formal freedom to conduct their lives as they see fit' (Rose, 1999: 23). This is Sheldon's understanding of the Abortion Act: it shifted power away from a centralised state and channelled it through a range of institutions and practices, thus 'governmentalising' abortion.

The 1967 Abortion Act, in this sense, did not result in the deregulation of abortion, but rather in a new form of regulation of abortion using the capacities of the medical profession to oversee and manage pregnancy instead of the direct intervention of the state. Sheldon stresses the highly gendered nature of this process. The new regulatory role of the medical profession, she argues, was made possible only by appealing to particular constructions of women seeking abortions. Analysing parliamentary debates over Steel's Bill, she observes that women are typically depicted as vulnerable, irresponsible or irrational – as victims of social circumstance in need of protection, or as 'feckless girls' (1997: 37) unready for motherhood. Participants also emphasise maternity as a female norm, even when abortions are carried out – abortion is often justified in order to avoid overstraining a woman's 'capacity as a mother' or in terms of the needs of existing children in the family. These accounts of women as unable (whether by nature or through circumstance) to take responsibility for their own lives underpin the decision to transfer power to the medical profession (1997: 32-48).

New laws concerning abortion in the UK are thus, for Sheldon as for other feminist critics, a far cry from the liberal measures they are often assumed to be. Rather, they implemented a new form of regulation which utilised the medical profession's capacity for administrative oversight. In political debate as in legislative practice, abortion is recast as a 'health' issue. This means that decision-making power is granted to doctors, rather than to women seeking

[1] For an explanation of the term 'governmentality', see Chapter Three Section 3.1.

abortion, ensuring that the final say in abortion is not made by pregnant women themselves. However, for Sheldon, medicalisation goes beyond this power shift. In order to open abortion to medical scrutiny and intervention in this way, the gendered nature of women seeking abortions (as vulnerable, irresponsible and irrational) had to be reemphasised, and placed in opposition to the rational, impartial and competent nature of the medical profession. 'Legalisation' in this format does not therefore entail women's ability to make decisions about their own reproductive capacities. Rather, 'liberal' abortion legislation is underpinned by, and propagates, the assumption that women are incapable of making such decisions unaided. In this understanding, medicalisation therefore disempowers women.

There is much that is useful about accounts of the medicalisation of abortion, as they demolish the popular conception of the 1967 Act as a liberalising measure. However, the assumptions they make about the state are troubling[1]. These accounts assign a unitary nature to the state and medical profession and offer a linear narrative of how abortion legislation developed. Sheldon in particular is keen to assign clear, unified motives to the state and law. She states that 'the law clearly aims to protect medical autonomy and discretion rather than to grant substantive rights to the woman' (1997: 27) as a result of 'the state's attempts to bring under control women seeking to terminate pregnancies' (1997: 30). This is true also of Petchesky's account of why states intervene in reproduction. The medicalisation of abortion is

[1] The medicalisation critique more generally, though valuable in that it gives the lie to the common assumption that medicine is 'neutral' or somehow 'detached' from society, is also problematic in that it tends to assume that the interest in controlling women is consistent across the entire medical profession. Gaps in this literature, however, expose the existence of tensions within the medical profession. Though there is some writing employing the medicalisation critique to discuss movements for demedicalisation such as home birth and nurse-led care, the focus of these works is generally on activists in, for example, the alternative birth movement (Daviss, 2001) or on women's experiences of hospital versus home births (Fox and Worts, 1999). The medicalisation critique, as it is expressed by the authors discussed above, cannot explain developments such as the push for nurse-led care *within* the NHS (Wintour, 2008), or recent recommendations that women who have already had children consider home births (Press Association, 2012).

thus presented as almost inevitable in some feminist analysis, the result of an equally patriarchal state and medical profession conspiring to control women. It seems somewhat defeatist for feminists to envision the state in this way – if outcomes are predetermined and negotiation is foreclosed (the logical implication of accounts which fail to consider *struggles* over abortion legislation), why bother to engage in feminist politics at all?

Perhaps more problematically, these accounts conflate the motivations behind legislation with the effects of this legislation. The existing linear narratives of abortion legislation gloss over the fact that state strategies for managing abortion are not entirely coherent – while we can see the effect or function of abortion laws, discerning the motivations behind them is much trickier. The process by which abortion legislation is made in the United Kingdom challenges accounts of the state as a unitary, strategic actor: abortion legislation does not often originate in the hands of the executive but rather in Private Members Bills and amendments, and MPs are generally allowed a free vote (Marsh and Chambers, 1981). While the executive does have a role to play, the heightened capacity of MPs to influence abortion law makes it difficult to speak of the state as a unitary actor in creating abortion legislation. Moreover, in treating the state as a monolith with clear motives, Sheldon contradicts her use of a Foucauldian analytical framework and focus on the 'governmentalisation' of abortion. As I will argue in more depth in Chapter Three, Foucault does not link biopolitical regulation straightforwardly to state intentions or ambitions, and in fact notes that this form of regulation is often pioneered outside of or on the margins of the state (Rose, 2007: 53).

2.5 The 'state feminism' approach

A rather different view of British abortion politics has arisen from work conducted by the Research Network on Gender and the State (RNGS). RNGS was a long-term comparative research project focusing on the impact of women's movements on the policy process in different countries, and producing several books on different issues, among them Dorothy McBride Stetson's (later Dorothy McBride) collection (2001c). Joni Lovenduski, summarising some of the findings of the project, argues that over the last 30 years, women's movements have been successful in expanding women's political representation, especially when they have forged links with women's policy agencies (WPAs), an alliance described as 'state feminism' (Lovenduski, 2008: 173-4). Other research undertaken by RNGS has focused on the ability of movements to impact the policy process by gendering policy debates; that is, by inserting 'frames' that highlight gender differences (2008: 175). A frame, as defined by McBride Stetson, is 'an explicit expression of why the issue deserves government attention and action' (2001a: 3). Ferree *et al.* provide a more detailed definition of frames as 'thought organizers' (2002: 13) which

> call our attention to certain events and their underlying causes and direct our attention away from others. At the same time, they organize and make coherent an apparently diverse array of symbols, images, and arguments, linking them through an underlying organizing idea that suggests what is at stake on the issue. Framing deals with the *gestalt* or pattern-organizing aspect of meaning (2002: 14).

For the RNGS, an important goal for feminists is to *gender* the frame of policy debates, thus bringing women's interests into the policy-making arena (McBride and Mazur, 2010: 35). Once a debate has been gendered, and the outcome of the debate is consonant with feminist goals, it can be said that the women's movement has been successful (Lovenduski, 2008:

176). The RNGS framework also provides a typology of possible 'state responses' to movement activity:

> *dual response*, where the state accepts women into the process and effects policy which coincides with movement goals; *co-optation*, where the policy-makers bring women participants into the process but do not render policy the movement desires; *pre-emption*, where the state gives policy satisfaction to the movement but does not include women into the policy process on the issue; and finally *no response*, where the movement achieves neither access for women nor policy success (McBride Stetson, 2001a: 12).

The chapters in *Abortion Politics, Women's Movements and the Democratic State* (McBride Stetson, 2001c) apply the RNGS framework to the issue of abortion cross-nationally. Like other RNGS projects, they evaluate how far women's movements and WPAs have been able to 'gender the dominant frames of the policy debates in terms that would improve the status of women' (McBride Stetson, 2001a: 4). The chapter dealing with abortion politics in Britain explores several separate Parliamentary debates. Firstly, it explores two 1970s debates: the 1975 White Bill, which would have restricted the grounds for legal abortion and the freedom of abortion clinics, the equally restrictive 1979 Corrie Bill. Secondly, it examines the 1990 HFE Act, which lowered the time limit for legal abortion from 28 to 24 weeks' gestation. The HFE Act was not originally intended to deal with abortion, but ended up incorporating debates over 'late' abortion instigated by the Alton Bill of the late 1980s (McBride Stetson, 2001b).

WPAs were not heavily involved in the latter two debates. Nonetheless, women MPs were highly active, and McBride Stetson finds that feminists were consistently successful in achieving their goals with respect to abortion policy. The White and Corrie Bills failed, and while the HFE Act did technically lower the time limit, this outcome was generally regarded

as a success for the pro-choice movement: many exceptions were secured for women who needed later abortions, a potential lowering of the time limit to 18 weeks was avoided, and in any case a limit of 24 weeks was already considered to have been achieved in clinical practice (Hohmeyer, 1995: 42). Moreover, by 1990 the women's movements' issue frame – that abortion is primarily a matter of women's rights – had been successfully established in policy debates. McBride Stetson asserts that in each debate, movements secured a 'dual response' from the state, meaning both that women were included in the policy process, and that policy outcomes were in line with movement goals. She concludes that 'policy makers have reached a resolution of the conflict over the abortion law' (McBride Stetson, 2001b: 155).

Viewed through a 'state feminism' lens, British abortion politics looks very different from the gloomy picture painted by analyses rooted in the medicalisation critique. In McBride Stetson's account, feminists are active in defending and even in creating the law, as evidenced by analysis of parliamentary debates and the activities of women's policy agencies and women's movements. 'The state' does not appear as a monolithic entity with a top-down approach to policy-making, driven by an underlying aim of controlling women. Rather, women and feminists are active participants in the creation of regulations and policy.

This difference can be explained by RNGS's debt to various authors who have pointed to the need to '[deconstruct] the monolithic state' (McBride and Mazur, 2010: 7-8), among them 'new institutionalists' such as James March and Johan Olsen (1984; 1989) along with a host of feminist theorists who have noted the complexity of 'the state', notably Judith Allen (1990), Rosemary Pringle and Sophie Watson (1992) and Suzanne Franzway, Dianne Court and Raewyn Connell. (1989). These theorists have argued against attempts, such as Catharine MacKinnon's, to describe the state as essentially 'male in the feminist sense' (MacKinnon,

1989: 161), enforcing male dominance through law. Franzway *et al*. (1989), point out, firstly, that women's struggles *have* been historically significant. Law-making and legal procedures have been subject to some feminist influence, even if this has not been widespread. Secondly, the norm of legal objectivity has actually been used to advance women's interests in areas such as civil liberties and anti-discrimination laws. MacKinnon's theory cannot explain why this should be so, as she equates objectivity solely with male dominance (Franzway *et al*. 1989: 30).

Further, Allen (1990) uses the history of abortion in Australia to demonstrate the dangers of making general pronouncements about the state. The Australian history of abortion, she argues, is marked by a series of tensions between different arms of the state and between non-state actors. In 1903, a Royal Commission blamed women for causing Australia's 'population crisis', as more than a quarter of all pregnancies were being terminated. The law, as in the US and UK decades later, was becoming unenforceable. Despite the Commission's findings, policing of abortion remained rare. From the 1950s, abortion services were increasingly medicalised. However, by this time, abortion provision was also subject to intervention by the police, who extorted money from doctors and threatened them with arrest if they did not pay a certain amount each week. Because of this, prices for medical abortion rose far too high for many women, and a back-street market emerged, undercutting medical abortionists' fees. After several doctors were arrested – in an attempt to dispel talk about police corruption – a legal ruling secured the right of doctors to perform abortions in certain circumstances. Subsequently, prices fell to less than half that of abortions performed a decade earlier (1990: 31-2).

As Allen observes, it is difficult to explain this history with reference to some underlying state essence or agenda. Rather, it seems to generate tensions – between the Royal Commission, the police, doctors, and women seeking abortions – which have only partial resolution.

> 'The state' could be represented as a site of conflict, a contradictory – not to say, a *very* contradictory unity, beset by the law of uneven development – some parts saturated in pro-natalism and foetocentrism; others addicted to the bureaucratic rationality of the newly professionalized men of medicine; others functioning pragmatically as profitable enterprises; still others committed to the liberal virtues of the modern, small, consumption-oriented child-centred family (1990: 33).

Being steeped in such literature, the RNGS approach to abortion politics is more conceptually refined than the medicalisation critique in terms of how it handles the state, allowing for the possibility that feminists might influence policy-making. Subsequently, it chimes with recent feminist research which has suggested that the presence of women in legislatures does potentially make a difference, at least in policy areas concerning women *qua* women (e.g. Childs, 2002; Lovenduski and Norris, 2003; Campbell *et al.*, 2010). Nonetheless, this more celebratory account of feminist engagements with the state has its own oversights.

As I have noted, McBride describes the conflict over British abortion law as 'resolved'. With the benefit of hindsight, it seems unlikely that such a resolution was ever truly reached: the Dorries and Field amendment, 'sex-selection' scandal and raids on abortion clinics demonstrate that abortion is once again a hot topic in the UK. More problematically, however, the RNGS approach leaves certain events of the 1980s and 1990s unexplained. McBride Stetson notes, briefly, that UK women's movements were not successful in achieving their long-term goal of reforming abortion law to reduce medical power over abortions (2001b: 154); medicalised abortion law persists to this day in spite of feminist critique. Feminist

legislators have in fact made several attempts to loosen medical control over abortion. In the early 1980s, pro-choice MP Jo Richardson (Labour) asked leave to introduce a bill to improve the availability of NHS terminations, but the motion was defeated by 215 votes to 139. More recent attempts by both Labour and Conservative women to allow self-referral for abortions up to 12 weeks' gestation were either defeated or never put to the vote (Sheldon, 1997: 114), and similar amendments to the 2008 HFE Act were guillotined from the debate. Yet the implications of this for research into 'state feminism' are not considered; indeed, any consideration of medicalisation's effects on women is missing from the RNGS analysis.

The plight of these attempts at reform gives a somewhat different picture of the success of state feminism. According to the RNGS's typology of outcomes, the 'state response' to these motions is more along the lines of a *co-optation* – women (among them self-identified feminists) were involved in the policy process but did not achieve the policy outcome desired by the women's movements. Indeed, if women's movements and MPs have been successful in establishing the framing of abortion as primarily 'about' women's rights, it is hard to say why there has not been more Parliamentary support for further reform. Other approaches to frame analysis may help explain this oversight.

Myra Marx Ferree's nuanced analysis of framing in abortion debates (Ferree *et al.*, 2002; Ferree, 2003) recognises that women's movements are situated relative to certain political and cultural climates, and that there may be more than one 'feminist' way of framing abortion as a policy issue. Ferree stresses that frames operate within cultural and discursive contexts. Some frames are structurally disadvantaged while others are more culturally resonant and more likely to achieve prominence in public debate on an issue (2003: 305). Ferree *et al.* (2002) demonstrate this through a comparative analysis of public debate on abortion in Germany and the US, arguing that different frames are more prominent in each country due to the cultural

backdrop of political debate: the US tendency to distrust the state as opposed to Germans' more positive view of the state as a caring and protecting 'father' (2002: 66), but also differences in the self-interpretations of the women's movements in each country. To many US feminists, liberal conceptions of equal rights are central to feminism, whereas German feminists have historically been more likely to reject 'rights' discourse as bourgeois (2002: 72-3).

Set against this backdrop, it is not difficult to explain why abortion is generally discussed more in terms of the relationship between the individual and the state in the US and more in terms of foetal life in Germany, or why pro-choice speakers most often frame support for liberal abortion laws in terms of gender-neutral individual freedom in the US and in terms of gendered 'women's self-determination' in Germany (Ferree *et al.,* 2002: 114-118). Nonetheless, Ferree stresses that the strategies employed by the pro-choice movement should not be reduced to attempts at cultural resonance. The most resonant frames are also those which are most easily co-opted into the dominant discourse, and many movement actors seek long-term change to this dominant discourse rather than short-term political gain such as the defeat of a particular anti-abortion bill. This is why radical[1] frames can be attractive to movement actors even though they are by definition non-resonant (2003: 305). The lesson to take from Ferree's analysis is that there is almost certainly more than one 'feminist' frame operating in abortion policy debates. Movement framing is likely to change in order to resonate with changing political climates and goals, and some ideas may be structurally disadvantaged from the start.

[1] Ferree states that 'radical' frames are those which are 'less defensible in [a particular] discursive context, but whose success implies more fundamental change' (Ferree, 2003: 306). As I will discuss in Chapter Three, I would go further and define a radical political demand as one which contests a fundamental norm of a regime or practice (Glynos and Howarth, 2007: 115) or draws attention to its contingency (Dean, 2008; 2010).

The project of McBride Stetson and RNGS, in contrast, assumes a relatively undifferentiated and discrete feminism which can simply be 'inserted' into policy debates. In order for RNGS projects to deem a frame 'feminist', it must 'identify with women; be explicitly gendered; represent women; improve the status of women; challenge gender hierarchies' (Lovenduski, 2008: 189n1). This framework does posit a distinction between 'Movement State Feminism' and 'Transformative State Feminism' – the former promotes 'ideas, actors, and demands based on gender consciousness, women's solidarity, and the cause of women' while the latter goes further by explicitly recognising patriarchy and gender hierarchies and seeking to overturn them (McBride and Mazur, 2010: 5).

Nonetheless, despite the distinction between MSF and TSF, for RNGS 'feminism' remains relatively undifferentiated. We know that even 'transformative' feminisms are not all alike, differing, for example, in *where* they identify patriarchy, *which* gender hierarchies they emphasise, and *what* their strategy is for doing so. In fairness, all definitions of feminism are contestable and the RNGS project had the difficult task of finding a relatively uncontroversial definition with which to work. However, the lack of sensitivity to context and to variations in feminist strategies means that the RNGS analysis overlooks a key struggle in abortion debates – over whether it is women or doctors who should make the final decision to abort, and what the implications of this struggle might be.

Conclusion

The oversights and problems in the existing literature on British abortion politics offer some pointers for the construction of a new analytical framework. My critique of the medicalisation literature indicates the importance of avoiding an overly pessimistic account and recognising

that there *is* a place for feminism in abortion policy-making – the state is not a monolith. At the same time, however, it would be unwise to abandon the medicalisation critique entirely. The 'state feminism' approach to abortion politics overlooks important feminist discussions which have identified the potential implications of abortion rights to a sexist social order. The opening sections of the chapter identified the significance of abortion for women as a signifier of sexual and reproductive freedom and departure from traditional gender roles.

This is not to suggest the mere existence of abortion as an option resolves all problems concerning women's sexual and reproductive rights. Rich has argued that if abortion is a right, it is only one stepping-stone to free motherhood and needs to be implemented in tandem with a host of other reproductive rights and freedom from exploitation, poverty, rape, and other oppressive conditions (1986: xxiii). Petchesky (1986) has drawn attention to the social conditions in which the choice to abort is made, arguing that reproductive 'choice' cannot be considered in the abstract: a choice made, for example, primarily due to economic worries cannot truly be considered a 'free choice', and the ability to choose to have an abortion may mean little to women faced with the prospect of forced sterilisation. Meanwhile, Kelly Oliver observes that an unintended consequence of 'choice' rhetoric has been the implication that if a woman decides not to abort, she has 'chosen' pregnancy (Oliver, 2010: 768) – an oversimplification of the complex reasons women continue with an unplanned pregnancy. Moreover, abortion has been deployed as a governmental technique for the purpose of bringing women's bodies into line. The potential radical implications of abortion do not preclude the incorporation of abortion into a heterosexist and antifeminist disciplinary framework. In fact, from certain perspectives they seem to necessitate it.

Consequently, the Act and the regulatory system it brought into being could be viewed as operating in a way that mitigates abortion's radical social implications. By refiguring abortion

as a ‘health issue’, the Act not only legitimised medical intervention but reinforced a certain gendered construction of women seeking abortions as incapable of making autonomous decisions about their bodies and lives. It replaced the radical liberation of ‘abortion on demand’ with new techniques for managing women’s bodies, with doctors often justifying abortions *in terms of* motherhood and the family and reemphasising women’s natural role as mothers. In short, the Act worked to de-fuse abortion: instead of signifying the liberated, child-free woman taking control of her own body, abortion came to signify the overburdened mother or frightened ‘girl’ in need of paternal intervention. Medicalisation thus served to restore state legitimacy and quell demands for reform without radically upheaving the gendered social order. This antifeminist refiguring of abortion’s meaning has been overlooked by analyses of ‘state feminism’ and abortion. Yet as I will show in later chapters, it has important consequences for actors in contemporary abortion politics, who must, when articulating demands, somehow incorporate doctors and medicine.

This does not mean that the analyst should assume the existence of a unitary state actor with clear and coherent motivations in creating abortion law – Allen’s incisive analysis of Australian abortion regulation demonstrates the folly of this. In fact, Allen argues that a ‘theory of the state’ is not useful to feminism – ‘the state’, if it can be said to exist, is too contradictory an entity to be labelled the ‘cause’ of the oppression of women (1990: 33). However, while I would certainly agree that there is tension between different ‘arms’ of the state, I am wary of attempts, such as Allen’s, to depict it as entirely fragmented. Many feminist theorists have rejected conceptions of the state as unitary or as essentially patriarchal without abandoning it as an object of investigation. As O’Connor, Orloff and Shaver point out in response to Allen, ‘the state has not lost its centrality in institutionally fixing and resourcing particular discursive categories’ (1999: 11). While there may be tensions between

the activities of different branches of the state – and differences in how they impact on differently-situated women – it is still possible to observe 'social policy regimes' which fix patterns across a variety of policy areas (1999: 12). O'Connor *et al.* draw upon the work of Connell (1994), who sees the state as *gendered* – not inherently, as some feminists imply, but as a result of historical developments. The 'gender' of the state is only partially crystallised, and amenable to change.

The 'state' does exert its own distinct pressure on those who try to engage with it. Moreover, state rationalities – or, as O'Connor *et al.* put it, 'policy regimes' – of a sort (i.e. pro-natalism and 'bureaucratic rationality') can be observed in the middle of the tensions outlined by Allen. As I will argue in the next chapter, even if the operations of 'the state' are riddled with contradiction, there are also constant efforts to smooth over tensions and strengthen bonds between different state projects. The challenge, then, is to present a suitably complex account of the state's operations while maintaining awareness of history and of the (partial) fixity of policy regimes. Chapter Three puts forward a solution which draws upon the Foucauldian concept of governmentality, Nikolas Rose's account of governmental rationalities, and the discourse analysis of Laclau and Mouffe.

CHAPTER THREE. GOVERNMENTALITY AND FEMINIST POLITICS

Introduction

Chapter Two argued for the need to somehow theorise the state without resorting to essentialist statements about its nature. This chapter argues that the concept of governmentality, along with others taken from discourse theory, can help us make sense of 'the state', helping us navigate the fragmentation and dispersal identified in the previous chapter. This dispersal means that feminist actors may well have a role to play in policy regimes and are not automatically either excluded or co-opted. However, this chapter also asserts that the analysts must ask what involvement in policy regimes might mean for feminism itself, as some analyses of feminist engagement with the state suggest that it can result in the loss or exclusion of certain discourses and practices. Accordingly, the chapter sets out an analytical framework which can account for both the complexities of the contemporary state and those of contemporary feminist politics, and introduces some important terminology which will be used in later chapters.

Section 3.1 introduces the concept of governmentality as a way of overcoming the shortcomings of existing literature on British abortion regulation. Chapter Two argued that medicalisation should not be seen as an inexorable process involving the collaboration of the state and medical profession (whose interests are assumed to be automatically aligned) – but also that the persistence of the medicalised abortion regime in the face of feminist opposition needs to be explained. A governmentality framework is of use here as it does not assume that the interests of actors such as the medical profession are pre-given, but does allow for distinct regimes and rationalities to be identified amidst fragmentation. This section also introduces

the work of Nikolas Rose, in particular the concept of translation, which describes the process by which relations amongst subjects are established 'such that the problems of one and those of another seem intrinsically linked in their basis and their solution' (Rose and Miller, 1992: 184). As Chapter Four demonstrates, translation is of central importance in analysing the relation between the state and the medical profession established by the 1967 Abortion Act. The concepts of governmentality and translation are rooted in discourse theory, so some explanation of discourse is necessary. Section 3.2 further elaborates some of the theoretical assumptions of the research and how these pertain to my understanding of discourse, introducing the work of Laclau and Mouffe, Glynos and Howarth, and discussing Foucault in more depth.

These discussions further emphasise my point that the creation of abortion legislation need not necessarily exclude feminist ideas, as governance is dispersed and policy regimes do not have any necessary 'male' identity. However, Section 3.3 cautions that governmental feminisms are not therefore unproblematic: feminist strategies and practices tend to change according to context and opportunity structure, and sometimes these changes are worth critiquing. This is further demonstrated in a discussion of various works on feminist movements and the state. These have all, in different ways, demonstrated some of the costs which may be incurred by activist engagement with the state or incorporation into governmental regimes. As Section 3.4 shows, a further reason to be cautious is the risk that elements of feminist argument may be (mis)appropriated by forces which may be normatively suspect from a feminist perspective, such as neoliberalism and neo-imperialism, but also anti-abortion activism.

The final sections put together an analytical framework capable of taking these difficulties into account. Section 3.5 introduces Jonathan Dean's (2010) work on feminist radicalism and argues that Dean's reworking of the concept of radicalism can aid analysis of the diversity of feminist strategies, allowing the extent to which they challenge prevailing norms and practices to be evaluated. Section 3.6 introduces the 'logics of critical explanation' (Glynos and Howarth, 2007), which assist in characterising the assumptions underpinning governmental regimes and in accounting for the inertia or 'grip' of these regimes – undertheorised in Dean. Dean's radicalism along with Glynos and Howarth's logics form the backbone of the analytical approach applied in the following chapters. Finally, Section 3.7 discusses the institutionalist approaches which are becoming influential in feminist political science, drawing parallels between feminist institutionalism and the approach applied here.

3.1 From 'the state' to governmentality

If there is no 'essential' state, what can we say about the state? As Chapter Two argued, denying that the state has an essence does not have to mean accepting complete fragmentation – the state's 'gender' is still *partially* crystallised, and distinct regimes and rationalities can be observed amidst fragmentation. From Michel Foucault onwards, the literature on governmentality provides a way of conceptualising contemporary politics without resorting to pronouncements about an 'essentially male' state. As such authors have noted, while '[it] is in fact vain to look for the hand of the state everywhere pulling the strings of micro-disciplinary power' (Gordon, 1991: 27), power and control can be observed even at the micro-levels of society.

The term ‘governmentality’ denotes a form of governance involving a complex network of institutions and apparatuses and entailing a need to forge connections between state and non-state institutions (Rose and Miller, 1992: 176). Studies of governmentality share some features with the medicalisation critique: both depict the ongoing encroachment of disciplinary mechanisms into all aspects of life. However, Rose argues, these developments

> are not best understood in terms of a relentless augmentation of the powers of a centralizing, controlling and regulating state. The thesis, inspired by Jürgen Habermas, that ‘the state’ has increasingly colonized ‘the lifeworld’ is misleading, not least because the very nature and meaning of state and lifeworld were transformed in this process (Rose, 1999: 18).

For Foucault, the expansion of disciplinary mechanisms cannot be put down to the ‘*étatisation* of society’. The state is in fact ‘no more than a composite reality and a mythicised abstraction, whose importance is a lot more limited than many of us think’ (Foucault, 1991: 103). He details how the notion of the primacy of the state was challenged as long ago as the sixteenth century by critics of Machiavelli’s *The Prince*. For Machiavelli, the objective of the exercise of power lay in strengthening the principality, taken to mean ‘not the objective ensemble of its subjects and territory, but rather the prince’s relation with what he owns, with the territory he has inherited or acquired, and with his subjects’ (Foucault, 1991: 90). Put simply, the art of government was about protecting the fragile link between governor and governed from external and internal threats. For the anti-Machiavellian literature, however, the art of government was more than this. The prince, critics argued, was not unique in his principality: practices of government were employed by many kinds of people, for example, teachers, heads of family, and so on. There was, then, a multiplicity of forms of government, of which the prince’s relation to the state was only one mode (1991: 91).

The art of government thus meant the establishment of continuities between the power of the prince and other forms of power. To encapsulate this tendency, Foucault introduced the term 'governmentality', by which he meant three things: firstly, the ensemble of institutions, networks and practices making up this form of power; secondly, the tendency which has led to the pre-eminence of this type of power over other forms; and thirdly, the process by which the state becomes 'governmentalised' (1991: 102-3). For contemporary analysts, the *dispersal* of governance among a combination of institutions, knowledges and disciplinary practices is one of the chief characteristics of governmentality (Rabinow and Rose, 2006: 199-200). Wendy Brown detects four key features. Firstly, governmentality harnesses human needs and capacities that might otherwise be unproductive, fashioning and integrating subjects instead of explicitly coercing them. Secondly, it has a vast range of points of operation and application, including individuals, populations, and body parts. Thirdly, it works through a wide range of social powers which are often not politically accountable (such as, in the case of abortion regulation, the medical profession). Finally, it 'employs and infiltrates' ostensibly non-political discourse (Brown, 2006: 73-4).

These institutions and practices do penetrate deeply into the lives of citizens. However, the strategies and networks employed are highly complex:

> These links between the political apparatus and the activities of governing are less stable and durable than often suggested: they are tenuous, reversible, heterogeneous, dependent upon a range of 'relatively autonomous' knowledges, knowledgeable persons and technical possibilities (Rose, 1999: 18).

In other words, any alliance formed between the state and feminists (and indeed, the state and the medical profession) is fragile and subject to change. State strategies and rationalities should not always be expected to be internally coherent: indeed, often governments attempt to

construct ethical bases for their actions simply due to a need for some kind of 'intellectual technology' to aid in figuring out what to do next (Rose, 1999: 27-8). Hence, this kind of governance is dispersed and contradictory.

Foucault nonetheless often conceptualised governmental practices in terms of social control and 'discipline' (e.g. Foucault, 1977). Rose (1999) sees things somewhat differently. His thesis is that, in the English-speaking world at least, we have moved away from the 'disciplinary' society towards a society where *freedom* has become the organising principle of government. However, this 'freeing' of social life has been accompanied by the development of new, though often non-coercive, ways of shaping and managing conduct. This has involved forming alignments (which, as outlined above, are fragile and require work) between the objectives of government authorities and the personal projects of their subjects (1999: 48; see also Foucault, 1982). It has also involved establishing certain relations *amongst* subjects 'such that the problems of one and those of another seem intrinsically linked in their basis and their solution' (Rose and Miller, 1992: 184) – for example, the relations established between producers and shopkeepers, or doctors and patients. Rose calls this *translation* (1999: 48). Unlike disciplinary power, it does not (usually) involve the coercion of subjects – rather, it changes the structures[1] within which subjects are able to enact their freedom.

The concepts of governmentality and translation are useful in that they allow us to talk in a meaningful way about the programmes of government, even while rejecting the conception of the state as a unitary actor. While 'the state' may not have coherent interests or intents, it is still possible to identify distinct rationalities in the activities of government. Moreover, the concept of translation implies that the interests of agents in governmental networks do not

[1] This structural change is not achieved independently of the subjects themselves – rather, subjects are complicit in effecting this kind of change. The concept of translation therefore relies upon a certain conception of agency, which is explored in more detail later in the chapter.

pre-exist political activity – they are established and linked together through processes of negotiation. This suggests that translation is fundamentally a discursive activity. While Rose accords language a central role, arguing that it is constitutive of government, he only offers a brief commentary on its nature (1999: 28-31). He does nonetheless state that his analysis is not primarily concerned with uncovering the 'true' meaning of texts. Rather, it is concerned with identifying the 'intelligibility' (1999: 28) or 'regimes of truth' (1999: 29) which make the production of knowledge – and thereby the activities of government – possible:

> the exercise of government has become enmeshed with regimes of truth concerning the objects, processes and persons governed – economy, society, morality, psychology, pathology. Government has both fostered and depended upon the vocation of 'experts of truth' and the functioning of their concepts of normality and pathology, danger and risk, social order and social control, and the judgments and devices which such concepts have inhabited (1999: 30).

It should be noted that these regimes are not closed systems, and that any 'historical epistemology' attempting to identify them should not assume 'a somewhat calm and peaceful succession of bodies of knowledge' (1999: 29). The terrain of discourse is characterised by 'conflicts over who can speak, according to what criteria of truth, from what places, authorized in what ways' (1999: 29). Nonetheless, the concept of a regime seems to imply a discernible programme of government whose meaning is at least *partially* fixed. To explain what this means it is necessary to explore the concept of discourse in more detail.

3.2 Discourse, articulation and the state

Rose's debt to Foucault's account of discourse is clear. In *The History of Sexuality*, Foucault stresses the importance of recognising the 'tactical polyvalence of discourses' (1981: 100). Discourse, he argues, should not be simplistically imagined as divided between categories of

> accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies … We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy. (1981: 100-1)

Crucially, 'discourse' here does not simply mean a system of ideas or false consciousness. Rather, a discourse is 'an organic and relational whole, embodied in institutions and apparatuses, which welds together a historical bloc around a number of basic articulatory principles' (Laclau and Mouffe, 2001: 67). Crucially, discursive structures have a material character: a differential position within a discourse is not merely the *idea* of an object, but the object itself (2001: 108).

Foucault's scepticism concerning the divisions accepted/excluded and dominant/dominated does, however, make conceptualising governance and contestation tricky. The very notion of contestation implies the dominance of some knowledges over others. If discourse is characterised by multiplicity and dispersion, how is one to identify 'regimes of truth' which exclude certain knowledges and thus determine which political demands will be seen as legitimate? The previous chapter has suggested the need to retain some sense of the fixity of structures in theorising the state. Indeed, discursive fixity, however partial, is indispensable if we are to make sense of anything at all: 'The impossibility of an ultimate fixity of meaning

implies that there have to be partial fixations – otherwise, the very flow of differences would be impossible' (Laclau and Mouffe, 2001 [1985]: 112).

Foucault does, however, assume a partial fixity of meaning. As Bent Flyvbjerg (2001) has pointed out, his emphasis on multiplicity does not mean that 'anything goes': Foucault is a contextualist who sees discursive strategies as *situated*. As Flyvbjerg summarises: 'the present effectively limits the possible preferences; humans cannot think or do just anything at any time' (2001: 99-100). This perspective underpins Foucault's attempts to construct a genealogy or 'history of the present' in order to explain power relations. It is important to Foucault that history not be construed as the search for the origin or essence of an object: the genealogist will find 'not a timeless and essential secret, but the secret that they [things] have no essence or that their essence was fabricated in a piecemeal fashion from alien forms' (Foucault, 1984: 78). Similarly, history should not be envisaged as a linear unfolding of interrelated events. Foucault employs the concept of *heritage* (rather than that of *origin*) to differentiate his approach to historical analysis from that of the conventional historian. While the past is important, it has not imposed a predetermined form on the present. The task of the genealogist is not to uncover an unbroken continuity from the past to the present, but to identify 'the accidents, the minute deviations – the errors, the false appraisals, and the faulty calculations that gave birth to those things that continue to exist and have value for us' (1984: 81).

It follows that the fixity (or, to Foucault, *regularity*) of the present – the way it limits human thought and action – is not an effect of the essential nature of the state or any other structure but is *imposed* upon things through discourse. Discourse must be conceived as 'a violence that we do to things, or, at all events … a practice we impose on them; it is in this practice that the events of discourse find their regularity' (Foucault, 1971: 22). It is therefore both a discontinuous activity and a means of imposing order on the world. This tension between

fixity and contingency is never fully resolved by Foucault, however. His genealogical analyses are generally too sweeping to focus on isolated moments of contingency and struggle in much depth, tending to focus instead on broad historical epochs (e.g. Foucault, 1977; 1981; 2001 [1967]). As such he is unable to give a detailed account of how change occurs. Critics of Foucauldian accounts have argued that in spite of a theoretical emphasis on discontinuity, in practice they offer little room for human agency, sometimes depicting agents as helplessly caught in webs of discourse (Lupton, 1997; Bevir and Rhodes, 2005).

This is the thrust of Mark Bevir and Rod Rhodes' interpretivist critique of post-structuralism. They argue that many post-structuralists hold the view 'that meanings exist as quasi-structures governed by a semiotic code or random fluctuations of power' (2005: 172), causing them to reject the notion of individual autonomy from discourse. In contrast, while Bevir and Rhodes acknowledge that individuals always operate against a discursive background and are therefore not autonomous, they argue that this is not a valid reason to wholly reject the concept of agency:

> We can accept that people always start with a discourse or tradition and still see them as agents who can act and reason in novel ways to vary this background. Proponents of an interpretive approach have no reason to throw agency out with autonomy. When they defend a capacity for agency, however, they might recognise that it always occurs in a social context that influences it. Agency is not autonomous – it is situated (2005: 172).

The concept of 'situated agency' allows Bevir and Rhodes to mediate between structural fixity and contingency. Actors always inherit beliefs and traditions and are enmeshed in discourse but are capable of reflecting upon these traditions and concepts, and of rejecting, modifying or developing them. Hence, for Bevir and Rhodes, actors' self-interpretations should be central to social science. Meanings and beliefs are constitutive of actions, rather

than differentiable from them. Moreover, social practices are radically contingent[1], as actors may interpret situations in a number of different ways. Political science, it follows, should be about *interpreting interpretations* rather than simply analysing institutions and structures, as focusing solely on institutional constraints obscures agency and the potential for change. (2005: 171-2).

Bevir and Rhodes' approach, while valuable in that it demonstrates the centrality of agency to political life, does not by itself lead to the construction of adequate accounts of inertia, change and contestation. As Jason Glynos and David Howarth remark, the argument that agents have the capacity to change or reject any aspect of a tradition raises the question of why some aspects of a tradition might be more appealing than others, or more likely to resist change (2007: 77-8; 2008: 161). Answering this question is surely important to any satisfactory account of political contestation, and is certainly essential to accounts of 'state'/governmental feminist activity which wish to do more than evaluate the success of the 'insertion' of feminism into public debate. Let us briefly revisit the earlier assertion that McBride Stetson's account of state feminism cannot explain why, given the apparent success of the women's movement in establishing a feminist frame in parliamentary debates on abortion, it has nonetheless been unsuccessful in achieving reform (see Chapter Two Section 2.5). To tackle this problem, the 'grip' of the existing regime needs to be accounted for. Yet 'situated agency', as it does not offer a rubric for categorising and analysing the content of traditions and beliefs, is of little help here.

Glynos and Howarth argue that 'an ontology which foregrounds the radical negativity and contingency of structure itself' (2007: 78) is of more use when thinking about the relationship

[1] *Radical* contingency differs from *empirical* contingency in that the former points to the 'undecidable' or 'incomplete' nature of structures, whereas the latter implies the possibility that something which initially appears contingent may yet be subsumed under a higher-order process (Glynos and Howarth, 2008: 109-10).

between subject and structure. Their ideas concerning social science explanation more generally are highly important to my approach, and will be discussed further in Section 3.6. However, it is to the 'contingency of structure' which I now turn. Glynos and Howarth adopt their view of structure from the work of Laclau and Mouffe (2001 [1985]). Laclau and Mouffe's work is a significant attempt to deal with the structure-agency problematic. They follow Foucault in viewing structures as *imposed* on the world through discourse. Structures, furthermore, cannot be separated from the practices which constitute them. Practices establishing relations among elements, thereby partially fixing meaning, they call *articulations* (2001: 105). As for Bevir and Rhodes, practices are radically contingent.

Laclau and Mouffe's full terminology, which I adopt, is as follows:

> we will call *articulation* any practice establishing a relation among elements such that their identity is modified as a result of the articulatory practice. The structured totality resulting from the articulatory practice, we will call *discourse*. The differential positions, insofar as they appear articulated within a discourse, we will call *moments*. By contrast, we will call *element* any difference that is not discursively articulated (2001: 105).

Articulation, then, bears more than a passing resemblance to what Rose calls translation. Each is a practice which establishes certain relations between elements or subjects, altering their identities in the process – indeed, the most pertinent difference seems to be that Rose is explicitly referring to the activities of government, and the subjects enmeshed in governmental networks.

Crucially, the structured totality which emerges from articulation is *never* closed. This is due to what Derrida (1978) terms 'structural indecidability' and Glynos and Howarth call 'the irreducible presence of negativity' (2007: 105): even when social structures crystallise to the

extent that they provide actors with a set of 'rules' to follow, these rules can never capture all of their instantiations:

> To put it in more concrete terms, when we encounter a moment of ambiguity in rule-following – what do I do now? – or when we seek to render an alien set of practices intelligible – why are they doing what they do? – we can only offer up our best interpretation of the situation (Glynos and Howarth, 2007: 67; see also Wittgenstein, 1967).

When structures break down and rules become ambiguous (termed *dislocation*), the incompletely sutured nature of social structures may become visible, enabling new possibilities and allowing subjects to identify differently – occasionally, in fact, provoking subjects to challenge existing regimes (Glynos and Howarth, 2007: 105). While the practice of articulation does not produce a closed totality, however, it does generate 'totalising effects' (Mouffe, 1995: 318) which limit the discursive field without completely dominating it. What this means is that it is impossible to identify a single principle or mechanism underlying subordination, as MacKinnon, for example, attempts to do with her theorisation of the 'male' state. However, structures are *partially* fixed, allowing for the existence of systematic effects of subordination producing concrete effects in social practice (Laclau and Mouffe, 2001: 117-8).

This brings us back to the question of 'the state' and governmentality. The above discussion implies that 'state' structures must be partially fixed even if the state has no *necessary* form. However, Foucault avoided attempting to construct a general theory of the state, preferring to focus on micro-politics and the dispersal of power instead of the state as an institutional site. This meant that he was able to avoid the pitfalls of general proclamations about the state's 'essence'. However, this depiction of the state as entirely fragmented neglects the organisational factors which make it possible for the state to act effectively (Jessop, 2007: 68)

and ‘discourages any analysis either of systemic axes of domination or of continuities in state practices’ (Brodie, 1997: 227). As Janine Brodie points out, while the state may act in contradictory fashions, it is also possible to discern distinct state forms historically and geographically (1997: 227). ‘The state’ is, then, not an amorphous entity but is partially fixed.

The work of Bob Jessop, who moves between state theory and the structure-agency problematic in his strategic-relational approach (SRA) (Jessop 1996; 2007), is useful in defining what the state *is*. In the SRA, structures (including the state) are not ‘abstract, atemporal and unlocated’ (1996: 126) and only have meaning in the context of actors pursuing specific strategies. Hence, the state is *socially embedded*. Nonetheless, the state can in some senses be distinguished from wider society as ‘it is peculiarly charged with overall responsibility for maintaining the cohesion of the social formation of which it is merely a part’ and it is ‘continually called upon by diverse social forces to resolve society’s problems’ (2007: 7). Accordingly, Jessop offers this preliminary definition of ‘the state’:

> the *core of the state apparatus* can be defined as a distinct ensemble of institutions and organizations whose socially accepted function is to define and enforce collectively binding decisions on a given population in the name of their ‘common interest’ or ‘general will’ (2007: 9; emphasis in original).

