SALLY SHELDON

INTO THE HANDS OF THE MEDICAL PROFESSION: THE REGULATION OF ABORTION IN ENGLAND AND WALES

Thesis submitted for assessment with a view to obtaining the Degree of Doctor of the European University Institute.

Florence, August 1994

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"One example has been given to me by a general practitioner of a girl, unmarried, and, therefore, one of the minority of cases of illegal abortion, who came to him about two or three months ago, said she was pregnant, and that she wished to have her pregnancy terminated...She said to him that she had come because of the Bill. "I believe that I have grounds under that", she said. He told her, "I happen to know the sponsor of the Bill. I have looked at the Bill and do not think that under it you have grounds." He talked to the girl and put her in touch with people who could help her. Her pregnancy is now going through in the normal way. It does not follow that because women desire termination it will automatically be carried out. If we can manage to get a girl such as that into the hands of the medical profession, the Bill is succeeding in its objective. If the Bill had not been before Parliament, if the girl had thought that what she sought was something illegal and was not to be talked about, and had, therefore not gone to the doctor, she might have had the baby after nine months of great anxiety: she might, as often happens have taken some substance, or have inflicted some injury upon herself which might have aborted the baby, admitted her to hospital to take up time in a gynaecological bed, and, possibly, have left her with a permanent injury. Worse than that, she might have been driven to the desperate situation of committing suicide. Worst of all, she might have been among the statistics of the average of 30 women a year who die of operations at criminal hands. None of those things happened, because she thought she would get a good hearing from that doctor. If the Bill encourages that kind of climate, it will have been worthwhile."[1]

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[1] David Steel, on presenting his *Medical Termination of Pregnancy Bill* (which was to become the *Abortion Act*) for its third reading in the House of Commons, H.C. Deb. Vol. 750, Col. 1349, 1967 (13 July).

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I would like to dedicate this work to my father, A.T. Sheldon (1927-1990).

Sally Sheldon
2 August 1994.

CONTENTS

CHAPTER 1: REGULATING ABORTION: CONTROLLING WOMEN?

"Conscious activity to control human fertility is as intrinsic to the social being of human groups as the activity to control and organize the production of food. What changes over time and from one social context to another is who controls fertility, under what conditions, through what means, and for what purposes"[1].

"The rights and interests of the mother emerge, not now solely concerned with her protection from unsafe abortions, but instead also with her autonomy and ability to determine what should happen to her body. This development has marched hand in hand with the emergence of a strong medical profession and with the phenomenon of science-based medicine...Until Parliament or the European Court of Human Rights intervenes, the supremacy of the English medical profession, coupled with its increased (and continually increasing) ability to provide safer and less risky abortion procedures, have resulted in the legal acceptance of the medicalization of abortion"[2] .

"Many members of the medical profession have traditionally been at the forefront of the family planning movement. They have pioneered a great deal of what has been achieved so far. However, other members of the medical profession provide serious obstacles to reproductive choice. Being the recipients of high levels of education, and considering themselves guardians of scientific knowledge concerning reproductive choices, so many of them resent decisions and activities which are carried out beyond their control. This resentment is often reflected in their opposition to approaches for service delivery which involve the community or enable other health-care providers to carry out procedures which have traditionally been performed by medical doctors"[3].

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[1] Petchesky (1984a; 25).

[2] Grubb; (1990; 156, 157).

[3] Dr Halfdan Mahler (1993; 26).

In the 1960s, women's movements across Europe claimed the abortion issue as their own, with the key contention that the question of who controls female fertility is a political one, involving fundamental choices as to the position and role of women within society (see Dahlerup; 1986). Control of access to abortion services was seen as an attempt to exercise control over women's sexuality and fertility and