However, this definition is not exhaustive: there are other institutions above, around and below the state ‘core’ whose relation to it is uncertain and changeable, and their nature depends on the nature and history of the society in which they are embedded. Crucial, however, is the *socially acknowledged* character – in other words, the legitimacy – of the state’s political functions. This recalls Petchesky’s argument that states intervene in abortion in order to preserve their own legitimacy. However, according to Jessop, the forms legitimacy takes vary and are constituted through discourse: hence the centrality of articulation to the

activities of government and in constituting the state. How 'the state' is constituted discursively is therefore critical in the creation of policy, which is informed by (often contested) ideas about the nature and purpose of government – the 'meso-narratives' (Brodie, 1997) underpinning political practices. The significance of discourses about the state for gender politics has already been highlighted by some feminist theorists, as Section 3.3 illustrates.

3.3 Governmental feminism?

An important implication of the Foucauldian notion of discourse is that feminist discourses, like other discourses, 'are not once and for all subservient to power or raised up against it' (Foucault, 1981: 100-1). In other words, feminist discourses are not necessarily by nature 'against' the *status quo*. If, as posited above, contemporary government is dispersed and operates through a range of social powers, this opens up the possibility for feminism to become a part of governing rationalities. Thus, an important question is, what place has feminism come to occupy within governmental networks, if any? Research into 'state feminism', despite its problems, does demonstrate that feminism has been incorporated into the activities of government to some extent, whether through the activities of women's policy agencies, 'gender mainstreaming' or women legislators (Squires, 2007), and that this incorporation does not amount to a simple co-optation.

Nonetheless, it is important to avoid an overly celebratory account of governmental feminism[1], especially if 'state' bodies and rationalities are at least partially fixed: the 'gender

[1] The label 'state feminism' is somewhat tricky. While the term was originally coined by the Norwegian political scientist Helga Hernes to indicate, broadly, 'feminism from above in the form of gender equality and social policies' (Hernes, 1987: 153), it has more recently come to specifically denote the work of WPAs (see for

selectivities' (Jessop, 2005: 157) of the state may make some feminist strategies easier than others. For this reason, Wendy Brown advises that feminists seeking to expand relationships with the state – especially feminists asking for the state to protect women – do so with caution:

> Whether one is dealing with the state, the Mafia, parents, pimps, police, or husbands, the heavy, dual price of institutionalized protection is always a measure of dependence and agreement to abide by the protector's rules (Brown, 1992: 9)

As Brown argues, state regulation and protection may be better for women than a 'state of nature', but 'such choices feature nowhere a meaningful politics of freedom' (1992: 10).

Research also suggests that feminist ideas may be diluted or fragmented upon entering networks of governance. For example, Childs *et al.* (2013) observe that certain notions – such as the idea that abortion is common, even normal – are missing from recent parliamentary debates on abortion, even in the contributions of feminists. For this reason, it is important to ask how feminist discursive strategies might change according to actors' goals and political opportunity, how 'the movement' decides what it wants, and how feminism links up to a broader discursive and governmental context. The analyst must also avoid the assumption that discourse which centres women will be, by nature, 'against' the *status quo*, or at least progressive. As Karen Celis notes, the demands of feminist movements may be diverse, contradictory and conflicting (2009: 100-1).

My point is not simply that we should recognise diversity for diversity's sake. The content of apparently feminist contributions in legislatures might be shown to be problematic upon

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example Outshoorn, 2004; Lovenduski, 2005; Haussman and Sauer, 2007; Outshoorn and Kantola, 2007; McBride and Mazur, 2010). In light of this, and to reflect the theoretical commitments of the research, I use the term 'governmental feminism' from now on to denote the entrance of feminist discourses and ideas into governmental rationalities.

careful inspection – indeed, some feminist researchers are pessimistic about the claims and strategies of governmental feminism, and for many feminists, whether to integrate with the state or remain autonomous has been something of a dilemma (Randall, 1998: 187-8). This reality is also often overlooked in the British literature. The early focus on statistical representation of women in policy arenas has given way to a focus on 'critical actors' – 'legislators who initiate policy proposals on their own and/or embolden others to take steps to promote policies for women' (Childs and Krook, 2009: 138) – rather than women as an undifferentiated mass. Childs *et al.*'s article (2013), moreover, indicates a fresh focus on discourse and how women alter the terms of political debate, while the RNGS project focused specifically on feminist ideas in the policy process (McBride and Mazur, 2010). However, this research still hopes to identify some sort of mechanism or lever for inserting feminism (or 'women-centred' discourse) into the state and for maintaining its presence once there. What the implications of this might be for feminism – what happens to feminism when it is successfully institutionalised – is undertheorised.

Ferree's (2003) account of resonance and radicalism indicates that compromises may be made when feminists engage with governmental projects. The need to frame movement goals in a way which is culturally resonant results in feminist discourse which is easily appropriated and may not achieve long-term political change. Many assessments of the achievements of 'state' feminism are therefore rather more mixed than those of RNGS. Alexandra Dobrowolsky, for instance, finds political changes resulting from the activity of women MPs and WPAs since the late 1990s to be 'at best modest, at worst worrisome'. Their strategies, she argues, have been highly conventional and have resulted in slow reform, while 'their discursive claims have been, for the most part, limited to promoting an undifferentiated gender identity through increases in women's representation' (2003: 129).

Dobrowolsky is only able to make such claims because she acknowledges a multiplicity of possible feminist strategies and focus closely on the content of discursive claims, rather than assuming an undifferentiated feminism. The importance of focusing on the specificity of movement discourse and how 'the state' is constructed is further reinforced by Johanna Kantola's (2006) discussion of British and Finnish feminisms. Kantola notes that 'the state is present implicitly in feminist struggles for political change that are not explicitly about the state' (2006: 20) and demonstrates that the way in which the state is constructed in feminist discourse has an effect on the kinds of policies produced as a result of feminist public engagement. Finnish feminists, she argues, have historically constructed themselves as state 'insiders', seeing the Finnish state as a vehicle for achieving gender equality and a carer protecting women from outside forces, such as other European countries and their lack of adequate care networks (2006: 50-63). While this approach has served feminists well in the creation of childcare policy, it has had a more detrimental effect in shaping Finnish engagements with the state over domestic violence. First, due to the construction of Finland as a 'woman-friendly welfare state', it was difficult for politicians to accept the widespread existence of domestic violence. Secondly, once the need for domestic violence policy had finally been established, proposed solutions remained state-centric due to the lack of critical discourse about the state, even though autonomous women's refuges in countries such as the UK had been shown to have helped women greatly (2006: 105-8).

However, it is not only the way in which the state is constructed that is at issue here. The interaction of feminist and other apparently counter-hegemonic norms and practices with the activities of government may transform these norms and practices in ways which are not wholly desirable: the way the state has been constructed places certain constraints on movement actors and makes some discursive strategies more feasible than others. For

example, the construction of the state as asexual, identified with the 'public' rather than the 'private' sphere of emotion, sexuality and the body, has meant that lesbian and gay activists must work to justify homosexuality as a legitimate public topic (Cooper, 1995). Lesbian and gay rights groups have responded by advocating for a safe private space of sexual freedom, identifying homosexuality as a matter of privacy. While this way of framing sexuality has had considerable success, it has made it difficult to demand that state bodies positively support gay rights through education, adoption provision and community funding. Furthermore, '[b]ecause proactively heterosexual strategies are naturalized into invisibility, it is lesbian and gay forces who remain vulnerable to claims that they are trying to push into the public realm unacceptable sexual practices' (Cooper, 1995: 68-9).

'Femocrats' and women's policy agencies have certainly been active in transforming feminist practices into a 'resonant' format. As Squires observes, the strategies adopted by these actors tend to render feminist practices compatible with broader policy objectives, and in particular with neoliberal policy commitments (2007: 2; 2008: 195). 'State' feminism has become increasingly technocratic, involving the formation of professionalised networks of gender experts. These networks work with a conception of representation which tends to be statistical and utilitarian, relegating more participatory approaches, and marginalise 'those whose knowledge is not readily amenable to objectification, driving a wedge between those perceived to be making special interest claims and those capable of transcending their own narrow concerns to make objective judgments' (Squires, 2008: 199). This is a good example of translation in action, bringing the 'solutions' required by feminists in line with wider policy regimes. The 'solutions' put forward may construct gender relations in different ways: 'different understandings of gender are attached to different reform approaches' (Eveline and Bacchi, 2005: 497)

Thus, governmental feminisms risk the exclusion of particular discourses, and may themselves be problematic. Feminism has been ambiguous in what it requires from the state: does it need the state to foster respect for women's personhood, or does it need the state to protect women from men, thus generating what Anna Yeatman terms a 'paternalistic-patriarchal' state (1997: 145)? As later chapters demonstrate, this ambiguity is rife in abortion debates, as participants persist in calling for a paternalistic form of state involvement in abortion provision. The discursive strategies employed by governmental feminisms have implications not only for the eventual policies produced, but also for the kinds of issues on which feminists are able to take effective action. This is somewhat troubling as it suggests that the more 'radical' frames, which seek to effect long-term change, may be increasingly shut out of feminist discourse as it becomes more institutionalised and resonant with the mainstream. Close feminist engagement with the state may paradoxically, therefore, result in it becoming difficult for certain feminist demands to receive a public airing. This is not to argue that feminists should not attempt to engage with the state, but simply to point out that the danger of a 'watering-down' of feminism is more pressing than commonly assumed in the recent literature. This process should not be reduced to a mere 'co-option' of feminism – as Franzway *et al.* point out, 'notions of simple co-option and incorporation assume that the process is unproblematic for the state. The argument grants such omnipotence to the state that everything is grist to its mill' (1989: 148). Those 'co-opted' are not completely passive, and attempts to incorporate them often mean concessions must be made. Hence, a fundamental question for research on feminism and the state to ask is how feminism has been 'assimilated' in political debates and to what extent it still challenges prevailing discourses.

3.4 Appropriation of feminism

A final risk incurred by feminisms which achieve cultural resonance is that of appropriation. As Ferree observes, resonant frames are the most easily co-opted into the dominant discourse (2003: 305). This alerts us to the possibility that elements of feminist rhetoric and reasoning may be adopted and adapted by forces antithetical to feminism. This certainly seems to be the case with governmental feminism; for example, Davina Cooper notes that where feminist discourse is incorporated by one government body, this may be challenged or undermined by the activities of others, for example in the use of apparently feminist anti-pornography judgments to disproportionately restrict access to lesbian and gay pornographic texts (1995: 71). Others have noticed similar trends elsewhere. As later chapters will demonstrate, their analyses are highly pertinent to the study of abortion politics.

The appropriation of elements of feminist rhetoric has been observed by Angela McRobbie in a critique of the politics of New Labour. McRobbie argues that the 'Third Way' involved a simultaneous borrowing from and erasure of feminism: New Labour attempted to distance itself from feminism, due to its association with the 'old' left, but could not maintain this distance, in part because 'feminism now occupies the peculiar position of being seemingly universally disliked, while at the same time it has crept into the realm of popular common sense' (McRobbie, 2000: 99). Accordingly, Anthony Giddens, one of the principle architects of the Third Way, espoused a kind of 'sexual politics without the "f" word' (McRobbie, 2000: 103), involving sexual equality and a more active role for fathers in the care of children, without acknowledging the impact of feminist theorising in this area. Similarly, Ulrich Beck, another key Third Way theorist, praised women's increased labour market participation – but attributed this to individualisation, not feminism (2000: 105). Meanwhile, New Labour's cuts

in spending and privatisation of social insurance made the kind of 'democratic family' theoretically espoused by these authors more difficult to achieve in practice.

Other (mis)uses of feminism have been observed by Hester Eisenstein and Nancy Fraser, who argue that feminism has unwittingly aided the development of neoliberal globalisation. Noting the simultaneous rise of neoliberalism and second wave feminism, Eisenstein observes that the latter acted as a 'cultural solvent' (2005: 487) to the latter, eroding traditional structures of authority. Liberation from the traditional roles of child-rearing and housekeeping came to signify the right to participate in the labour market and, Eisenstein asserts, this was capitalised on by corporations. Fraser, meanwhile, argues that narratives of female advancement and gender justice have been used to invest neoliberalism with morality:

> Endowing their daily struggles with an ethical meaning, the feminist romance attracts women at both ends of the social spectrum: at one end, the female cadres of the professional middle classes, determined to crack the glass ceiling; at the other end, the female temps, part-timers, low-wage service employees, domestics, sex workers, migrants, EPZ [export processing zone] workers and microcredit borrowers, seeking not only income and security, but also dignity, self-betterment and liberation from traditional authority. At both ends, the dream of women's emancipation is harnessed to the engine of capitalist accumulation (2009: 110-1).

These observations indicate how easily a feminist pro-choice ethos may be appropriated, especially since, as I argued in Chapter Two, liberal abortion laws have come to signify women's participation in the labour market. Yet elements of feminist reasoning have not only been appropriated in the interests of neoliberal capital, and while the authors discussed above focus on the later 1990s and 2000s, appropriation of feminist rhetoric was occurring long before this. Indeed, feminist arguments and ideas have long been used to support an anti-abortion position. Pro-life activists in the United States have endeavoured to use women's

history to this end, attempting to decouple the issues of abortion and women's rights by appealing to historical feminist leaders they allege to have opposed abortion, and thereby suggesting that liberal abortion laws are not in fact in women's best interests (Thomas, 2012).

Thomas convincingly demonstrates that this use of history is inaccurate and misleading. However, similar arguments have already been observed in the UK. Deborah Steinberg (1991) notes that supporters of the restrictive 1988 Alton Bill frequently engaged the language of rights, in particular reproductive rights, when making their arguments. Most notably, Alton and his supporters constructed women as victims of an exploitative medical practice and of male power and irresponsibility. While Steinberg's analysis implies that this was a new development, following chapters will show that attempts to decouple abortion from women's rights have been a feature of parliamentary debates on abortion ever since feminism entered the parliamentary arena.

3.5 Theorising radicalism

The realities of feminist translation into 'government-friendly' formats and appropriation of feminist rhetoric by antithetical forces require an analytical framework which can accommodate such complexities, without thereby assuming that feminism is simply co-opted upon entering the governmental arena. Jonathan Dean's *Rethinking Contemporary Feminist Politics* (2010) is useful for my purposes here, as an account of recent feminist politics which tries to be neither overly celebratory nor entirely dismissive of the achievements of contemporary feminists. Informed by discourse theory and by poststructuralist feminism, Dean offers an appraisal of contemporary feminist politics in the UK by conducting case studies of three feminist groups: the campaigning organisation The Fawcett Society, the

domestic violence charity Women's Aid, and the website The F-word. This section gives an overview of some key concepts used by Dean and why they are useful to my analysis, but also makes note of what is missing.

Especially significant for my project is Dean's attempt to reformulate our understanding of radicalism. The previous chapter argued that the UK's abortion regime should not be viewed as the direct outcome of the dominance of a patriarchal state and medical profession over women's reproductive function, and that the contributions of feminist actors should be acknowledged – but also that 'state feminism' should not be seen as having 'succeeded' in abortion debates in any straightforward manner. Similarly, Dean argues that existing accounts have tended to characterise contemporary feminist politics too generally and simplistically, either uncritically celebrating the recent 'resurgence' in feminist activism or constructing a pessimistic narrative of institutionalisation, decline and loss. To counteract these trends, Dean proposes a different understanding of radicalism, one which allows the significance, along with the shortcomings, of recent feminist activity to be recognised.

For Dean, feminist radicalism is not necessarily tied to particular spaces, such as women-only groups, or practices, such as autonomy from the activities of government. As he points out, there was nothing intrinsically radical about the women-only spaces which emerged out of seventies feminist activism. Rather, these groups were radical because of how they were constituted: 'they provided new configurations of, for example, the public/private distinction, women's sexuality and the relation between the personal and the political' (2010: 34). This understanding of radicalism is drawn primarily from the work of Ernesto Laclau (Laclau and Mouffe, 2001) and that of Linda Zerilli (2005).

Laclau, sometimes in collaboration with Chantal Mouffe, formulated a theory of radical politics in which no practice is necessarily radical, yet everything is potentially open to radical politicisation (Dean, 2010: 43). Political agendas, Laclau and Mouffe argue, are formed through the construction of 'chains of equivalence'[1] linking together political demands which have no necessary relation to one another (Laclau and Mouffe, 2001: 128). Consequently, a political demand may become radical 'if it is inscribed within a (pluralistic) counter-hegemonic chain of equivalence' (Dean, 2010: 43) – for example, a woman who experiences sexual harassment at work may become radicalised when she establishes linkages between her grievance and other objections to the company's practices. 'Counter-hegemonic' agendas, moreover, are those which contest the fundamental norms of a regime or practice (Glynos and Howarth, 2007: 115) or draw attention to their contingency (Dean, 2008; 2010). Crucially, radical politics is not confined to the space 'outside' the state and potentially cuts across the state/civil society distinction. Indeed, for Laclau and Mouffe, the idea that state and civil society should be kept separate:

> does not furnish the Left with any theory of the surface of emergence of antagonisms which can be generalized beyond a limited number of situations. It would appear to imply that every form of domination is incarnated in the state. But it is clear that civil society is also the seat of numerous relations of oppression, and, in consequence, of antagonisms and democratic struggles (Laclau and Mouffe, 2001: 179).

However, Dean suggests that Laclau's 'counter-hegemonic' politics, while a useful starting-point for theorising radicalism, is purely reactive and oppositional and under-theorises the creative and imaginative elements of radicalism (2010: 47). To augment the Laclauian definition of radicalism, Dean draws upon the work of Zerilli. Zerilli (2005) advances a

[1] The concepts of *equivalence* and *difference* will be discussed in more detail in Section 3.6.

feminist reinterpretation of the work of Hannah Arendt – a theorist sometimes regarded as hostile to feminism (Benhabib, 1993) – which emphasises the importance of imagination to political action. Zerilli, like Arendt, stresses the importance of imagination in countering instrumentalist mentalities, whereby things are judged solely according to their function or utility:

> this philistinism threatens … the political realm … because it will judge action by the same standards of utility which are valid for fabrication, demand that action obtain a pre-determined end and that it be permitted to seize on all means likely to further this end (Arendt cited in Zerilli, 2005: 174).

Thus, pure instrumentalism devoid of imagination threatens freedom and spontaneity, as actions which do not further utility cannot be judged as valuable. The 'world-building' power of imagination is subsequently central to a freedom-centred politics in which 'political actors act *together* in ways which bring into existence things and ideas which did not exist before' (Dean, 2010: 53; emphasis in original). Dean sees an imaginative world-building politics at work in the activities of the Fawcett Society, a British organisation which campaigns on women's issues. On questions of childcare and work-life balance, the specific proposals put forward by the Fawcett Society are relatively moderate. Nonetheless, these proposals are frequently made alongside an invocation of the image of a Scandinavian-style welfare-state model, suggesting that while Fawcett may adopt a gradualist political strategy, its politics are underpinned by a vision of more radical change, which acts as a 'discursive horizon into which Fawcett's demands are inscribed' (2010: 79). The idea that politics requires imagination, Dean argues, is already implicit in Laclau:

> think of the example of the woman who becomes radicalised after experiencing sexual harassment … First, there is an experience of newness and unpredictability at the point where

> linkages between her grievance and other grievances are established. Second, there is a moment of freedom as imagination: the lack of a *necessary* link between her grievance and other concerns is such that imagination is required in the process of articulation (2010: 57; emphasis in original).

Dean's reformulated understanding of radicalism is significant, in that it allows for an assessment of radical politics which does not assume that some practices are essentially radical, and avoids characterising the state as one-dimensionally patriarchal. This allows the analyst to recognise the creativity and vitality of many 'non-autonomous' feminist political practices. Indeed, Laclau and Mouffe's argument that oppression is not solely 'incarnated within the state', and that Left politics may cut across the state/civil society distinction, chimes with feminist critiques of the public/private dichotomy. Nonetheless, one important discussion is missing: Dean skims over the issue of feminist assimilation to prevailing norms and practices. This is a very pressing feminist concern and, given this chapter's assertion that governmental feminisms are often problematic, it is not enough to demonstrate that non-autonomous feminist practices need not *always* result in loss of radicalism. While Dean does note in places that assimilation is a possible upshot of feminist engagement with masculine institutions (e.g. 2010: 50-1), in his eagerness to challenge accounts of contemporary feminist politics as *wholly* a politics of assimilation, his account verges on the naïve optimism he is keen to avoid. In consequence, Dean gives little thought to why and how assimilation *does* occur, or why feminist politics does not always produce meaningful change.

3.6 Logics of explanation

The work of Glynos and Howarth is helpful here as it provides an analytical framework which distinguishes between 'sedimented' practices and practices which involve contestation and

change. It also, crucially, provides a way to explain the persistence of practices – such as medicalisation, perhaps – which might be deemed normatively suspect. Adopting a Laclauian ontology, Glynos and Howarth offer a model of the relationship between discourse and practice. *Regimes* (denoting orders, systems or discursive formations) structure *social* practices. However, *political* practices can shape or reorder the regime itself (2007: 106). This model allows them to introduce their explanatory schema, which consists of a typology of *logics* underpinning regimes and practices: *social*, *political* and *fantasmatic*. This schema is helpful in accounting for the 'grip' of regimes but also in explaining change. The *logics*, fantasmatic logic in particular, aid explanation of why some structures are more 'fixed' than others. This section outlines the typology of logics which will be used in following chapters, and explains how they can be useful to an analysis of abortion politics.

The concept of a *logic* bears some resemblance to the *rules, traditions* and *rationalities* already discussed in this chapter. Logics make practices and regimes intelligible: 'when we talk about the *logic* of a practice or a regime of practices we seek to capture those aspects which make it tick' (Glynos and Howarth, 2007: 135, emphasis in original). More specifically, '*the logic of a practice comprises the rules or grammar of the practice*, as well as *the conditions which make the practice both possible and vulnerable*' (2007: 136, emphasis in original). Logics set out a particular set of subject positions and objects along with a system of relations and meanings connecting them. These relations make certain expressions intelligible: for example, the meaning of 'fair price' or 'supply and demand' depends on the relations between key actors set out in the 'logic of the market'. Naming a logic also captures the conditions making a practice or regime possible, and must provide the means to answer, for example, questions concerning the conditions under which the institution of the market was made possible, as well as which processes ensure its maintenance (Howarth, 2005: 323;

Glynos and Howarth, 2007: 136-7). Crucially, logics do not subsume practices in the sense of a causal law; rather, they allow them to be described and characterised (Glynos and Howarth, 2007: 139, 179), and for continuities across contexts to be identified (Dean, 2010: 60).

As previously noted, Glynos and Howarth divide logics into three types: social, political and fantasmatic. *Social* logics are akin to the rules governing social practices. However, as noted earlier, no system of rules can completely subsume social practices: the latter 'contain possibilities and a contextual richness that cannot be captured by any one expression of them' (2007: 137). Social logics aid in characterising particular practices or regimes – the Thatcher regime, for instance, can be characterised in terms of a network of logics including logics of marketisation and centralisation (2007: 137). Crucially, social logics deal with *sedimented* practices, which have passed into common sense or at least become routinised. In doing so, they appeal to the (partial) fixity of structures, seeking to characterise patterns and regularities in practices (while of course holding onto the idea of open-endedness) (2007: 139-40).

Political logics, on the other hand, are concerned with how practices and regimes were formed and how they are being transformed; thus, they relate to change and contestation (2007: 141). They are, in other words, concerned with the institution of the social, but also its possible de-institution or contestation (2007: 142) – the *diachronic* aspects of practices and regimes. In accounting for the emergence of regimes, political logics thus help fulfil the need for an historical account, incorporating the outcome of past struggles – deemed important by some feminist theorists of the state (Halford, 1992: 159-60; Pringle and Watson, 1992: 69). It should be noted that while political logics may emerge as a result of dislocation, dislocation can also be reabsorbed within a social logic:

> Consider the experience of many academics who suddenly find that certain administrative tasks actually have a negative impact on their teaching and research, despite being explicitly

> designed to enhance them ... one may complain to colleagues at every available opportunity about the nature of this bureaucratic madness, just as one would complain about depressing weather. In this case, public contestation is kept at bay, and so the social dimension is foregrounded. Alternatively, the dislocation may be politically constructed. One may begin to wonder how it is that she came to be in this situation in the first place, and may begin to publically challenge it in the name of something different. (Glynos and Howarth, 2007:112)

Glynos and Howarth develop Laclau and Mouffe's concepts of *logics of equivalence* and *difference*, which themselves draw upon concepts from structural linguistics, in order to further characterise political logics. Logics of *equivalence* divide the world into two camps. Laclau and Mouffe give the example of millenarian movements, the logic of which divides the world into 'peasant culture representing the identity of the movement, and urban culture incarnating evil' (2001: 129). Equivalence captures the associative or substitutive relation in language: when the social has been divided into 'us' and 'them',

> two or more elements can be substituted for each other with reference to a common negation or threat. That is to say, they are equivalent not insofar as they share a positive property (though empirically they *may* share something in common), but, crucially, insofar as they have a common enemy (Glynos and Howarth, 2007: 144)

While the logic of equivalence is 'a logic of the simplification of political space', the logic of *difference* 'is a logic of its expansion and increasing complexity' (Laclau and Mouffe, 2001: 130). The practice of 'divide and rule' is one example: the separation of 'ethnic or national groups into particular communities or indirect systems of rule ... is invariably designed to prevent the articulation of demands and identities into a generalized challenge to the dominant regime' (Glynos and Howarth, 2007: 145). Difference captures the combinatory or

syntagmatic relation in language, where elements are kept distinct, separate and autonomous (2007: 144).

A final point in the typology of political logics concerns the characterisation of political demands as *radical* or *hegemonic*. *Radical* demands contest the fundamental norms of a practice or regime. *Hegemonic* demands – which may also be radical – come to represent a challenge to a regime by successfully generalising their relevance: for example, a demand for higher wages and better working conditions by workers in one sector may be taken up by workers in adjacent sectors (Glynos and Howarth, 2007: 115-6). Glynos and Howarth do not make much of the distinction between radical and non-radical demands. However, as my discussion of Ferree and Dean has demonstrated, it is critical in evaluating the form taken by contestation, and radical discourses are less likely to achieve short-term success. It can be extrapolated from this that political logics which incorporate radical demands will be less likely to alter the practices they contest, at least in the short term – but also that political logics which are resonant or non-radical are unlikely to significantly alter a regime in the long term.

Finally, *fantasmatic* logics (alternatively 'logics of fantasy') explain why subjects are 'gripped' by specific practices or regimes. They aid in understanding the 'inertia' of social practices – their resistance to change – but also 'vector' of political practices – the speed and direction of change when it does happen (Glynos and Howarth, 2007: 145). Fantasy operates to obscure or 'cover over' the radical contingency of social relations. It achieves this through a narrative which promises a fullness-to-come once a certain obstacle or threat is overcome (the beatific dimension of fantasy), or foretells of disaster if the obstacle is insurmountable (the horrific dimension) (Glynos and Howarth, 2007: 147; Glynos, 2008: 283). Logics of fantasy may operate to *sustain* practices, such as workplace exploitation (Glynos, 2008), that

might otherwise be deemed ethically or normatively suspect. However, they may also *mobilise* the subject against a particular obstacle (Glynos and Howarth, 2007: 145-152). Fantasmatic logics therefore go further than Bevir and Rhodes' account of 'situated agency', accounting for the appeal of aspects of traditions and their resistance to change. For this reason, they may be helpful in explaining why the medicalisation of abortion persists in spite of the insertion of feminist arguments about abortion into the political debate.

This threefold typology of logics can be of great use in analysing abortion politics. For starters, it is rigorous, allowing for a methodical categorisation of discourses which goes beyond a simple division between 'feminist' and 'non-feminist' frames. It allows for distinction between discourses which sustain existing regimes and discourses which challenge them, and moreover provides various ways of characterising the latter: as radical and/or hegemonic, as employing the logics of equivalence or difference, and so on. This typology of logics is called upon in the following chapters to help make sense of abortion debates. Finally, and importantly, it may help in explaining why certain regulatory regimes persist. However, there are two brief points to add concerning my own methodological approach.

My first point concerns genealogy and historical analysis. Glynos and Howarth do stress a genealogical aspect to their approach. Political logics are explicitly concerned with the *diachronic* dimension of practices and regimes – the way they emerge and are contested. However, a political logic, following the discussion of Foucault in Section 3.2, should not be perceived as the 'origin' of a particular practice or regime, but rather as a particular point in its heritage: the past has not imposed a predetermined form on the present, and to assume otherwise would be to underestimate the role of agency and political struggle. My approach, in charting the history of abortion politics through a *series* of political events and legislative battles (in other words, potentially encapsulating a succession of regimes rather than

documenting the emergence of a single regime), has much in common with Foucault's genealogical method. However, it is more modest in scope, paying closer attention to individual moments of dislocation.

My second point concerns the relationship between two concepts discussed in this chapter: translation and articulation. The concept of translation is employed by Rose to explain how policies and programmes are realised:

> In the dynamics of translation, alignments are forged between the objects of authorities wishing to govern and the personal projects of these organizations, groups and individuals who are the subjects of government. It is through translation processes of various sorts that linkages are assembled between political agencies, public bodies, economic, legal, medical, social and technical authorities, and the aspirations, judgements and ambitions of formally autonomous entities, be these firms, factories, pressure groups, families or individuals (Rose, 1999: 48).

Following my synopsis of Laclau and Mouffe, translation can clearly be seen as a kind of articulation: it involves the formation of a structured totality which alters or establishes new relations between elements, or in this case, social actors. Subsequently, *translation* will be used to denote any process by which a governmental project articulates relations between actors.

The 1967 Abortion Act, Chapter Four suggests, is one such governmental project, articulating relations between the key actors in the abortion policy triad – the state, doctors, and women – and a host of other actors. Accordingly, my first empirical task is to identify the political logics involved in the emergence of the current regulatory regime governing abortion, and the relations they establish between actors. The *social* logics of abortion regulation – that is, how doctors, patients and health officials behave in everyday practice, fall more within the remit of

medical sociology (for example see Beynon-Jones, 2012; 2013). This is not to say that the social (as opposed to political) dimension of abortion discourse is irrelevant – sedimented (and thereby rarely questioned) practices, such as the doctor-patient interaction, are inevitably appealed to in parliamentary debates on abortion regulation. Fantasmatic logics were also crucial to the passage of the Act: the hate figure of the back-street abortionist loomed large in reformist arguments and mobilised support for change.

3.7 Discourse theory and feminist institutionalism

The above discussion has stressed that discursive, institutional and historical context matter to feminist political activity, from how 'the state' is understood and achieves legitimacy to how feminist practices are translated in order to resonate with wider policy objectives. As a result, this chapter would not be complete without a discussion of the institutionalist approaches which are increasingly informing feminist research in political science. The 'new' institutionalisms asserted that institutions are more than just neutral arenas in which political action takes place; rather, they exert their own pressure on the actors within them (March and Olsen, 1984; 1989). To institutionalists, context matters, although different authors see institutions in different ways: as, for example, simply the 'rules of the game' which actors must follow, the aggregate effects of past decision-making, or as relatively coherent sets of cultural norms, symbols, and practices (Hall and Taylor, 1996). Institutionalism has recently become of interest to feminist researchers, and the resulting feminist institutionalism (FI) has stressed the gendered nature of political institutions: gendered constructions and behaviour are 'are intertwined in the daily life or logic of political institutions' (Mackay *et al.*, 2010; see also Kenny, 2007; Mackay and Krook, 2011).

Discourse theory and the new institutionalisms often seem to speak a different language. This thesis chiefly borrows the concepts and terminology of the former, as they make up a sophisticated toolkit for unpicking elements of different discourses. However, there are affinities between the two approaches: discourse theory stresses that discursive strategies must be seen as situated against historical context (as indicated by the concept of a *logic*). This chimes with the general argument of (feminist) historical institutionalists that 'history matters' (e.g. Waylen, 2009) – that the events of the past affect the possible outcomes of future events (Sewell, 1996). The newer, constructivist or 'discursive' form of institutionalism shares discourse theory's emphasis on the role of ideas, which it treats as *constitutive* of institutions, rather than the other way around (Blyth, 2003; Hay, 2006; Schmidt, 2008). Yet, as David Moon points out, constructivist institutionalism also tends to treat ideas as 'relatively coherent cognitive frames' (2013: 112) and neglects exploration of their specific elemental makeup and, crucially, their fluidity. This recalls my earlier criticism of RNGS for their failure to closely inspect the changeable content of 'feminist frames'.

For this reason, the *logics* approach is of more use to this project. However, discourse theory and FI may be fruitfully drawn together by treating institutions as sedimented discourses, as Kulawik (2009) does. The benefit of such an approach is that it draws attention to the specific makeup of the ideas constituting institutions: how they articulate different elements and subjects together, altering their identity in the process. By declining to treat ideas as internally coherent discrete units it also allows the conflicts, tensions and compromises that may feature in different discourses to be made apparent. This approach has already been applied in an analysis of an abortion regime by Radka Dudová (2010), who finds a path-dependency of sorts in Czech abortion politics wherein pro-choice feminists rely heavily on institutionalised/sedimented discourses about abortion when constructing public arguments,

which in turn prevents other solutions to the abortion 'problem' from being thought and publically expressed. Nonetheless, institutions need not be seen solely as constraints. I recognise, following Kathleen Thelen, that institutions also operate as strategic resources for actors (2003: 213), who may choose to make use the elements of institutions which are strategically useful to them. As the thesis demonstrates, the medicalised regime of abortion regulation has been drawn upon by feminists in creative ways, although it has also frequently operated as a constraint.

Conclusion

This chapter has introduced the analytical framework which will be used in the rest of the thesis. This framework involves concepts taken from discourse theory: primarily, social, political and fantasmatic *logics*, and a reworked definition of radicalism which includes the concepts of *world-building* and counter-hegemonic *chains of equivalence*. Such a framework is necessitated by Chapter Two's assertion that the state is not a unitary actor but rather fragmented. Section 3.1 introduced the concepts of governmentality and translation as ways of making sense of this dispersed governance: while government may not have any essential object, distinct governmental projects can be observed which involve particular 'regimes of truth' and the formation of alignments between the objects of authorities and the personal projects of the subjects of government. As Chapter Four will demonstrate in more detail, a process of translation is at work in the 1967 Abortion Act, linking the objects of regulatory authorities to those of the medical profession and of women seeking abortion (in other words, between the three corners of the 'policy triad' identified by McBride Stetson).

It is important to re-emphasise that the networks of actors involved in government rule are diverse, with no essential nature. This means – as feminist researchers who have rejected the notion of an 'essentially male' state have realised – that feminist actors may well play a part in governmental rule. But, as the discussions in Sections 3.3 and 3.4 indicate, there is reason to be cautious. Governmental feminisms often face a pressure to transform their practices into a format compatible with wider policy regimes, meaning certain discourses and practices are likely to be excluded – from demands for positive support for gay rights from state bodies to a democratic-participatory approach to policy-making. Further, elements of feminism which achieve a 'common sense' status are vulnerable to appropriation to normatively problematic ends.

To accommodate these complexities, my research requires an analytical framework that, firstly, allows the differing contents of parliamentary feminisms to be evaluated. Dean's reconceptualisation of radicalism works to this end, as it provides criteria for evaluating the extent of feminist radicalism without tying radicalism to any particular spaces or practices – what matters is the extent to which feminists are able to articulate their demands within a counter-hegemonic chain, and inscribe these demands within an imaginative horizon where the world is substantially different. Secondly, this analytical framework must assist in the identification of the 'regimes of truth' which make the activities of government possible, acknowledging that these activities are necessarily discursive. Glynos and Howarth's *logics* are helpful here, as for starters they allow patterns to be identified which cut across contexts. They also allow distinction between the discourses and practices which have become sedimented and achieved the status of common sense and those which relate to change and contestation. Finally, and crucially, they can help account for the inertia and resistance to

change of regimes such as medicalisation, as well as for the speed and direction of change when it does happen.

Using the concepts introduced in this chapter, it is now possible to formulate some guiding questions for the research. Firstly, what are the prevailing governmental rationalities or logics at work in the regulation of abortion, how were these negotiated and contested, and what accounts for their inertia? Secondly, to what extent have governmental feminisms challenged these logics, and to what extent could they be said to be 'radical'? Finally, and following my discussion of McRobbie and others, (how) have elements of feminist discourse been (mis)used in political debates on abortion, whether in service of the *status quo* or for other purposes?

Before analysing feminist engagements with abortion law, however, it is necessary to trace how the current regime was negotiated. While there is very little in the way of feminist argument in debates over the 1967 Abortion Act, analysis of these debates will help contextualise current debates; firstly, by elucidating what it is that is currently being contested; secondly, by identifying the regime's points of weakness; and thirdly, by revealing the development of logics which, as I will later demonstrate, have persisted into the present day. This is the object of Chapter Four.

CHAPTER FOUR. THE 1967 ABORTION ACT AND THE LOGIC OF MEDICALISATION

Introduction

While health was established as a legitimate ground for abortion in 1938, the 1967 Abortion Act further institutionalised the medicalisation of abortion. As John Keown observes, the Act might seem an 'approximation not to the proposals of ALRA, which inspired and organised the cause of reform, but to the recommendations of medical bodies' (Keown, 1988: 85), an interpretation shared by Sheldon (1997) and Fyfe (1991). This chapter develops such accounts. It argues that while medical recommendations did come to dominate the Act, medicalisation was not an easy process. Rather, the Act came about as the result of protracted struggle and negotiation – 'horse-trading', as some activists saw it (Munday and Houghton in Furedi and Hume, 2007: 11, 30) – between diverse elements and actors. There was a great deal of resistance to the new regime – among parliamentarians, of course, but crucially, also among the medical profession, many of whom did not initially accept the 'social' role entailed by performing abortions for reasons other than the pregnant woman's physical health. Establishing the *logic of medicalisation* underpinning abortion regulation therefore required multiple redrafts and negotiations of the so-called 'social clause', which allowed abortions for reasons generally considered non-medical.

David Steel's Medical Termination of Pregnancy Bill, which eventually became the Abortion Act, was not the first attempt to liberalise abortion law. Several such Bills were introduced in the 1950s and 1960s (Marsh and Chambers, 1981: 13). However, the most successful of these was the Silkin Bill, which was passed to Steel after he drew third place in the Private Members' ballot. Section 4.1 gives a brief overview of the various drafts of the Silkin Bill and

the gradual narrowing of the grounds for abortion covered by the clauses of the Bill. It was Clause 1 (c), nicknamed the 'social clause', that was most controversial. The clause allowed for abortion if 'the health of the patient or the social conditions in which she is living (including the social conditions of her existing children) make her unsuitable to assume the legal or moral responsibility for caring for a child'. Clause 1 (a) was thought by many critics to contain inappropriate 'social' concerns, allowing abortion if it was considered that the strain of caring for a child might damage a woman's mental health. The various incarnations of these two clauses remained controversial throughout the passage of the Steel Bill.

Section 4.2 then turns to medical commentary on abortion before the Act had completed its passage through Parliament. The commentary considered includes the reports on legalised abortion published by the major medical organisations after the publication of Steel's draft Bill: the British Medical Association (BMA), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal Medico-Psychological Association (RMPA) and the Medical Women's Federation (MWF). Also discussed are the minutes of a conference held by the Family Planning Association in 1966, along with commentary in articles and letters to the British Medical Journal from 1963 to 1967. Commentators can be roughly divided into two groups: the 'medical reformists' (4.2.i) who supported Steel's Bill and were generally in favour of a medicalisation of abortion, and the 'medical purists' (4.3.ii) who opposed or were at least sceptical of the Bill. This latter group tended to distinguish between 'types' of doctors, challenging the view of a medical profession united in favour of the Bill, and viewed the inclusion of 'social' concerns as a threat to doctors' roles and identity. This *logic of medical purity* presented a considerable challenge to the Bill.

Sections 4.3 to 4.5 contain analysis of the parliamentary debates, starting at Second Reading (Hansard, 1966) and tracing their development through Committee stage (Hansard, 1967a; b)

to Report stage (Hansard, 1967c; d) and in the Lords (Hansard, 1967e; f). This is supplemented by data from interviews conducted by BPAS with Steel and other reformists (Furedi and Hume, 2007) along with Steel's own commentary on the Act (1971). Section 4.3 deals with the social clause, identifying a clear *logic of medicalisation* developing as the clause was redrafted: a Bill which started out by separating 'social' concerns from 'medical' concerns ended up breaking down this distinction completely and incorporating both concerns in the same clause under the banner of 'sociomedicine' (see Table 1, p.94), thus challenging the logic of medical purity underlying the arguments of opponents in Parliament and elsewhere.

Section 4.4 revisits Sheldon's points concerning the ways in which the Bill was gendered. While concurring with Sheldon that medicalisation relied on the construction of women as victims or 'tired housewives' (1997: 32) in need of paternalistic medical care, I add that this construction drew on rhetorics of fear and threat in a way that helped strengthen the 'grip' of medicalisation on the parliamentary imagination: medical control over abortion seemed to provide the only escape from a situation in which women were victimised by back-street abortionists using horrifying methods. Section 4.5 briefly touches on the issue of notification of abortion to the Ministry of Health, one way in which the Act constituted doctors as state agents in the management of abortion.

Finally, Section 4.6 turns to medical commentary after the Act became law. The data considered include articles in the British Medical Journal, the proceedings of a symposium held by the Medical Protection Society, Royal College of General Practitioners, and RCOG in 1969, and polls of doctors in the 1970s (Keown: 1988: 121). My analysis suggests a partial sedimentation of the logic of medicalisation during this time: medical commentary after the

Table 1. 'Social' concerns in the Silkin and Steel Bills.

Bill	**Stage**	**Wording of the social clause(s)**
Silkin (first)	Second Reading (Lords)	1. It shall be lawful for a registered medical practitioner to terminate pregnancy in good faith – a) in the belief that if the pregnancy were allowed to continue there would be grave risk of the patient's death or of serious injury to her physical or mental health resulting from either giving birth to the child or from the strain of caring for it, or ... c) in the belief that the health of the patient or the social conditions in which she is living (including the social conditions of her existing children) make her unsuitable to assume the legal or moral responsibility for caring for a child or another child as the case may be, ... *Clause 1 (c) was the most controversial of these, although many critics saw the provisions concerning the 'strain of caring for' another child in 1 (a) as involving unacceptable 'social' concerns.*
	Committee (Lords)	At Committee stage, reference to the patient's 'social conditions' was removed from 1 (c) and replaced by provisions concerning her 'adequacy as a mother'. *Despite cutting the explicit reference to 'social conditions', Silkin made it clear that these would still be covered by the clause. An amendment to strike out Clause 1 (c) was moved, but failed.*
	Report (Lords)	Clause 1 (c) struck from the Bill by 81 votes to 51.
Silkin (second)	Second Reading (Lords)	This draft of the Bill again made reference to 'adequacy as a mother'.
	Committee (Lords)	The provision concerning 'adequacy as a mother' was changed to one dealing with 'capacity as a mother', meaning it now covered cases where the pregnant woman herself felt she could not cope with a(nother) child. *This version of the clause was preferred by the Lords and adopted by a four-to-one majority. However, the Bill was withdrawn and passed to David Steel.*
Steel	Second Reading (Commons)	1. Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if that practitioner and another registered medical practitioner are of the opinion, formed in good faith – a) that the continuance of the pregnancy would involve serious risk to the life or of grave injury to the health, whether physical or mental, of the pregnant woman whether before, at or after the birth of the child; or ... c) that the pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be; ...

		At this stage, Steel viewed 1 (a) as simply clarifying the existing law, and argued that 1 (c) was essential to liberalisation.
	Committee (Commons)	Clause 1 (a) was substantially widened, now allowing the patient's 'well-being' and 'total environment' to be taken into account. However, Clause 1 (c) was struck from the Bill (on Steel's suggestion) by an amendment moved by Bernard Braine.
	Report (Commons)	Words concerning the patient's 'well-being' struck from 1 (a). *Steel argued that the removal of provisions for 'well-being' would not significantly change the Bill, as 'health' included the concept of wellbeing.*
	Committee (Lords)	An amendment moved by Lord Dilhorne and approved by 87 votes to 86 removed the provisions in 1 (a) pertaining to the physical or mental health of the pregnant woman's existing children.
	Report (Lords)	The words 'or any existing children of her family' were restored by 86 votes to 69.

Compiled from: Hansard; Hindell and Simms (1971).

Act passed was much more favourable toward 'social' abortions and a 'social' role for doctors.

In charting the development of the Act in this way, this chapter helps contextualise the debates analysed in following chapters. As Chapters Five to Seven demonstrate, many of the logics and political strategies which developed in debates over the 1967 Act recurred and were developed in later debates. The logic of medicalisation presented a particular challenge to feminists, who were often hostile to the medical control over abortion it entailed, yet felt compelled to defend the Act from anti-abortion attacks. However, ideas that challenged this logic also remained a feature of abortion debates into the 21st century, in particular the notion of a realm of 'pure' medicine threatened by encroaching 'social' concerns.

4.1 The history of the Act

Before the 1967 Act came into existence, the regulation of abortion was largely governed by case law. A legal ruling in 1938 allowed abortions to be performed if there was danger to the health, including mental health, of the pregnant women. However, it remained unclear how grave the threat to the woman's health would have to be for an abortion to be performed, and one of the functions of the Abortion Act was to clarify existing case law (Keown, 1988: 49-83). Contrasting the eventual Act with the Steel Bill as originally drafted, along with its predecessor, the Silkin Bill, highlights the amount of compromise that went into its creation. The history of what came to be known as the 'social clause' is particularly illuminating. Lord Silkin's first Bill, the first abortion Bill to receive considerable attention, was heavily based on a draft drawn up by Glanville Williams, a prominent member of the Abortion Law Reform Association (ALRA). Introduced in the House of Lords in November 1965, its first section caused considerable controversy, and ran as follows:

1. It shall be lawful for a registered medical practitioner to terminate pregnancy in good faith –
    a) in the belief that if the pregnancy were allowed to continue there would be grave risk of the patient's death or of serious injury to her physical or mental health resulting from either giving birth to the child or from the strain of caring for it, or
    b) in the belief that if the pregnancy were allowed to continue there would be grave risk of the child being born grossly deformed or with other serious physical or mental abnormality, or
    c) in the belief that the health of the patient or the social conditions in which she is living (including the social conditions of her existing children) make her

unsuitable to assume the legal or moral responsibility for caring for a child or another child as the case may be, or

d) in the belief that the patient became pregnant as the result of intercourse which was an offence under sections one to eleven inclusive of the Sexual Offences Act 1956 or that the patient is a person of unsound mind.

It was Clause 1 (c) which caused the most controversy among the Lords, although many also objected to 1 (d), and to the provision in 1 (a) allowing abortions to avoid injury resulting from the strain of caring for a child. Silkin's opponents felt that sexual offenses or social conditions could not in themselves justify abortions. After the Bill was granted a Second Reading, Silkin met with ALRA to discuss revisions. Clause 1 (c) was narrowed, becoming a clause focusing on the patient's 'inadequacy as a mother' but not taking account of the social conditions in which she lived (Hindell and Simms, 1971: 134-141).

At Committee stage, the Bill was amended to strike out the provision for abortion on the grounds of rape altogether. At this stage, an amendment to strike out the 'social' clause (1 (c)) was also moved, but failed. At Report stage the Bill's opponents were better prepared, arguing that the clause called upon doctors to make 'non-medical' decisions which were outside their remit. The clause was struck from the Bill. This was seen as a serious loss by ALRA, but nonetheless the Bill received a Third Reading unopposed (Hindell and Simms, 1971: 148-152).

Silkin introduced a similar Bill in the new Parliament in 1966, which was given an unopposed Second Reading. However, by Committee stage Silkin had redrafted the Bill, altering the wording of the 'social' clause to provide for 'capacity as a mother'. This redrafted clause was no longer intended to cover cases where a woman would be 'inadequate' as a mother but

simply cases where the pregnant woman herself felt she could not cope with (another) child. This version of the clause was preferred by the Lords, and adopted by a four-to-one majority. However, following Committee stage, the Bill was withdrawn and passed to David Steel, who had drawn third place in the Private Members' ballot and had a good chance of successfully bringing a Bill through the House of Commons (Hindell and Simms, 1971: 153-4).

In redrafting the Bill, Steel took advice from ALRA, who asked that the concept of 'well-being' be inserted in Clause 1 (a), that any doctor regardless of status should be permitted to perform abortions, that rape should be reinserted as a ground for abortion, and that the requirement that abortions be notified to the Ministry of Health be dropped. Steel's Bill reinstated the subclause dealing with rape, but required that two doctors authorise abortions in all cases except emergencies. While it did not drop the requirement for notification, neither did it allow for notifications to be revealed to police officers. The subclause concerning 'capacity as a mother' was kept in the Bill, but the concept of 'well-being' was not introduced at this time (Hindell and Simms, 1971: 158-60). The new Clause 1 ran as follows:

1. Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if that practitioner and another registered medical practitioner are of the opinion, formed in good faith –
    a) that the continuance of the pregnancy would involve serious risk to the life or of grave injury to the health, whether physical or mental, of the pregnant woman whether before, at or after the birth of the child; or
    b) that there is a significant risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; or

c) that the pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be; or

d) that the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape.

However, these provisions were the source of much controversy among both Parliament and the medical profession, and subject to considerable redrafting until the distinct 'social clause' was again eventually removed. The following sections will analyse discourse surrounding the Bill as it passed through Parliament and eventually became the Abortion Act.

4.2 Medical opinion before the Abortion Act

This section discusses the views of the major medical organisations along with 'unofficial' medical commentary appearing in the *British Medical Journal*, the press, conferences and public debates. Doctors at this time were particularly concerned with preserving clinical freedom, prompting considerable wariness of state intervention. The major medical organisations all favoured medicalisation, recommending abortion be legal only when certified by registered doctors. What is striking, however, particularly in unofficial commentary, is the level of hostility expressed towards the proposed legalisation of 'social' abortions. While some representatives of the medical profession – unsurprisingly, perhaps, the Royal Medico-Psychological Association (RMPA), as well as doctors with ties to the Family Planning Association – stressed the need for abortion on social grounds, this does not seem to have been a widely shared view. Much medical commentary expressed anxiety about a potential pollution or violation of the role of the doctor, brought about by the intrusion of

'social' concerns into the medical realm. This section covers the arguments used by reformists before turning to how these were countered by opponents.

4.2.i The medical reformists

The BMA's report was relatively neutral. It called for clarification of the law, observing that existing case law did not specify the *extent* to which there must be a threat to the pregnant woman's health for an abortion to be legally justifiable, and recommending that these indications not be defined too closely (1966: 41). However, it did not in any depth tackle the question of abortion on 'social' and/or 'psychiatric' grounds, focusing instead on administrative difficulties. Among these was the question of notification. The report stated that the organisation was in favour of notification, but only as a source of health statistics and not for the police to access without a court order. Notifications were to become a crucial issue in the negotiation of a 'socially responsible' identity for doctors.

Other organisations, however, were more outspoken. The medical body by far the most in favour of reform was the RMPA. Its official report on therapeutic abortion held that 'all social circumstances should be taken into account' as criteria for legal abortion (1967 [1966]: 167). This was justified by using a broad definition of 'health' which included both 'direct' and 'remote' effects on well-being; the latter including, for instance, the strain of a large family. The report also argued that, in some cases, abortions may be conducted for the good of society as a whole: for example, it asserted that mental illness may lead to inadequate parenting, which in turn is likely to produce antisocial children. However, it also stressed that there must be no 'right' to an abortion and no abortions conducted without the proper medical examination: 'In particular, we believe that we should resist attempts to make the termination of pregnancy lawful merely on the grounds that it is inconvenient to either or both parents'

(1967: 168). As such, the RMPA constructed the medical profession, including psychiatrists, as the guardians of both health and society.

The MWF, like the RMPA, utilised a broad definition of 'health' and argued that the 'total environment and circumstances of the pregnant woman should always be carefully considered' (1966: 1512). However, it suggested removal of the 'capacity as a mother' clause, asserting that it would be impossible for doctors to assess this. Overall, its recommendations were, even more so than the reports of other medical organisations, in favour of medicalisation, stating not only that abortions should only be legal when certified by two doctors, but also that '[it] is of overriding importance that a climate of opinion should obtain whereby a woman should consult her doctor as soon as she thinks she is pregnant'[1] (1966: 1512).

The medical voices most overwhelmingly in favour of change were, unsurprisingly, found at a conference on legalised abortion held by the Family Planning Association in 1966. Participants frequently argued that the distinction between the medical and the social was false. Sir Dugald Baird, for example, stated that

> To say that termination of pregnancy is permissible for medical but not for social reasons seems to me quite unjustifiable. This attempted distinction takes no account of the effect of customs, tradition, education, the new status of women in society, and a host of other factors which influence health, happiness, and efficiency (1966: 16).

[1] It is ironic that the medical body with the most explicitly feminist aims should also have been the most explicitly in favour of the medicalisation of pregnancy, given the feminist critiques discussed in Chapter Two. However, it should also be noted that the MWF's report includes an appendix written by a dissenting member of the Committee, which states in unequivocal terms her belief that the right to decide whether a pregnancy should continue 'belongs to the pregnant woman herself and no-one else' (MWF, 1966: 1514).

Such speakers used the term ‘health’ to encompass a broad range of factors, as well as aligning themselves with a progressive agenda. In this manner, consultant Rowena Woolf utilised the concept of ‘prevention’ to similar effect:

> This is the only part of Medicine where prevention is hardly attempted. I know that it is possible to get most women through pregnancy and labour, but what about the rearing of the child? What about the effect of another child on a family already overloaded psychologically and financially (1966: 71)?

This argument brought abortion into line with other medical practices. In this construction, it was not the introduction of legalised abortion which threatened to distort the medical role, but the fact that abortion was currently restricted: doctors were being prevented from carrying out their duty to prevent sickness and disease. This emphasis on blocked or threatened identity was repeated in a contribution by Carne, which argued that the vagueness of case law was making doctors afraid:

> Faced with a lump in the breast which might be malignant, the general practitioner knows what has to be done for his patient and he knows what arrangements he must make to see that the right treatment is provided. Faced with a child with an acute appendicitis, he knows how to arrange emergency surgery – and whom to contact to see it is done. When he is consulted by a woman with a post-menopausal bleed he knows that he must get the opinion of a competent gynaecologist, and he knows exactly how to do that. But will that gynaecologist who is willing to advise on any other gynaecological problem be willing to advise on the indications for a termination – and to carry out the operation if it is indicated (1966: 75)?

Here, abortion is again constructed as an issue of health – a gynaecological problem like ‘any other’, aside from the legal restrictions. Once again, the law prevents the GP from carrying out ‘his’ role and duty to the patient. These discursive configurations – of abortion as a

'health' issue, of 'health' as including social concerns, and of the doctor as socially aware and responsible – later became key features of the logic of medicalisation underpinning legalised abortion.

4.2.ii The medical purists

While many were in favour of reform, they were vigorously opposed by others in the profession – perhaps most damagingly by the RCOG. Distinct patterns can be discerned in the arguments of those opposed to reform, amounting to a *logic of medical purity*. This logic operated by, firstly, breaking down the continuity between psychiatrists, gynaecologists and other doctors, and between physical and psychiatric health, established in the arguments of reformists (a relation of difference). Secondly, it emphasised a narrow realm of strictly 'medical' practices and complaints, opposed to and threatened by the perceived encroachment of 'social' concerns and the interference of the state (a relation of equivalence).

The RCOG published the most cautious of the reports of the medical organisations (RCOG, 1966). It favoured a law which simply provided clarification of existing case law, and noted that even without clear statute law there was little to prevent a gynaecologist carrying out an abortion 'when he considered it to be indicated on medical grounds' (1966: 850). In opposition to certain proponents of reform who claimed to be struck by the ease of performing abortions given the proper training and equipment (e.g. Potts cited in Furedi and Hume, 2007: 40), it stressed that the 'dangers' of inducing abortion could only be weighed up by an expert. In doing so, the report emphasised the difference between obstetricians and gynaecologists and other 'medical men' (in particular psychiatrists), presenting the former as the true guardians of legal abortion. Indeed, this emphasis is made explicit towards the end of the report, where the following is stated:

> The interpretation of any new Abortion Act and its application to medical practice in this country would be largely the responsibility of obstetricians and gynaecologists. It would therefore seem wise that legislators should be reasonably sure of their cooperation before deciding on any alteration of the Law (RCOG, 1966: 853).

Further, the report downplayed the importance of psychiatric indications, arguing that these may be 'exaggerated' (1966: 850). Psychiatric grounds for abortion were placed in sharp contrast to physical grounds, in a passage underpinned by specific ideas about women's 'maternal instinct':

> Whilst the continuance of pregnancy can have a psychological rather than physical ill-effect, so can induced abortion. There are few women, no matter how desperate they may be to find themselves with an unwanted pregnancy, who do not have regrets at losing it. This fundamental reaction, governed by maternal instinct, is mollified if the woman realizes that abortion was essential to her life and health, but if the indication for the termination of pregnancy was flimsy and fleeting she may suffer from a sense of guilt for the rest of her life (1966: 852).

Thus, the report both constructed women as naturally maternal and dismissed the possibility that psychiatrists might be appropriate arbiters of when abortion is justified.

Outside of the major medical organizations, the discussion followed a similar pattern. Many doctors were worried that legal reform would somehow pollute the profession with social concerns, and many more were extremely wary of cooperation with the state. These anxieties are exemplified by the arguments of the psychiatrist Myre Sim and the gynaecologist Hugh McLaren, both prominent opponents of 'abortion on social grounds'. In an article published in the *British Medical Journal* (BMJ), Sim drew a strict line between medical and social

concerns, contending that that members of the profession 'should be doctors of medicine, not socio-economic prophets' (1963: 145) and moreover that under proposed reforms,

> psychiatrists are expected to disregard the clinical facts in order to satisfy a desire for a social reform … It is essentially a socio-economic problem with the psychiatrist being exploited, for he at present provides the most convenient way around the legal situation (1963: 148).

McLaren, speaking to the Society for the Protection of Unborn Children (SPUC) and on television, similarly designated abortion 'nothing to do with the art of healing'. Moreover, he suggested that the Steel Bill represented 'state control of doctors', drawing comparisons with Nazi Germany (Catholic Herald, 1967).

While this latter argument is obviously an extreme example, similar concerns over pollution or violation of the medical role and state interference with medical practice were frequently voiced in the *BMJ*. An article by Lord Brain noted with approval that Lord Silkin had approved several amendments to his Bill suggested by the medical profession, and stressed that the idea of 'inadequacy of the mother' was both ill-defined and non-medical (1966: 727-8). Brain also warned that if women felt they were legally entitled to an abortion (as, it was feared, they might if the legal grounds for abortion were too closely defined) 'this may embarrass the doctor-patient relationship' (1966: 729). A little later, a *BMJ* leading article warned that certain provisions of Steel's Bill, 'if taken separately from a consideration of the mother's health, could lead medical men into making decisions on other than their expert knowledge' (BMJ, 1966: 1608). In these arguments, it is not restrictive abortion laws which threaten the medical profession, but the encroachment of 'social' concerns and the state.

The *BMJ*'s correspondence pages were little different, with discussion again centring on whether carrying out abortions was an appropriate role for doctors and expressing wariness of

the state. Concerning potential pollution of the medical role, letter writers argued, for example, that 'the sanctity of life, whether actual or potential, must be guarded carefully by us all in the medical profession in accordance with our long-established ethical standards and basic training to preserve life' (Pells Cocks, 1966: 539); that 'physicians are fundamentally concerned with making people better when they are ill and with preventing illness whenever possible [and abortion does little to achieve this]' (Clyne, 1966: 1482-3); that abortion on psychiatric grounds would be a case 'of the medical profession bending its scientific backbone in order to accommodate public opinion' (Johnson, 1966: 646); and that once the Act came into law, it would become difficult for doctors to oppose abortion being accepted 'as the remedy for many ... social evils' (Shackleton Bailey, 1967: 352). Concerning medical cooperation with the state, writers worried that politicians would 'decide the issue for us' (Pells Cocks, 1966: 539), and proclaimed that the requirement for notification

> smacks of pressure being brought to bear on gynaecologists, of snooping, and of police control, and the thin edge of the wedge would inevitably ultimately affect every branch of the profession, and indirectly the general public (Theobald, 1966: 978).

There were, of course, opposing voices. For example, MacGillivray argued that the medical responsibility 'to relieve human misery' included abortion to alleviate the suffering of women with unwanted pregnancies (1965: 1433). Similarly, de Soldenhoff stressed the validity of abortions for 'social economic, or moral reasons' (1966: 1168) – albeit while expressing a strong hostility to legal reform and the red tape that would accompany it. The expansion of the notion of health to include social concerns was, however, not widely accepted by *BMJ* correspondents. Overall, the letters challenge the picture of a medical profession in happy alliance with the state – rather, they contain a great deal of fear and wariness.

4.3 The social clause

Overcoming these fears required the creation of a logic of medicalisation which could transform doctors into 'socially responsible' agents of governmental regulation. This section will argue that this was achieved in part through redraft after redraft of the objectionable 'social clause' of the Act until it was eventually scrapped in favour of a broad clause which promoted the concept of 'sociomedicine' (more details of these clauses can be found in Table 1). This section traces the development of, and debates over, the 'social' concerns included in the Steel Bill during its passage through Parliament.

In his Foreword to Hindell and Simms' *Abortion Law Reformed*, Steel responds to the authors' claim that the loss of the social clause watered down the Abortion Act: social conditions, he argues, 'cannot be and ought not to be separated from medical considerations. I hope that the Abortion Act by its very drafting has encouraged the concept of socio-medical care' (Steel, 1971: 7). However, in Steel's opinion his strategy for dealing with medical demands was far from slavish, in fact consisting largely of 'playing one body off against the other' (1971: 8). This, he continues, is justified as it would be inappropriate for Parliament to accept the word of the medical bodies as final:

> Parliament is sovereign. Pressure groups and specialist bodies do indeed influence what happens there, and rightly so. But, especially in private members' legislation, Parliament must exercise its judgment amid the tumult of conflicting advice. Its bills are its own property and nobody else's (1971: 8).

Nonetheless, it is clear that medical objections had a large part to play in the withdrawal of the distinct social clause. In an interview conducted by BPAS decades later, Steel justified the clause's removal by arguing that the Bill's original 'categorisation of abortions as A-B-C-D was wrong … one should simply have a general approach to the subject which left the

judgment in the hands of the medical profession' (in Furedi and Hume eds., 2007: 51). It was the categorisation of abortions in this way that was most controversial among doctors, whether due to fears that women would feel they had a right to an abortion in certain defined circumstances, or because it was felt that it was not appropriate for doctors to decide on 'social' issues.

4.3.i Second Reading

Steel's speech at the Second Reading of the Bill was quite different, and evidently contained some ideas with which he came to disagree. Steel described his original Clause 1(1,a), which would have allowed doctors to abort if to continue the pregnancy 'would involve serious risk to the life or of grave injury to health, whether physical or mental, of the pregnant mother, whether before, at or after the birth of the child', as simply 'mak[ing] declaratory and clear[ing] the existing law' (Hansard, 1966: 1073). He went on to argue that in fact, to leave out the social clause would place too great a responsibility on doctors.

> If we in Parliament decide that we want cases of severe social hardship to be considered, we ought to say so. We ought not to demand of the medical profession that they should slip these in under a general Clause relating to physical and mental health (1966: 1074).

Using a broader definition of health which could include 'social well-being', he elaborated, would be 'possibly slightly dubious' (1966: 1074). While Steel's thoughts concerning the need to distinguish between 'social' and 'health' concerns changed over the course of the debate, the speech constructed a frontier that persisted in the rhetoric of the Bill's supporters throughout the Bill's journey through Parliament; that is, equivalences were created between doctors, pregnant women and the state, where all three were faced by a common enemy – the 'back-street' abortionist. As in other speeches, women were depicted overwhelmingly as

victims of illegal abortion (among other things). If only, the narrative went, women seeking abortions could be delivered from illegal abortionists into the hands of a properly registered doctor – acting, of course, in accordance with regulations set out by the state – a problem confronting all three could be tackled. For women, this problem was the 'back-street butchery' to which they were vulnerable (Steel in Hansard, 1966: 1079). For doctors, this was the need to assist women critically injured by these abortions, and the inability to prevent 'butchery' by performing safe abortions themselves. And for the state apparatus, of course, this was the mounting illegitimacy of the existing law (but also, in various constructions, the need to 'protect' women and/or doctors). The articulation of doctors, women and the state in this way was furthered in the debates which followed, particularly in discussion of, and attempts to amend, the so-called social clause.

A great number of participants in the debates were sceptical of the inclusion of social concerns as grounds for legal abortion. For some, this was due to a genuine mistrust of (some) members of the medical profession, whom, it was felt, might abuse this provision. Others, however, were influenced by the scepticism of the major medical organisations – for example, Conservative MP Bernard Braine, who worked closely with these organisations throughout the Bill's passage (Keown, 1988: 99-100). These latter objections provoked considerable redrafting of the clause until its eventual removal – however, in the view of some opponents, the final form the Act took 'smuggled in' social concerns in much the same way as decried by Steel in his opening speech at Second Reading.

In the Second Reading debate, supporters of the Bill persisted with the idea that abortion might be justified on social grounds. Many appealed to 'social problems' such as poverty and overcrowding, but others explicitly expressed the idea that 'health' might include social considerations. Notably, (then Labour) MP David Owen argued that 'the profession must …

accept that society has the right to make certain demands on it … social and economic background is a vital part of health' (Hansard, 1966: 1114). Like the accounts of pro-reform doctors, these arguments also emphasised blocked identity, depicting restrictive law as preventing doctors from carrying out their duty to help the patient. Proponents described the doctor consulted by a woman seeking an abortion as 'in distress' (Lyons in Hansard, 1966: 1090) and having difficulties providing adequate treatment (Vickers in Hansard, 1109).

Oppositional discourses attempted to break down this articulation; firstly, by breaking down the assumption underlying some supporters' arguments that the medical profession could be considered a coherent whole. Instead, these arguments divided the medical profession into numerous dissimilar groups. Labour MP William Wells, for example, painted a complex picture, noting that the BMA supported change, but not quite that proposed by Steel, that the RCOG was less certain of change, and that Birmingham gynaecologists were almost uniformly against change (Hansard 1966: 1082-3). Likewise, Conservative Bill Deedes sought to show that medical opinion was complex and divided:

> it is unwise to calculate here too much by consensuses. Certainly, there is a minority of doctors averse to the termination of pregnancies in any circumstances. There must be a minority who strongly support the termination of pregnancies in particular circumstances. There is another minority, a small minority, willing to consider termination of pregnancies without too close regard for circumstances (Hansard, 1966: 1091).

Employing a logic of difference, such arguments worked to make it more difficult for reformists to articulate the demands of 'the medical profession' as a unified whole. The most popular challenges to the discourse of supporters, in addition, furthered the idea of a 'pollution' of doctor roles and a desire to keep the 'social' and 'medical' realms separate. These arguments stressed that 'social' problems should have 'social' solutions. For example,

see Peter Mahon's response to David Owen: 'Does my hon. Friend, in all seriousness, consider that abortion is the remedy for the social evils which he is outlining?' (Hansard, 1966: 1114) and Sir John Hobson's statement that 'I do not think it is right to commit to the hands of doctors decisions on social and economic problems which are to be solved by the termination of prospective life' (Hansard, 1966: 1135). Opponents of reform implied that the Bill would somehow distort the role of the medical practitioner, as in Wells' observation that

> [David Steel] was very frank in saying that it was not really a question of health … One of the fundamental objections to the Clause is that it makes doctors arbiters not of medical questions, but of social ones (Hansard, 1966: 1085),

along with Deedes' assertion that 'doctors have been treated as subsidiary agents, agents to perform whatever we may consider right or wrong' (Hansard, 1966: 1091) and Kevin McNamara's fear that 'the doctor, on the uncorroborated evidence of the patient, is to be placed in the position of judge and jury' (Hansard, 1966: 1130).

4.3.ii Committee stage

Before Committee stage, the pressure of these arguments and those of the medical bodies prompted Steel to amend the social clause. ALRA was strongly in favour of the clause's retention and opposed to the subsumption of social concerns under the banner of 'health', with one member writing that the result would be to 'continue the present practice of making the psychiatrist the scapegoat for such terminations when we all know perfectly well that the mother's mental health isn't the crucial issue' (Diggory cited in Hindell and Simms, 1971: 175). Steel eventually amended Clause 1(1,a) so that doctors could consider risks to the patient's 'well-being' and her 'total environment actual or reasonably foreseeable' (Hindell and Simms 1971: 177), believing that both BMA and reformers could interpret these

provisions to suit themselves. Meanwhile, he proposed to withdraw the clause concerning the woman's 'capacity as a mother' and pregnancy as a result of rape, although some extra words were inserted into (1,a) allowing 'the health of any existing children of the family' to be taken into account (1971: 185).

During Committee stage, Steel explained that he had dropped the reference to 'capacity as a mother' as it as it appeared to allow 'entirely separate, non-medical grounds for abortion' (Hansard, 1967a: 110). He did not conceal the fact that the new Clause 1 still allowed social grounds; however, he argued that these should not be considered separately from medical concerns but as 'part and parcel of a correct medical judgment' (Hansard, 1967a: 110), and stressed that the aim of the Bill was to make life easier for the profession (Hansard, 1967a: 111). Of course, criticisms were raised, particularly concerning the broadness of the concept of 'well-being' (e.g. Pannell in Hansard, 1967b: 182; Dalkeith in Hansard, 1967b: 185). Bernard Braine decried 'the appalling difficulty of putting on the shoulders of two medical men the responsibility for making what may be largely social value judgements' (Hansard, 1967a: 115). This was countered by David Owen, who argued that health involved much more than 'illness and complete mental breakdown' (Hansard, 1967a: 145).

4.3.iii Report stage

At Report stage Steel withdrew the language of 'well-being'. This was seen as highly significant by both supporters and opponents of the inclusion of 'social' concerns, but Steel argued that it would not make a dramatic difference to the Bill, as 'health' included the concept of well-being (Hansard, 1967c: 963). Accordingly, debate continued to rage over whether it was appropriate to ask doctors to make 'social' judgments, with participants again arguing that doctors are not 'qualified' to make these judgments (e.g. Glover, McNamara in

Hansard 1967c: 969, 1029). Some participants suggested that social workers would be better equipped to make these decisions (e.g. Jenkin in Hansard, 1967c: 967)

A significant contribution came from Conservative Jill Knight, who continued with the theme of 'social solutions to social problems': local authorities could deal with housing, social workers could help overburdened mothers, and the benefits system could help with financial difficulties (Hansard, 1967c: 1033). Interestingly, Knight's speeches frequently employed a progressive rhetoric, underlining, for example, the need to

> have more homes and better facilities and give the parents a rest in caring for [disabled children] or every scrap of help we can, thus sharing the burden… Society is more and more recognising its responsibilities and bearing them (Hansard, 1967c: 1074-5).

4.3.iv Lords

The above lines of argument continued during debates in the House of Lords. Lord Silkin, moving the Bill's Second Reading in the Lords, expressed his disappointment at the removal of the social clause, claiming that 'in the course of its passage through the other place[1] the Bill has been considerably emasculated' (Hansard 1967e: 260). However, others felt that the Bill still allowed abortion on social grounds. Viscount Barrington, most notably, listed the forms the clause had taken in both the Silkin and Steel Bills, from 'inadequacy as a mother', through 'capacity as a mother', to 'well-being' – and finally, 'the health of the mother and/or the existing children of the family' (Hansard 1967e: 269). This, he continued, was a far more dishonest way of allowing abortion on social grounds than the 'well-being' clause (Hansard 1967e: 270). Accordingly, participants in the Lords debates continued to challenge the

[1] The euphemism 'the other place' or 'another place' is, by tradition, used by members of one House of Parliament to refer to business conducted in the other.

inclusion of ‘social’ concerns – whether these included ‘the health of the existing children of the family’ or simply a broad interpretation of the health of the pregnant woman.

However, some supporters of the Bill were prepared with a response. Lord Platt, for instance, argued that surely what Clause 1(1,a) refers to

> is in fact a medical indication, because it refers to the physical or mental health… But, even if this is interpreted as being a social rather than a medical provision, surely doctors for centuries have taken into account the social conditions of their patients before prescribing treatment for them. I know that I have always tried to do this and, what is more, I have always taught my students that they do not understand the full implications of a case unless they have taken into account the social state in which the patient lives (Hansard, 1967e: 317).

Later, in the Lords Committee stage, Lord Chorley argued that the objectionable words ‘refer to the physical and mental health of the children. It is not on purely sociological grounds at all’ (Hansard, 1967f: 1004). He continued,

> this is called the social clause, because the social element obviously comes into it; but, basically, it is a medical problem affecting the mental and physical condition of the children. ... Any doctor who tried to decide the thing on purely social grounds, without considering its effect on the mental and physical life of the children, would be going against the law (Hansard, 1967f: 1011).

In such arguments, Chorley and others like him appear to be becoming frustrated with their opponents’ refusal to accept the crucial concept of ‘sociomedicine’. The latter part of Chorley’s argument involves a lot of rhetorical manoeuvring around the role of ‘medicine’, as not simply assessing social circumstances, but rather their effect on ‘mental and physical life’. It is not clear how the two situations differ. However, in spite of several attempts at

amendment – some of which were almost successful – Clause 1(1,a) emerged from the Lords unscathed and incorporating a broad definition of 'health'.

By the later stages of the Bill's passage through Parliament, a distinct logic of medicalisation can be discerned in the arguments of Steel and his supporters. This logic breaks down the distinction made by opponents between social and medical concerns, instead articulating a range of concerns – adequate living conditions, good parenting, psychiatric *and* physical well-being – together using a broad definition of 'health'. In this articulation, the role of doctors is not threatened by the need to take all these into account when assessing abortion patients. Rather, it is threatened by the legal situation without the Abortion Act – as are women and the state.

4.4 Gendering the Bill

As convincingly argued by Sheldon, the passage of the Bill, in particular of the social clause, relied heavily on specific gendered discourses. The notion that women might have a 'right to choose' seldom cropped up in the parliamentary debates other than dismissively. Rather, women were constructed overwhelmingly as 'tarts and tired housewives' (Sheldon, 1997: 32) – either as fickle and irresponsible, or as weak and vulnerable victims in need of paternal care (Thomson, 1998: 101-2). Abortion was also frequently justified in terms of motherhood (remember the Silkin and Steel Bills' initial focus on 'capacity' or 'adequacy as a mother') and the family – hence the inclusion of 'the health of any existing children' in the eventual Act. These points need repeating: as later chapters demonstrate, the gendering of the Act is something which feminists and pro-choice actors engaging with abortion law must still confront.

For anti-abortion participants, women seeking abortion were simply irresponsible, irrational and frivolous 'girls' (Sheldon, 1997: 36-8) who were potentially complicit in the corruption of the medical profession with 'social' concerns. However, the reformists overwhelmingly portrayed women as vulnerable. I have already noted the importance of psychology in validating abortions for reasons other than a strictly physical threat to the pregnant woman's health. 'Psy' discourses of this kind often situate women as particularly vulnerable to a 'shattering blow' to their mental health (Flatseth and Madsen, 2013). David Owen – one of the most outspoken proponents of 'sociomedicine' in the debates – touched on the themes of both vulnerability and motherhood in his speech at Second Reading. Firstly, he observed that 'a woman is susceptible to depression at times of pregnancy' (Hansard, 1966: 1113), before going on to depict 'a woman who … shares her bed with her husband and two children, with perhaps two other children living and sleeping in the same room' (Hansard, 1966: 1114). Such a woman, if 'precipitated into a depression deep and long lasting' would be 'incapable of looking after those children' (Hansard, 1966: 1115).

Women, in the arguments of Steel's supporters, were also extremely vulnerable to exploitation by the illegal abortionists. These arguments expose the fantasmatic dimension of the logic of medicalisation. Medicalisation promises a fullness-to-come involving happy mothers, happy families, and a harmonious relationship between women and doctors. However, in order to achieve this idealised scenario, legislators must overcome the threat of back-street abortionists, depicted in evocative language – whether the 'grey-faced woman' with 'Higginson's syringe and a soapy solution' or the more expensive 'hasty medical man whose patient returns to a distant town, there to lie in terror and blood and without medical attention' (Dunwoody in Hansard, 1966: 1089). In these arguments, an illegal abortion can

never be an empowering experience[1]. These arguments are often, again, rounded off with fears for such women's families, such as this from Dame Joan Vickers, quoting a *Lancet* article:

> Countless women undergo the dangers of unprofessional abortion when no pregnancy exists and without having received any medical opinion whatever. Yet it happens that with invalidation or death of these mothers the family disintegrates, for around their health and their capacity to tend the children the whole house revolves and, therefore, these mothers are the very last to be permitted to jeopardise their well-being. (Hansard, 1966: 1109-10)

These images help explain the 'grip' of medicalisation on the parliamentary imagination. The language of vulnerability and threat assists the overall argument that women seeking abortions need to be delivered into the hands of the medical profession – not simply in order to access a clean and safe procedure, but in order to receive paternal 'guidance' whether an abortion eventually takes place or not. As Steel phrased it:

> It may well be that in many cases the effect of introducing the Bill will be that instead of a woman having a back-street abortion, she will discuss the matter with her family doctor, in some way be reassured and feel that she has been offered some guidance, and no abortion will take place at all (Hansard, 1966: 1076).

[1] 'Back-street' abortionists were not necessarily evil, irresponsible and/or unskilled across the board. In the four years leading up to *Roe vs. Wade*, an underground feminist collective in Chicago codenamed 'Jane' successfully carried out many abortions using techniques which were, by available accounts, safe and effective (Kaplan, 1997). In Belgium, before the liberalisation of abortion laws in 1990, illegal abortion clinics were common and provided safe, inexpensive abortions (Hadley, 1997: 45-6). However, in many cases women, in particular poorer women, have had to resort to potentially dangerous methods.

4.5 Notifications

One aspect of the Bill which seriously worried members of the medical profession was the issue of the notification of abortions to a government authority. This was due to the considerable wariness of the state already noted, and fear of pollution by 'social' concerns. While in favour of notification for research purposes, many doctors were concerned that the police would be able to easily access abortion records – as one doctor said, this might result in 'snooping, and ... police control' (Theobald, 1966: 978). There were also concerns that notification might compromise women's privacy and doctor-patient confidentiality. The medical bodies therefore recommended that notifications should only be disclosed on production of a court order. This request was not conceded, as Steel felt it was sufficient to leave regulations relating to disclosure to the Minister of Health (Keown, 1988: 105).

Critics of the Bill such as Jill Knight and Bernard Braine argued that the medical recommendations on notification should be included in the Bill, but their Amendments failed. In response, Steel declared the requirement for notifications to be a 'safeguard against abuse' and racketeering (Hansard, 1967d: 1249). However, as Keown has pointed out, its effectiveness for this purpose is limited – for an abortion to be legal under the Bill and subsequent Act, the doctors involved (presuming they are properly certified) need only to have decided 'in good faith' that the procedure was necessary. The absence of good faith is extremely difficult to prove (Keown, 1988: 131-2). Hence, notifications serve more as a source of statistics and information on abortion – to ensure, in short, that abortion remains *knowable* and hence *governable*. Sheldon treats notifications as a kind of governmental technology:

> A dark mass of female criminality which had been perceived as profoundly threatening to the existing social order (and, in particular, to the family) is thus brought into the open, and

> isolated in the bodies of individual women where it can be contained, monitored and controlled. The problem of abortion is changed from one of widespread and unquantifiable devi*ance*, to one of isolated, identifiable and treatable devi*ants* (1997: 29; emphasis in original).

What the Act also achieved, however, was the constitution of doctors as *quasi-state agents* in the collection of this information. This, as we have seen, was not an easy prospect for the medical profession to stomach. Keown suggests that the provisions for notification were only accepted by doctors in return for substantial medical freedom, ensuring that the decision to abort remained in their hands (1988: 165).

4.6 After the Act

Analysis of medical commentary in the years immediately following the Act delivers signs of (some) sedimentation of the logic of medicalisation. Evidence that the Act successfully established a 'social' identity for doctors is present in the proceedings of a symposium held by the Medical Protection Society, Royal College of General Practitioners, and RCOG in 1969. Like the debates preceding it, the symposium contained considerable discussion of doctors' roles and responsibilities. Margaret Dudley-Brown, for example, stresses that doctors, as gatekeepers to abortion, bear a responsibility to find out everything about a patient's circumstances in situations where 'there are not obvious clear-cut medical reasons for abortion', and to relay this information to other consultants involved (Dudley-Brown, 1969: 5). This apparent acceptance of the social role of doctors also recalls the paternalistic, doctor-knows-best image underlying Parliamentary debates on the Act – indeed, the gendered aspect of appeals to medical authority is made more explicit by Tooley, who objects to

patients' desire for privacy, describing such patients as 'hysterical and demanding' (Tooley, 1969: 11).

Many MPs feared that, under the Act, the 'statistical argument' (that early-term abortions are safer than carrying a pregnancy to term) could be used as legal justification for abortion on demand, giving greater control to pregnant women. However, Tooley uses this argument to reinforce medical authority over abortion, arguing that if all first-trimester abortions are legal, it is for the doctor to decide whether they are appropriate (1969: 9). Tooley's contribution persists with the image of the socially responsible doctor – far from being divorced from 'social' concerns, this doctor makes it his duty to adjudicate on them. This, of course, is predicated on the knowledge that the eventual decision to abort will remain in the hands of the doctor.

Perhaps the most compelling evidence of a shift in attitudes can be found in a *BMJ* leading article in 1971. In opposition to a pre-Act piece which worried about doctors making decisions 'on other than their expert knowledge' (BMJ, 1966: 1608), the article asserted that the decision to abort (or not) on 'social' grounds falls under a 'fundamental right to exercise professional judgment' (1971: 261). While adopting a disapproving tone towards women who are pregnant as a result of unprotected sex, the article conceded that 'It is no answer to say that women must pay for their mistakes and have the babies' and instead suggested that 'doctors should encourage the attitude that unless a child is really wanted sexual intercourse without contraception is an act of selfish irresponsibility by both parties' (1971: 261).

This is not to say that 'abortion on demand' or 'on request'[1] was widely regarded as legitimate at this time, even if 'social grounds' were becoming increasingly accepted. Many

[1] As Keown notes, 'abortion on demand' may be distinguished from 'abortion on request' in that the former refers to a woman's right to access abortion independently of the decision of a doctor, whereas the latter refers to

doctors continued to express concern over the way the Act was being interpreted, especially in the private sector, allowing abortions 'for reasons of convenience' (Lewis cited in Keown, 1988: 112). However, this should not be mistaken for widespread rejection of a social role for doctors: rather, as is evident from the arguments of Dudley-Brown, Tooley, and the suggestions of the *BMJ*, it was felt that doctors should be performing this role with more care and attention, and without simply granting the patient her wishes. The notion that the medical role was somehow being polluted by the intrusion of the social began to recede from public debate, with 75% of doctors approving of 'social' abortions in 1974 (Keown: 1988: 121). By the mid-1970s, both the BMA and RCOG had accepted the legitimacy of abortion on social grounds (Marsh and Chambers, 1981: 73-7).

Discussion

Many of the findings of this chapter are largely in accord with Sheldon's – in Parliamentary debates, women are constructed as vulnerable and in need of paternal protection, and doctors are constituted as paternal and as social agents. These are the key moments in the logic of medicalisation underpinning the 1967 Act. However, what is clear is that the Act required a great deal of negotiation between disparate elements – it did not, as implied by other accounts, draw upon a ready-made affinity between state and medical profession. Crucially, this negotiation involved a transformation of the identity of the medical profession – a *translation* which served to link women, doctors and the law together in a particular way.

One crucial aspect of this translation was the negotiation of doctors' identities. Reformists insisted:

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a doctor's decision to abort on no other grounds than the patient's request. However, in practice they are often used interchangeably to mean the latter (1988: 111)

> that it was within the doctor's sphere of duty and competence to promote this type of health, i.e. not only *should* the doctor take into account social factors, but he *could* measure and evaluate them (MacIntye, 1973: 125).

Clearly, the prospect of taking on a 'social' role was a bitter pill for many doctors to swallow, despite various academic accounts which contend that, to a certain extent, the medical profession has always had a social role. Before the Act, medical discourse on legalised abortion was preoccupied by the need to preserve a certain role for doctors. Even doctors in favour of abortion on social grounds attempted to situate such abortions within 'our duty to relieve suffering'. While these concerns began to recede after the Abortion Act came into effect, I do not want to suggest that the Act simply forced the profession to accept a 'social' identity in spite of its scepticism – if this had been possible, the original incarnation of the social clause might have remained intact. Rather, my contention is that the repeated re-drafting of the Silkin and Steel Bills, especially of this clause, constituted a sustained attempt to achieve the legalisation of 'social' abortions in a way that gelled with doctors' pre-existing understanding of their role and identity – as 'relieving suffering' but above all as 'protecting health'. The increasingly broad definition of 'health' expounded by Steel as the debates went on, combined with the gradual erosion of explicit provisions for 'social' conditions, allowed doctors to approach an understanding of abortions as necessary for 'health' in a wide range of circumstances, and of themselves as responsible for 'health' in its broadest sense.

The logic of medicalisation was thus governmentalising in that it transformed medical professionals into governmental agents, responsible not only for adjudicating pregnant women's decision to abort, but also for assisting the compilation of statistics which render abortion observable and knowable. However, it also made women into governmental subjects with a duty to manage their own bodies in a certain way. This was achieved by the

transfiguration of women seeking abortions into *patients*. Again, it must be stressed that the Abortion Act does not represent a hard-won *right* to have an abortion. Women cannot legally 'self-abort'[1]; in fact abortions are only legal when certified by two registered medical practitioners, in a hospital or other venue approved by the Secretary of State[2], and notified to the Department of Health. As Sheldon observes, this serves to make abortion identifiable and treatable. Moreover, the constitution of women as (properly) patients is not incidental but an express aim of the Act: Steel and others remarked frequently during debates that one of its most desirable effects would be to encourage women to consult their doctors. Similarly, the MWF explicitly linked the legalisation of abortion to the development of a state of affairs where a woman visits her doctor as soon as she thinks she may be pregnant.

Additionally, debates surrounding the Act began to position the *foetus* as a patient whose needs must be balanced with those of the pregnant woman (Steel cited in Furedi and Hume eds., 2007: 50-1). The emergence of the 'foetal subject' as a person and patient deserving treatment in its own right has worried feminists (Addelson, 1999; Duden, 1999; Michaels and Morgan, 1999; Lupton, 2013). It has, in many arguments, provided grounds for unnecessary invasive medical procedures, served to further objectify women's bodies and provided new criteria for judging women before and during pregnancy (Petchesky, 1987; Spallone, 1989).

The role of the state was not discussed as overtly in the debates as that of doctors and women seeking abortions, but it was often implicitly assigned a role. It was regularly assumed to be responsible, in a paternalistic sense, for the well-being of women and doctors. Participants in favour of reform listed wrongs and social problems that 'we' must put right (e.g. Vickers,

[1] In making this comment I do not mean to suggest that self-abortion is necessarily preferable to abortion carried out by medical professionals; however, it would entail a right to bodily integrity which is lacking in the 1967 Act (see Purdy, 2001: 255-7 for a discussion of self-abortion in relation to US law).

[2] Before the Act was amended by the Health Services Act 1980, the Minister of Health could also carry out this function.

Short in Hansard, 1966: 1109; 1158-61). The Act thus constructed a paternalistic-patriarchal state (Yeatman, 1997), concerned with protecting women from social evils but not, perhaps, with granting them bodily autonomy. At the same time, however, a limited role was proposed for the state in the actual business of regulating the circumstances under which abortion could be carried out, and this was the subject of prolonged debate (e.g. Hansard 1967c: 896-906; 940-959). Dissidence was quelled by invoking medical authority: doctors, as experts on health, would of course know better than Parliament whether an abortion should be carried out. Nonetheless, the same participants argued in favour of mechanisms such as notification to act as a check on the irresponsible or immoral doctors who might abort purely for financial gain. Hence a tension emerged between the image of the moral, paternal and responsible doctor who could be given free rein to carry out abortions, and that of the immoral, profit-hungry racketeer who should remain the subject of state vigilance. This tension became a focal point for those in favour of further restrictions to legal abortion, as later chapters will demonstrate.

The overriding effect of the logic of medicalisation was to re-inscribe abortion with meaning, making it less threatening. This was achieved, firstly, by constructing abortion as a 'health' issue, but also through a particular gendering of health: to justify abortion, the Act's supporters repeatedly invoked distinctively feminine modes of suffering (of the frightened young woman, the overburdened mother, or the tragic victim of the back-street abortionist) which might damage (mental) health, and impair women *in their function as women* (that is, as wives and mothers). Hence, the possibility that abortion might signify autonomy, self-determination and bodily integrity was constrained, and abortion instead came to signify a return to sanctioned feminine roles. As I suggested in Chapter Two, medicalisation thus operates to contain abortion's unsettling or radical implications.

However, this does not mean that the more ‘radical’ meaning of abortion discussed in that chapter has evaporated. Abortion’s relation to the female body will always provide a basis for it to resist subsumption under medical and governmental discourses. Moreover, the logic of medicalisation is not uncontested by those opposed to legal abortion. As following chapters will demonstrate, the opposing logics discussed here – which stress the differences between doctors and the threat to the medical profession from the ‘social’ – remained powerful in later debates. Nonetheless, the particular construction of the doctor-patient relationship encoded in the Act – vulnerable, weary women on the one hand and responsible, paternalistic doctors on the other – has channelled these debates in a certain direction.

CHAPTER FIVE. 1969-1980: SOLVING THE 'WOMAN PROBLEM'

Introduction

While feminist arguments were not really a feature of debates over the Steel Bill, distinctly feminist voices were heard in 1970s debates over abortion. The 1967 Act was a significant improvement on the pre-Act situation, where richer women were able to access abortion covertly in private clinics, but poorer women had to resort to much more dangerous methods. However, as the Act placed abortion under medical control rather than allowing abortion on demand, it sat uneasily with feminist calls for a right to choose. This placed feminist actors in a difficult position – the gendered implications of the Act were troubling, but at the same time it was essential to defend it from attacks from opponents of legal abortion. As this chapter demonstrates, this difficult position meant that the arguments produced by pro-choice feminist MPs often contained tensions and inconsistencies.

Attacks on the Act were frequent in the 1970s, and underpinned by the perception that widespread 'abuses' of the Act were occurring in the private sector. The alleged abuses ranged from abortions being carried out 'on demand' despite Parliament's intentions, to high charges and low standards of care for women undergoing abortion. Public outrage over these claims heightened in 1974 after a series of articles were published in the *News of the World*, and later as the book *Babies for Burning* (Litchfield and Kentish, 1974), by freelance journalists Susan Kentish and Michael Litchfield. The journalists made several shocking allegations: that samples of both journalists' urine received positive results at pregnancy testing centres who refer for abortion (Kentish was not pregnant); that many abortion doctors were Nazi sympathisers; that viable foetuses were being killed; and that at least one doctor had agreed to sell foetuses to be made into soap. These claims were later challenged in a

Sunday Times report, which discovered, for example, that one of the 'Nazi sympathisers' was Jewish and had lost his wife and son at Auschwitz (Francome, 1984: 166-8).

Nonetheless, these and other allegations influenced several MPs to introduce anti-abortion Bills during this period. Such claims served to undermine the notion of the 'socially responsible' doctor which was central to the Act's logic of medicalisation. However, there was another powerful image underlying the Act: that of the weary, vulnerable women in need of paternal guidance. Up to this point, the Act's supporters had been able to present themselves as the protectors of these women, meaning that those attempting to amend the Act had a 'woman problem' to grapple with. This chapter charts the various attempts to solve this problem. Section 5.1 outlines the first of several attempts at amendment, the St. John-Stevas Bill. Norman St. John-Stevas framed the Bill as a measure to promote public morality, which he saw as threatened by the actions of irresponsible doctors. As such, the Bill challenged the construction of doctors underpinning the Act. However, for the most part St. John-Stevas avoided the topic of women seeking abortions, except to comment that their interests might run counter to the interests of the public morality he was seeking to promote.

This ambivalence concerning women seeking abortion was problematic for the would-be reformists. As Section 5.2 demonstrates, MPs in favour of retaining the *status quo* were able to call powerful arguments to their aid, emphasising the vulnerability of women seeking abortion and utilising the horror figure of the back-street abortionist. These discourses were further reinforced by the Report of the Lane Committee, which was set up in 1971 to examine the workings of the Act after pressure from the pro-life lobby. The anti-abortionists were further challenged by the entry of feminist discourses into the debate. These discourses, outlined in Section 5.3, explicitly framed abortion as a women's issue. Women MPs speaking in these debates portrayed themselves as 'speaking for women' both inside and outside of

Parliament in their opposition to the Bills, and linked their campaigns on abortion to an extensive set of feminist demands. However, these were articulated alongside a general reluctance to contest the logic of medicalisation underpinning the Abortion Act, and the tension between the Act and the 'right to choose' was rarely made explicit.

Nonetheless, both feminists and other defenders of the Act were able to present themselves as acting for or defending women. Section 5.4 discusses the reformers' response to these discourses. This section argues that during this period, anti-abortion discourse moved away from a conservative emphasis on public morality and towards an appropriation of the liberal-paternalist and feminist arguments that had been elements of the logic of medicalisation. However, it retained an ambivalent attitude towards both, and this is demonstrated in Section 5.5's discussion of female vice and virtue in abortion debates.

The principal materials considered in this chapter are the Second Reading debates of the St. John-Stevas (Hansard, 1969), Irvine (Hansard, 1970), White (Hansard, 1975), Benyon (Hansard, 1977) and Corrie (Hansard, 1979) Bills, as these were the most significant Bills introduced during this period (see Table 2, p.129). Excluded from consideration were the Hunt Bill of 1971 and the Braine Bill of 1978 – as neither received a Second Reading, there was little material to be analysed. The St. John-Stevas Bill also never received a Second Reading, but as a Ten Minute Rule Bill, was discussed briefly at First Reading. Also excluded was the Grylls Bill of 1974 – this Bill went to Standing Committee, but was not debated at Second Reading. This chapter also considers the Report of the Lane Committee (1974), as the Committee's findings had a considerable impact on Parliament and were referenced in many of the debates to come.

Table 2. Abortion Bills 1969-1980

Bill	**Stage reached**	**Key provisions**
St. John-Stevas, 1969	First Reading	Required one of the two doctors who certify an abortion to be a consultant gynaecologist in the NHS.
Irvine, 1969-70	Second Reading	Required one of the two certifying doctors to be a consultant gynaecologist in the NHS, or a medical practitioner of equivalent status approved by the Secretary of State for Social Services.
Hunt, 1971	First Reading	Prohibited the charging of fees for referring or recommending persons to medical services or treatment (specifically aimed at abortion advisory services).
Grylls, 1974	Standing Committee	Similarly prohibited the charging of fees for referring or recommending persons to medical services or treatment.
White, 1974-5	Select Committee	Increased surveillance of private clinics, laid down statutory conditions for their approval, and prevented them being financially associated with referral bureaux. Also prohibited abortions from being carried out on non-resident women, lowered the upper time limit from 28 weeks to 20 weeks and required that the pregnancy must present a 'grave' risk to the life or health of the pregnant woman for an abortion to be carried out.
Benyon, 1977	Standing Committee	Required one of the two certifying doctors to have at least five years' clinical standing; prevented financial links between referring organisations and abortion clinics; introduced statutory conditions for the licensing of clinics; and reduced the upper time limit to 20 weeks. Also attempted to introduce new protections for conscientious objectors.
Braine, 1978	First Reading	Lowered the time limit for legal abortion to 20 weeks; clarified the law regarding conscientious objection; prevented financial association between abortion clinics and pregnancy advisory bureax.
Corrie, 1979	Report stage (adjourned)	Tightened the licensing of abortion clinics and ensured that they could not be financially associated with referral agencies; lowered the time limit for legal abortion to 20 weeks; inserted the words 'grave' and 'serious' into the Act; amended the conscience clause of the Act to allow greater protections for conscientious objectors.

Compiled from: Hansard; Marsh and Chambers (1981).

5.1 Contesting the 1967 Act

While sponsors of the amending Bills introduced in this period often claimed that their aim was simply to 'improve' the Act, each of these Bills did in some way undermine the logic of medicalisation that the Act had formalised in law. The first such Bill was sponsored by Conservative MP Norman St. John-Stevas in 1969 (Hansard, 1969). As a Ten Minute Rule Bill, it had little chance of progressing past First Reading, and St. John-Stevas' primary aim was simply to air his views to the House. The Bill's one provision would have required one of the two doctors who certify an abortion to be a consultant gynaecologist in the NHS. This amendment had already been discussed at length and defeated during the Committee stage of the Steel Bill, and St. John-Stevas was denied a first reading by 210 votes to 199 (Marsh and Chambers, 1981: 21-2).

In his speech at First Reading, St. John-Stevas explained that his Bill's purpose was to confront the 'rackets' developing in abortion provision. In doing so, he appealed to a widespread perception that multiple abuses were occurring in the private sector, with a number of doctors focusing on profit above all else and 'not observing the normal standards of medical care' (in Hansard, 1969: 412). St. John-Stevas framed the issue as one of public morality, appealing to a 'moral consensus' that abortion should not be banned, but that abortion on demand should not be allowed either (Hansard, 1969: 411-2). This consensus, he argued, was being violated, and legislation was needed to address 'the demands of the social, moral and medical strength and reputation of the country' (Hansard, 1969: 414).

Regarding doctors, St. John-Stevas' speech employed the logic of difference observed in Chapter Four, delineating different classes of doctors who cannot easily be grouped together. On the one hand were the 'racketeers' – the irresponsible doctors who cared more about profit than duty and whose actions 'amount[ed] almost to medical negligence' (Hansard, 1969: 412-

3). On the other hand was the figure of the responsible and ethical gynaecologist – 'a responsible medical person, highly qualified and highly placed' (Hansard, 1969: 413). Thus, the speech attempted to undermine the logic of medicalisation by implying not a unified, self-regulating medical profession but a range of disparate doctors, from the unethical, medically negligent and poorly qualified to the responsible, qualified and knowledgeable. Furthermore, it arrogated to the state the ability to decide which doctors were to be considered qualified enough.

St. John-Stevas' speech and Bill thereby attacked the key assumption of the Act concerning the medical profession. They challenged the Act's treatment of the medical profession as a self-regulating whole, capable of dealing with these matters on its own. Instead, the Bill attempted to establish a place for further, formal state intervention. In addition, and perhaps more damagingly, the speech challenged the idea of the socially responsible doctor established during the Steel Bill's passage through Parliament. Rather than the benign paternal guardians the Act's supporters had envisioned, private doctors in St. John-Stevas' speech were constructed as irresponsible, profit-hungry and immoral. The Bill therefore represented an attempt to de-governmentalise abortion and re-consolidate power in the more 'traditional' arms of the state.

However, the speech was less thorough in its challenge to the gendering of the Act. In fact, St. John-Stevas barely mentioned women until the end of the speech, aside from a joking acknowledgment that 'an agnostic mother of nine' might have been a more fitting person to introduce the Bill (Hansard, 1969: 411). The final words of the speech, however, indicated an uneasy acceptance of the image of the tired, vulnerable woman underpinning the Act, acknowledging the importance of tending to 'the needs of the individual mother, for whom we should certainly have concern and compassion' (Hansard, 1969: 414). Of course, St. John-

Stevas quickly returned to his conservative moral stance, adding that these needs must be balanced with the moral demands of society. Nonetheless, these closing words seem to indicate a belief (or at least a desire to be seen to acknowledge) that the 'psy' discourses and social concerns behind the Act were, to an extent, legitimate.

Subsequent attempts to amend the Act also targeted the alleged abuses taking place in the public sector and similarly distinguished between classes of doctors deemed appropriate or inappropriate for the certification of abortion. This was attempted in different ways, whether by requiring that one of the two doctors who approve abortion should be a consultant gynaecologist (as in the St. John-Stevas and Irvine Bills) or have been registered as a medical practitioner for at least five years (as in the Benyon Bill), or by setting stringent conditions for the approval of clinics (the White and Corrie Bills). Some of these Bills would have also restricted the grounds for legal abortion, or lowered the upper time limit to 20 weeks' gestation (see Table).

These Bills all challenged the logic of medicalisation underpinning the Act, although they did this in different ways. However, when it came to the place of women in their arguments, they were on less certain ground. The image of the tired and vulnerable woman who needs an abortion to avoid becoming a 'mental wreck', along with that of the women butchered by the back-street abortionist, had been firmly established in the parliamentary imagination during the passage of the 1967 Act, and indeed remained an important feature of pro-choice discourse, as Section 5.2 demonstrates. Moreover, the burgeoning feminist movement of the 1970s had provided powerful arguments in favour of liberal abortion laws and 'a woman's right to choose', arguments which began to enter parliamentary debate in the mid-70s and are detailed in Section 5.3. The sponsors and supporters of amending Bills therefore had to grapple with the 'woman problem' if they were to successfully alter the Act.

5.2 Defending the *status quo*

Those opposed to any alteration of the 1967 Act already had a whole repertoire of arguments at their command. In Parliamentary debates, the continued use of psy discourses and horror stories of 'back-street butchers' allowed opponents of the Bill to present themselves as the protectors of vulnerable women. In addition, these MPs challenged the logic of difference employed by the would-be reformists, stressing rather the unity of the medical profession and the potential damage caused by heightened state intervention. Backing up these accounts was the Report of the Lane Committee, appointed in 1971 to examine the workings of the Act. The Committee's eventual report reasserted the logic of medicalisation underpinning the Act, and stressed the need for governmental networking between doctors and the state rather than the coercion of the former by the latter.

5.2.i Parliamentary debates

Opponents of the Bills often accepted that 'one or two' doctors in the private sector (Steel in Hansard, 1969: 416) might be behaving unethically, but minimised the significance of this. Such abuses, they argued, would be more appropriately solved by tighter administrative controls rather than by new statutory measures. Overall, they rejected the different 'classes' of doctors proposed by many of the Bills:

> A doctor is a doctor. What can be more absurd than to have special categories of doctors in circumstances like this? As soon as a man is registered he becomes responsible for affairs of life and death every week, every day, yet for the purposes of termination of pregnancy he has to have a five years' registration (Cronin in Hansard, 1975: 1826).

The heightened level of state control of doctors the Bills would have established was especially disturbing to some:

> Is it suggested that a termination is lawful if it is done by a consultant gynaecologist in the Health Service and near murder if it is done by a gynaecologist outside it? … Have we reached the stage, in this field and in none other, to force people into the National Health Service? Is this a new monopoly in State medicine being suggested from the benches opposite? This is the astonishing thing. Is this a new tyranny coming from the opposition (Houghton in Hansard, 1970: 1701)?

Opponents of the Bills continued to back a governmentalised approach to abortion provision, in which direct state intervention is minimal and the medical profession is considered capable of self-regulation. The benefits of this were argued to be many. Some pointed out, for example, that the 1967 Act had actually resulted in *more* regulation of (now legal) abortion provision (e.g. Short in Hansard, 1970: 1669). For the most part, however, opponents revisited the liberal-paternal arguments which had proven successful in justifying legal abortion in the first place. Such 'social' arguments ranged from the concern that the Bills might result in higher maternal mortality rates due to significant delays in NHS provision (Steel in Hansard, 1969: 417), to noting the downturn in 'illegitimacy' rates (Hansard, 1970: 1692-6), to warning of a whole range of social ills:

> I believe very much in the sanctity of life. I think that is one of the central issues for all of us, whichever side we take on this Bill. I do not want to see a situation in which we have more physically and mentally handicapped children; more sick and handicapped mothers; more deaths in childbirth; more unwanted children, with all the social problems that will involve; more child abuse from those who are unable to care for their children and did not want to have them; more broken lives, and more broken families ... That is my view of the sanctity of human life (Ennals in Hansard, 1979: 908-9).

Such concern for fixing social problems was articulated alongside narratives of the trauma to the mental health of women who had 'more children than they could emotionally, rationally

or financially cope with' (Fairbairn in Hansard, 1977: 1853). The figure of the back-street abortionist continued to loom large in these speeches, with the 'untold physical and emotional harm' (Ennals in Hansard, 1979: 906) caused by illegal abortionists serving as a caution against the Bills. While these speakers sometimes distanced themselves from 'right to choose' arguments (Steel in Hansard, 1975: 1770), these narratives of trauma allowed opponents of the amending Bills to present themselves as the protectors of vulnerable women, and the Bills' supporters, by implication, as being 'against' women. As David Steel, quoting the Lancet, put it in his speech against the St. John-Stevas Bill: 'Things were certainly much easier for the gynaecologists before the public and Parliament had made their wishes known in the Act – but they were much harder for women' (Hansard, 1969: 420).

5.2.ii The Lane Committee, 1971-74

After considerable pressure from the anti-abortion lobby for the 1967 Act to be re-examined, the Lane Committee was appointed in 1971 with the Hon. Mrs Justice Lane as chair. However, the same lobbyists were critical of the Committee and the eventual Report it produced: firstly, its composition was felt to be skewed in favour of legal abortion; secondly, its terms of reference only included administrative questions about the working of the Act. Consideration of the morality of abortion was outside its remit (Marsh and Chambers, 1981: 23). The Committee produced its Report in 1974. The Report was mainly favourable towards the Act, although it did recommend non-statutory measures be taken to counter private sector abuses. The only legislative change it recommended was that the time limit for legal abortion be lowered from 28 to 24 weeks (Lane Committee, 1974).

Like participants in parliamentary debates, the Report elaborated a logic of medicalisation underpinned by psy discourses and assumptions of female vulnerability. Its opening pages

situated the 1967 Act with reference to the social changes of the preceding decades and the social ills ameliorated by legal abortion: ‘the burden of often repeated, unwelcome and debilitating child-bearing’ and ‘the serious mental stress which may result from an unwanted pregnancy ‘ (Lane Committee, 1974: 4). The Report went on to detail the consequences of failure to achieve a wanted abortion. The risk of a ‘reactive depression’ (1974: 53) was foregrounded, as was the adverse effect on the chances of marriage for the ‘mother of an illegitimate child’ (1974: 60), although the possible effects on schooling and training were also mentioned.

The Report’s recommendations regarding practitioners relied heavily on the principle of medical freedom. Proposals that only certain categories of doctors might be allowed to certify abortion were regarded as an ‘injustice’ to ‘responsible doctors’ (1974: 66). The Report rejected this kind of state intervention in favour of an emphasis on the ability of the profession to self-regulate:

> We consider that it should properly be for the medical profession to set and enforce its own standards of ethics and practice, and that this should be done without excluding from any particular branch of medical work practitioners who have not offended against these standards (1974: 66).

Thus, the Report promoted governmental networking involving translation between the aims of doctors and the state, rather than the coercion of the former by the latter. However, the same vision of a responsible and self-regulating medical profession was used to recommend against allowing abortion on demand or request. This stance was justified, firstly, with regard to ‘good medical practice’ (1974: 65) and the ideals of sociomedicine:

> that a patient should be treated as a whole person viewed in the light of personal physical and mental health and social conditions and not merely as one suffering from a particular disease or condition requiring amelioration or cure (1974: 64).

Secondly, the Report justified its recommendation against abortion on request by appealing to the potential effects on, and character of, women seeking abortion:

> Further, some women would find the burden of making their own decision, unsupported, a heavy one and in such cases the operation might well be followed by emotional turmoil and feelings of guilt. Additionally, they would be more vulnerable to pressure from parents, husbands or boy-friends. Another advantage of permitting abortion on demand might in some cases be to encourage neglect of contraceptive precautions (1974: 65).

In this passage, women appear as *either* vulnerable – susceptible to psychological trauma and manipulation – *or* irresponsible – unlikely to manage their bodies responsibly without paternalistic guidance. The Report's recommendations concerning medical practice therefore illustrate how the logic of medicalisation cuts both ways. It guards against heightened state control over and restriction of access to abortion – but its paternalistic logic undermines the notion of a 'right to choose' and constructs women as incapable of responsibly exercising this right.

5.3 Feminism enters the debate

Parliamentary feminism during this time was constituted of two sets of politics. One comprised a radical contestation of gender regimes in Parliament and beyond, and the other was committed to defence of the 1967 Act and its underpinning principles. Steering a course between being overly celebratory and overly pessimistic, this section demonstrates that pro-

choice women MPs clearly articulated a feminist agenda – often hostile to what one termed the 'maleocracy' of Parliament – in each debate, and contested the gender regimes operating in Parliament and society. However, the same MPs tended not to examine the workings of the 1967 Act with the same critical lens, and produced narratives of female vulnerability and 'acceptable' abortion which ultimately undermined any commitment to the principle of 'choice'. Nonetheless, these arguments must be viewed in context: in defending the Act, feminist MPs were forced to defend the problematic constructions of women seeking abortion which underpinned it.

5.3.i Narrating 'acceptable' abortion

Lesley Hoggart (undated), examining pro-choice activism during the 1970s, notes that forging alliances with Parliament and trade unions had significant consequences for feminist activists. This contact with 'political reality', she argues, resulted in the National Abortion Campaign (NAC) neglecting its feminist principles and radical politics. This was a precursor to what she sees as a wider deradicalisation of feminism – 'the price feminists paid for becoming involved in state agencies and mainstream political institutions in the 1980s'. In the mid-70s, NAC was firmly in favour of a woman's right to choose and opposed to the liberal-paternalism of the Act, its stated aim 'not only to reject familial policies but actively to challenge the authority of the state to govern women's choices' (Hoggart, undated). According to Hoggart, however, NAC's radicalism proved difficult to sustain. Firstly, NAC was dragged into engagement with Parliamentary politics, in spite of its wish to remain outside of formal politics. This caused some tensions in the movement:

> The revolutionary feminist policies of NAC moved it to reject the tactics of a parliamentary pressure group, but there was always a contradiction between NAC's inclination towards such

> a rejection and the knowledge that policy struggle over existing legislation is necessarily centred on Parliament. … Whilst NAC pointed to the inadequacies of the 1967 Abortion Act, the concern expressed in the House of Commons was to make the 1967 Act work effectively as a public health measure within definite limits (Hoggart, undated).

As a result, radical demands were side-lined in favour of a strategy of defending the 1967 Act, however problematic the Act was from a radical perspective. NAC's leadership judged that a working alliance with the labour movement, notably the Trades Union Congress (TUC), would be vital to achieve this goal, and by 1979, it was aware that its radical aims were unlikely to mobilise this group. The Campaign Against Corrie (CAC) was thus launched, as a broad-based campaign involving both NAC and trade union activists, which would campaign alongside NAC. Unlike NAC, however, CAC did not situate abortion rights in the broader context of women's rights and women's liberation. Rather, it emphasised the possibility that the Corrie Bill would disproportionately affect working-class women, potentially meaning a return to back-street abortions. This strategy was successful, and Corrie withdrew his Bill on 26 March 1980 once it became clear that it would not succeed.

Hoggart thus identifies two sets of politics operating within NAC during this period: firstly, the call for free abortion on demand situated within the broader context of women's liberation, and secondly, the inclusive, defensive politics of CAC. A CAC poster demonstrates this well (CAC, undated). The poster mimics a *Peanuts* comic strip, but the characters discuss the Corrie Bill, focusing on the proposed restriction of the upper time limit for legal abortion to 20 weeks' gestation. Abortion, characters stress, 'is a great emotional trauma – it needs a lot of thinking about'. The poster emphasises the vulnerability of women with unplanned pregnancies, and the possibility that unwanted children might be abused: 'if women are forced to have children, they may better them through nervous strain or

resentment'. The poster is obviously designed for broad resonance, and there is no mention of a 'right to choose' or other feminist language – rather, it translated feminist demands into a format which resonated with the logic of medicalisation.

This is a good example of what Jeannie Ludlow has termed 'the trauma-tization of abortion' (Ludlow, 2008). Ludlow identifies a 'hierarchy of abortion narratives' at work in pro-choice rhetoric. Firstly, there are the narratives deemed 'politically necessary' to tell: those involving trauma and women's vulnerability – to rape, incest and domestic violence as well as to back-street abortion. Secondly, there are the narratives considered 'politically acceptable'. These concern contraceptive failure rates, women's financial difficulties, and foetal anomaly. Finally, there is a third category of narratives – 'the things we cannot say' (2008: 30). These include narratives of failure to use contraception (correctly or at all), of multiple abortions, of grief after abortion and of the economics of abortion provision. The latter category is, according to Ludlow, most familiar to clinic workers, but the most downplayed in public pro-choice discourse.

5.3.ii Feminism in Parliament

While Ludlow's work focuses on pro-choice activism in the United States, a similar emphasis on 'acceptable' abortion can be observed in British abortion politics. A feminist contingent was beginning to develop in Parliament during this time, and by the time of the White Bill's Second Reading, there were several women willing to speak up in Parliament and frame abortion explicitly as a feminist issue. According to Elizabeth Vallance, the Bills were seen as a serious threat by Labour women MPs. Angry that their male colleagues seemed so indifferent to such an important issue, these women were galvanised by the abortion debates, and Vallance argues that the threats to the 1967 Act were largely responsible for the group

identity women MPs managed to forge in this period (Vallance, 1979: 75; 88-90). This subsection evaluates the feminist argument using the framework developed in Chapter Three.

Probably the most active pro-choice woman speaking in these debates was Renée Short. Short was no stranger to abortion debates, having sponsored a Ten Minute Rule Bill dealing with abortion before the Steel Bill was introduced. Other notable participants include Lena Jeger, Jo Richardson and Maureen Colquhoun. In these women's arguments, abortion is explicitly framed as a *women's* issue, and connected to questions of women's parliamentary representation. Speaking 'for women' features prominently as a theme:

> It is, above all, a subject that concerns women. Practically all the women on this side of the House support the original 1967 Act and oppose this proposed amendment. I am sorry that there are not women on the other side of the House who are apparently anxious to take part in this debate, for this is a matter that concerns women very much indeed (Short in Hansard, 1975: 1813).

> I speak for women in the House and outside. When I speak about women outside the House I refer to women in our own organised movement and in the Labour and trade union movement who also support the Act (Short in Hansard, 1975: 1814).

> We have heard a lot of statistics today. I sometimes wonder whether we are talking about women at all. Perhaps if there had been more women Members of Parliament present today on the Opposition benches, we might have heard a wider variety of contribution. I must remind the House that this is International Women's Year (Jeger in Hansard, 1975: 1830).

In addition, these MPs frequently articulated this feminist agenda together with a labour movement agenda, pointing out that women from the upper classes had never had trouble obtaining abortions, and that it was working-class women who would suffer most from any restrictions (e.g. Short in Hansard,1975: 1814; Jeger in Hansard, 1977: 1829). However, by

far the most explicit articulation of pro-choice demands into a counter-hegemonic chain of feminist demands was made by Colquhoun, who explicitly connected the issue of abortion to issues of women's representation, discrimination and equal pay.

> We seem to be considering constantly anti-women measures, which preoccupy this male-dominated Chamber. Perhaps I should suggest to the Prime Minister that he appoint a woman Minister with Cabinet rank to guard the rights of women. Then perhaps we should not have the kind of legislation that is constantly cropping up in this House to prevent women from having the right of abortion (Colquhoun in Hansard, 1977: 1847).

> As a woman and as one of the small minority of women Members, I protest about the legislation that is set out by men. We have had the fundamentally weak Sex Discrimination Act and the Equal Pay Act, which have been of almost no significance to women when they get down to the nitty-gritty of having to use these laws, which have engendered a hardening attitude towards women. There are constant attempts to change the 1967 legislation in order to make it clear to women that their bodies are definitely not their own. They are the subject of laws to be made in this House, by and large, by the maleocracy. Whichever way one looks at it, the House of Commons is not a democracy but a maleocracy (Colquhoun in Hansard, 1977: 1847).

There were elements of radicalism in these contributions. Women MPs explicitly constructed a chain of equivalence between access to abortion and other women's issues: in particular, the matter of women's representation in Parliament, but also, in Colquhoun's speech, those of discrimination and equal pay. These demands formed the basis of their group identity in opposition to the male-dominated House or 'maleocracy', which was figured as hostile or at least indifferent to women's interests. Implicit in this was an imaginative politics which envisioned a world in which there are more women in politics guarding women's interests – including women in the Conservative party, and in the Cabinet.

Nonetheless, as Chapter Three argued, counter-hegemonic agendas also contest the fundamental norms of a regime or practice. Women MP's speeches in these debates certainly contested the 'maleocracy' of the House of Commons and the gender regimes operating in society as a whole. However, with the exception of Colquhoun's contributions, they were far less radical when it came to critiquing the norms underpinning the 1967 Act. If anything, the centring of doctor's narratives rather than women's narratives was furthered in these speeches. For example, Jeger asked the House to consider 'the awful decision which faced doctors in the days before the law was changed', and centred the doctor's perspective in the tale of a woman who died after having an illegal abortion:

> I speak as a doctor's wife, and my husband used to work in a very poor part of the East End of London … I remember my husband being called out to see a girl who had undergone an abortion and who had interfered with herself in a horrible way. My husband got the girl into hospital and she died there. The next thing that happened was that a policeman arrived and said to my husband 'You sent her into hospital and were the last doctor to see her'. My husband replied 'I can only say that if I had carried out the operation it would not have gone septic' (Jeger in Hansard, 1975: 1828-9).

Women MPs also actively articulated the interests of women and doctors together, assuming that these interests must necessarily be aligned:

> The other particularly dangerous provision is in Clause 9. It is incredible that this House, the so-called bastion of democracy, should be even thinking of giving power to the police to investigate records, take away doctors' files and break that confidential link which has always existed between doctor and patient and which we should jealously preserve. It is monstrous, not only because women and doctors are involved but from the point of view of civil liberties (Richardson in Hansard, 1977: 1870).

> It is a denial of the rights of women to decide how many children to have and when she will bear them, and the thing I find equally objectionable is that is displays complete mistrust of the medical profession in a way that is truly astonishing (Short in Hansard, 1977: 1799).

In addition, abortion was constructed as being like any other medical practice, with participants stressing the unity of medical practice in opposition to the logic of difference employed by the Bill's supporters (e.g. Short in Hansard, 1977: 1803). Sometimes, the medicalisation of abortion was explicitly linked to narratives of trauma:

> I submit that it is an extremely traumatic experience for a woman to have to go through an abortion at all, and she must be particularly desperate to have to come to this country to have it carried out. She is in need of help and compassion. It is astonishing that we in the House of Commons should seek to celebrate International Women's Year by making this differentiation. If a foreign gentleman comes to London to have his prostate fixed, he does not get sent home. How can we divide the specialities of medicine? How can we try to single out one element in the practice of medicine and ascribe to it a different branch of legislation (Jeger in Hansard, 1975: 1830-31)?

Such attempts to establish a continuity between abortion and other medical procedures reinforced the notion that doctors, not pregnant women, know best when it comes to abortion. Overall there appears to be a tacit acceptance of the logic of medicalisation underpinning the Act. While MPs constructed equivalential chains which linked together a series of demands concerning 'women's issues', this was not done in a way which contested the fundamental norms underpinning the 1967 Act and the provision of abortion. Considering the extent of the feminist critique of medicalisation, this is a worrying omission: the problematic notions of gender underpinning the Act went unchallenged.

It must be noted that pro-choice women were in a difficult position in these debates. Doctors' and women's interests were not only constructed as aligned by participants, but *constituted* that way by the Act, which solved the problem of women's access to abortion by transfiguring women seeking abortion into patients. Defending women's access to abortion therefore necessitated, to some extent, defending a medicalised *status quo*. Moreover, pro-choice participants in the debates did not necessarily accept medicalisation wholesale. While Maureen Colquhoun was the only of these women to also overtly criticise the 1967 Act and call for legislation giving women a full right to choose (Hansard, 1977: 1947), tensions emerged in other feminist accounts as participants noted the existence of 'reactionary chauvinist doctors' (Short in Hansard, 1977: 1801) and patchy NHS provision.

Nonetheless, overall the contributions of these women served to reinforce, rather than to undermine, the logic of medicalisation. A fantasmatic logic of trauma-tisation developed in their speeches which constructed women as heavily threatened – by male sexuality but moreover by 'back-street butchery' (McDonald in Hansard, 1979: 1882) and restrictive abortion law. These accounts utilised gruesome imagery:

> The knitting needle is no joke. Before the 1967 Act was passed I worked in an office where there was a young junior of 15. She came in late one morning. I asked her why she was late. She said 'It was my mum. She fell again. We had her jumping up and down off the kitchen table all night. She has one or two instruments and I hope they will do the job' (Richardson in Hansard, 1979: 928).

It is no surprise that these narratives of back-street butchery should have been deemed politically necessary to tell by pro-choice MPs: many women did indeed die in appalling circumstances before the 1967 Act came into effect, and their deaths provide a powerful case for legal abortion. However, by contrasting the figure of the back-street abortionist to that of

the responsible and ethical doctor (as for Jeger's husband: 'if I had carried out the operation it would not have gone septic'), these narratives served to cover over the contingency of medicalisation and foreclose other options. Narratives of trauma-tisation mobilised against attempts to restrict the terms of the Act, but they also reinforced the logic of medicalisation, as implicit in these narratives were images of the paternal and protective doctor who can protect women from such tragedies.

5.4 Anti-abortion discourse: appropriating the mantle of feminism?

This section turns to 'reformist' discourse from the Irvine Bill to the Corrie Bill. The sponsors and supporters of these Bills were often avowedly anti-abortion, but viewed a more gradualist approach as more likely to be successful, although some supporters claimed to be merely concerned with tackling 'abuses' of the Act. Analysis of their contributions in Parliamentary debate, however, reveals a shift away from the conservative concern with 'public morality' emphasised by St. John-Stevas, towards a seemingly more progressive concern with the protection of vulnerable women. This latter concern seems designed to cut into the Act's supporters' monopoly on sympathetic accounts of women seeking abortion, which had been critical in bringing the Act through Parliament in the first place.

At the forefront of such contributions were narratives of 'villains and victims' (Lee, 2003; 2013). These involved, on the one hand, continued use of a logic of difference distinguishing 'responsible' from 'irresponsible' doctors, 'specialised' from 'non-specialised', 'experienced' from 'inexperienced' and so on. The use of this logic of difference served to undermine the pro-Act assertion that doctors could reliably self-regulate on the matter of abortion, instead emphasising the need for core state intervention to separate the wheat from the chaff. On the

other hand, these narratives presented women as 'victims' of legal abortion, vulnerable to exploitation by villainous doctors – a significant shift away from St. John-Stevas' construction of individual women's interests as somehow at odds with the moral demands of society. These arguments clearly represent attempts to weaken the claim of those in favour of the *status quo* to be 'on women's side'. Indeed, elements of the reformists' speeches very much resemble feminist rhetoric concerning women's rights and entitlements. However, tensions remain in the reformists' construction of women seeking abortion, and these are elucidated in Section 5.5.

5.4.i The Irvine Bill, 1969-70

The Irvine Bill's Second Reading debate occurred in February 1970. Similarly to the St. John-Stevas Bill, the Bill would have required one of the two certifying doctors to be a consultant gynaecologist in the NHS, or failing that, a medical practitioner of equivalent status approved by the Secretary of State for Social Services. The Bill was 'talked out' at Second Reading, meaning its allocated time was used up in debating, with no vote ever being taken. Nonetheless, it had the support of the BMA and RCOG, which claimed to be concerned only 'to safeguard the interests of the health of the women concerned' (Hansard, 1970: 1655). This was the framing given to the Bill by its sponsors during the Second Reading debate.

Irvine's speech centred on the standards and safety (or lack thereof) of abortions carried out in the private sector. Like St. John-Stevas, he employed a logic of difference designating different categories of doctors, from the 'racketeers' to the responsible specialists. The fear figure of the 'professional abortionist' (Hansard, 1970: 1657) who only cares to profit from abortion featured heavily in the speech. Opposed to this was the consultant gynaecologist with a 'responsible medical opinion' (Hansard, 1970: 1664), who is able to 'give specialised

attention to girls who require it' (Hansard, 1970: 1663). This 'divide and rule' tactic served to legitimate calls for increased state intervention to separate the responsible specialists from the profit-hungry racketeers.

These arguments were familiar from the St. John-Stevas Bill. However, Irvine's speech was much stronger in how it handled the 'woman problem', containing language very similar, in fact, to that used to legitimate the 1967 Act. Irvine stressed the vulnerability of 'girls' who seek abortion and the need for paternalistic intervention:

> One girl came to see me last week. After three hours in a clinic she was sent home, and two days later she had to go to a National Health Service hospital, where she was desperately ill for six weeks. Another girl, about whom I heard yesterday, was in a clinic for one hour, and subsequently had to spend 13 days in a National Health Service hospital because of the problems which had arisen. Another girl said that the conditions in the place to which she went were rather like Piccadilly Circus (Irvine in Hansard, 1970: 1664-5).

In this subversion of pro-choice discourse, the private sector abortionist has replaced the back-street abortionist in a fantasmatic logic mobilising *against* the Act. This logic dis-articulates the idea of the vulnerable woman from the logic of medicalisation, and rearticulates it in a logic where women are *threatened* by doctors and paternalistic state intervention is necessary. Irvine is subsequently able to present himself, rather than his opponents, as the socially progressive protector of vulnerable women: 'I want to see that humanity is offered to girls in this condition, and that they get proper medical care' (Hansard, 1970: 1665).

Nonetheless, there remained tensions in this vision. These became more evident with St. John-Stevas – who also sponsored the Bill – made his speech. St. John-Stevas' speech began in the same vein as Irvine's, complaining of abortion 'mills' with poor standards of care

(Hansard, 1970: 1675). However, following an intervention by Renée Short, St. John-Stevas dismissed her for her 'theological view of the right of women to have abortions on demand' (Hansard, 1970: 1675). By the end of his speech, St. John-Stevas had returned to the conservative framing of the Bill as an issue of 'the requirements of public morality', opposed to and privileged over 'the needs of women' (Hansard, 1970: 1683).

5.4.ii The White Bill, 1974-75

As the Lane Committee had come under considerable fire due to its remit and composition, its Report did not serve to quell anti-abortion activity. By the time the White Bill reached its Second Reading in February 1975, the Department of Health had already taken administrative action to prevent the worst 'abuses' in the private sector. However, its actions were not widely publicised, and many MPs were unaware of its efforts (Marsh and Chambers, 1981: 28-9). In combination with the publication of *Babies for Burning* the previous year, this meant that parliamentary support for changed abortion law remained considerable. However, by this time there was also a notable cohort of women MPs who explicitly framed abortion as an issue of women's rights.

The White Bill would have increased surveillance of private clinics, laid down statutory conditions for their approval, and prevented them from being financially associated with referral bureaux (this latter provision would have severely impeded the work of charitable organisations such as BPAS). Unlike previous Bills, however, it would also have prohibited abortions from being carried out on non-resident women (more in this in Section 5.5), lowered the upper time limit from 28 weeks to 20 weeks and removed a clause from the Act that provided apparent basis for the 'statistical argument' (that early abortions are always safer than carrying a pregnancy to term, and therefore always legal), replacing it with one

specifying that for an abortion to be carried out, the pregnancy must present a ‘grave’ risk to the life or health of the pregnant woman. This would have rendered a large proportion of abortions illegal. It would also have undermined the inclusive definition of medicine underpinning the Act, in which a broad range of ‘sociomedical’ concerns may be seen to require intervention, and undermined the idea that doctors are capable of making this decision without state involvement. The Bill was forwarded to a Select Committee and lapsed at the end of the parliamentary session.

As with the St. John-Stevas and Irvine Bills, the Bill’s supporters employed a logic of difference which separated responsible and irresponsible, qualified and under-qualified doctors. In these constructions, doctors’ roles were polluted by the involvement of ‘non-medical people’ (White in Hansard, 1975: 1760) in advising and referring on abortion, justifying further state intervention. The issue of doctors’ conscientious objection to abortion, which had been discussed briefly in previous debates, took up a significant amount of time at the Second Reading of the White Bill. Supporters of the Bill expressed their fear that doctors and nurses were being ‘victimised in their own professions’ (Delargy in Hansard, 1975: 1842) for not carrying out abortions.

While a separate matter from the private sector abuses, the conscience issue had the benefit of underscoring sponsors’ emphasis on differences between ethical and unethical doctors, and further suggesting that doctors’ proper medical roles were being polluted by abortion: ‘There are gynaecologists who believe that their role is to bring life into this world and who find it too repugnant that their task should involve the ending of life’ (Abse in Hansard, 1975: 1785). These doctors were thrown into sharp relief by the ‘totally unscrupulous’ (Grylls in Hansard, 1975: 1789) doctors who were ‘openly boasting’ (Braine in Hansard, 1975: 1856) about the

availability of abortion on demand, with the implication that those in the latter category were not mindful of what medicine is really about.

With the White Bill also came another shift in the construction of women seeking abortions. White's opening speech indicated an acceptance of the narratives of trauma-tisation promoted by the Act's supporters:

> Until such time as the "New Jerusalem" comes along with no bad housing, no poverty and no alcoholic husbands, I insist that abortion must be made available for women with problems (Hansard, 1975: 1757).

Significantly, however, the speech downplayed paternalistic narratives of vulnerability in favour of appropriation of the feminist language of women's rights and entitlements:

> Women who go into these clinics are entitled to feel sure that they are properly conducted medically and surgically and that they are within the law. Women are entitled to proper privacy, and to feel sure that they have had a genuine pregnancy test; society is entitled to be satisfied that the clinics are charging proper rates, keeping proper accounts and paying tax (Hansard, 1975: 1759).

Interestingly, in this construction women's interests/'entitlements' and society's interests are once again aligned rather than opposed. Other supporters of the Bill continued to push the notion that women might be hurt by abortion, claiming an increase in psychiatric cases since the Act was passed (Jones in Hansard, 1975: 1765; Taylor in Hansard, 1975: 1835) and noting women's vulnerability to exploitation by private clinics: 'We have no illusions about the inexhaustible ingenuity of the evil men who for private gain will prey upon women in trouble' (Abse in Hansard, 1975: 1780). Supporters who used this line turned narratives of trauma-tisation to their advantage, breaking off a privileged moment in liberal-paternal discourse on abortion (the vulnerable woman) and rearticulating it into anti-abortion arguments.

5.4.iii The Benyon Bill, 1976-77

The recommendations of the Select Committee which examined the White Bill were relatively restrictive. The Committee members most in favour of the *status quo* walked out, feeling that its recommendations were bound to undermine the Act (Marsh and Chambers, 1981: 32); meanwhile, ALRA and NAC refused to submit evidence (Select Committee on Abortion, 1976: 2). The Benyon Bill was based on the Committee's recommendations. Unlike the White Bill, it did not attempt to insert the words 'grave' and 'serious' into the Act. However, it would have required one of the two certifying doctors to have at least five years' clinical standing; it would have prevented financial links between referring organisations and abortion clinics (again making the work of charitable bodies difficult); it would have introduced statutory conditions for the licensing of clinics; and would have reduced the upper time limit to 20 weeks. It also attempted to introduce new protections for conscientious objectors. The Bill completed its Committee stage but lapsed at the end of the parliamentary session.

The Bill, and subsequent debate, again employed a logic of difference, dividing doctors up into categories. However, rather than emphasising the difference between specialised and non-specialised doctors, the requirement for one of the certifying doctors to have five years' standing introduced the idea of a gradient of medical experience. The Bill's supporters argued that doctors 'fresh from training' (Kellet-Bowman in Hansard, 1977: 1843) could not be relied upon to make such importance decisions, and that inexperienced doctors might take the decision 'in a cavalier way' (Abse in Hansard, 1977: 1883). In addition, participants depicted the medical profession as somehow tainted by the profits (potentially) involved in abortion provision (Kellet-Bowman in Hansard, 1977: 1843), a taint which extended to their ability to offer impartial counselling and advice (Benyon in Hansard, 1977: 1786; Braine in Hansard,

1977: 1829). (When pointedly asked why he was against profit-making from abortion ‘when he supports profits in virtually every other matter’, Braine retorted that abortion ‘is not like any other medical procedure’, as it involves the destruction of life [Hansard, 1977: 1830]). Conscientious objection remained a point of contention, with supporters of the Bill again constructing ‘responsible’ doctors as victimised by the Act and by legal abortion.

In this debate there was less effort made to appropriate feminist discourses of rights and entitlements, although supporters continued to present themselves as the protectors of vulnerable women: ‘the important thing is that the woman should be helped to come to the right decision and that she should not be pressurised in any way whatever’ (Benyon in Hansard, 1977: 1786). Benyon stressed the Bill’s benefits to women and argued out that his proposals would give the DHSS an opportunity to improve the standards of after-care for women undergoing abortions (Hansard, 1977: 1787). Others emphasised the ‘shattering’ nature of abortion for women (Braine in Hansard, 1977: 1834). This emphasis on the potential damage caused to women by abortion allowed supporters of the Bill to dismiss calls for abortion on demand as ‘extreme’ (Braine in Hansard, 1977: 1827), and to portray easy access to abortion as the result of ‘abuses’ rather than the realisation of a right:

> The inevitable result has been the development of a large and flourishing sector in which, because the motivation was not care of the woman but the making of profit, the ‘social’ clause has been interpreted so freely as to constitute abortion on demand (Braine in Hansard, 1977: 1827).

In such arguments, the concept of abortion on demand is disconnected from feminist arguments concerning reproductive rights and instead conceptually linked to anti-women practices and exploitation.

5.4.iv The Corrie Bill, 1979-80

The Corrie Bill, like the White Bill, was also aimed at abolishing the 'statistical grounds' for abortion, and as such was more far-reaching than the Benyon Bill. Again, it would have tightened the licensing of abortion clinics and ensured that they could not be financially associated with referral agencies. It lowered the time limit for legal abortion to 20 weeks and inserted the words 'grave' and 'serious' into the Act. Like previous Bills, it also amended the conscience clause of the Act to allow greater protections for conscientious objectors. The Bill went all the way to Report stage, but eventually ran out of time and failed.

During his speech at Second Reading, Corrie clearly saw himself as continuing the work of sponsors of previous Bills, noting that the subject of abortion had 'been well debated, but no conclusion has ever been reached' (Corrie in Hansard, 1979: 892). Like others before him, Corrie framed his Bill with reference to public 'outcry' about the 'effects' of the 1967 Act (Hansard, 1979: 892). He touched upon the familiar theme of exploitation in the private sector, but foregrounded the apparent prevalence of abortion on demand. Doctors who favoured this practice, he noted, could use the 'statistical argument' to justify carrying out abortion on demand in the first 12 weeks of pregnancy without fearing prosecution (Hansard, 1979: 892-3). That said behaviour was 'unethical' was of course implicit in this argument. However, Corrie's speech focused not on the character of such doctors but the difficulty of controlling them: 'whatever a politician's views are, the medical person is the one who sees the patient and who will make the decision in the end' (Hansard, 1979: 894). The risk that doctors might go against the wishes of Parliament was thus used to justify further state intervention, undermining the concept of the socially responsible doctor who operates best with minimal interference.

Constructing women seeking abortions, Corrie emphasised the risks to their health and well-being from abortion (Hansard, 1979: 896). This was echoed by his supporters. Braine, for example, stressed the need to guide 'frightened young girl[s]' down the right path (Hansard, 1979: 963-4), while Ancram talked of the importance of prioritising women's 'health, well-being and protection from exploitation' (Hansard, 1979: 912):

> Abortion is not a simple act for a woman to undergo. It is not simply a social convenience; it is a medical act. In many cases it is a medical operation, with medical, biological and psychological implications (Hansard, 1979: 916).

These potential dangers to women helped stress the need for a purer and more 'scrupulous' (Ancram in Hansard, 1979: 917) medical care, the provision of which would be facilitated by legislative intervention. Notably, Corrie appropriated to himself the ability to speak and act 'for women':

> I have received many letters from unhappy women. Many of them bitterly regret having had their abortion and express in their letters the importance of counselling. If only they had known what it all entailed, they would not have gone through with the abortion (Corrie in Hansard, 1979: 896).

This claim had the double effect of undermining pro-choice feminists' claims to be speaking for women beyond the House, and decoupling abortion rights from women's rights. However, there remain some tensions in such accounts, as evidenced by Corrie's brief discussion of 'fathers' rights' in abortion:

> We have the strange position at the moment that the rights of the woman are total. It is she, and she alone, at the end of the day, who can decide whether to keep the baby. The father has no say whatever (Hansard, 1979: 896).

In this statement, there is obvious anxiety that women's reproductive rights somehow jeopardise the status of fathers-to-be. Yet this seems at odds with the general emphasis on women's vulnerability: are women threatened by abortion, or threatening? This undecidability can be observed throughout discourses on abortion, as the following section demonstrates.

5.5 Female vice and virtue in abortion discourse

Some ambiguities in anti-abortion discourse during this period have already been observed. Firstly, there is the disconnect between initial conservative accounts of abortion, which opposed 'the needs of individual women' to 'the needs of the nation', and emerging accounts of the women hurt by legal abortion and in need of protection. These tensions are further exposed by uneasiness over fathers' rights and fathers' status with regard to abortions. This section details additional tensions in the construction of women seeking abortion. Firstly, it outlines images of the 'brazen' abortion patient, who seems to be the polar opposite of the 'broken' woman envisaged by Steel's supporters: boastful and un-traumatised by her circumstances, she is prepared to lie and deceive to get what she wants. Secondly, the section discusses anxieties over 'foreign' women travelling to Britain for abortion: these women are alternately vulnerable and exploited victims, or criminals taking advantage of British medical services.

These tensions in the construction of women seeking abortion are connected to anxieties concerning female virtue and vice. In abortion debates, women are alternately presented as virtuous women who have done everything 'right' or as moral corrupters leading the country into vice – the 'tarts and tired housewives' noted by Sheldon (1997: 32). On a deep level, such fears are often connected to ideas about national identity and doubts about the future of

the nation. Women's child-bearing and child-rearing capacity has served to situate them as the nation's moral guardians, raising the next generation – but this in turn stimulates anxiety about women's capacity for vice. Female virtue and vice may therefore be policed particularly closely due to the effects they are seen to have on the nation (Boryczka, 2012). The connection of female vice to concerns about national identity are particularly apparent in the panic over the influx of 'foreign women' to Britain for abortion.

5.5.i 'Brazen' and 'broken' women

In the debates over the Steel Bill, women seeking abortions were often constructed as somehow 'broken': worn down physically and emotionally and at risk of becoming a 'mental wreck' if forced to continue with the pregnancy. The women in these narratives had generally done everything 'right' – they had had several children, worked hard to look after them, and simply could not bear the strain of any more. In other words, due to their virtuous nature, these women 'deserved' abortions. As we have seen, in the 1970s MPs continued to use this construction to defend the 1967 Act, while their opponents appropriated the figure of the virtuous, vulnerable woman to their own ends.

However, the Lane Committee's Report reveals anxieties bubbling under the surface. The Report states that the Committee received complaints about 'hectoring', demanding patients who believed they were entitled to abortion under the Act, or were willing to lie or make threats of suicide if they were refused abortion (Lane Committee, 1974: 9). Some abortion patients, the complaints continued, had a 'brazen' or 'boastful' attitude which upset other patients in hospital wards (1974: 110). Women seeking successive abortions were singled out in this regard (1974: 83). These women, it appears, were not thought to be traumatised

'enough' by their circumstances or by the prospect of abortion, and their immoral behaviour was thought to be enabled by the Act.

The Lane Report thus exposed some deep-seated anxieties about female vice connected to the issue of abortion. The Report's response to these criticisms was perhaps more progressive than the depictions of brazen, immoral women:

> It seems to us that such women are often among those most in need of sympathetic attention and of abortion. The very fact that a woman is prepared to undergo repeatedly what, to most women, is a distressing experience and one to be avoided in future, may point to some psychological or other problem affecting her health (1974: 83-4).

Nonetheless, in resorting to psy discourses to 'defend' women who had multiple abortions, the Report also de-normalised them and indeed all women who didn't appear as traumatised by abortion as popular wisdom dictated they should. Thus, dominant abortion discourses only allow constructions of women as either virtuous and vulnerable, or vicious.

5.5.ii Abortion 'scandals' and national identity

A significant element of the abortion 'scandals' in the 1970s was the perception that a high number of abortions were being performed on non-resident women, due to the criminalisation of abortion in other countries and Britain's relatively high upper time limit. In particular, MPs were concerned about taxis 'touting' at airports for women seeking abortion and driving them to expensive private clinics. This concern was fed by media stories about 'package deals' on abortion in Britain being offered in other countries (Steel in Hansard, 1970: 1697; Houghton in Hansard, 1970: 1702). These suggestions were only a murmur at the time of the St. John-Stevas Bill – the sponsor noted these 'disturbing' stories but stressed that his concern was

chiefly with the Act's impact on the British (Hansard, 1969: 412) – but during the Irvine Bill, MPs expressed their fears that London was now seen as an 'abortion capital' by the rest of the world (Hansard, 1970: 1656).

By the time of the White Bill, the outcry had swelled to a crescendo[1]. The Bill contained a provision prohibiting abortions being carried out on such women. Crucially, the outcry spoke to anxieties over national identity and the future of Britain, with MPs pondering the question of what kind of society 'we' were becoming and how the rest of the world saw 'us'. These anxieties were not only held by the Bill's supporters: even David Steel was concerned that some doctors had 'brought considerable reproach on this country, both at home and abroad' (Hansard, 1975: 1769). Concerns regarding abortion and national identity had also been expressed to the Lane Committee, which received complaints that the private sector had brought the country 'into disrepute' (Lane Committee, 1974: 132), particularly by touting at airports and advertising abroad (1974: 133).

Nonetheless, the Committee's report was ambivalent in its treatment of women. In much of its summary of the evidence, women seem to be indulging in vice: they are breaking the law in their own countries, and it is impossible to know whether they are lying to doctors about their circumstances (1974: 141). The Report, moreover, noted 'powerful arguments' that it is morally wrong for doctors to 'lend themselves to the commission of such offences' (1974: 141), although it eventually concluded that it would be extremely difficult to bring in legislative measures to deal with this (1974: 141-3). In this construction, women's vice threatened the medical profession by leading it into disrepute. However, this account clashes with accounts of female vulnerability in the Report, such as the observation that many non-

[1] By the time of the Benyon Bill, the issue had abated slightly as figures reported a decrease in women travelling to Britain for abortion. Anxieties over 'foreign' women were not even mentioned during the Corrie debate.

resident women seeking abortion were being 'hijacked' by touts – driven to a clinic other than the one to which they had intended to go and charged extortionate fees (1974: 131; 136-7).

Similar tensions can be observed in the debate over the White Bill. The idea that 'foreign' women were being exploited of course fitted the overall construction of women as endangered by abortion, and White stressed the need to protect women 'lured' to Britain for this purpose:

> I must stress this foreign traffic, not because I am anti-German, anti-French or anti-Italian, but because of one of the comments in the Lane Report. I disagree with a good deal of the report, but I agree with it when it says: 'It would undoubtedly be more difficult, if not impossible, to ensure their implementation in respect of non-resident women.' The reference there is to counselling, after-care and making sure that these women get the attention they should have (Hansard, 1975: 1758).

However, White's supporters decried the 'repugnance' of this behaviour (Abse in Hansard, 1975: 1783), stressed its criminal aspects (Braine in Hansard, 1975: 1856), and argued that such women 'take advantage of our medical services' (Winterton in Hansard, 1975: 1816). As Renée Short wryly noted, these women were seen as 'strangely polluting' (Hansard, 1975: 1830) by many MPs. As a result, tensions remained in anti-abortion discourse even as it attempted to appropriate narratives of trauma-tisation: women were at once portrayed as exploited and in need of help, and as polluting elements leading the country into vice.

Discussion

As Chapter Four noted, the 1967 Act rests on the dual constructions of doctors as socially responsible and women seeking abortion as vulnerable. The discussion in this chapter demonstrates the lasting effects of this gendering: anti-abortion speakers have had to find

ways to deal with their 'woman problem', but something of a woman problem has also been present for feminists seeking to defend the Act. It would be too simplistic to either celebrate feminist activity on abortion as entirely 'successful', or present a sweeping narrative of the decline of radicalism. An extensive feminist agenda *was* articulated in the debates, and maintained into the 1980s and 1990s. Nonetheless, for the most part, pro-choice women declined to contest the logic of medicalisation underpinning the 1967 Act, even though it conflicted with the logic of a right to choose they espoused. The narratives of trauma and vulnerability employed by these women undermined calls for a right to choose and instead reinforced the paternalistic-patriarchal state intervention legitimated by the Act.

Hence, feminist abortion politics after the Act comprised an *incomplete* radicalism, willing to contest gender regimes and articulate counter-hegemonic demands – until it came to the Abortion Act itself. This demonstrates that radicalism does not necessarily disappear completely when feminists enter formal political institutions, but also demonstrates the ease with which it can be compromised, and the need for caution. The need to defend the Act from anti-abortion attacks resulted, it seems, in a translation of feminist goals to sit comfortably (or not-so-comfortably) with the 'progressive' principle of 'social medicine' and the medical control it entailed. As such, feminism was employed in defence of the governmental regime of medicalised abortion provision.

As soon as feminist discourses entered the debates they were adapted by anti-abortion speakers, demonstrating feminism's vulnerability to appropriation. Section 5.4 documented attempts at a 'woman-friendly' but still broadly anti-abortion discourse, which ranged from stressing women's 'entitlements' to portraying women as hurt and damaged by abortion and by abortion clinics. Sponsors of the Bills often claimed to be acting on behalf of women who had written to them. As their opponents made similar assertions, the claim to be acting 'for

women' became somewhat emptied of meaning. While none of Bills passed, this doesn't mean that anti-abortion politics wasn't significant during this period. Some of the Bills commanded a great deal of Parliamentary support but fell afoul of the usual difficulties afflicting Private Members Bills. Corrie's Bill in particular failed mainly because of time constraints, although the strength of Corrie' opposition and the government's refusal to give the Bill extra time also played a part (Marsh and Chambers, 1981).

Nonetheless, anti-abortion discourse remained ultimately ambiguous and confused in its relationship to women and feminism. Supporters of the Bills alternated between portrayals of women seeking abortion as exploited victims and immoral criminals. Anxieties concerning female virtue and vice were further elaborated in evidence to the Lane Committee. Portrayals of female virtue and vice are important, not only because of their role in mobilising for and against the 1967 Act, but because they became an important feature of feminist discourses on abortion in 1988 and 1990, as Chapter Six demonstrates.

Finally, a conspicuous absence from the debates was any awareness of a connection between abortion and racial politics. During this period, claims emerged that some doctors treated women differently according to their race. One black woman, for example, was granted an abortion – but later found that the same doctor never granted white women abortions or the pill, and wanted to stop the black population rising (McGrane and Nicholls, 1977). Black feminists continued to draw attention to the fact that abortion provision might have different significance to different women during the 80s (Bhavnani and Coulson, 1986). However, such an awareness was not to enter the debate until the 21st century, and even then with significant problems.

CHAPTER SIX. 1981-1990: TECHNICISATION AND BACKLASH

Introduction

The abortion debates of the 1980s came to focus on the problem of 'late' abortions above all else. Recent advances in medical technology meant that premature babies were surviving at earlier stages of gestation, and many people had come to see the 28-week upper limit for legal abortion as outdated. Advances in foetal imaging technology had also resulted in a proliferation of images of the foetus, used by opponents of abortion as 'evidence' of foetal personhood. This 'technicisation' of abortion was, according to McNeil, one of the most important developments in abortion rhetoric during this period (1991: 157). The debates took place on the watch of a Thatcher government which was increasingly coming to be seen as 'uncaring' due to its cuts to the NHS and failure to provide high-tech facilities (1991: 150). These cuts meant that women seeking abortions on the NHS were faced with many difficulties and delays; in this sense, 'late' abortions were to an extent a creation of the system. However, many of the Bills introduced in this period would have 'solved' the problem by policing women, not the NHS, more closely (1991: 150).

Along with Ellie Lee, McNeil notes that the debates took place in a new moral climate involving heightened fears about sexuality, where abortion was viewed as a symptom of moral decline. These fears became evident in the idea that women might suffer from 'post-abortion syndrome' – the implication being that a price must be paid for separating women's sexuality from reproduction (McNeil, 1991: 157-8; Lee, 2003: 85). McNeil and Lee's accounts converge with other feminist accounts of what has been termed a 'backlash' against feminism. According to Susan Faludi's influential book on the subject, backlash has two elements: firstly, attempts to halt or turn back the tide on advances in women's equality; and

secondly, attempts to blame feminism itself for women's unhappiness (Faludi, 1991: 9-10). For Faludi, the anti-abortion movement in the US was an exemplar of backlash politics. Abortion and birth control were seen as threatening as they gave women the freedom to have sex on their own terms (1991: 412), and were therefore subject to antifeminist attack. Faludi notes that the imagery used by the anti-abortion movement in the 1980s 'bore all the hallmarks of the New Right ideology that had preceded it' (1991: 414), involving moralistic language and regarding feminism as the enemy. While their campaigns were often hostile towards women seeking abortion – 'babykillers' – they also frequently depicted women, along with foetuses, as the 'victims' of abortion (1991: 414-5).

This chapter argues that although anti-abortion actors in the parliamentary debates of this period did not often explicitly blame feminism for the problems facing women and society, their activity was still saturated by backlash politics. Meanwhile, feminist arguments were perhaps more problematically gendered than in the 1970s and pro-choice contestation of the Act and the logic of medicalisation was scarce. However, this is not to say it was non-existent. In the early 80s, Jo Richardson introduced a Ten Minute Rule Bill which aimed to improve women's access to abortion on the NHS (Hansard, 1981). However, this was quickly followed by a Lords Bill sponsored by Lord Robertson of Oakridge, which, similarly to the Corrie Bill, would have only allowed abortion if a pregnancy presented a 'serious' risk to a woman's health, 'substantially' greater than if an abortion were carried out (Hansard, 1982). Analysis of these Bills' debates reveals similarities with the debates of the 1970s: feminist arguments frequently reinforced the logic of medicalisation by constructing women as patients, while anti-abortionists challenged medicalisation by focusing on the irresponsibility of abortion doctors. However, some new themes also emerge, as opponents of legal abortion

began to criticise men's sexual behaviour in a manner resembling feminism. Hence, my discussion of these two debates acts as a bridge between this chapter and the previous chapter.

After the failure of the Robertson Bill, parliamentary activity on abortion was quiet for a few years until the introduction of a Bill in the House of Lords by the Bishop of Birmingham, which would have reduced the upper time limit to 24 weeks (Hansard, 1987). The Bill's opponents were generally in favour of a 24 week limit, but criticised the way the Bill would have achieved it: the Bill would have placed the burden of proving that the foetus was not capable of being born alive on the doctor carrying out the abortion, and could in practice have made far more abortions illegal than intended (Houghton in Hansard, 1987: 1413). However, the Lords Select Committee made alterations to the Bill which would have mitigated these problems, and it was taken up in a later Parliamentary session by Lord Houghton (Hansard, 1989b), where it received a Third Reading in the Lords but never progressed to the Commons.

Meanwhile, the House of Commons saw a flurry of anti-abortion activity reflecting concerns familiar from the 1970s. Several Bills were introduced between 1987 and 1989 which attempted various strategies to reduce the number of abortions: reductions in the upper time limit, differential treatment for non-resident women; attempts to prevent doctors receiving financial benefits from performing abortions; new rights for conscientious objectors and amendment of the grounds on which an abortion could be carried out. However, most never received a Second Reading debate, while Ann Widdecombe's attempt to lower the upper time limit (Hansard, 1989a) was interrupted due to lack of time. The notable exception is David Alton's Bill, which would have reduced the upper time limit to 18 weeks (Hansard, 1988). The Bill's progress was adjourned at Report stage. However, the concerns raised by both the Alton and Bishop of Birmingham/Houghton debates were incorporated into debates over the

1990 Human Fertilisation and Embryology (HFE) Act (for a full list of abortion Bills introduced in this period, see Table 3, p.168).

The Act was an item of government legislation which aimed to deal with new developments in human reproductive technology. However, several MPs tabled amendments to the HFE Bill to reduce the time limit for legal abortion from anything from 26 weeks to 18 weeks, or to change the grounds on which abortion could be allowed. Emma Nicholson (Conservative) tabled an amendment allowing self-referral for abortions up to 12 weeks[1], but this was not put to the vote. Harriet Harman (Labour) also tabled an amendment to allow abortion up to 12 weeks with the consent of only one doctor, but this was defeated by 228 votes to 200 (Sheldon, 1997: 114).

While Parliament eventually voted to lower the upper time limit to 24 weeks[2], this was a result of the decision that in certain cases the Infant Life (Preservation) Act did not apply to abortion law, meaning that exceptions could be procured to permit women to obtain necessary abortions (McBride Stetson, 2001b: 151). Since a potential limit of 18 weeks had been successfully avoided, this was regarded as a success by the pro-choice movement (Hohmeyer, 1995: 42; McBride Stetson, 2001b: 151). However, Sheldon argues that the debate also signified a wholesale acceptance of medicalisation by pro-choice actors, who emphasised medical knowledges in constructing their arguments and accepted that viability should be the principal concern when deciding whether an abortion should be allowed:

[1] This would have led to abortion on request rather than abortion on demand, as women seeking abortions would still have had to obtain the consent of their doctor. However, for pregnancies of up to 12 weeks' gestation it would have removed the two-doctor rule and the requirement that to continue the pregnancy would endanger the woman's health (even in the broadest sense of the term). Thus, it would have entailed a *partial* de-medicalisation of abortion.

[2] A 24 week limit in practice means that abortions can be carried out at 23 weeks and 6 days at the latest (Turner interview, 2013).

> The mutually accepted framework of the abortion debate increasingly posits the issue as a narrow medical question, revolving exclusively around the status of the foetus and at what (medically determined) point its claim to protection becomes paramount. To accept an essentially medical framework for debate seems doubly dangerous given that, as has been seen, many of the problems faced by women seeking termination are related to medical control. (Sheldon, 1997: 106; see also Steinberg, 1991)

This chapter analyses the debates surrounding the above Bills. These are all Second Reading debates, with the exception of the Richardson Bill, which did not reach Second Reading but had a brief debate at First Reading, and the HFE Bill, the relevant debate on which was actually a Committee debate but was considered to be 'like a Second Reading debate' (Paisley in Hansard, 1990: 171) by the participants. Also analysed is data from an interview with Alice Mahon, a former Labour MP and pro-choice feminist who was active in the debates on both the Alton Bill and the HFE Bill. Unfortunately, other participants in the debates were unavailable for interview.

The chapter demonstrates that during the late 1980s in particular, several important new themes emerged in abortion discourse, most obviously a focus on advances in technology alongside a focus on abortion for reasons of foetal abnormality. In feminist arguments, there was also a noticeably increased use of narratives of acceptable abortion, involving vulnerable women who have done nothing 'wrong'. I argue that while understandable in context, this strategy was unhelpful on the whole as it reinforced a distinction between 'deserving' and 'undeserving' women, and implied that access to abortion should be grounded in female virtue rather than any conception of women's rights, equality or bodily autonomy. In anti-abortion discourse, on the other hand, the image of the virtuous, vulnerable woman was subverted and undermined. Anti-abortion actors simultaneously appropriated elements of

Table 3. Abortion Bills 1981-1990

Bill	**Stage reached**	**Key provisions**
Richardson, 1981	First Reading	Required health authorities to provide abortion facilities free of charge.
Lord Robertson, 1982	First Reading	Required pregnancy to present a 'serious' risk to a woman's health, 'substantially' greater than the risk presented by abortion, for an abortion to be carried out.
Bishop of Birmingham, 1986-7	Lords Select Committee	Reduced the upper time limit to 24 weeks.
Bruinvels, 1987	First Reading	Reduced the upper time limit; required the father of the foetus to be consulted before abortion could be carried out.
Leigh, 1987	First Reading	Required a medical practitioner treating a non-resident woman to give notice of abortion to a medical practitioner in her home country.
Winterton, 1987	First Reading	Required medical practitioners referring women for abortion to make a declaration that they had no financial interest in the place where the abortions were performed.
Alton, 1988	Report stage (adjourned)	Reduced the upper time limit to 18 weeks.
Widdecombe, 1989	First Reading	Required a medical practitioner treating a non-resident woman to give notice of abortion to a medical practitioner in her home country.
Widdecombe, 1989	Second Reading (adjourned)	Reduced the upper time limit to 18 weeks.
Hargreaves, 1989	First Reading	Required ancillary workers to give a positive indication of assent before being required to perform or assist at an abortion (in order to protect the rights of conscientious objectors).
Amess, 1989	First Reading	Required doctors and nurses to give a positive indication of assent before being required to perform or assist at an abortion (in order to protect the rights of conscientious objectors).
Bennett, 1989	First Reading	Required medical practitioners referring women for abortion to make a declaration that they had no financial interest in the place where the abortions were performed.
Braine, 1989	First Reading	Amended the grounds on which an abortion could be carried out.
Lord Houghton, 1989	Lords Third Reading	Took up Bishop of Birmingham (1987) Bill, with Committee amendments.
HFE Bill, 1990	Became HFE Act	The Bill's main purpose was to deal with advances in

		reproductive technology. However, several amendments were tabled. The eventual Act lowered the upper time limit to 24 weeks.

Compiled from: Hansard; Sheldon (1997).

feminist arguments and implied that feminism and the sexual revolution were responsible for women's unhappiness, in language similar to that used in the backlash politics of the United States.

6.1 The early 1980s: continuities and changes

In some senses, these early 1980s debates are an extension of the debates of the late 1970s. The issues raised reflect those of earlier debates: medical irresponsibility and 'abortion on demand' remain prominent fears. However, these debates represent significant developments in two ways. Firstly, the Richardson Bill was the first attempt to improve women's access to abortion since 1967 using a legislative measure, although other attempts to liberalise abortion law by amending the HFE Bill would be made later on. Secondly, there was a slight shift in the argumentative strategy of opponents of legal abortion. In these arguments, it was not only abortion clinics who exploited women but men in general, mirroring similar claims made by feminists.

6.1.i The Richardson Bill, 1981

Jo Richardson's National Health Service Act (Amendment) Bill was an early attempt to bring a liberalising agenda to Parliament. The Bill, which had its First Reading debate in July 1981, aimed to improve the availability of abortion on the NHS by making it a duty for health authorities to provide abortion facilities free of charge. As a Ten Minute Rule Bill, the

Richardson Bill had barely any chance of becoming law. However, it was denied a First Reading by 215 votes to 139. In her speech, Richardson argued that patchy provision of abortion meant that the NHS had failed in its duty to women. She observed that better provision on the NHS would lead to fewer delays, allowing abortions to be performed as early as possible. This emphasis on the need for abortions to be carried out early foreshadows the distinction between 'early' and 'late' abortion which would become pivotal in later debates.

Richardson's speech made conspicuous use of the logic of medicalisation. Throughout, women were constructed as patients, and women's rights and needs were construed as the demands that patients could legitimately make of the NHS: 'it is indefensible that the NHS should not provide treatment for women who are legally entitled to treatment under the law' (Hansard, 1981: 877). Accordingly, abortion was constructed as a medical necessity that the NHS was failing to provide. Richardson backed this argument up with statistics relating to the patchiness of abortion provision in different areas, and implied unfairness:

> NHS abortion provision varies widely, as many women outside this House know to their cost. In 1979 the NHS in Dudley performed only 6 per cent. of all abortions, Sandwell 7 per cent. and Kirklees 11 per cent.; while in Tyneside it performed 92 per cent., as it did in West Glamorgan; the figure in Gateshead was 93 per cent., and in North Devon 94 per cent (Hansard, 1981: 877).

Like reformists before her, Richardson framed the Bill as a matter of protecting women, emphasising the need for a 'humane' attitude towards women who need 'sympathetic treatment' (Hansard, 1981: 879). If Parliament and the NHS failed to do this, she warned, women might once again turn to the back streets.

Conservative MP Jill Knight spoke against the Bill, using arguments familiar from the 1970s. She challenged the medicalised framework used by Richardson, arguing firstly that abortion was unlike other medical services provided by the NHS:

> Nowhere from the start does [the National Health Service Act] mention abortion because, unlike all the services that it mentions, abortion is not supposed to be available to all comers (Hansard, 1981: 879).

Abortion was contrasted to 'real' medical necessities – 'kidney failure, mental health care, cancer and scores of others' (Hansard, 1981: 880) – which, according to Knight, had a far greater need of funding. Knight did accept that *some* abortions might be medically necessary, but utilised a much narrower definition of 'medical necessity', observing that abortion was already available on the NHS for women with a *real* need. Wider availability of abortion in the private sector, she argued, was due only to the actions of irresponsible doctors complying with the letter of the law but not its spirit (Hansard, 1981: 879).

6.1.ii The Robertson Bill, 1982

Lord Robertson of Oakridge's Bill was similar to the Corrie Bill in that it would have required pregnancy to present a 'serious' risk to a woman's health, 'substantially' greater than the risk presented by abortion, for an abortion to be carried out. This would have eliminated the 'statistical argument' for abortion and rendered most abortions carried out on 'social grounds' illegal. However, an amendment moved by Lord Houghton to delay the Bill's Second Reading by six months was passed, and the Bill never progressed further. At the Second Reading debate in December 1982, Lord Robertson framed the Bill as a solution to the 'problems' of abortion on demand and abortion for 'trivial' reasons (Hansard, 1982: 57).

Doctors, he argued, were acting irresponsibly, facilitated by a Government which was failing to take action against them:

> It cannot be disputed that considerable numbers of doctors used the Act as a basis for granting abortion on demand, and no action is being taken to stop them. Doctors promoting such a policy justify their actions by the so-called statistical argument which claims that the statistics show that the risk to the life of the pregnant woman is smaller if the pregnancy is terminated in the early months than if it is allowed to continue (Hansard, 1982: 56).

Such arguments were familiar from 1970s attempts to undermine the logic of medicalisation by stressing the differences between doctors. However, Lord Robertson's speech also indicated some emerging themes in anti-abortion rhetoric. The first of these was a vivid description of foetal development:

> For that baby, life started in some form at the moment of conception. The early weeks of her existence in the womb saw the physical development of her body happen almost incredibly quickly. By 30 days her main organs were already in recognisable form and she had a heart pumping blood she had made herself. In other babies, electric brainwaves have been recorded as early as 40 days, and this must indicate that the mind has started to develop. In this connection, Professor Sir William Liley, generally regarded as the father of foetological medicine, has stated: "We know the baby is responsive in utero to touch, to light, to sound and to stimuli which at least you and I would consider painful" (Hansard, 1982: 58-9).

This argument utilised the new knowledge and imagery made available by developments in medical technology. While the protection of 'the unborn' had always been a feature of anti-abortion rhetoric, the use of such imagery heralded the emergence of a 'foetal subject' who would become central in later debates, and in doing so challenged the logic of medicalisation by stressing that it was vulnerable foetuses, not women, who needed protecting.

Lord Robertson's speech also indicated a new tactic for undermining feminist arguments. The speech simultaneously disavowed feminist claims and appropriated them to a pro-life agenda. Lord Robertson opened by arguing that women's right to control their own fertility did not exist in law and was not at stake in the debates (Hansard, 1982: 55-6); however, he later went on to use ideas about women's sexual and reproductive freedom to justify his Bill:

> It must surely be obvious that women today are treated by men in a more cavalier way than ever before. It is more difficult for a woman to say "No" to the sexual act than it used to be, not least because abortion is held up as an extension of contraceptive measures. When the so-called worst happens, and a pregnancy occurs, it is only too easy for the man concerned to wash his hands of the whole business and put the woman under pressure to have an abortion, regardless of the dangers to her health or of her own convictions (Hansard, 1982: 58).

This rhetoric clearly echoed earlier feminist arguments concerning women's treatment at the hands of men. However, in comparing gender relations now to gender relations as they 'used to be', it implicitly blamed societal changes and the sexual revolution – and by extension, feminist values – for this treatment. As such, it demonstrates both the resourcefulness of anti-abortion actors in appropriating elements of feminist arguments and the continuing tensions as these actors simultaneously attempt to reject and blame feminism.

6.2 Defending the 1967 Act

This section turns to debates from 1987 onwards. Opponents of restrictive Bills during this period used many familiar arguments. Women seeking abortion were generally represented as vulnerable and needy, 'frightened, unwise, indecisive, uncertain, anguished, full of second thoughts, and impoverished' (Morrison in Hansard, 1988: 1258-9), seeking abortions 'for

reasons beyond their control' (Henderson in Hansard, 1987: 1428). These arguments relied heavily on narratives of acceptable abortion, and used personal trauma, rather than bodily autonomy or reproductive freedom, to justify the need for 'choice':

> I should like to go back to the start of my medical career, when I was a student in 1968. That is when I first experienced the workings of the Abortion Act 1967. The first girl I saw was 15 years old. She did not really know what it was all about and she did not understand what happened. She just knew that she wanted to go back to a normal life and that she did not want to bear a child, and she did not. The other woman was in her early 40s with a large number of children. She could not face the reality of bearing another child and she, too, was relieved of that burden. That is what the 1967 Act gave women in this country. It gave them an element of choice (Moonie in Hansard, 1988: 1247).

Once again such narratives led participants to emphasise the horror of back-street abortions as the only alternative to the *status quo*. The figure of the back-street abortionist was explicitly connected to women's vulnerability:

> A return to back-street abortions will mean a return to deaths and trauma, and the people who will suffer are those whom the House should most want to protect. The vulnerable, the not very intelligent and the inadequate will be driven to the backstreet abortionists, who will be laughing all the way to the bank (MacKay in Hansard, 1988: 1238).

> The things that were going on in back steets, the hardship and cruelty that women—sometimes young and ignorant, sometimes suffering from a situation which they did not understand—were deplorable (Lord Ennals in Hansard, 1989b: 1492).

Such arguments were nothing new. However, these participants also introduced a new category of people affected by late-term abortions: women carrying severely disabled children (and, crucially, their families). Those in favour of relatively liberal access to abortion

emphasised the importance of giving women the 'choice' of whether to have a disabled child, and the ability to monitor the likelihood of disability using new technology. However, as Steinberg has pointed out, these arguments were not truly in favour of a 'right to choose':

> Although they (arguably) reflected awareness of the fact that women, with no significant social support system, bear the heavy burden of caring for physically 'disabled' children, these arguments none the less constructed the legitimacy of abortion in eugenic, rather than woman-centred terms. Abortion was not considered legitimate because a woman has the 'right' to control her own body (a position which would not dictate the reasons why a woman might want a termination) … It is a special-case argument, that women should have access to 'late' abortions on an exemption basis (Steinberg, 1991: 187).

Moreover, participants justified late-term abortions on the grounds that they might restore women to motherhood. According to these arguments, if a woman is compelled to carry a severely disabled foetus to term 'there is no way in which she will bring another child into the world' (Lord Winstanley in Hansard, 1987: 1430-1):

> We have had many letters from medical bodies urging us not to support the Bill. More impressive than those is a short letter that I received from a constituent who said: "Having had a late termination (about 19-20 weeks) because it was discovered my baby had severe abnormalities I know what I am talking about. It was a disturbing event for me but not as bad as giving birth after 9 months to a baby the doctors said would not have lived anyway. Parents must have the choice to make their own decision in cases like this. I know I personally could not have coped with a full term baby being born like this. I have had a healthy daughter since this tragic event but I am sure I would never have had the courage to become pregnant again if I knew that I would have to go 9 months and not be offered a late termination had the baby had the same abnormalities" (Hansard, 1988: 1241).

Abortion was hence legitimated on gendered grounds, as encouraging women to have families. Thus, the more radical meanings of legal abortion – such as women's ability to reject motherhood – were denied. The argument that abortion might actually *help* women fulfil their role as mothers is familiar from debates over the Steel Bill. However, concerns about foetal abnormality in the late 1980s gave it new focus.

6.3 Feminism, medicine and female virtue

Feminists reacted forcefully to the restrictive Bills and amendments. According to Mahon, fighting the Alton Bill involved coordination between women of all parties – whereas some Labour men were 'less than helpful' and obstructed their efforts (Mahon interview, 2013). The 1990 HFE Bill involved two attempts by women to liberalise access to abortion by doing away with the two-doctor rule, although neither of these were successful. This section covers the explicitly feminist demands these women made in the debates, as well as the ways in which their speeches constructed women seeking abortion.

6.3.i Chains of feminist demands

Pro-choice women MPs frequently situated their arguments in relation to their status as a minority in Parliament. Moreover, they often referred to the need for the women in Parliament to work together and to forge a group identity in order to protect women's rights. As Mahon told me, in reference to divisions within the Labour movement over women's reproductive freedoms: 'there were enough of us to persuade them to get their hands off our sexual and reproductive rights: they were ours, not theirs' (Mahon interview, 2013). This combative language and sense of a strong male/female divide was reflected in the Parliamentary debate:

> Women must say – hon. Members who are women must say – that we have consciences and that we exercise them daily as women and that women exercise their consciences when making choices about abortion. We do not need the men in the Chamber to borrow our consciences for us and to take that decision (Primarolo in Hansard, 1990: 247).

> The remarkable consensus on this issue stretches from every woman Labour Member right across to the Conservative Women's National Committee. That consensus arises not because we have suddenly all become the same sort of people, but because as women we share some life experiences (Wise in Hansard, 1988: 1291).

> [The House of Commons] is overwhelmingly male, and it is important to remember that fact when discussing abortion. ... Conservative Members who have spoken against all forms of abortion are the enemies of women (Mahon in Hansard, 1990: 233).

Parliament's preoccupation with female reproductive capacity was neatly subverted by Dawn Primarolo, who suggested that to restrict access to abortion would be akin to forcing men to be sterilised (Hansard, 1990: 246-7). Such observations were articulated alongside an explicitly feminist agenda linking together a series of demands, exemplified in this contribution by Mildred Gordon:

> The whole question of abortion is closely linked to other campaigns that women have been fighting for many years … [W]e need improved sex education. We need contraceptives of all kinds, freely available and free. We need better housing and employment and training opportunities. We need safer childbirth – our record is not among the best in the advanced world. We must do away with some of the more recent 'conveyor belt practices' connected with childbirth in hospitals, which have a traumatic effect on the baby during birth. We want nursery provision for young children. We want money for medical research into foetal abnormalities to discover them at an earlier stage. We need money for disabled people and money to provide facilities for them. We need money from the Government, as of right, for

> women who are carers of children, the disabled, the sick and the old (Gordon in Hansard, 1988: 1284).

Others called for improved family planning services (Mahon in Hansard, 1990: 233; Harman in Hansard, 1990: 260), increased maternity support (Richardson in Hansard, 1988: 1273) and changes in men's attitudes towards women (Gorman in Hansard, 1990: 230). Attempts to restrict access to abortion, moreover, were linked to heightened anti-woman activity on the part of the New Right:

> The underlying reason is that the new Right in America goes around bombing abortion clinics, photographing women who go there for abortions and sending the photographs to their neighbours. That is the kind of crude behaviour that comes from the new Right. The growing new Right in Britain is saying that women should stay at home and bear children and care for elderly and disabled people. They are not in favour of public expenditure; they want to push women back into a traditional role and deprive them of the freedom to control their lives (Short in Hansard, 1988: 1262)

Clare Short's observation that anti-abortion activity was connected to an anti-feminist backlash was insightful: the relevance of backlash to abortion politics will be explored in Section 6.4. But it is also a fitting example of the ways in which women participants in the debates situated their demands in relation to equivalential chains of demands and a far-reaching rejection of the *status quo*. 'Women's issues' was a privileged signifier in their arguments, serving to network different demands together. As Mahon put it:

> Let me tell you something, with women's issues. They're backing off on other prejudices now, and this gay marriage bill I think's brilliant, personally I think it's brilliant. But it always comes back with women … it's the most enduring inequality, is the one between the sexes (Mahon interview, 2013).

6.3.ii Medicalisation and technicisation

As in the 1970s, pro-choice MPs did criticise the working of the 1967 Act, although this was generally done indirectly, by referring to the difficulties and unnecessary delays which might face women seeking abortion (Richardson in Hansard, 1988: 1272). The most explicit critique of the Act was advanced by Emma Nicholson (Conservative), who had attempted to amend the HFE Bill to allow self-referral. Nicholson did not use the explicitly feminist language of some of her peers. However, unlike other women MPs, she did explicitly contest the norms underpinning the Act, arguing that 'the Act places a succession of minor hurdles in the way of the pregnant mother trying to obtain an abortion' (Hansard, 1990: 250) which could lead to a delay of months before an abortion could be carried out. Nicholson stressed the vulnerability of women, whose credibility might be 'wrecked' by the delay, and accepted the need for some medical control 'so that society can satisfy itself that [women are] not using the medical profession as a source of late contraception'. Nonetheless, her contribution was significant, as she placed the blame for delays squarely on the Act (rather than the NHS or restrictions on the private sector, as others did), and pointed out that abortions are not always carried out for health reasons (Hansard, 1990: 249-51).

This is not to say that other pro-choice MPs were not privately critical of the Act. In her interview, Mahon expressed regret that further liberalisation of abortion law had not been achieved:

> I don't like this idea that you've to go to two doctors. I mean, what is wrong with just going along to your local clinic and seeing a nurse practitioner even? Or a doctor, we're allowed this. So what is this psychological pressure on women? 'Naughty girls, you must go in front of the doctor!' (Mahon interview, 2013)

For the most part, however, the speeches indicate the continued sedimentation of the logic of medicalisation. Once again, the interests of women and doctors were articulated together, and both construed as equally threatened by restrictive amendments (Richardson in Hansard, 1988: 1277). Furthermore, the figure of the medical professional was frequently appealed to in justifying women's 'choice':

> I would leave it to the woman, her medical adviser and her family to make the decision (Gorman in Hansard, 1990: 232).
>
> The medical decision and the woman's decision are what is relevant (Primarolo in Hansard, 1990: 247).
>
> It is my view … that up to 12 weeks the mother's wish, in conjunction with her general practitioner's decision, should be sufficient to allow her an abortion (Nicholson in Hansard, 1990: 250).

'Choice', in these arguments, does not appear to be a right; rather, it seems to be dependent on the approval of the doctor. The construction of abortion as 'a medical matter … to be argued medically' (Wise in Hansard, 1988: 1289) resulted in women's rights being transmuted into *patients'* rights, and the demands women could legitimately make being restricted to the demands a patient might make of the health services:

> The British Pregnancy Advisory Service, the Pregnancy Advisory Service and other organisations in the charitable sector are not permitted to do terminations after 24 weeks. Both those advisory services have compiled an interesting and moving dossier of cases that illustrate the problems that women face through delays or obstruction in the NHS, through doctors failing to diagnose pregnancy, through failure by patients to recognise pregnancy, through failure of methods of contraception or failed pregnancy tests, as the result of

> menopausal problems or because the females concerned are very young. I have cited some cases, but there are many more (Richardson in Hansard, 1990: 187).
>
> It is sinful and unforgiveable that many women who come forward for abortions before 12 weeks have post-18 weeks abortions because of delays in our National Health system and because of delays caused by doctors processing their cases (Short in Hansard, 1990: 257).

Finally, these arguments were commonly framed by appeals to medical science rather than to rights or freedoms. This involved centring the issue of foetal viability as the cutting-off point for when abortion should be legal. Pro-choice MPs observed that advances in medical science meant that abortions after 24 weeks' gestation were already becoming rarer (Short in Hansard, 1988: 1261; Short in Hansard, 1990: 256-7) and stressed that the weight of medical opinion was behind a 24-week limit (Harman in Hansard, 1990: 262). While these arguments were deployed against Alton and his supporters, they nonetheless accepted in theory the distinction between 'early' and 'late' abortions which was becoming central to pro-life arguments (Steinberg, 1991: 177-8).

6.3.iii Female virtue and acceptable abortion

What is most striking about pro-choice contributions in these debates is the heightened use of narratives of female vulnerability and acceptable abortion. These narratives tended to feature young and frightened girls, post-menopausal women who may not have realised they were pregnant until late in the pregnancy, women with serious health conditions and women carrying foetuses with severe abnormalities (Short in Hansard, 1988: 1246; 1261; Richardson in Hansard, 1988: 1273; Richardson in Hansard, 1990: 186-7; Harman in Hansard, 1990: 261-2). Accounts of female vulnerability were bolstered by readings from personal correspondence and tragic cases involving the MPs' own constituents, for example:

> One of my constituents is a simple parent with a violent husband. She has three children, the oldest of whom is aged l4½. They live in a freezing, hard-to-let house. The house is so cold that they live effectively in one room. Last December, the 14-year-old daughter gave birth to a premature baby. The baby is ailing. The local hospital cannot keep it in, although its health demands that it returns to hospital frequently. That baby has been born and is physically perfect, although it is weak. Some people have tremendous stresses and strains on their lives. They might have forgiven that 14-year-old girl, and her mother, for having an abortion in those circumstances. I certainly would, and I hope that hon. Members who do not always agree with me would (Richardson in Hansard, 1988: 1273).

Female vulnerability has always been a feature of pro-Act discourse. However, pervading feminist narratives in this period were ideas concerning female virtue and innocence. In such narratives, the women seem to do everything 'right': they are either middle-aged mothers (carrying out their duty by having already had children) or vulnerable (and therefore not 'frivolous') girls. Their contraception failed, or they had been diagnosed as menopausal. They may well have been under great stress or even scared, or they may have discovered that the foetus was severely disabled. This concern with the morality of 'late' abortion is most explicit in this contribution from Baroness Lockwood:

> A wife may find herself pregnant and realise that she is carrying a child which could be born with the AIDS disease *through no fault of her own*. It may be the fault of her husband, but *it is not her fault*. … Some 50 per cent. of late abortions are to young people under 20, according to the study of the Royal College. *The pregnancies of some of these girls are not necessarily due to promiscuity or curiosity.* Sometimes it is a consequence of abuse or rape and that leads to difficult circumstances. This is a group that needs our understanding and sympathy (Baroness Lockwood in Hansard, 1987: 1437-8; emphasis mine).

However, speeches emphasising the 'faultlessness' of women seeking abortion were also a feature of the Commons debates. Narratives asserting the rights of women who do not use contraception, have multiple abortions, or are not traumatised by the prospect of abortion – 'the things we cannot say' – were missing.

That feminist participants might soften their stance by emphasising women's vulnerability rather than women's rights or freedoms is understandable. Parliament during this period could be extremely hostile towards women speakers. When asked about her experiences of being a woman in the House of Commons, Alice Mahon stated that 'the place reeks of male dominance … it comes out of the panelling' (2013) and told me that in her time in Parliament, she had been mocked for her Yorkshire accent, the lobby of Parliament lacked a women's toilet, and comments were frequently passed on women's clothing. This hostility can be difficult to observe when reading Hansard, as parliamentarians' reactions to speeches are typically not recorded, but sometimes it becomes evident, such as in Clare Short's response to an interruption to her speech:

> [Interruption.] Hon. Members may laugh. They always laugh and sneer when we talk about the status of women and their freedom. The behaviour of hon. Members is absolutely consistent (Short in Hansard, 1988: 1262).

What can also be difficult to discern from Hansard is participants' sense of anger and outrage at what had happened to women before the 1967 Act came into effect, and what might happen if restrictive amendments were passed. This outrage came across more forcefully during my interview with Mahon, as she recounted her experiences as a nurse before 1967:

> If a woman's made her mind up, that she don't want to carry that baby, for a variety of reasons, they're not going to make her change it … I remember special-ing a woman one night, and she died actually, a teacher. And walking out, after they laid her out, I could see her

> little brother and her mother, sitting waiting to go in and look at her. That stays with you, that kind of thing. You don't lose that. She'd just decided, this young woman, she wasn't going to have that child. She'd made a couple of attempts, and eventually she succeeded, but she killed herself in the process (Mahon, 2013).

These stories are important to tell and provide a powerful argument against attempts to restrict access to abortion. Nonetheless, the emphasis on the innocence and virtue of women seeking late abortions is unhelpful, as it sets up a binary between deserving and undeserving women and implies that women's access to abortion should be grounded in virtue rather than right.

6.4 Anti-abortion discourse

Many of the themes of anti-abortion discourse in the 1980s are familiar. The would-be reformists continued to reject the notion of doctors as governmental agents, worrying about untrustworthy doctors performing abortion 'on demand' and depicting abortion clinics as somehow exploiting the women who visited them. These participants also expressed concern about the capacity of doctors and nurses to refuse to perform an abortion, and 'persecution' of conscientious objectors. All in all, these arguments reveal an enduring logic of medical purity, in which doctors' roles and identities are threatened by the 'corrupting and degrading business' (Alton in Hansard, 1988: 1233) of abortion. Importantly, this is also a logic of *difference* which contests the logic of medicalisation by undermining its construction of doctors as equally capable of intervening on the issue of abortion.

As Steinberg notes, there were several significant developments in anti-abortion discourse during the debate on the Alton Bill:

> an unprecedented scientific dimension to the construction of fetal personhood … the growth of the currency of the language of rights; and the incorporation and subversion of the language and concepts of the women's liberation movement (including the language of women's 'reproductive rights') (Steinberg, 1991: 175-6).

This section charts how these developments played out in all of the debates during this period, and draws attention to the ways in which anti-abortion activity at this time also constituted a backlash against feminism. Steinberg also observes that anti-abortion rhetoric began to distinguish between 'early' and 'late' abortion. 'Late' abortion was a new concept, framed by Alton supporters as a new kind of criminality, and graphic images of such abortions were used as a way of undermining the legitimacy of abortions generally. According to Steinberg, outlawing 'late' abortions would only have been the tip of the iceberg: 'the Bill was deliberately styled to initiate an incremental erosion of legal abortion, beginning with "late" abortions' (1991: 176).

6.4.i Virtue, vice and 'frivolous' abortion

During the debates, anti-abortion participants continued to push the idea that abortion harms women. Most commonly, they argued that abortion itself caused women physical and emotional damage. Alton argued that his Bill would mean fewer women would be 'emotionally and psychologically scarred' (Hansard, 1988: 1230) by abortion, and others continued this line of argument (Braine in Hansard, 1988: 1245; Viscount Massereene and Ferrard in Hansard, 1989b: 1480; Viscount Buckmaster in Hansard, 1989b: 1481; Cormack in Hansard, 1990: 208)[1]. These arguments once again took up the theme of exploitative clinics

[1] Claims that abortion damages women's mental health are made frequently in abortion debates. However, the evidence is thus far inconclusive (see Chapter Seven).

who ‘run a profitable industry in human weakness’ (Kellet-Bowman in Hansard, 1988: 1232) and the vulnerability of women at the hands of doctors:

> One issue that has not been considered carefully enough is that, for whatever reason, pregnant women may be in a traumatic state, so that, when a medical adviser suggests that an abortion might be wise, the woman's thoughts immediately turn down that road (Smyth in Hansard, 1990: 240-1).

New to anti-abortion arguments, however, was the idea that women are vulnerable to exploitation not only by clinics, but also by their male partners and lovers. This appropriation of feminist rhetoric on abortion will be revisited in Subsection 6.4.iii.

Female virtue and vulnerability also played a part in the construction of ‘certain categories of women’ (Cormack in Hansard, 1990: 207) who were to be allowed an abortion in all cases, women who were ‘in dire need and distress’ (Braine in Hansard, 1990: 219). Similarly to feminist constructions of female virtue, these women have done nothing ‘wrong’ – they are victims of rape, incest or faulty genes, and ‘a pregnancy that was never wanted or never sought’ has been ‘thrust upon’ them (Cormack in Hansard, 1990: 208).

However, unlike in feminist discourse, the subject of female vice came up frequently in these contributions. The distressed, virtuous women in the above arguments were opposed to women who sought abortions for ‘frivolous’ reasons. These involved the familiar ‘social’ reasons; however, these arguments were also fuelled by fears of an epidemic of abortions for minor disabilities:

> Should any handicap—a club foot, deafness, blindness or any other handicap—mean that the child should be aborted? Is it a sufficient reason to get rid of a child (Knight in Hansard, 1988: 1250)?

> Not long ago there was a great to-do in the national press because Guy's hospital advertised for mothers to come forward with children suffering from hare-lips and facial deformities to have pre-natal surgery, of which we are all in favour. They asked those mothers to come forward because they were considering abortions for those reasons (Widdecombe in Hansard, 1990: 197).

Anti-abortion participants also challenged the claim that restrictions on 'late' abortions would primarily affect frightened young girls and weary mothers, pointing to statistics apparently showing that the majority of abortions after 18 weeks were carried out on single, childless (and by implication, less deserving) women (Paisley in Hansard, 1990: 237; Duffy in Hansard, 1990: 253). In this way, the logic of medical purity used by those in favour of abortion restrictions was combined with a *logic of female purity* which divided women into the categories of 'deserving' and 'undeserving' and thus challenged the depiction of the Act as a measure to help the vulnerable. This logic drew equivalences between deserving women, who had behaved in a morally correct manner and were simply the victims of circumstance, and between undeserving women, who sought abortions for trivialities – whether personal inconvenience or eugenic purposes – and hadn't performed any maternal duties. This logic demonstrates the danger inherent in appealing to female virtue in order to justify legal abortion: ideas about female virtue can easily be subverted by arguing that virtuous women will 'choose life' when given the right support, or undermined by demonstrating that women seeking abortion are not particularly 'virtuous' after all.

6.4.ii Foetal subjects

As previously noted, the debates took place in the context of advances in foetal imaging technology and advances in medical science which allowed foetal life to be sustained outside

the uterus at an earlier stage of gestation. As Rosalind Petchesky has observed, anti-abortion activists were quick to use this imagery to transform the foetus into a 'person' in the popular imagination. Petchesky focuses on *The Silent Scream*, a 1984 US film depicting an abortion and purporting to show the foetus attempting to escape the cannula and screaming silently. The film was framed as new knowledge allowed by a new 'science of fetology', allowing abortion to be witnessed 'from the victim's vantage point' (Petchesky, 1987: 266). While *The Silent Scream*'s claims were rebutted by various members of the medical community, it had a large influence on political life in the US. Petchesky attributes this to the seemingly 'objective' nature of photography – its assumed ability to capture 'literal reality' – in spite of foetal imagery's tendency to depict the foetus as suspended in mid-air, abstracted from the pregnant woman (1987: 268-9). Because it depicted the foetus in this way, this imagery was pivotal in allowing the foetus to be constructed as a separate, autonomous being and subject in its own right:

> the autonomous, free-floating fetus merely extends to gestation the Hobbesian view of born human beings as disconnected, solitary individuals. It is this abstract individualism, effacing the pregnant woman and the fetus's dependence on her, that gives the fetal image its symbolic transparency, so that we can read in it our selves, our lost babies, our mythic secure past (1987: 270).

Such images were also disseminated in the UK. As Sarah Franklin notes, supporters of further restrictions on legal abortion in the 1980s skilfully used such imagery to produce 'a social category of fetal personhood which has an enhanced ontological validity and specificity' (1991: 196). To a much greater extent than in the 1970s, parliamentary debate in this period involved graphic descriptions of both foetal development and 'late' abortion. Anti-abortionists depicted the 18-week foetus as 'fully formed' (Smith in Hansard, 1988: 1257)

and therefore little different from a full term baby. Such descriptions were often accompanied by vivid and horrifying accounts of late-term abortions, for example:

> It is a lottery as to whether or not, because of the late stage of its development, the baby of 18 weeks or more will be aborted in the most cruel way with its limbs torn from its body and its head crushed, as many doctors and nurses have testified (Braine in Hansard, 1988: 1245).

> As we have already heard, the preferred method in private clinics is dilation and evacuation. That method involves inserting a pliers-like instrument into the uterus and crushing the baby's skull. That baby is then dismembered and removed piece by piece. No anaesthetic is used on the child, even though, as the right hon. Member for Castle Point said, from seven weeks' gestation a baby can feel pain. In other words, the baby is writhing in agony during those procedures (Alton in Hansard, 1990: 226-7).

Some of these contributions explicitly referenced *The Silent Scream*, presenting it as a factual account of abortion (e.g. Viscount Buckmaster in Hansard, 1989b: 1481). By transforming the foetus into a 'baby' who is 'fully formed' and can feel pain, anti-abortion participants were able to construct it as a patient in its own right who can make the same demands of doctors that a woman can, and is potentially threatened by female vice. In keeping with their emphasis on female vulnerability, these participants often referred to the foetus itself as female.

> 600 abortions are undertaken every working day, some even on the grounds of the gender of the child, simply because it is a little girl. (Alton in Hansard, 1988: 1230)

> One is talking not just of the woman's choice—and one must remember that the foetus might be female. At times, the debate has resembled a contest between male and female. The tragedy is that the selective abortion techniques that are now available could be used not only to breed heirs for the Upper House but to reduce the number of women in a society that did not value them as much as our society does today. (Smyth in Hansard, 1990: 242)

This strategy recalls the advice of an American anti-abortion handbook of the same period, which explicitly advised activists to borrow feminist language and apply it to the aborted female foetus (Faludi, 1991: 414). While this manifestation of the claim that abortion harms women was not explored very far in the 1980s debates in Parliament, it would become a much larger point of contestation in the 21st century, as Chapter Seven shows.

6.4.iii Appropriation and backlash

Some of the anti-abortion speeches made use of some very obvious borrowing from feminist discourses. The speakers used several strategies which subverted feminist strategies on abortion, which involved arrogating the ability to speak 'for women' to themselves (Robertson in Hansard, 1987: 1421) and privileging (or claiming to privilege) women's experiences in their arguments. One key difference from the anti-abortion/'pro-woman' rhetoric of the 1970s was a new emphasis on men's sexual behaviour as problematic:

> Men must, of course, approach the debate with humility and sensitivity. We rarely have to suffer the practical day-to-day experience of an unwanted child. We rarely hear about unmarried fathers, only about unmarried mothers. We do not hear about men having illegitimate children, only women, and how often men smugly talk about fallen women. We never hear about fallen men. Women are frequently pressurised into abortions by men. Men too often leave a woman in the lurch, having used their sexuality without responsibility. Those who maintain that abortion is purely a woman's issue do women no service; it allows men to evade their responsibilities, and without changes in men's attitudes women will not be truly liberated (Alton in Hansard, 1988: 1235).

> Free and easy abortion is in the interests of men because it removes the problem of pregnancy, and women are well aware of that (Duffy in Hansard, 1990: 253).

In such arguments, female vulnerability was no longer just about exploitation by doctors, but also about men's mistreatment of women. Awareness of feminist ideas was demonstrated throughout, and Alton's opening speech in the Second Reading debate of his Bill quoted a feminist author who called abortion 'killing' (Hansard, 1988: 1231). However, what is striking about these speeches is not only the tendency to borrow from feminism, but that it went hand in hand with attempts to indirectly *blame* feminism for the troubles now facing women and society. Men's unacceptable behaviour was not, as in feminist arguments, linked to centuries of male dominance. Rather, it was implied that women's mistreatment at the hands of selfish men was a consequence of the erosion of traditional values linked to feminism and the sexual revolution:

> Many of the things that most hon. Members would hold dear are held a little more tenuously than they were 23 years ago. … One has to face the fact that marriage is no longer the central institution that it was. One has only to do some canvassing, as I did in Mid-Staffordshire recently – not that it did much good – to realise that for two people of different sex to live in the same house in different names is much more common that it was 20 years ago. One has only to consider the statistics for children born out of wedlock, or the increasingly powerful demands, which I shall not expand on at the moment because it would be out of order, from some sections of the community for women to be allowed to have children without any thought of marriage, to realise that there have been many changes (Cormack in Hansard, 1990: 210-11).

> At the heart of the debate about contraception and family planning … is the need to recognise that when love and a sense of responsibility is removed from sexual relations, there will always be tragedy (Alton in Hansard, 1990: 221).

Such remarks demonstrate the deeply conservative nature of anti-abortion activity and reveal that many participants saw abortion as at once a cause and signifier of social change, in much

the same way as discussed in Chapter Two. As Bennett put it: 'freely available abortion has changed the nature of society' (Hansard, 1988: 1261). This is classic backlash politics: from the claim that 'society' would be better off if the changes associated with feminism were reversed, to the claim that feminism and feminist demands have actively harmed women.

Discussion

Once again, my account of feminist activity in abortion debates has been mixed. Radicalism, in Dean's sense, did exist in feminist arguments. The demand for (relatively) liberal access to abortion was inscribed within a counter-hegemonic chain of demands including improved welfare services for women, better sexual education and changes in men's attitudes and behaviour. However, 'world-building' radicalism was less evident: women MPs seemed reluctant to invoke the image of a brighter future, perhaps because they had been pushed into a defensive position by the volume of attacks on abortion rights. What is also disconcerting about the feminist contributions of this period is the extent to which they relied upon narratives of female virtue and vulnerability in order to justify women's access to abortion. This strategy seems reasonable at first: images of women aborting for 'trivial' reasons such as club foot or personal inconvenience were rife in the arguments of anti-abortionists, and there may well have been a strongly perceived need to counter them. Nonetheless, as Boryczka observes, 'attributing value to one category of people still occurs at the expense of denying it to another' (2012: 61). Due to the dualistic nature of virtue and vice, the argument that some women need abortions 'through no fault of their own' implies another category of women who *are* at fault, and *don't* deserve access to abortion.

As Chapter Four demonstrated, the logic of medicalisation – and therefore the 1967 Abortion Act – is sustained by narratives of female vulnerability. This means that feminists forced to defend the Act find it difficult to escape such narratives. It would be unfair, however, to argue that medicalisation was *completely* unchallenged by feminists during this period. The Harman and Nicholson amendments to the HFE Bill in particular demonstrate that acceptance of medicalisation was more fragmented than allowed by Sheldon in her analysis. However, important parts of its logic remained unchallenged and this generated tensions for feminism. The logic of medicalisation was in some senses a useful discursive resource for feminists. Constructing women seeking abortion as primarily *patients* allowed feminists to argue that obstructions to abortion access meant that the state and medical profession were failing in their duty to women. However, over-reliance on medical necessity to justify abortion results in questions of women's rights, reproductive freedom and bodily autonomy being eclipsed (Purdy, 2001; Skinner, 2012). 'To the public eye, the woman as an active social agent, a decider, a person with the capacity to determine her own future, fades from view' (Hadley, 1997: 242). Appeals to medical necessity also render advocates of legal abortion vulnerable to claims that abortion isn't a 'real' need or is indeed harmful to women.

Constructions of virtue and vulnerability in feminist arguments also reveal an implicit acceptance of governmental logic. Virtuous women in these arguments exhibit self-discipline: they are careful and take steps to prevent pregnancy, confer with doctors, and need abortions 'through no fault of their own'. In short, they actively manage their own bodies, in a process similar to that identified by Dominique Memmi in her analysis of decriminalisation of abortion and euthanasia in France:

> abortion, especially when repeated, indicates a failure of contraception, of the sensible control of the desire for a child; it is a poorly "controlled", poorly "planned" desire for a child. While

> the advent of procreative techniques is no doubt a sign of the scientist's rational control over nature, our point here is that it is accompanied by a delegation of that rational control to the ordinary citizen. To put it more precisely, the citizen is asked to use his or her body "reasonably" (Memmi, 2003: 652).

Attempts to undermine the idea that abortion is medically necessary cropped up frequently in anti-abortion discourse, which attempted to dispel the impression that abortion could be considered a medical need with stories of women aborting for 'trivial' reasons. These stories indicate the danger of narratives of acceptable abortion, which are easily subverted and undermined. The arguments of the anti-abortionists also frequently appropriated elements of feminist rhetoric, claiming to speak on behalf of women and to be interested in ending women's exploitation. Nonetheless, these arguments at the same time utilised a conservative morality, implying that feminism and the social changes of the 1960s and 70s had in fact been bad for both women and society in general. Anti-abortion discourse in the 1980s was therefore just as conflicted as feminist discourse, attempting to simultaneously appropriate and scapegoat feminism. While none of the amendments sought by anti-abortionists came to pass, this faction should not be discounted. The Alton Bill in particular came close to becoming law but was eclipsed by the HFE Act. Moreover, the arguments established in these debates were revisited by anti-abortion forces even in the 21st century.

CHAPTER SEVEN. 1991-2013: FRAGMENTED MEDICINE, DISARTICULATED FEMINISM?

Introduction

In the 1990s, after the passage of the 1990 HFE Act, a handful of anti-abortion Bills were introduced. However, none of these progressed very far, and after 1996 there was a long period of relative quiet on the abortion front. The 1997 general election saw an unprecedented 120 women MPs returned to Parliament, many of whom sought specifically to articulate women's interests in Parliament (Childs, 2000; 2002). As one former Labour woman MP elected in 1997 told me, the high intake of women 'started to change the culture' of Parliament, making it easier for women to express certain views (Morgan interview, 2013). Many of these women would later be highly active on pro-choice issues.

Despite the lack of political activity, however, abortion provision began to change in practice. After the 1980s, a gap opened up between the law and practice as doctors became increasingly liberal in their attitude towards abortion and less inclined to stand in the way of a woman's decision. Meanwhile, more and more abortions are carried out in the charitable sector, making abortion more widely available than ever before. Nonetheless, anti-abortion doctors may still place obstacles in the way of women seeking abortion, although the extent to which this is a problem is unclear (Francome and Freeman, 2000).

Medicalisation continues to present problems in other ways. In 2011, the British Pregnancy Advisory Service (BPAS) made a bid to allow women to undergo early medical abortion (EMA) in their own home. EMA requires a woman to take two pills 24-48 hours apart. In the UK, both of these pills must be taken in a clinic, meaning that women who have to travel a long distance to get to a clinic may begin to miscarry on their journey home. BPAS argued

that the law could be interpreted so that both pills would be prescribed in a clinic, but women would be allowed to take the second pill at home, as in many other countries. However, the Department of Health opposed this move, and a high court judge ruled that both pills must be taken under medical supervision (Greasley, 2011). This ruling appears to reflect the on-going conviction that abortions must be closely observed and controlled, even if this causes difficulties for women.

Starting from the mid-2000s, there was once again a flurry of anti-abortion political activity. This perhaps reached its apex in 2012 when the Care Quality Commission (CQC) conducted shock inspections on a number of clinics amid allegations that regulations were not being followed (Department of Health, 2012). The public's attention was drawn to the issue of abortion in the same year when an Indian woman, Savita Halappanavar, died in an Irish hospital after doctors refused to terminate the pregnancy that endangered her life (Waterfield, 2013). While this case relates to Irish abortion law and is not within the remit of the thesis[1], one interviewee suggested that the shockwaves following Halappanavar's death have reinvigorated abortion politics in Britain (Green interview, 2013).

Nonetheless, the terms of Parliamentary debate remain similar. As Lee (2013) notes, anti-abortion discourse remains dominated by a dichotomy between 'villains' (abortion providers) and 'victims' (women who have abortions)[2]. However, this chapter describes a number of new anti-abortion strategies which emerged in the 2000s and went beyond the familiar topics of viability, abortion clinic profiteering, and conscientious objection. Principal among these were attempts to introduce various provisions relating to pre-abortion counselling, justified using the language of 'a woman's right to know'. However, 2012 and 2013 also saw outrage

[1] For a discussion of Halappanavar's death and the politics of abortion in Ireland, see Lentin (2013).

[2] Whether abortion presents a risk to women's mental health remains contested. MPs tasked with investigating evidence related to abortion in 2007 described the evidence as inconclusive (Science and Technology Committee, 2007; Iddon interview, 2013; Turner interview, 2013).

over claims that abortions were being performed due to the sex of the foetus, leading to fears that the UK is threatened by a new form of 'gendercide'.

In order for these new strategies to be discussed fully, this chapter is organised slightly differently to previous chapters. Firstly, Section 7.1 gives an overview of how the abortion debate was 'kept alive' in the 1990s by a handful of Bills and debates dealing with new abortifacient drugs, the method of abortion known as dilation and extraction (D&X), and renewed attempts to change the grounds under which an abortion could be carried out (Hansard, 1991; 1996a; 1996b). However, the chapter's main focus is on activity in the 21st century. Section 7.2 looks at mandatory counselling Bills from 2005 to 2007, arguing that these further the claim that abortion harms women, but are novel in their seeming encouragement of a 'social' role for doctors and their borrowing of feminist language in agitating for a 'right to know'. This section analyses Parliamentary debates (Hansard, 2006; 2007) but also explores how government documents constructed women seeking abortion as essentially vulnerable (Department of Health, 2005; 2007).

Section 7.3 turns to the debate over the 2008 Human Fertilisation and Embryology Act, to which several MPs attached amendments dealing with abortion. Considered in this section is the Commons debate over the abortion amendments (Hansard, 2008), plus the Report of Science and Technology Committee that influenced the debate (Science and Technology Committee, 2007b). Bolstering the argument are interviews with two former members of the Committee (Iddon and Turner interviews, 2013), Julie Morgan (a former Labour MP who was involved in pro-choice organising during this time, and spoke in the 2008 debate) and Shadow Equalities Minister Kate Green (who, while not an MP in 2008, has perspectives on strategy in this debate). While the debate covered the familiar ground of viability, it also saw a continuation of trends established in 2005-7 concerning a 'right to know' and the pastoral

doctor. This section also finds that feminist activity in the debate was sustained but cautious, showing little change from contributions in 1988-90 other than a 'shrinking' of feminist demands. This, however, must be seen in context: as doctors' attitudes are becoming more liberal, and as access has opened up in practice, challenges to the 1967 Act are less urgent. However, women seeking abortion still represented in a way that makes the normalisation of abortion difficult.

Section 7.4 deals with abortion politics after the failure of amendments to the 2008 HFE Act. After 2008 there were a series of abortion debates, many of which were adjournment debates on which a vote is not taken, and mainly again dealt with the issue of counselling. However, the attempts at reform pioneered by Nadine Dorries now called for *non-mandatory* counselling which is nonetheless independent of abortion providers. The section argues that this is a way of eroding faith in abortion providers that shows some continuity with past anti-abortion strategy, despite Dorries' claims to be pro-choice. The section also finds that pro-choice feminists in this period sustained their Parliamentary activity despite the perception that Dorries amendment was unlikely to get anywhere, due to the perceived need to demonstrate a strong contingent of pro-choice MPs.

This final section also considers the recent developments around the 'sex-selection scandal'. After a *Daily Telegraph* sting exposing 'sex-selective' abortions occurring in some clinics, the issue was taken up by Fiona Bruce MP in a Bill calling for increased monitoring and regulation of abortions conducted on these grounds. I argue that while sex-selective abortion may worry feminists for good reasons, the Bill had the effect of undermining pro-choice feminism in two ways. Firstly, it challenged the articulation of abortion as primarily an issue of women's rights by presenting it as particularly threatening to female foetuses. Secondly, it depicted an unbridgeable gulf between pro-choice feminists and vulnerable young Asian

Table 4. Abortion Bills 1991-2013

Bill	**Stage reached**	**Key provisions**
Lord Braine, 1995	First Reading	Prohibited the use of dilation and extraction ('partial-birth' abortion).
Viscount Brentford, 1996	First Reading	Prohibited the abortion of foetuses with Down's syndrome.
Peacock, 1996	First Reading	Prohibited the use of dilation and extraction ('partial-birth' abortion).
Amess, 1996	First Reading	Amended the grounds for legal abortion so that the pregnancy would have to present a 'substantial' risk to a woman's health in order for an abortion to be carried out.
Robertson, 2005	First Reading	Prohibited abortion except in the case of rape or incest or if the woman's life was endangered by the pregnancy.
Dorries, 2006	First Reading	Required women seeking abortions to receive mandatory counselling followed by a 'cooling off' period before medical practitioners would be allowed to certify an abortion.
Winterton, 2007	First Reading	Required women seeking abortions to receive mandatory counselling followed by a 'cooling off' period before medical practitioners would be allowed to certify an abortion.
Dorries, 2007	First Reading	Required women seeking abortions to receive mandatory counselling followed by a 'cooling off' period of seven days before medical practitioners would be allowed to certify an abortion.
HFE Bill, 2008	Became HFE Act	Several restrictive and liberalising amendments concerning abortion were attached. However, none made it into the eventual Act.
Health and Social Care Bill, 2011	Became Health and Social Care Act	Nadine Dorries and Frank Field tabled an amendment which aimed to strip providers of the ability to offer counselling, requiring instead that it be provided by an independent organisation. However, the amendment failed.
Bruce, 2013	First Reading	Required the Secretary of State to compile statistics on the gender ratios of foetuses aborted and imposed harsher penalties on those found to have assisted such an abortion.

Compiled from: Hansard.

women which cannot be bridged by traditional pro-choice politics, thus interrupting feminism's ability to speak to a diverse range of women (for a full guide to the Bills introduced in this period, see Table 4, p.199).

7.1 After 1990: anti-abortion politics in decline?

After the 1990 HFE Act passed there was little Parliamentary activity on abortion for several years, aside from a 1991 adjournment debate (where no measure is put to the vote) on the early medical abortion drug RU486 and a handful of private members' bills, none of which reached Second Reading. Sheldon argues that early medical abortions present a difficulty for anti-abortionists as the foetus is much less recognisable as a 'baby' at this stage of gestation, thereby detracting from the focus on the foetal subject (1997: 130). This assessment seems accurate: in the mid-90s, two bills were introduced which dealt with a particularly gruesome method of late-term abortion, thereby shifting focus back onto the foetus, although only Elizabeth Peacock's was debated. This section deals with the RU486 debate, the debate on the Peacock Bill, and another anti-abortion Bill introduced by David Amess.

7.1.i Early medical abortion

Mifepristone, earlier known as RU486, is a drug used to induce abortion in the early stages of pregnancy. It was licensed for use in EMA in the UK in 1991 and is used in the first nine weeks of pregnancy (Sheldon, 1997: 126-9). As taking mifepristone is a relatively simple, non-surgical procedure, the drug had the potential to shift the balance of power during the abortion procedure in women's favour. As Sheldon notes, its licensing provoked the fear, among anti-abortionists, that abortion was becoming too easy or trivial, and arguments against

mifepristone often implied ‘that women need to suffer in order to be deterred from reoffending’ (Sheldon, 1997: 131).

However, in the Parliamentary debate over mifepristone, anti-abortion MPs chose to represent women seeking abortion in a different way. Participants who opposed the licensing of mifepristone either implicitly challenged the notion of increased agency by depicting women not as choosing subjects but as unwitting ‘guinea pigs’ (Winterton in Hansard, 1991: 895) of the pharmaceutical industry or depicted increased agency in abortion as itself traumatising:

> Unlike a surgical abortion, the user of RU486 removes the remains of the child herself after the abortion. It is not like a clinical abortion where the foetus is removed under a general anaesthetic. The woman has to take part in the abortion (Hind in Hansard, 1991: 886).

Such arguments challenged the logic of medicalisation by undoing its construction of abortion as a measure to protect the vulnerable. However, pro-choice commentators had their own concerns about the introduction of mifepristone, noting that in practice, it resulted in more medical control of abortion, not less: the administration of mifepristone involves heightened medical supervision entailing multiple visits to a clinic (Sheldon, 1997: 133-9). Furthermore, as Sheldon observes, in the Parliamentary debate supporters of the decision to license mifepristone were careful to stress that its use would not diminish medical control of abortion, and that its administration would be in accordance with the terms set out in the 1967 Abortion Act (1997: 134).

> Its use will be confined to approved places and, as with other methods of abortion, will require the agreement of two doctors who will have to give their signature in good faith. It is not abortion on request (Richardson in Hansard, 1991: 892).

In addition to Sheldon's observations it is worth noting that parliamentary pro-choice discourse continued to construct women as patients, and articulate the interests of women and doctors together:

> The drug will save theatre time and theatre staff. It will save the surgeon's time. It will save anaesthetists, theatre nurses and anaesthetic nurses. It will save porters, equipment and anaesthetic agents. I hope that that considerable saving of resources and the freeing of resources will be redirected into providing a comprehensive national health service for abortion, with less delay for women … I support self-referral for abortion in the first three months of pregnancy. I realise that that view is not shared by everyone. That practice would ease NHS delays and, for the first time, would give women rights to decide whether to continue with a pregnancy (Richardson in Hansard, 1991: 893).

This is an interesting statement which requires some unpicking. On the one hand, it is an explicit call for demedicalised abortion provision and a right to choose. On the other, it is also fairly obviously an attempt to translate women's interests or goals into a format compatible with the objectives of medical providers and health administrators. This is a creative use of discursive resources on Richardson's part, and allows her to demand not only self-referral for abortion but also vastly improved NHS provision. However, it risks suggesting that women's rights are worth pursuing only insofar as they fit with governmental objectives.

While agreeing that the mifepristone provision has in practice been highly medicalised, Sheldon remains optimistic about its use. Mifepristone, she argues, may radicalise understandings of abortion because it allows women to feel more in control during the actual process of abortion itself: it does not require women to be hospitalised or undressed in the presence of a stranger (1997: 139-40), and allows women to take a more active role and doctors a more passive one. Moreover, in practice its administration has sometimes involved

only minimal supervision as doctors do not always strictly abide by rules regarded as medically unnecessary (1997: 143). In addition, in recent years providers and medical organisations have argued in favour of a demedicalisation of EMA, allowing these abortions to happen at home. Nonetheless, the extent to which this was resisted by the Department of Health demonstrates that medicalisation is still important to politicians, if not for the medical profession.

A final important feature of the mifepristone debate is the unique difficulty it presented for anti-abortion participants. As Sheldon notes, drugs inducing an early medical abortion 'make it more difficult for the anti-choice movement to rest their arguments on considerations of a foetus which is less easily represented as a recognisable "baby" at this stage of gestational development' (1997: 130). Instead of focusing on the foetus, opponents of mifepristone focused on alleged dangers to women's health and the potential 'trauma' resulting from abortion. Sheldon implies that this shift in focus away from the foetus might be part of a broader shift towards the use of 'medical' discourses above all else. Nonetheless, this chapter argues that in later debates in the 1990s and in the 21st century, anti-abortionists found new ways of focusing on the foetus.

7.1.ii Keeping the debate alive

When asked about the potential for further restrictive legislation to be brought in, Brian Iddon predicted that 'people will keep chipping away, keeping the thing alive through the Ten Minute Rule Bills' (2013). This, essentially, is what happened in the 1990s after the low-key RU486 debate. Several restrictive Bills were introduced between 1991 and 1996. Firstly, David Amess (Conservative) introduced a Bill to prohibit the use of techniques for selecting foetal sex. This is not considered here, as Amess pledged that the Bill would not seek to

amend the Abortion Act (Hansard, 1993: 769); however, its focus on apparent risks posed to 'little girls' by reproductive technology would be echoed in later Bills. In 1995, Lord Braine introduced a Bill to prohibit 'partial-birth' abortions, and in 1996, Viscount Brentford attempted to prohibit the abortion of foetuses with Down's syndrome. However, neither of these Bills received a Second Reading debate. More successful – in airing the issue in Parliament if not in becoming law – were two Ten Minute Rule Bills introduced by Elizabeth Peacock and David Amess in 1996.

Peacock's Bill moved to prohibit so-called partial-birth abortions. More commonly called Dilation and Extraction (D&X), these abortions involve the dilation of the cervix so that the foetus can be removed intact. D&X has attracted controversy, particularly in the United States, due to the nature of the procedure, which requires the brain of the foetus to be suctioned out. Nonetheless, this procedure is only rarely used in the US, and never used in the UK – neither at the time Peacock's Bill was introduced nor in the 2000s, according to the Commons Written Answers (Hansard, 2003).

This, however, did not deter Peacock from introducing her Bill. In her speech at First Reading, she noted that 'there is nothing to stop the general practitioner from using' D&X, and that 'there is no legal requirement for practitioners to notify the use of the technique' (Hansard, 1996a: 1041). While the object of contention was somewhat new, this line of argument recalls earlier challenges to the logic of medicalisation which depicted doctors as irresponsible and impossible to control, rather than benign and socially responsible. Also familiar from 1980s debates is the graphic depiction of the abortion procedure:

> The practitioner, guided by ultrasound, pulls the living unborn child through the mother's vagina, except for the child's head, which is deliberately kept just within the uterus. The

> practitioner then puts surgical scissors or another medical instrument into the back of the skull, inserts a catheter and sucks out the brains (Peacock in Hansard, 1996a: 1041).

Peacock's speech, unlike earlier speeches of mifepristone opponents, had an obvious affinity with 1980s depictions of violence against 'the unborn'. Since the Bill had no useful legislative purpose, as D&X was not being used in the UK, I suggest that Peacock's Bill represented an attempt not to change the law but to refocus abortion discourse on the foetus, the 'horror' of abortion, and the danger of medical power – as Ann Clwyd put it in her opposing speech, 'to shock and repulse people' (Hansard, 1996a: 1043). Focusing on the foetus of course challenges the logic of medicalisation, which relies on a dual depiction of doctors as responsible and women as vulnerable. Instead, these graphic accounts of abortion depict the foetus as the true victim, and doctors as either butchers or themselves victims of legal abortion. Female vice also rears its head in these accounts: Peacock claimed that most 'partial-birth' abortions 'are purely elective … another name for abortion on demand' (Hansard, 1996a: 1042).

This renewed focus on the foetus does not mean that anti-abortion legislators had abandoned medical arguments. Two weeks later, Amess introduced a Bill which, like previous Bills, would have amended the grounds for legal abortion so that the pregnancy would have to present a 'substantial' risk to a woman's health in order for an abortion to be carried out (Hansard, 1996b). There was little new in Amess' speech: he worried about abortions being performed for 'purely social reasons' and went on to stress the potential risks to a woman's physical health (an alleged increased risk of breast cancer) and mental health (from 'post-abortion trauma') (Hansard, 1996b: 776-7). As a Ten Minute Rule Bill, this Bill had a meagre chance of becoming law; indeed, neither Amess' nor Peacock's Bill was pressed to a vote.

After a huge swing to Labour in the 1997 General Election – including an unprecedented intake of female MPs – the issue of abortion went quiet for almost nine years.

7.2 2005-2007: Prohibition, counselling and cooling off

In this period, Conservative MPs Ann Winterton and Nadine Dorries introduced Bills which would have required women seeking abortions to receive mandatory counselling followed by a 'cooling off' period of seven days before medical practitioners would be allowed to certify an abortion (Hansard, 2006; 2007). Both were Ten Minute Rule Bills which did not progress past First Reading, although Dorries later introduced a second Bill which was not debated but was subject to a Department of Health impact assessment (Department of Health, 2007). Similarly assessed was a Bill, introduced by Laurence Robertson (Conservative) but not debated, which would have prohibited abortion except in the case of rape or incest or if the woman's life was endangered by the pregnancy.

Nadine Dorries in particular requires introduction here, as she has maintained a high profile in abortion debates. While Dorries claims to be pro-choice and a feminist, her campaigns have been attacked by abortion rights advocates (Abortion Rights, 2012). The counselling Bills came under fire for the delays and impediments they would have placed in the way of women seeking abortion. This section argues that these Bills represent a continuation of anti-abortion strategy in depicting abortion as something that harms women, but are also innovative in their use of the concept of a 'right to know'.

7.2.i Medical purity, progress and a 'right to know'

In their speeches at the First Reading debate of each Bill, both Dorries and Winterton situated their Bills within a narrative of progress. This is somewhat at odds with the conservative values expressed by some anti-abortion participants in earlier debates. However, it is perhaps unsurprising as since at least the 1980s, anti-abortion activism has made use of, and been boosted by, new technologies surrounding prenatal care and the foetus. This technology was referenced by Dorries to support her assertion that medical knowledge had 'moved on' since 1990:

> In 1990, when the House set the abortion limit at 24 weeks, viability—the date at which a foetus could survive outside the womb—was the principal consideration. Science has moved on, and so should the debate. Advanced medical scanners are now used by people such as Professor Campbell, one of the UK's most highly respected neonatologists, and I am grateful to him for his help and insight. The images produced by ground-breaking foetal monitoring techniques show the layperson how a foetus looks and behaves in the mother's womb (Hansard, 2006: 155).

What is surprising, given past anti-abortion emphasis on medical irresponsibility, is that this narrative is explicitly tied up with ideas about what doctors want:

> Doctors do not like foeticide and they do not like late abortions (Dorries in Hansard, 2006: 156).

> Even the Royal College of Obstetricians and Gynaecologists has been forced to admit that increasing numbers of the younger generation of their members are refusing to have anything to do with the operation, which is causing considerable anxiety and is probably the reason why so many NHS abortions are carried out in clinics and paid for by the NHS. We are finding the same development among general practitioners, who are refusing to refer girls for abortion—

> and believe me, it will not stop there. Younger doctors are showing a great deal more mettle than their forebears on any number of issues (Winterton in Hansard, 2007: 138-9).

However, the idea that abortion victimises doctors and goes against medical ethics has always been a facet of the logic of medical purity espoused by anti-abortion actors. Dorries and Winterton simply emphasised this aspect over the image of the irresponsible, uncontrollable doctor which featured heavily in past debates. Indeed, Winterton suggested that these doctors would soon become a thing of the past, 'seen out' by a 'more enlightened' generation (Hansard, 2007: 139-40). Such claims stressed the *differences* between doctors, challenging both the notion of a medical consensus surrounding abortion, and the underlying assumption of the 1967 Act that abortion provision was consonant with medical roles and identities.

Dorries and Winterton's depiction of women in their speeches was also innovative. Like previous anti-abortion actors, they appropriated and subverted both liberal-paternal conceptions of female vulnerability and elements of a feminist discourse of rights and empowerment. As in previous debates, women's vulnerability and the risks of abortion were highlighted, and Dorries and Winterton even referenced the same study:

> We now know beyond doubt—thanks to the comprehensive, respected Ferguson study undertaken over 25 years—that women who have abortions subsequently have twice as many mental health problems and three times the risk of major depressive illness as women who have not had an abortion or who have carried a pregnancy to term (Dorries in Hansard, 2006: 156).

> the New Zealand study showed that even women without past mental health problems are at risk of psychological ill effects after abortion. It showed that women who had abortions had twice the amount of mental health problems and three times the risk of major depressive

> illness of those who had given birth or never been pregnant (Winterton in Hansard, 2007: 140).

Although the research cited[1] may be new, the notion that abortion harms women has long been a feature of anti-abortion arguments, as it challenges the conception of the Act as a protective measure. What was innovative about these speeches – and the push for 'informed consent' in abortion provision more broadly – however, was the way they tied the construction of women as vulnerable and at risk from abortion to a feminist rhetoric of empowerment. This coupling of feminist and anti-abortion ideas hinged on the concept of *knowledge* and the right to be properly informed:

> The latest piece of major research on the possible effects of abortion on women's mental health was carried out in New Zealand and was led by a scientist who supports abortion on demand. Evidently, however, he also supports *a woman's right to know what she is choosing* (Winterton in Hansard, 2007: 139; emphasis mine).

> I call that [mandatory counselling and 'cooling off'] a woman's right to know and to choose, because *without information, what choices does a woman have?* A period of informed consent is about empowerment—it is about whether or not the decision to abort is fully thought through. It is about making an informed decision (Dorries in Hansard, 2006: 156; emphasis mine).

This strategy is disarticulatory in the sense that it attempted to decouple abortion rights from feminism, thereby undermining the credibility of feminists speaking in favour of the *status quo* and situating Dorries and Winterton as those truly concerned with protecting women's rights. Indeed, Winterton's speech took aim at pro-choice feminists, whom she termed 'the

[1] As previously noted, the findings of this study are contested. Other research has not found evidence that a 'post-abortion syndrome' exists (e.g. Robinson *et al.*, 2009; Munk-Olsen *et al.*, 2011). By way of explanation, one interviewee observed that 'scientific evidence in the mental health field is extremely difficult' (Turner interview, 2013).

abortion sisterhood' (Hansard, 2007: 138), in multiple ways. As well as emphasising the 'right to know', Winterton attacked the 'sisterhood' for their criticism of 'crisis pregnancy centres'[1], depicted as neutral organisations simply seeking to provide help and support to women (Hansard, 2007: 138). Likewise, she described birth control activist Margaret Sanger – seen by some as a feminist pioneer (Chesler, 2007; Coates, 2008) – as a eugenicist who 'was not interested in women's rights' (Hansard, 2007: 139). In this way, her speech sought to blame feminism, or at least pro-choice feminists, for women's suffering, while at the same time attempting to arrogate elements of feminist arguments to herself.

7.2.ii Feminists respond

Speaking to oppose the Dorries and Winterton Bills were two Labour women MPs, Chris McCafferty and Laura Moffatt. Both challenged what they saw as the assumption that women seeking abortion do not know their own minds, emphasising that most women seeking abortion have made up their minds long before speaking to a medical professional (Moffatt in Hansard, 2007: 141) and should be allowed to make this choice on their own terms (McCafferty in Hansard, 2006: 159). In doing so, they depict women as reasonable and competent – a far cry from the image, often found in the contributions of early supporters of legal abortion, of women as frightened and irrational. On the other hand, these accounts are somewhat tinged with assumptions about female virtue and faultlessness. Take McCafferty's insistence that women seeking late abortions 'have *compelling reasons* and often face *extremely difficult or unusual circumstances*, perhaps the catastrophic long-term illness of another, older child' (Hansard, 2006: 158; emphasis mine). This is yet another narrative in

[1] Crisis pregnancy centres are non-profit organisations offering counselling and help to women with unplanned pregnancies. According to a mystery shopping exercise conducted by Education for Choice, while the counsellors in these organisations are generally well-meaning, they often operate with an anti-abortion agenda, and many do not provide impartial advice (Education for Choice, 2011).

which the woman seeking abortion is a victim of circumstance who did everything 'right' – and is possibly already a loving mother.

There is nonetheless a limited radicalism in these speeches. There is little in the way of world-building in the Zerillian sense, but this is perhaps because McCafferty and Moffatt's role in speaking against the Bills was purely reactive and allowed little room for imagination and creativity. There are chains of equivalential feminist demands present: the Laclauian sense of radicalism. Both McCafferty and Moffatt called for improved sex education and access to contraception as better ways to tackle the problems identified by Dorries and Winterton:

> As I have said many times in the House, the best way of reducing the number of unintended pregnancies is to improve women's access to contraception, as well as educating women and men about sexual health. This cruel Bill – for it is a cruel Bill – is an attack on women's reproductive rights (McCafferty in Hansard, 2006: 159).

> A delay in treatment results in abortion taking place later and at greater emotional and financial cost. It would undoubtedly force some women to continue a pregnancy against their wish, but the best way to reduce the numbers of unintended pregnancies is to improve women's access to contraception, as well as educating women – and men – about sexual health (Moffatt in Hansard, 2007: 141-2).

Opposition to the restrictive Bills was therefore situated within a chain of feminist demands. However, this chain appears to be much shorter than in earlier debates, during which feminists linked together demands for liberal abortion laws with demands for better housing, employment and maternity support, to name a few.

7.2.iii The Department of Health responds

Under the Labour government, the Department of Health produced impact assessments of Robertson's Bill and Dorries' second counselling Bill (Department of Health, 2005; 2007). While these were very different Bills – Robertson aimed to prohibit abortion entirely, with very few exceptions, while Dorries claimed to be in favour of legal abortion – the assessments are similar enough that they are worth mentioning here, as they demonstrate how ideas about female vulnerability have become inscribed in the process of 'evidence-based policy-making'.

The assessments sought to calculate the 'impact' (Department of Health, 2005: 2) or 'effect' (2007: 3) of the proposed Bills. They are suffused with the language of EBP: women, providers etc. are figured as 'stakeholders', and the effects of the Bills figured in terms of risks and costs. The assessment of the Robertson Bill found that the risks it posed to women involved, among others, suicide, feigned suicide (in order to convince doctors that the woman concerned needed an abortion), death from illegal abortion and damage to mental health from being forced to continue the pregnancy (2005: 7-8). The predicted costs were estimated to be £750 million a year in medical costs, welfare, social care, education and others. The assessment of the Dorries Bill found that it would have involved risks to mental health, a small number of self-induced pregnancies, and financial difficulties for those living in poverty, among other risks (2007: 9-10). In addition, the Bill was estimated to involve a cost of £74 million a year in costs to the NHS, counselling costs, and benefits.

Of course, these assessments were useful to the pro-choice cause in one sense, as their findings supported the case against the Bills. Nonetheless, they considerably flatten the terrain of abortion politics by seeking only 'what works' (Parsons, 2002; Sanderson, 2003). This is most evident from the 2005 assessment's reduction of the complexity of feelings involved in anti-abortion sentiment to 'a socio-moral benefit to members of the public that are pro-life'

(Department of Health, 2005: 14). However, the 'evidence-based' approach may also be detrimental to pro-choice politics. By formulating the 'problem' of abortion in terms of a calculation of the 'risks' and 'costs' incurred by 'stakeholders', they effectively exclude questions of rights, autonomy and liberation. Instead, the 'impact' of a proposed item of legislation can only be figured as that which is directly observable and can be measured. This in turn necessitates the construction of women as primarily vulnerable, as the only women visible to evidence-based impact assessments are those who are deemed to be 'at risk'.

7.3 The Human Fertilisation and Embryology Bill 2008

In the mid-2000s, the Labour government became aware of a need to update the 1990 HFE Act. The Human Fertilisation and Embryology Authority, the statutory body regulating human embryo research and reproductive technology, had been 'making the law on the hoof' (Iddon interview, 2013) while trying to keep up with technological advances, and it was recognised that new primary legislation was needed. As in 1990, anti-abortion parliamentarians attempted to attach amendments to bring the upper limit for legal abortion down to anywhere between 22 and 12 weeks (including a campaign by Dorries for a reduction to 20 weeks) and to require the provision of counselling. However, the outcome was heavily influenced by a Report of the Science and Technology Committee on legal abortion (2007b), which found there to be little evidence suggesting foetal viability rates had improved below 24 weeks' gestation. In a series of divisions, Parliament voted to keep the 24 week limit.

Several MPs also attempted to attach liberalising amendments to the Bill. These amendments would have removed the rule requiring two doctors to certify before an abortion could be carried out, extended the Act to Northern Ireland where it still does not apply, permitted

nurses to carry out abortions where suitably trained, and extended the range of locations where abortions could take place – including allowing women to complete EMA at home. However, the Government tabled a programme of motions which changed the order in which amendments were called for discussion, and guillotined the time allowed for debate. This ensured that there was no time to debate the liberalising amendments (Sheldon, 2009: 4).

7.3.i Report of the Science and Technology Committee

In the mid-2000s, the Labour Government had realised that the 1990 HFE Act was in need of updating, and wanted the help of the House of Commons Science and Technology Committee in doing so. This led the Committee to produce a report on human reproductive technology in 2005 (Science and Technology Committee, 2005), which was followed up by reports into chimaera and hybrid embryos (2007a) and abortion (2007b). These reports led in turn to the formation of an ad hoc Joint Committee with the House of Lords, resulting in the publication of the Human Fertilisation and Embryology Bill (Iddon interview, 2013). The Committee hadn't initially planned to discuss abortion at all. However, it came to conduct an inquiry into abortion after a suggestion from the Government that since anti-abortion actors were likely to attempt to amend the Bill to alter abortion legislation, it would be worthwhile to consider whether there had been any scientific developments relating to abortion since 1990 (Turner interview, 2013). The Committee explicitly ruled out consideration of ethical and moral issues surrounding abortion (Science and Technology Committee, 2007b: 5), and attempted to emphasise evidence from those seen to be the most neutral (Iddon interview, 2013). Nonetheless, it received a large volume of evidence from both pro-life and pro-choice campaigners (Iddon interview, 2013; Turner interview, 2013).

The inquiry looked for evidence pertaining to four key areas: the upper gestational limit for legal abortion, abortion for foetal abnormality, the potential impact on the aborting woman's health, and issues surrounding access and procedure. Regarding the upper gestational limit, the Report found that survival rates below 24 weeks had not improved since 1990, although they had improved from 24 weeks onwards (2007b: 22). The inquiry also considered the issue of consciousness and foetal pain, again concluding that there was little evidence that pain is consciously felt by the foetus, especially below 24 weeks. It also looked at reasons why women might present for 'late' terminations, stressing that many women did not realise they were pregnant until a late stage in the pregnancy. However, it also found that 41% of women present for late abortions because they 'struggle to take the decision to have an abortion' (2007b: 28).

The section of the Report relating to foetal abnormality focused on whether further clarification of the definitions of 'abnormality' and 'handicap' in the Act were necessary. The Report indicated that some submissions to the inquiry had expressed concern over abortions for clubbed feet and cleft palates, although it concluded that it would not be feasible to create an exhaustive list of abnormalities allowing abortion (2007b: 29-31). Regarding the risks to mental health posed by abortion, the Report found the evidence inconclusive (2007b: 47), and Iddon suggested that more research needed to be done in this area (interview, 2013). However, it found that the physical health risks of abortion were minimal, that the RCOG's guidelines in this area were correct, and that women undergoing abortions were generally well informed of any risks (2007b: 48-51).

The Committee's recommendations concerning access and procedure contrast sharply with those of the Lane Committee of the 1970s, which justified its support for medical control of abortion by depicting women as irrational, vulnerable, and incapable of responsibly exercising

a right to choose. The 2007 Report framed issues of access to abortion in terms of the need for abortions to be carried out as early as possible, and recommended a loosening of medicalisation in several ways, including allowing a more active role for nurses in the provision of abortion (2007b: 38-9), and letting women undergo EMA at home[1] (2007b: 42). However, its observations concerning the two-doctor rule are the most significant. The Committee suggested that the 'crazy' (Iddon interview, 2013) need for two doctors be removed on the basis that it might cause delays (2007b: 35). Evidence submitted to the inquiry generally cited medical reasons for removing the rule, noting that 'no other medical or surgical procedure' requires two signatures (2007b: 33). Moreover, evidence from Sally Sheldon suggested that the requirement for two signatures runs counter to the principle of patient autonomy (2007b: 33).

These arguments might be seen as medicalising due to the translation of women's rights into patients' rights. However, they may also simultaneously indicate the destabilisation of the medicalised framework for abortion regulation. In the 1966-7 debates, this framework was achieved through the construction of abortion as being 'like other medical procedures'. However, recent criticism of the two-doctor rule uses the same argument in order to undermine the basis for medical control. Medical organisations themselves criticised the need for two doctors in their evidence to the Committee (2007b: 33), and a BMA document published in the same year recommended the removal of the two-doctor rule and the need for women seeking abortion to meet specified medical criteria, 'so that first trimester abortion is available on the same basis as any other medical treatment – on the basis of informed consent' (BMA, 2007: 5). Meanwhile, the pro-life group SPUC advocated retaining the rule:

[1] The Committee's support for home EMA was not unanimous, even among pro-choice members. When interviewed, Iddon expressed concern that complications might set in for some women, and that the process might be difficult to deal with (interview, 2013).

> This is a particular kind of procedure. You are talking about a medical procedure often being prescribed for a social reason or a psychiatric reason and that is highly unusual in medicine. Usually a medical procedure is done for a medical reason (Science and Technology Committee, 2007b: 35).

Strikingly, this argument uses the logic of medical purity – that there is a clear distinction between the 'social' and 'medical' realms – in order to justify medical control of abortion. This is markedly different from the concerns of anti-abortion politicians in the 1966-7 debates, who argued that decisions on 'social' matters should not be committed to the hands of doctors. The fact that the social/medical binary may now be used to justify medical control suggests a fragmentation of the logic of medicalisation. Medicalisation may have been based on the idea that 'doctor knows best', but if doctors themselves are recommending a shift away from medical control, it is unclear what this now means.

7.3.ii Anti-abortion arguments

Two members of the Committee, Nadine Dorries and Bob Spink, published a dissenting Minority Report indicating concern over how the Inquiry had selected evidence. While Iddon and Turner, along with the Report itself, emphasised the attempt to find a neutral ground in the inquiry, the Minority Report suggested that the process of evidence selection had been shaped by 'ideological and financial interests' (Science and Technology Committee, 2007b: 71). However, it was not made clear what these interests were. Dorries and Spink criticised several aspects of the report. Firstly, they took issue with the validity of EPICure 2, the key study informing the Committee's conclusions on foetal viability (2007b: 73-4). Secondly, they emphasised what they saw as significant health risks of abortion and stressed the need for a 'right to know' (2007b: 78-9). Finally, they expressed anxiety that allowing women to

undergo EMA at home would result in ‘a more relaxed attitude’ among young women concerning abortion and contraception. This brings to mind Sheldon’s observation that anti-abortion discourse requires women to suffer ‘in order to be deterred from reoffending’ (1997: 131).

Similar concerns were expressed in the 2008 debate. Anti-abortion participants continued to situate restrictive amendments in the context of ‘new evidence’ regarding the foetus and ‘advances in modern medical science’ (Leigh in Hansard, 2008: 227), arguing that liberal abortion laws are ‘perhaps outdated now, given the advances in science in recent years’ (Pritchard in Hansard, 2008: 233). There was also a sustained use of graphic descriptions of foetal development, presenting the foetus as a person and subject in its own right:

> Scientific evidence increasingly suggests that unborn children feel pain at 16 weeks. That is not simply a stress response; it is a physiological response, perhaps not the same as in a fully grown adult, but a physical and even emotional response beyond the norms of passive reflex. Pain is felt, which is why specialist, gifted surgeons who perform surgery on babies in the womb use anaesthetic. Now, 4D imaging reveals that 16-week-old unborn babies are very much alive and kicking, although their limbs are too small to be felt by the mothers (Pritchard in Hansard, 2008: 234).

Again, these descriptions were found alongside shocking descriptions of abortion depicting violence against the foetal subject:

> the baby was given a lethal injection of potassium through the mother's abdominal wall, into the baby's heart. The process was supervised by an ultrasound scanner, so that the doctor could see exactly where the needle was going – into the foetal heart. The baby died and 24 hours later went through the process of surgical dismemberment and removal (Dorries in Hansard, 2008: 259).

As Childs *et al.* (2013) note, anti-abortionists also drew upon the image of the 'social' abortionist who lacks a sense of responsibility, noting that 'social' abortions account for the vast majority of abortions (Leigh in Hansard, 2008: 226) and take place 'for the convenience of the parents' (Curtis-Thomas in Hansard, 2008: 231). Female vice was implicit in these arguments, which challenge the pro-choice depiction of women presenting for late abortions as virtuous and vulnerable. Pugh, for example, picked up on statistics concerning reasons for late abortions published in the Committee Report, observing that over 40% of late abortions 'result, in a sense, from late choices' (Hansard, 2008: 252). In a similar vein, Dorries complained that some women 'demand' a late termination 'with no good reason' (Hansard, 2008: 261), recalling old fears that women are not traumatised 'enough' by abortion (see Chapter Five, Section 5.5.i).

Yet at the same time, anti-abortion participants continued to stress the harm done to women by abortion, whether in the form of an increased physical risk or in terms of damage to mental health (e.g. Curtis-Thomas in Hansard, 2008: 228-9; Pritchard in Hansard, 2008: 234). In one occasion an MP brought attention to the harm done to 'girl' foetuses (Leigh in Hansard, 2008: 227). These participants also presented themselves as acting 'for women', continuing to call for a 'right to know' (Curtis-Thomas in Hansard, 2008: 228) about alleged health risks and even making explicit appeals to feminism:

> a cursory glance at 19th-century and even early 20th-century social history reveals that it was the feminist movement, alarmed by a male-dominated medical profession, that led the charge against liberalising abortion laws (Pritchard in Hansard, 2008: 233).

That such arguments existed alongside constructions of women which emphasised female vice suggests an on-going tension in anti-abortion politics between the desire to appeal to a

conservative vision of gender roles, and the need to grapple with the 'woman problem' presented by the 1967 Act.

What is most notable about anti-abortion contributions in this debate is the near-absence of the 'irresponsible doctor' theme. Although this theme was still present among the Lords (Childs *et al.*, 2013), MPs displayed an apparent acceptance and encouragement of the pastoral role of medical providers in guiding men and women onto the 'right' path:

> When a man presents for a vasectomy at a doctor's surgery, the doctor does not say, 'Come in, sit down and take your trousers off.' He says, 'I think you ought to think about this for a little while.' If the man involved is under the age of 30, childless and not yet married, the doctor may well say to him, 'I think you ought to think about this seriously' (Curtis-Thomas in Hansard, 2008: 229).

> I had a vasectomy on the national health. I went to see my GP, who said, 'I want to speak to your wife.' My wife and I both sat there and agreed that a vasectomy was the way forward for us as our own personal form of contraception. The GP then sent us away for three or four days, after which my wife and I both saw the consultant, and again we both agreed that a vasectomy was the way forward. I entirely agree with the hon. Lady that if that time for thought is right for a man having a vasectomy … there must be a provision for more time to think and consult when it comes to such a serious decision as having an abortion (Penning in Hansard, 2008: 242-3).

These two very similar accounts suggest that anti-abortion discourse no longer always rejects the notion of the 'socially responsible' doctor. This is the novelty of counselling amendments: they subvert feminist arguments by transforming 'a right to choose' into 'a right to know', but also subvert the notion that the 'socially responsible' doctor will *enable* women to have abortions.

7.3.iii Feminist arguments

Like those speaking in support of restrictive amendments, pro-choice feminists prioritised medical evidence in their arguments. Dawn Primarolo, now Minister of State for Public Health, spoke in support of existing time limits, emphasising her focus on the evidence concerning foetal viability even when directly challenged about the morality of abortions in specific circumstances (Hansard, 2008: 248). However, Primarolo also made it clear that she was consciously situating her arguments with respect to how Parliament had decided the matter in the past:

> on every occasion the House has considered this issue, it has used viability, as determined by the evidence from the medical profession, in order to provide its starting point (Hansard, 2008: 245).

Others similarly prioritised scientific evidence. However, the interview data suggests that this was at least in part done strategically:

> I think they were much more receptive to the medical evidence. I think that was the thing that won it, that kept things at bay. I don't think the feminism and the women's issues would resonate with some people in Parliament (Morgan interview, 2013).

The perception that it was evidence 'that won it' was shared by the other interviewees, who believed that anti-abortion actors were unlikely to win the argument in Parliament without evidence that viability rates were improving (Iddon interview, 2013, Turner interview, 2013). Turner observed that the evidence may not have been the deciding factor for many people whose moral and political views played a part, but that it gave people the 'confidence' to resist restrictive amendments, especially Dawn Primarolo in her role as a Minister. Kate Green, who was not an MP at the time but has been quite active in abortion politics, expanded on this. For Green, arguments concerning evidence are not only *necessary* in order to counter

anti-abortionists' claims regarding foetal viability, but also an *easy* way to address the issue, as anti-abortionists are 'disingenuous in their use of evidence' (Green interview, 2013).

However, Green also noted that the factors concerning a woman's decision to abort were just as important, if more difficult, to discuss. This view seems to have been shared by pro-choice MPs active in the 2008 debate, many of whom centred women and women's rights in their speeches (Childs *et al.*, 2013) and explicitly represented the debate as about 'women's right to choose' (McCafferty in Hansard, 2008: 245; Morgan in Hansard, 2008: 269-70). While Morgan stated her belief that abortion should be more accessible (Hansard, 2008: 268), there was very little else by way of critique of the 1967 Act – far less so than in the 1990 debate. However, some context is required here: the 1990 debate took place against a backdrop of cuts to the NHS causing delays, whereas by 2008 charitable sector provision of abortion had expanded, rendering abortion far more accessible. Moreover, participants in the 1990 debate were able to discuss an amendment to end the two-doctor rule, but similar discussion was guillotined in 2008. Nonetheless, it is still the case that feminist arguments continued to appeal to the figure of the doctor as a justification for 'choice':

> Surely it is better to go with the judgment of the doctor, discussing the matter together in the light of her particular circumstances (Morgan in Hansard, 2008: 269).
>
> Abortion should be a private decision, between the patient and her doctor, just like any other medical treatment (McCafferty in Hansard, 2008: 238).

Demands for maintaining abortion access were again situated within a broader chain of demands. However, these demands were, as in the 2006 and 2007 debates, rather truncated compared to previous decades:

> What has been proven to reduce abortions is comprehensive sex education and unrestricted access to effective contraception and early safe abortion services (McCafferty in Hansard, 2008: 237).
>
> Many of us … would seek to improve sex education, relationships education and contraception (Mallaber in Hansard, 2008: 254).

Feminist speakers continued to represent women seeking abortion as vulnerable. Again, it was late abortionists who were primarily deemed to be vulnerable in these contributions (Morgan in Hansard, 2008: 234; Primarolo in Hansard, 2008: 246-7). However, the mandatory counselling amendments were also seen as potentially victimising women by forcing them to receive information they weren't in a state to hear (Primarolo in Hansard, 2008: 249). These speakers also drew upon narratives of acceptable abortion to support their case, such as this example read out by Mallaber:

> I was 19, my father had died and I was looking after my 8 siblings with my mother who could barely afford to keep us. I couldn't face telling my mum about my pregnancy—things were so difficult. If I couldn't have an abortion I'd have killed myself. Now I've been able to go to college, learn to read and write, play a full role in society and bring up a family of my own (Hansard, 2008: 256).

While such stories may be important to tell, as Childs *et al.* (2013) note, missing from pro-choice discourse are arguments that present abortion as a normal part of life that a diverse range of women experience.

Narratives of acceptable abortion also frequently centred on the issue of foetal abnormality as justification for 'late' abortions. In these narratives, women are constructed as responsible and reasonable choosers, often deciding to abort because they know it is best for the families and often for the foetus:

> Any reduction below the current 24-week limit would leave little or no room for women and couples to make a responsible, considered choice when a potentially serious abnormality is detected (McCafferty in Hansard, 2008: 239).

Unlike other arguments which focus on the vulnerability of women who seek abortion, these narratives do construct women as agents, active choosers rather than victims of circumstance. Yet, to reiterate Steinberg's (1991: 187) point, this is justified not on the grounds of a 'right to choose' (which would not dictate 'acceptable' reasons for termination) but on the grounds that disability is a 'special case' which legitimates abortions which might otherwise be unethical.

7.4 After the 2008 HFE Act

Unlike in previous decades, the debate on abortion does not seem to have died down following the failure of high-profile attempts to amend the 1967 Act. Nadine Dorries secured an adjournment debate on counselling in 2010 (Hansard, 2010), which was followed by an attempt to amend the Coalition Government's Health and Social Care Bill in 2011 (Hansard, 2011a). The amendment failed after Dorries' co-sponsor Frank Field (Labour) withdrew his support and Public Health Minister Anne Milton stated that legislation would not help address Dorries' concerns, but the Government promised to launch a consultation. Nonetheless, abortion counselling was again discussed in an adjournment debate later in the year (Hansard, 2011b).

The political climate seemed to shift further in favour of anti-abortion sentiment in 2012. After a *Daily Telegraph* sting uncovered evidence that doctors were agreeing to perform abortions because of the sex of the foetus (Watt *et al.*, 2012), followed by allegations that doctors were 'pre-signing' abortion certificates before seeing the woman in the clinic, the

Department of Health ordered the Care Quality Commission (CQC) to conduct a series of unannounced inspections on independent abortion providers (Department of Health, 2012). Later in the year, there was another adjournment debate during which several MPs expressed anti-abortion sentiments. However, during the debate the new Public Health Minister Anna Soubry announced that the Government had dropped the planned consultation into abortion counselling (Hansard, 2012). The Department of Health's sexual health framework, published in 2013, suggested that there were few problems with independent providers' provision of counselling (2013: 35-6).

Nonetheless, controversy over abortion continues. After assessing the more recent debates over counselling, this section assesses the state of pro-choice politics in Parliament in 2013, concluding that while pro-choice feminist activity has been sustained since 2008, its strategies have been cautious and pragmatic. Finally, it turns to the newest point of contention in abortion politics: sex-selective abortion. It concludes that while feminists may have good reason to be concerned about abortion for reasons of foetal sex, recent claims about its danger and prevalence can be seen as an extension of anti-abortion strategies for undermining the Abortion Act. Concerns about the prevalence of sex-selective abortion in Asian communities are disarticulatory in two senses: firstly, in that they attempt to uncouple abortion rights from notions of women's rights; and secondly, in that they attempt to foreclose the possibility that feminist politics could speak to (rather than *act on*) a diverse constituency of women.

7.4.i 'Non-mandatory' counselling

The Dorries and Field amendment would not, unlike Dorries' previous Bill, have imposed mandatory counselling or a 'cooling off' period. Rather, it aimed to strip providers of the ability to offer counselling, requiring instead that it be provided by an independent

organisation. While presented by Dorries as a mutual, rather than anti-abortion amendment, abortion rights groups worried that it would introduce delays in the process of obtaining an abortion, and that anti-abortion organisations might be contracted in order to provide counselling (Abortion Rights, 2011). Dorries' speeches in this and other debates seemed designed to reignite criticism of doctors, especially those involved in abortion provision. While opponents recognised that the amendment was unlikely to become law, it was perceived as part of a broader strategy of 'chipping away' of abortion rights by 'creating a climate of scepticism about the way in which abortions are carried out' (Green interview, 2013).

The debates again saw Dorries focusing on the vulnerability of women (e.g. Hansard, 2010: 896), who may even be 'coerced' into abortion (Hansard, 2012: 74). These arguments in places seem to invert the narratives of personal crisis and trauma told by many pro-choice feminists:

> I ask Members, just for a moment, to put themselves in the shoes of a 16-year-old girl who turns up at that clinic and does not know what to do. She is pregnant and panicking. Some of her friends tell her to have an abortion and some tell her not to. She does not want to tell her parents because she is scared of doing so. Her boyfriend is saying to her, 'You've got to have an abortion and get rid of it' (Hansard, 2011a: 370).

Dorries continued to represent herself as a feminist, citing her respect for Harriet Harman and 'what she has achieved for women and humanity' (Hansard, 2011a: 363), claiming to be acting on behalf of women who had asked her to propose new legislation (Hansard, 2011a: 373-4; 377) and even evading an attempt by the more openly pro-life McCrea to refocus the debate on the foetus, as 'the amendment is not about the unborn child; it is about the woman accessing counselling' (Hansard, 2011a: 375).

However, Dorries' contributions also pointedly attack abortion providers, who 'flout the law' (Hansard, 2012: 70) and are motivated by profit, not by caring for women:

> BPAS has advertised for business development managers, whose primary function is to increase its market share – those are its own words in the advert. If an organisation advertises that it wants to increase the number of abortions, can we trust it to provide vulnerable women who walk through that door with the counselling that they need (Hansard, 2011a: 377)?

In the later 2011 debate, Gavin Shuker expressed similar opinions, reciting stories of 'disinterested' counsellors, who 'presented [women's] abortion options like it was a sweet shop' (Hansard, 2011b: 629).

The debates elicited a strong feminist response, and a strong articulation of feminist demands:

> Women – both individual women and women in general – have been called in aid in this debate, and indeed they face very real problems in this society, here in 2011. They face spiralling employment as a direct consequence of the coalition's policies and the sexualisation of our culture, which affects younger and younger female children (Abbott in Hansard, 2011a: 381).

> I am sure we would all prefer a world in which there are fewer abortions; in which men and women have access to sex education, support and advice to make the right decisions for themselves; in which, should partners choose to engage in sexual relations, there is safe and confidential access to contraceptives; in which there is no rape or incest; and in which, if a woman becomes pregnant, she is not so afraid of family and community that she is unable to seek early advice and support (Malhotra in Hansard, 2012: 80).

These chains of demands go beyond the demands for sex education and contraception expressed in 2008. On the other hand, such contributions did still tend to privilege medical knowledges (Malhotra in Hansard, 2012: 80; Elliott in Hansard, 2012: 83-4), present abortion

as primarily a medical decision that 'must, at the end of the day, be between a woman and a doctor' (Abbott in Hansard, 2011a: 382), and depict the interests of women and doctors as aligned:

> the proposers of the amendment are asking us to believe, on the basis of purely anecdotal evidence, that tens of thousands of doctors, nurses and charity workers involved in the 190,000 abortions a year are wilfully ignoring both the law and the guidance of the British Medical Association and the Royal Colleges … The proposers of the amendment, I might add, also seem to be arguing that thousands of women do not actually know what they are doing (Abbott in Hansard, 2011a: 180-1).

However, alliance with the medical profession means something different in the 21st century. Firstly, as previously noted, the medical organisations now favour further liberalisation over medical control. Secondly, the growth of BPAS and other organisations has hugely changed the landscape of abortion provision, and leaders of the biggest providers are advocates for change (Furedi, 2008; Rickman, 2012). Ironically, then, allegiance with the medical profession now means allegiance with organisations who advocate for an end to, or at least loosening of, abortion's medicalised regulatory framework. Nonetheless, medicalisation persists and causes problems for some women, whether in the form of unnecessary delays (Furedi, 2008) or the continued resistance to allowing EMA at home. These problems are still under-discussed in parliamentary pro-choice discourse.

7.4.ii A reinvigorated pro-choice politics?

Abbott's speeches in the above debates in particular represent a more thoroughgoing challenge to prevailing norms than seen in the 2008 debates. One speaker's contributions do not constitute a trend, but what is interesting about the Abbott quotes above is that they

explicitly situates feminist demands in opposition to the Government's austerity measures – which have been regarded by many as disproportionately affecting women (MacLeavy, 2001; Women's Resource Centre, 2012). As the majority of pro-choice feminist speakers in such debates are Labour MPs, now in opposition, it may be that they are now more willing to situate their demands within a larger chain of counter-hegemonic demands than they were when the Labour Party was still in power. This may especially be the case as there is a general perception among Labour women that both Parliament and public policy grew more pro-women since the 1997 election (Childs, 2000; 2002; Green interview, 2013; Morgan interview, 2013), although how 'pro-women' New Labour policy really was is contested (McRobbie, 2000; Annesley *et al.*, 2007).

In any case, pro-choice activity in Parliament has been sustained since 2008. There is still cross-party group of MPs who are committed to fighting any attempts to restrict abortion access, including the current Minister for Public Health, Anna Soubry. According to Green, this group sees it as important to co-ordinate even when the threat is not very great:

> we felt it was so important at the time of Nadine's Bill to organise the voice in Parliament who are pro-choice. Not because we thought her Bill as such was necessarily going anywhere, but it was so important to show that there were a lot of people who would come back in this debate (Interview, 2013).

Green also suggested the powerful campaign in Ireland following the death of Savita Halappanavar had also aided the pro-choice cause in the UK, having highlighted 'how utterly non-discriminating the need for a termination can be' as well as how much can be lost when anti-abortion attitudes take hold.

However, there have been no recent attempts to liberalise the 1967 Act. Interviewees were all critical of the two-doctor rule and requirement for medical grounds:

> I think it's overprotective … the need for two doctors to certify implies that women somehow can't be trusted to make this decision, or that it's a hugely medically finely balanced decision, and I would like to see that examined again (Green interview, 2013).

> why do you have to have a reason to have an abortion if you really decide you don't want to go through with it? … I just wonder whether having to have a reason, or having to have the two doctors, may be a bit of a mechanical exercise (Morgan interview, 2013).

> we suggested that nurses should sign this HSA1 form, we saw no reason why it should be doctors to organise the consent (Iddon interview, 2013).

> It's all too easy for doctors who fundamentally disagree with abortion to withhold their signatures, therefore leaving a pregnant woman faced with increased delay in seeking to obtain an alternative (Turner interview, 2013).

While interviewees readily gave such opinions, they are harder to find in records of Parliamentary debate. The Government guillotine on the 2008 debate was a major reason for this, having removed a big opportunity for the merits of liberalising amendments to be discussed. Subsequently, the 2008 debate put pro-choice politicians in a reactive role, unable to move the discussion on:

> we've never been able to think in that way, because it's always been trying to defend, to try and keep things where they are, you know, so there's never been an opportunity to really sit down and calmly think about what would be the best way (Morgan, 2013).

Yet there are other, pragmatic reasons for the lack of efforts to liberalise the law. Although critical of elements of the Act, interviewees suggested, firstly, that it was working well enough in practice, and secondly, that attempts to reform the law wouldn't work as the 'climate' (Iddon interview, 2013) in Parliament is wrong:

> we've got a reasonably liberal and workable abortion law, and any woman who has good reason to want an abortion in Britain can get one (Turner interview, 2013).

> I wouldn't be going opening up the debate right for choice right now, when it seems that others may be seeking to make the debate more fiery … that's caveated by, I would be interested to know if there is evidence that this two doctors thing is actually acting as an obstruction (Green interview, 2013).

Interviewees were, therefore, as cautious and pragmatic concerning liberalising reforms as debate participants were in their use of arguments from evidence over all else.

7.4.iii Sex-selective abortion: a new battleground

Representation of the foetus as female was already a feature of debates in the 1980s, but this focus was renewed in the 21st century. Before the Bruce Bill, concern for the female foetus was raised by several:

> I would like to throw this in: what about the female baby, post-20 weeks? I often hear the argument, 'It is a woman's right to choose.' What about healthy female babies who are aborted at 24 weeks (Dorries in Hansard, 2012: 74; see also Leigh in Hansard, 2008:227 Shannon in Hansard, 2011a: 373)?

These interventions also saw the belated entry of race into parliamentary debates on abortion, as 'young Asian girls' were thought to be vulnerable to pressure to undergo sex-selective abortions (Dorries in Hansard, 2012: 75). Amess (Hansard, 2012: 85) also depicted the female foetus as *particularly* threatened by abortion after the *Telegraph* sting found a handful of doctors willing to perform abortions on the ground of foetal sex. The *Telegraph*'s reports portrayed doctors as failing in their regulatory role: uncontrolled by legislation and engaging

in criminal activity (Watt *et al*., 2012). They quoted David (now Lord) Alton as saying that sex-selective abortions were a product of abortion becoming 'routine' (Mason, 2012).

Fears about sex-selection were raised in the then Health Secretary Andrew Lansley's defence of the unannounced inspections on abortion clinics as an example of clinics' 'non-compliance' with the law (Lansley, 2012). However, according to Sheldon it is not all that clear whether sex-selective abortion is always illegal:

> Imagine a woman with two female children who comes from an ethnic group which places a very high value on sons. She and her husband live with her in-laws, who threaten to throw them out if she gives birth to another daughter. Imagine another whose husband beats her and tells her that she will be subject to far worse violence if she gives birth to a daughter. In each of these situations, we would wish for the woman to be able to leave an abusive situation or, better, to live in a world where such things do not happen. But while we wait for that world, a doctor who authorises a termination in such circumstances could make a strong legal case that she had acted in good faith to preserve the mental health of her patient (Sheldon, 2012).

The *Telegraph* reported that official statistical evidence potentially backed up claims that sex-selective abortion was taking place on a large scale. However, the Department of Health argued that it was not in the public interest to release the figures (Dominiczak, 2013).

These developments informed Conservative MP Fiona Bruce's Ten Minute Rule Bill. The Bill would have required the Secretary of State to compile statistics on the gender ratios of foetuses aborted, and impose harsher penalties on those found to have assisted such an abortion (Hansard, 2013). Bruce situated her Bill as an attempt to combat the 'gender discrimination', already taking place in 'some countries' and now threatening the UK:

> Here in the United Kingdom, a country that prides itself on striving for gender equality and tackling discrimination in all its forms, any indication of this most fundamental form of

> gender discrimination and violence against women must surely be investigated further (Bruce in Hansard, 2013: 170).

As well as expressing concern for the female foetus, Bruce depicted doctors as at best irresponsible, at worst 'committing a criminal offence' (Hansard, 2013: 170).

In critiquing this Bill, I do not mean to suggest that concerns about sex-selective abortion are baseless. The normalisation of abortion on grounds of foetal sex is perturbing for several reasons (see Widdows, 2009). However, what concerns me is the way in which the Bill ties into anti-abortion strategy more broadly. Chapter Six already noted that depicting the foetus as female has long been a pro-life strategy, with American anti-abortion handbooks advising activists to borrow feminist language and apply it to the foetus (see Section 6.4.ii). Seen in this context, claims about the threatened female foetus seem to be yet another permutation of the claim that abortion harms women, with the implication that access to abortion should be decoupled from the issue of women's rights. Indeed, in a BBC interview Bruce described the abortion of female foetuses as 'the worst form of violence against women' (Bruce, 2013).

The claims made about doctors' role in sex-selection are also congruent with past anti-abortion strategy. The depiction of doctors as irresponsible, even criminal, is familiar from debates in the 1970s and 1980s. Like other anti-abortion claims before it, the Abortion Statistics Bill subverts the two key elements of the logic of medicalisation: firstly, the idea that abortion is needed to protect vulnerable women; and secondly, the idea that doctors are competent and responsible enough to carry out this role.

Bruce and Dorries' claims about 'young Asian women' require extra examination as they recall observations Angela McRobbie has made about feminism since the mid-1990s. McRobbie uses the term 'disarticulation' to describe a way in which the institutional gains

made by feminism are eroded (2009: 24-53). Here, she is concerned with chains of equivalence in the Laclauian sense – or, more specifically, with the formation of allegiances between subordinate groups. If *articulation* captures how disparate political demands and identities are linked together, *disarticulation* refers to how such connections are unpicked, 'forcing apart and dispersing subordinate social groups who might have possibly found some common cause' (2009: 26). 'Post-feminist' discourses accordingly pitch Western women, seen as 'the fortunate beneficiaries of Western sexual freedoms', against women in non-Western cultures, and 'interrupts whatever chances there may be for feminism to speak again to a wider constituency of women' (2009: 26).

A similar process appears to be taking place in Bruce and others' activity on the issue of sex-selection. Disarticulatory claims are at once turned outwards, at activity in countries such as India and China that 'we' as enlightened British people must resist, and inwards, at Asian communities in Britain. In these claims, the young Asian women thought to be victims of such practices are pitched against (presumably white) Western women who are capable of exercising the freedom to choose. This has the effect of foreclosing the possibility of a pro-choice politics that encompasses these women's concerns (as exemplified by campaigns centred on the idea of 'reproductive justice'; see Silliman *et al.*, 2004; Smith, 2005), instead representing Asians as a problem community who must be 'acted on' rather than 'acted for'. This disarticulation of feminism is perhaps at its most obvious in an argument made by Dorries in the 2012 debate:

> I was staggered to hear what one MP who came up to me the other day said. Her actual words were, 'Every woman who wants an abortion knows exactly what she is doing.' Well, in her rather slick, well-educated Oxbridge world and her leafy shires I am sure they do, but what about the young Asian girl who was recently marched into a clinic in floods of tears by two

> family members? … Not every woman makes the decision because she went to university and marched up and down streets in Oxford and chanted about women's rights (Hansard, 2012: 74-5).

This contribution depicts a gulf between pro-choice feminists and vulnerable young Asian women which cannot be bridged by traditional pro-choice politics, thus interrupting feminism's ability to speak to a diverse range of women.

Discussion

Even compared to the 1980s debates, during this period there was little by way of criticism of the 1967 Act and of medicalisation in feminist arguments. Such speakers continue to represent abortion as primarily a *patient's* decision, made in the context of discussion with a doctor, rather than as, for example, a unilateral expression of bodily integrity and autonomy. However, I wish to temper this critique by noting that pro-choice feminists were largely forced into a reactive position in abortion debates: even when liberalising measures were attempted in the case of the 2008 HFE Bill, these were not debated in Parliament. Additionally, provision of abortion and the attitudes of medical professionals have improved such that change is not as urgent as it once was. Nonetheless, it does seem that pro-choice discourse in Parliament has moved on little since the 1980s.

My assessment of feminist radicalism in Parliament is again mixed. While demands for abortion access have still been situated within a chain of counter-hegemonic demands, up to and including the 2008 debate these were markedly shorter than in, for example 1988 and 1990, extending mainly to demands for better provision of sex education and contraception. This could be due to the fact that many of these speakers were Labour women, and the Labour

government at the time was seen as more 'women-friendly' than previous governments. Since the 2010 election, however, there has been a heightened critique of the *status quo*, as exemplified by Abbott's contributions. These actors have managed to sustain a pro-choice politics in Parliament, which is significant given that Conservative-dominated Parliaments tend to favour restriction of abortion laws (Cowley and Stuart, 2010).

Nonetheless, narratives of acceptable abortion and female vulnerability are still overwhelmingly prioritised in depictions of women seeking abortion. While I would not suggest that such stories should not be told, as Childs *et al*. (2013) note, the sense that abortion is a normal if not universal part of life, and something that a diverse array of women experience, is missing from pro-choice discourse. Moreover, the prioritisation of such narratives tends to reinforce the notion that there is no option other than medicalisation: since 1967, the figure of the vulnerable women has been heavily intertwined with that of the paternalistic doctor. Ideas about female vulnerability also contribute to the reluctance of some to allow EMA to be undertaken at home, due to a suspicion that women would not be able to 'cope' with their heightened agency in this process – even though recent research has found that many women find home EMA preferable to EMA in a clinical setting (Cameron *et al.*, 2010; Lohr *et al.*, 2010). Due to the particular conception of the doctor-patient relationship underpinning abortion law, it will be difficult to loosen the medicalisation of abortion if women continue to be represented as vulnerable and lacking in agency.

While pro-choice feminist discourse may have moved on little, there have been some important shifts in anti-abortion discourse. Attempts to restore doctors to their role as gatekeepers, rather than simply facilitators, of abortion have appeared in the form of counselling and 'cooling off' Bills. This is significant, as it envisages doctors in a pastoral, responsible role, assisting in the making of 'social' decisions rather than polluted by such a

role. This is a more subtle challenge to the logic of medicalisation than that found in arguments depicting doctors as irresponsible criminals, although such representations are still alive and well in anti-abortion discourse.

Anti-abortionists also continue to subvert the logic of medicalisation by depicting women as harmed by abortion, whether because of the traumatising nature of abortion itself or through their interaction with uncaring providers. However, this has taken on a new dimension in the past two years, with the depiction of the female foetus as particularly threatened by abortion. This narrative feeds into a broader cultural logic of disarticulation which pits 'us' in 'enlightened' Western society against 'them' in Asian countries and communities and forecloses the possibility of a feminist pro-choice politics which bridges such divides. Pro-choice actors in Parliament have so far been denied a chance to respond. However, if anti-abortion activity continues to focus on the 'sex-selection scandal', there will be an urgent need to respond to this logic, and this will of necessity entail an end to the reluctance to speak about race in abortion debates.

CHAPTER EIGHT. CONCLUSION

Introduction

This thesis has asked, and answered, three central questions. First, what are the prevailing governmental rationalities or logics at work in the regulation of abortion, how were these negotiated and contested, and what accounts for their 'grip' since the 1960s? Secondly, to what extent have governmental feminisms challenged these logics, and to what extent could they be said to be 'radical'? Finally, (how) have elements of feminist discourse been (mis)used in political debates on abortion, whether in service of the *status quo* or for other purposes? In order to answer these questions, it has employed a method of discourse analysis which draws from Glynos and Howarth's logics of critical explanation, and Dean's reformulated understanding of feminist radicalism.

The answers to these questions are important as they indicate difficulties and challenges in establishing feminist ideas in certain political arenas, and thus have implications for the (re)gendering of policy and for feminist politics in general. This chapter draws out these implications. Thus, Section 8.1 summarises the major findings of the thesis, comparing findings across chapters. These are broken down into developments in pro-choice feminist arguments, developments in anti-abortion arguments, and developments in understandings and meanings of medicalisation. Sections 8.2 and 8.3 explore the implications of the findings for feminist political strategy on abortion and feminist political analysis respectively. Comparing my findings to research on abortion politics in other countries, I argue that feminist adoption of medicalised discourse potentially impedes liberalisation, and that feminists need to be more proactive if the terms of the debate are to be shifted. I also reaffirm my argument from Chapters Two and Three that conceptualising feminist politics as a matter

of inserting ‘feminist frames’ into public debate is oversimplifying and overlooks some important tensions in governmental feminist activity.

Section 8.4 turns to the implications for feminism more generally. Firstly, I consider ‘conservative feminist’ interventions in the abortion debate, arguing that these should be resisted as they constitute disarticulatory practices which attempt to decouple the issues of abortion rights and women’s rights, as well as interrupting feminism’s ability to speak to a broad constituency of women. Secondly, I consider the prospects for feminist engagements with the state in general, arguing that my findings suggest that certain demands may be extremely difficult to articulate in ‘state’ arenas. However, the thesis does not stand alone as a commentary on the state of contemporary feminist politics in the UK. As Kantola notes, parliamentary debates provide a rich source of material for analysis which can give a useful overview of the extent to which feminist ideas have ‘filtered down’ to the state level (2006: 44). Nonetheless, a full picture of feminist engagements with the British state cannot be achieved from a case study of a single policy area in a single institutional site: the discourses mapped out in this thesis must be connected to broader feminist ideas about the role and meaning of the state, as well as to the broader context of changing state forms and changing ideas about state forms. Therefore, Section 5.4 sketches out some foundations of a future project which will ask what role feminists play in the construction of the state and what the implications of this are for the gendering of policy.

8.1 Major findings

The overarching finding of the thesis has been that constructions of women seeking abortions and doctors who authorise and perform them have been mutually dependent since the passage

of the 1967 Abortion Act. The Act drew upon a particular, gendered expression of the doctor-patient relationship, as constituted of vulnerable, irrational women who need paternalistic guidance from their doctors. As problematic as this may be for feminist advocates of legal abortion, they have tended to reinforce this construction, though very occasionally their arguments have pitted the chauvinistic doctor against women denied their rights. Other pairings have emerged in anti-abortion rhetoric: the unethical, profiteering doctor and the frivolous or exploited woman – and more recently, the paternalistic, *anti*-abortion doctor and the vulnerable woman in need of guidance. This section explores how these constructions developed across the decades.

8.1.i Pro-choice feminism

Feminist ideas were not really present in the parliamentary debates in 1966 and 1967, but a radical (in Dean's sense) parliamentary feminism emerged in abortion debates in the 1970s. The arguments made by these women involved both counter-hegemonic chains of demands (concerning, for example, women's representation, discrimination, and equal pay) and imaginative visions of a future in which women, and women's concerns, are better represented in Parliament. This continued in the 1980s, with feminist contributions to debates often hostile to the male-dominated environment of Parliament. By the 2000s, however, the equivalential chains in which abortion rights were situated came across as somewhat truncated – perhaps due to the perception that women's representation had substantially improved by this point – although there is some indication of a reinvigorated radicalism emerging in response to the Coalition government's policies.

While radical challenges to the parliamentary 'maleocracy' were frequent in the 70s and 80s, overall there was less willingness to challenge the logic of medicalisation underpinning the

1967 Act, in spite of strong feminist criticism from other quarters. In the 1970s debates, feminists tended to centre doctors', rather than women's, perspectives in their narratives and assume a natural alignment between the interests of women and doctors, even as feminists elsewhere were keen to challenge and criticise medicine as an institution (Ehrenreich and English, 2011 [1973]; Oakley, 1980; 1984; Morgan, 1988). By the 1980s, in the face of mounting delays in accessing abortion, feminist politicians began to criticise the system of abortion provision. Ultimately, though, such attacks were levelled at failings in the NHS rather than at the medicalisation encoded in the Act. Meanwhile, 'women's rights' were discursively transformed into 'patients' rights': a clever use of discursive resources which allowed pro-choice feminists to justify the demands they made of the state in a way which resonated, but also eclipsed questions of reproductive freedom and bodily autonomy. This took place against the backdrop of a growing 'technicisation' of abortion and acceptance that the 'cut-off point' for legal abortion should be the point of foetal viability as determined by medical science. In debates in the 2000s, feminists continued to prioritise scientific evidence in their arguments as well as placing emphasis on the figure of the medical professional as legitimating the choice to abort, in spite of the private feeling of some that doctors should not be needed for this.

Images of the aborting woman have necessarily been twinned with corresponding images of the paternal doctor. From the 1970s onwards, feminists accepted and promoted the Act's construction of women seeking abortion as essentially vulnerable. Initially, this merely involved the representation of such women as traumatised by their situation and in need of paternal guidance. But by the 1980s, feminist politicians were routinely constructing narratives of 'acceptable' abortion and representations of women as virtuous, needing abortions 'through no fault of their own'. In the 1990s and 2000s such women continued to be

represented as victims of circumstance who have done everything 'right'. Such representations are an understandable response to depictions of female vice and 'frivolity' in abortion debates, but risk solidifying the binary between 'deserving' and 'undeserving' women and distracting from abortion's importance to women's social status. Representations of aborting women as virtuous and vulnerable also impede the normalisation of abortion, precluding the portrayal of abortion as a relatively common procedure undergone by women from all walks of life.

Why did feminist arguments develop in this way? In abortion debates, feminists have been, for the most part, unable to set the frame of the debate, having instead to respond to the assumptions about female vulnerability encoded in the Act as well as to anti-abortion arguments. One interviewee made this explicit, stressing the necessity of responding to claims made by opponents even when one doesn't agree that, for example, the issue of foetal viability should dominate abortion debates to the extent it does: 'it's an argument that's in the debate whether it should be or not, and those of us who are pro-choice really need to address it' (Green interview, 2013). That feminist activity on abortion has been mainly reactive is partly due to lack of opportunity: participants did not have a chance to debate most of the liberalising amendments tabled to the 1990 and 2008 HFE Acts. Yet it is also a result of caution on the part of those who would prefer to see a change in the law – a feeling that existing abortion law, while far from perfect, works well enough in practice and opening up the debate would be too risky. While I am sympathetic to such concerns, it seems that pro-active measures are needed if the frame of the debate is to be shifted. Many of the assumptions which now dominate abortion discourse – the division between 'early' and 'late' abortion, for example – were, after all, the product of sustained efforts on the part of anti-abortion parliamentarians in the form of tens of restrictive Bills.

While there are signs that, since the 2010 General Election, feminists in abortion debates have been more willing to challenge the *status quo*, it is still too early to say whether this pattern will be sustained. I have argued above that the debate will not move forward if those who favour liberalisation are not more pro-active in their efforts and prepared to challenge medicalised discourses. Challenging medicalisation will, however, rely on maintaining links with abortion clinics and the medical profession. This is not the contradiction it seems: abortion providers and medical organisations are now two key sites of opposition to the medicalised *status quo*. Additionally, as Purdy points out, the critique of medicalisation should not entail removing abortion from the realm of medicine altogether: the problem is not necessarily medical techniques, which are generally safer than the alternatives, but rather the *culture* of medicine and the ways in which medical knowledges are produced and used (2001). What pro-choice feminists should be fighting is, firstly, what Sheldon terms medical *decisional* control over abortion: the lack of a legal right to abortion and the requirement that women request, rather than demand, an abortion from their doctors (1997: 58). Also to be resisted are the *paternalistic* control over abortion which constructs women as people who are incapable of, or cannot be trusted to, make a decision without paternalistic guidance (1997: 65-7), and the *normalising* control which requires

> that the woman open herself to the medical gaze and reveal quite intimate details of her personal life experiences in order to justify her request and convince the doctor, as it is the doctor's interpretation of her life experiences which will be valid and recognised for all official purposes. (1997: 68)

While decisional control over the abortion decision may be lessening in practice, as doctors are less inclined to interfere with a woman's decision, paternalistic and normalising control

continue to dominate abortion politics and provision, as even feminists draw upon medical authority as justifying and legitimating a woman's choice.

8.1.ii Anti-abortion politics

Since debates over the Abortion Act, anti-abortion arguments have been structured by a logic of medical purity which sees the medical profession as potentially tainted by the business of abortion – by its supposed immorality but even more commonly by inappropriate 'social' concerns. Later debates saw sustained anti-abortion challenges to the notion of the 'socially responsible' doctor. In the 1970s, such challenges mainly involved claims about the occurrence of 'racketeering' and other abuses in the private sector. In these arguments, the taint of abortion turned doctors into uncaring profiteers, who are opposed to the respectable doctors who want little to do with abortion. Occasionally, these latter doctors are presented as victimised, unable to progress in their careers if they have a conscientious objection to carrying abortion out. Similar ideas were expressed in the 1980s, and the concerns over 'partial-birth' abortion raised in the 1990s involved depictions of doctors as butchers who may be impossible to control, rather than the responsible quasi-state agents required by the Act. However, the 2000s saw a shift in the representation of doctors. The supporters of counselling and 'cooling off' amendments constructed narratives of progress, appealing to a 'new generation' of doctors who do not like abortion. Crucially, such doctors *are* seen as socially responsible agents with a regulatory function: these amendments assume that the doctor is capable of guiding women towards making the 'right' choice (which, it is implied, will often mean deciding against an abortion). Nonetheless, doctors who currently provide abortions are still represented as unethical and irresponsible in these arguments.

While challenging the logic of medicalisation seems to come naturally to anti-abortion participants in the debates, the Act caused them a 'woman problem' in that it situated them 'against' helping vulnerable women. Since 1967, anti-abortion politics has been characterised by attempts to solve this problem. Primarily, this has been attempted by portraying women who have abortions as victims of unscrupulous doctors and the trauma of abortion itself. However, the portrayal of women as victims has occasionally clashed with depictions of female vice such as in the case of the 'brazen' women who 'demand' abortions and the 'polluting' women who come seeking abortions from overseas. By the 1980s, anti-abortion MPs and peers were frequently deploying feminist language and concepts, complaining about women's sexual treatment at the hands of men and arguing that legal abortion lets men 'get away with it'. Yet this was not blamed on a history of male dominance but on the sexual revolution and loss of traditional values: some participants lamented that a 'sense of responsibility' had been removed from sex and that sex had been removed from the context of the traditional heterosexual marriage. In this way, the appropriation of feminism paradoxically coincided with a backlash rhetoric which identified feminism and social change as the *cause* of women's problems rather than the solution.

The 1990s saw continued emphasis on the alleged trauma of abortion and its potential to damage women's health. However, the counselling amendments of the 2000s involved innovations in the appropriation of feminism to the anti-abortion cause as well as in the depiction of doctors. These amendments could have resulted in barriers and delays in abortion access, but were nevertheless justified by the language of 'a woman's right to know'. At the same time, female vice was implicit in the arguments: one prominent supporter of counselling amendments complained of women who 'demand' abortions 'for no good reason'. Such innovations in anti-abortion discourse are not confined to the UK: 'pro-woman' anti-abortion

rhetoric has recently been observed in the US (Rose, 2011) and Canada (Sorette and Gordon, 2013). As Sorette and Gordon put it,

> contemporary 'conservative' political discourse is increasingly colonizing and employing explicit arguments, principles and narratives that have traditionally been associated with progressive feminist, pro-women and pro-choice movements. (2013: 158)

A final key theme in anti-abortion discourse has been that of the foetal subject. In contrast to popular perceptions, anti-abortion participants did not typically draw upon religious arguments about the value of human life, but, particularly since the 1980s, on what is seen as scientific evidence of foetal personhood. This has often entailed graphic descriptions of foetal development – often with the observation that such knowledge is only available due to technological and scientific advance – but also of the abortion procedure itself. The foetus is often depicted as female in these descriptions, but with the advent of the 'sex-selection scandal' and a subsequent Private Members Bill, 'girl' foetuses have been argued to be *particularly* threatened by abortion due to the importation of practices and attitudes from Asian cultures. Such arguments bear, of course, a similarity to earlier claims that abortion harms women. However, they also pit Western women, seen as the beneficiaries of more enlightened views about gender, against the young Asian women for whom it is assumed a pro-choice feminist politics cannot speak.

The continued claims to be acting 'for women' and appropriation of feminist language suggest that anti-abortion participants are still aware of how easily they may be perceived as having an anti-women agenda, hence the current strategies of claiming that abortion harms women or that female foetuses are particularly threatened. I forecast that these arguments will continue to be popular, as they undermine the construction of the Act as a measure to help vulnerable women, as well as challenging its constitution of doctors as socially responsible

quasi-state agents. Another area of contention is abortion on the grounds of foetal disability. This issue has long been raised by anti-abortionists concerned that women are aborting for minor disabilities such as cleft palate. Recently, however, Fiona Bruce MP chaired a Parliamentary Inquiry in Abortion on the Grounds of Disability (2013). Published in July 2013, the Inquiry's report fell outside the scope of this study. However, it raised concerns that practices surrounding abortion on the grounds of disability are discriminatory, and called for further restrictions on abortion access. Without being able to comment in much detail on the Inquiry's findings, I would predict that this will remain a popular point of contention in anti-abortion discourse, as allegations of discrimination in abortion practice undermine the conception of the Act as a liberal, progressive measure. Such allegations are difficult to challenge within a pro-choice discourse which relies on the construction of all abortions as 'necessary' to protect the health of the pregnant woman.

8.1.iii Medicalisation

The key innovation of the 1967 Act was in persuading doctors to accept the new 'social' responsibilities foisted on them without compromising their view of the proper role of medicine in society. This required multiple revisions of the Steel Bill, each of which further whittled down the Bill's explicit references to the 'social conditions' of the pregnant woman and eventually removed them altogether, justifying this move with the argument that 'health' can include a broad range of 'social' concerns which do not need to be explicitly stated. It worked: early resistance to 'abortion for social reasons' on the part of the major medical organisations had turned into acceptance by the mid-1970s.

Of course, this logic of medicalisation has always been contested by anti-abortion participants, who have long been disturbed by the prevalence of 'social' abortion and the

medical profession's complicity in providing such abortions. But the value of medicalisation is now also becoming less clear to supporters of legal abortion. The Act's constitution of doctors as gatekeepers to abortion access is less and less meaningful in practice, as doctors are increasingly liberal in their attitudes, especially in the charitable sector where the majority of abortions are carried out. The major medical organisations now recommend measures to de-medicalise abortion provision, resulting in a paradox: medicalisation relies on medical authority and the idea that 'doctors know best' when it comes to abortion, yet many doctors are unwilling to exert control over the abortion decision. In the face of this paradox, it is strange that a logic of medicalisation still dominates parliamentary pro-choice arguments (the private opinions of participants notwithstanding). A gulf has emerged between abortion law and abortion practice. All the same, legal medicalisation can still cause problems in practice as, for example, the recent High Court decision on EMA provision demonstrates.

Nonetheless, the changed terrain of medicalisation has presented new challenges to anti-abortion activity. In the 1960s, the only alternative to medicalisation appeared to be criminalisation, meaning that anti-abortion participants in debates were happy to challenge the Act's constitution of doctors as 'socially responsible' gatekeepers to abortion. Now, however, the fragmentation of medicalisation seems to imply further liberalisation, as obtaining an abortion becomes easier in practice and medical organisations recommend statutory measures to further improve access. This may explain the shift in anti-abortion tactics in the 2000s towards calls for increased counselling and 'cooling off' periods, which move to further medicalise abortion by requiring doctors to take a more active role in mediating women's choice: this seems to be an attempt to retain or increase existing medical control of abortion lest access become easier. All the same, as the controversy over recent *non*-mandatory counselling amendments demonstrates, such efforts still rely on a familiar distinction between

'good' (often anti-abortion) and 'bad' ('profiteering') doctors and call for heightened state intervention in order to remove the 'bad' doctors from abortion provision.

8.2 Implications for feminist strategy

If feminist arguments have generally been medicalised, what prospects does this offer for liberalisation of abortion laws? This section explores the implications of my answer to one of the guiding questions developed in Chapter Three: to what extent have governmental feminisms challenged prevailing governmental logics? My answer has been complicated but can be stated relatively simply: feminists arguments have often been radical in one sense but have simultaneously assimilated with the logics dominating the provision of abortion. Parliamentary feminism has often promoted a quite conservative picture of women as vulnerable and in need of state protection, reinforcing the Act's requirement for 'paternalistic-patriarchal' (Yeatman, 1997) state intervention into abortion. There is some evidence that this trend is not confined to abortion debates: Duschinsky, for example, notes a worrying convergence between feminist discourse on 'sexualisation' as a social problem and conservative ideas about female sexuality (2013). Such a convergence has important implications for both feminist political strategy and feminist political analysis.

Feminists' adoption of medicalised arguments is mirrored in other countries with similar frameworks for the regulation and provision of abortion. While there has so far been little Anglophone research on the intersection of feminism and the medicalisation of abortion globally, a few authors have argued that this strategy, while understandable, has impeded legislative change. In the Czech Republic, for example, advocacy for legal abortion has always been justified in terms of 'women's health' or even 'healthier motherhood' (Dudová,

2010). Feminists have responded to threats to abortion access by stressing the risks of illegal abortion to women's health, and avoiding use of the word 'feminism' as much as possible (2010: 966-8). Dudová argues that the reluctance to use more explicitly feminist language has prevented activists from pushing their agenda forward and, for example, extending abortion rights to 'foreign' women (2010: 968-71).

Similarly, US feminists tend to prioritise the health impact of illegal abortion and unwanted pregnancy in their arguments. For Laura Purdy, this has meant that 'the central political battle – arguing that women's access to abortion is necessary for the kind of self-determination men take for granted – remains unfought' (2001: 256). More recently, Daniel Skinner has developed this argument, advancing a critique of the pro-choice focus on 'medical necessity':

> However well intended, pro-choice advocates who evoke these kinds of arguments unintentionally suggest that abortion rights are substantively necessary only in relation to the social conditions they address, rather than to the existence of a self-authorizing, self-standing right to determine what one does with one's body. (2012: 12)

Skinner notes that the focus on medical necessity has had unintended consequences, for example the withholding of federal funding for abortions deemed unnecessary for physical survival, and the recent extension of such restrictions to private health-care providers who participate in government programs (2012: 3-10). The use of a medical necessity framework has also opened up the debate to attempts to demonstrate that abortion is *not* necessary to women's health, or is in fact harmful (2012: 13-14).

Of course, there are important differences between the UK and the above cases. Unlike in the Czech Republic, feminists in the UK have actively sought to bring feminist ideas into public debate and have often situated abortion rights in radical chains of feminist demands, as this thesis has demonstrated. In addition, there is perhaps less immediate danger than in the US

from attempts to demonstrate that abortion is not medically necessary, as abortion rights are both more widely available and less controversial with the general public in the UK (although this raises the question of why feminists continue to emphasise medical necessity in their arguments). Nonetheless, parallels with other countries signal the danger of using overly medicalised arguments, as strategic as they may seem in the short term. Skinner's assertion that abortion rights advocates are 'bound to lose' (2012: 1) when medical necessity is the dominant frame seems to be true for attempts to liberalise abortion provision in the UK: it is difficult, for example, to justify why women should be able to undergo EMA at home if the prevailing assumption is that abortion is a medical matter, to be controlled medically.

Once again, feminist use of medicalised arguments is understandable – in the past, they have needed to achieve argumentative resonance in order to establish a foothold in the debate. But if such arguments impede legislative and regulatory change, at some point it will be necessary to move on. As it becomes increasingly less clear what 'medical authority' means for abortion regulation, and as it seems unlikely that better evidence for an improvement in foetal viability pre-24 weeks will be produced, the opportunity is ripe to switch from a defensive to an offensive strategy. However, feminists will need to be able to frame the debate in their own terms, rather than in terms of female virtue, vulnerability and medical necessity, and this will require proactive measures which stress that a right to choose is a fundamental component of the right to self-determination, and does not dictate 'acceptable' reasons for abortion.

8.3 Implications for feminist political science

The above discussion also has consequences for feminist political science. Like Dean, my intention is not to construct a pessimistic and totalising account of feminist decline, or

describe governmental feminisms as having simply been absorbed into the *status quo*. The findings of the thesis contradict such a narrative: feminist MPs have often advanced radical, counter-hegemonic arguments, and where they have adopted medicalised arguments they have sometimes done so creatively, using, for example, the Act's constitution of women as *patients* to make the case for improving NHS provision of abortion. However, my findings also contradict more positive accounts of governmental feminism, with implications for feminist analysis.

The RNGS study of British abortion politics argued that feminists had succeeded in gendering the abortion debate by establishing the idea that abortion is a matter of women's rights. While this is true, the contention of this thesis has been that this is only part of the story. Reducing feminist arguments to the statement that abortion is a matter of women's rights is over-simplifying and overlooks the serious tensions in feminist contributions. Missing from the RNGS account is recognition of the fact that while feminist ideas have been successfully inserted into debates, they have also been *translated* into a form which resonates with the norms underpinning the 1967 Act. As argued above, this has resulted in the loss of elements of the feminist message – that abortion is relatively common, that it is not necessarily traumatic, and that it is a fundamental component of the right to self-determination. Acknowledging these missing discourses does not mean ignoring what feminists *have* achieved in Parliament: the expression of a wider feminist agenda which situates abortion rights within a broader series of demands. However, it challenges the notion of 'state feminism' as simply a matter of the 'insertion' of feminist frames into policy debates: these frames may be altered in the process.

My findings also have implications for feminist institutionalist analysis. A kind of path-dependency is at work in abortion politics: the Act constituted the interests of women and

doctors as aligned in a particular way, and feminists have been compelled to defend this expression of the doctor-patient relationship, just as anti-abortion participants have been compelled to undermine it. This discursive continuity has in turn prevented other 'solutions' to the abortion 'problem' from being thought. There are parallels here with Dudová's observation that feminist reliance on overly medicalised arguments has prevented institutional change in the Czech Republic.

Indeed, my discursive analysis has some similarity with, and lessons for, the institutionalist approach in treating certain regimes and practices as (partially) crystallised and difficult to change. It affirms Thelen's (2003) argument that institutions may act as both constraints and resources. The gendering of the Act has channelled pro-choice feminist arguments in a particular way, towards a focus on women's vulnerability and need for state protection, despite an apparent conflict with arguments made elsewhere concerning a 'right to choose' and the need for self-determination. For anti-abortionists, on the other hand, the Act created a 'woman problem' by forcing them to deal with its construction as a measure to help the vulnerable. Nonetheless, both sides show creativity and innovation in their use of the Act as a resource. For feminists, this has entailed a clever (if yet problematic) framing of the abortion issue as one of 'patient's rights', whereas for anti-abortionists, it has involved the claim that 'abortion harms women' and manipulation of 'right to choose' language.

However, the thesis has departed from constructivist institutionalism in providing a deeper exploration of the elemental makeup of 'feminist' and other frames. It has demonstrated the difficulties of treating ideas as discrete, internally coherent units which are unchanged throughout the policy process. This is evident in the case of feminist arguments about abortion. The basic content of these arguments – that abortion is a matter of women's rights – has remained unchanged over decades. However, elements have been added and subtracted,

sometimes in a way that introduces tensions and incoherence. For example, the notion of 'acceptable abortion' has been foregrounded since the 1980s, and 'women's rights' are increasingly expressed as patients' rights. These alterations to feminist arguments are important as they complicate the argument that feminist ideas have been 'successfully' established in the policy process: sometimes this success has also involved compromise, or the unwitting reinforcement of particular policy paradigms.

The governmentality approach utilised here also adds an extra layer to the analysis. The norms and ideas involved in the policy process are not confined to single institutional sites, but cut across them (Annesley, 2010). While this thesis has, for the most part, concentrated on a single institutional site, this insight is important. It is not just the interests, desires, norms, etc. of Parliament that are at stake in abortion politics, but the establishment of particular practices and attitudes among both the medical profession and women seeking abortion, and the alignments of their interests in a particular way. The innovation of the Act was in 'solving' the problems facing the problems facing both women and doctors with a single measure which also happened to restore legitimacy to a discredited law, and it cannot simply be reduced to an effect of parliamentary norms. Crucially, then, the governmentality approach allows both the occurrence and the lasting appeal of the Act – despite changes in both Parliament and the medical profession – to be understood.

Finally, my findings build on Squires' (2008) observations concerning the technocratisation of feminist politics. Unlike Squires, the thesis did not consider the norms and practices of WPAs and other 'bureaucratic' feminists who have clearly formed into professionalised networks which prioritise 'objective' knowledge. However, a related process can be observed in the transformation of parliamentary feminist arguments regarding abortion, which now increasingly focus on evidence and medical knowledge, a move seen as strategically

necessary. The translation of feminist goals into a form consonant with the requirements of evidence-based policy-making is, therefore, not confined to the activities of 'femocrats' but has in fact spilled over into the world of elected representatives. Further research is necessary to show whether this phenomenon is widespread (see Section 8.5), in line with the recent interest in the 'constitutive representation of gender' (Squires, 2008; see also Celis *et al.*, 2008; Childs *et al.*, 2010; Kantola and Squires, 2012) – *how*, not just *whether*, women's interests are represented.

8.4 Implications for feminism itself

Celis and Childs argue that researchers should not pre-emptively dismiss conservative feminists, or conservatives who claim to act for women, 'on the grounds that this is either false consciousness or that these women are but "a wolf in sheep's clothing"' (2012: 214). While I agree with this assertion, this thesis has had a clear normative slant, and it is my contention that acknowledging the diversity of attempts to act 'for women' does not need to mean abandoning critique. As Chapter Three argued, women's and/or feminist advocacy may be normatively or strategically problematic, and is subject to disciplinary power throughout the policy process.

The historical and contextual approach employed in this thesis aids in situating such interventions. Recent arguments made by self-styled conservative feminists regarding counselling and sex-selection show similarities to much older anti-abortion rhetoric, despite the use of feminist language of rights and discrimination. These interventions may thus be critiqued as *disarticulating* feminism in two ways. The first – a feature of anti-abortion rhetoric from the 1970s onwards – concerns to the attempt to decouple the issue of abortion

from broader issues of women's rights, primarily through the claim that abortion harms women. The second relates to recent concerns over sex-selective abortion, which pitch the UK, depicted as 'striving for gender equality', against 'some countries' where 'gender discrimination' is rife (Bruce in Hansard, 2013: 170). Such claims, according to McRobbie, are disarticulatory in that they unpick and prevent the articulation of a common cause between 'Western' and 'non-Western' women:

> 'Our' young women are encouraged to conceive of themselves are grateful subjects of modern states and cultures which permit such freedoms unlike repressive or fundamentalist regimes. This in turn suggests a specific mode of encountering and understanding other less fortunate women, who have no access to Western freedoms, or who at best might be encouraged to aim for such possibilities (2009: 27).

This passage recalls Eisenstein's (2005) argument that feminism acts as a 'cultural solvent' to globalisation, eroding traditional patriarchal structures and allowing neoliberal practices to take hold as well as helping legitimate military intervention in the Middle East. However, recent debates in the UK on abortion suggest that this kind of disarticulatory practice is not the sole province of American neoliberals but may also be used to service British conservatism. For McRobbie, such arguments thwart 'post-colonialist critique of how Western sexual freedoms are strategically deployed so as to support notions of civilisation and superiority' (2009: 27). Such critique may have been displaced by disarticulatory practices, but it is not impossible; in fact, it has developed in the United States in the form of a politics of 'reproductive justice' which stresses the class and race privileges inherent to the exercise of 'choice' and articulates the concept of reproductive rights together with an anti-capitalist, anti-racist politics (Silliman *et al.*, 2004; Smith, 2005; West, 2009). While the UK context is different, as the barriers to accessing abortion are not nearly as severe, a politics of

reproductive justice may be needed to counter recent conservative claims that the right to choose is only 'for' white, Oxbridge-educated feminists.

Although this thesis has critiqued the arguments made by conservative feminists, my normative argument also extends to the activity of pro-choice feminists, in particular the prospects of left-feminist engagement with state institutions. As I have argued, the state is not a unitary body, but its different 'arms', apparatuses and rationalities assert distinct pressures on those who engage with it. Feminists have often demanded state protection for women, thus generating what Yeatman calls a 'paternalistic-patriarchal' state (1997: 145). Wendy Brown has argued that we should be wary of such demands, as historically, the argument that women require protection has been a crucial justification for the confinement of women within certain spheres (1992: 9). Yet, at the time of her writing, feminists had not often considered such consequences:

> As potentially pernicious but more subtle in operation than the politics of protection inherent in state-centred feminist reforms are the politics of regulation entailed by many such reforms ... Yet with few exceptions, feminist political thinkers and activists eschew this assessment, pursuing various reforms without apparent concern for the intensification of regulation – the pervasively disciplining and dominating effects – consequent to them (Brown, 1992: 9-10).

Since the early 1990s, of course, many feminist theorists have turned their attention to the proliferation of regulation, discipline and normalisation – see, for example, Sheldon (1997) on abortion, and Lupton (2012; 2013) on pregnancy, reproduction and 'foetal citizenship'. Yet the politics of protection still dominates feminist activity in Parliament. Feminists have adopted and reinforced the construction of abortion as primarily a measure to help and protect the vulnerable. This in turn makes it difficult to demand liberalising reforms: why allow home EMA, for example, if medical oversight is vital for the protection of women? Moreover, such

arguments perpetuate expectations of a certain performance of femininity as justification for state protection: women who have abortions, we are assured, have behaved reasonably and virtuously, used contraception, maintained close communication with their doctors, and are often acting out of concern for the well-being of their existing children.

This is not to argue that feminist MPs have always adopted these ideals uncritically: interviewees were often more critical of UK abortion law in person than in parliamentary debate. However, the absence of expression of such demands in the parliamentary arena raises two important questions. Firstly, what does feminism require from the state? As Yeatman argues, the politics of protection represents a particular kind of feminisation, constituting women as subjects who require protection and requiring 'the suppression rather than the constitution of the capacities for agency of the subjects concerned' (1997: 151). For Yeatman, the alternative is a 'counter-discourse of women as subjects of power, capable of exercising the full range of agentic capabilities', and a state which constitutes women as agents in their own right (1997: 154). Such a discourse has not yet been fully actualised in public debate on abortion.

Secondly, what *can* feminists ask of the state? Contrasting the privately-held view of some of the interviewees that abortion law ought to be liberalised with the public focus on vulnerability and necessity suggests that there may still be barriers to the articulation of certain demands, even where 'feminist frames' have been successfully established in political debate. Rather, political arenas may favour the translation of demands into 'governance-friendly' formats. In the case of abortion legislation, this has meant that feminist demands tend to draw on a politics of protection, while arguments that emphasise women's agency tend to be downplayed. Yet this thesis has not sought to connect these specific demands to participants' wider beliefs about the role, nature and responsibilities of the state, and cannot

stand on its own as a statement on the 'state of feminism' in contemporary British politics: this will require further research.

8.5 Limitations and directions for future research

This thesis has not answered every question concerning the feminist politics of abortion in the UK. While discourse theory can help account for the 'grip' of particular discourses through use of the concept of fantasmatic logic, the thesis has not aimed to demonstrate which conditions contribute to the 'success' and 'failure' of attempts to (re)gender debates on abortion. Such a demonstration would require a larger-scale, possibly cross-national, study comparing the outcomes of attempts to gender political debates in different circumstances – such as those already carried out by RNGS. While such studies are useful, as I argued in Chapter Two they also tend to gloss over the finer points of feminist strategy and the ways in which it may lose some of its potential to challenge the *status quo*. The use of a discourse-analytic approach drawing on Glynos and Howarth's logics and Dean's reformulated radicalism was more appropriate for this purpose, but necessitated a smaller-scale study.

Moreover, due to an intensive focus on parliamentary debate, the finer details of interaction between MPs and peers and wider movement and professional actors have been outside the scope of this study. While some tentative explanations have been offered here, the research has also been unable to provide detailed accounts of the reasoning behind the arguments and discursive strategies used by individual participants in debates. The extent to which, for example, feminist MPs tended to represent women seeking abortion as traumatised due to an uncritical acceptance of the norms of the Act, or whether this was more commonly a deliberate strategy for achieving argumentative resonance, remains difficult to determine.

Analysis of interview data has allowed partial answers to such questions, demonstrating participants' awareness of the shortcomings of the Act, something that does not come across as clearly in parliamentary debates. However, a more complete picture could not be constructed. As no anti-abortion participants responded to requests for an interview, their motives in employing particular arguments remained opaque.

Finding out the condition of feminist engagements with the state more broadly necessitates a return to discourses about the state. As Kantola (2006) argues, feminist discourses *about* the state shape the form of feminist engagements *with* the state. However, broader, non-feminist discourses about the nature of the state are also important and have an impact on feminist discourses and strategies – 'context matters' (2006: 18). Hence, a first step of future research will be to connect the feminist discourses on abortion unearthed here to broader understandings of the role and responsibilities of the state.

This thesis has indicated a couple of relevant modalities at work in feminist arguments about abortion. First, as previously discussed, such arguments overwhelmingly draw from a politics of protection requiring the construction of the state and medical professions as protectors, and women as vulnerable. However, these arguments also contain a potentially conflicting modality which focuses on technical and medical evidence and primarily represents women as patients and women's rights as patients' rights. At the same time, feminist participants have utilised narratives of 'acceptable' abortion, representing women who seek abortions as people who have behaved ethically and reasonably – for example, using contraception, or acting out of concern for existing children. In the case of abortion for foetal abnormality, pregnant women are represented as acting to monitor and mitigate risk, visiting their doctors regularly and having an abortion if necessary.

While this modality may not at first appear to be 'about' the state, it runs parallel to broader socio-political shifts in understandings of reproduction and citizenship. Academic writing on pregnancy and 'risk' culture (Beck, 1992) has noted that:

> pregnant women are expected to engage in a bewildering array of risk-aversive behaviours to ensure the health and optimal development of their foetuses. Not only must they regulate the kinds of food they eat and drink, they must ensure that they take the right kind of supplements, avoid any kind of drugs, position themselves the correct way when lying down and ensure that they are knowledgeable about foetal development and testing technologies (Lupton, 2012: 330; see also Ruhl, 1999)

The prominence of risk-aversion during pregnancy has grown out of liberal conceptions of 'good motherhood' as involving self-discipline and self-sacrifice. Yet it has been given new emphasis and meaning in the context of a neoliberal political environment which increasingly requires individuals to take personal responsibility for their actions, health and wellbeing – and uses this notion of citizenship as justification for 'rolling back' the state. To be good 'reproductive citizens' (Salmon, 2011; Lupton, 2012), pregnant women must now shoulder the moral responsibility for their own pregnancies.

The concepts of risk and reproductive citizenship have not really permeated feminist political science. However, my findings suggest that they may be relevant to the making and gendering of policy. Having mapped parliamentary discourses pertaining to abortion, the next step of future research will be to ask how these interventions relate to broader societal understandings of citizenship and the state, and in turn, what role these understandings play in the (re-)gendering of policy. This will require analysis of what Brodie (1997) calls 'meso-narratives': discourses which structure the state as a form of political domination.

> Meso-narratives are an historical consensus about what is understood to be rational, progress, emancipation, justice, and so on. As such, they act as historically defined templates which underlie a policy field, shaping the content and delivery of public goods, and allowing for a certain measure of coherence in state activities (1997: 227).

In other words, meso-narratives assist in understanding where policy ideas come from. Future research will ask: what are the meso-discourses of the British state and how do these relate to reproductive (and sexual) health? How are they gendered? (How) have feminists resisted, challenged, or been complicit in their construction? In doing so, it will draw both from existing feminist scholarship in political science as well as the literature on British politics and governance (e.g. Bevir and Rhodes, 2003). This will entail moving beyond the single issue of abortion as well as beyond Parliament as a single institutional site, as meso-narratives cut across and are shaped in different institutional contexts, as is policy.

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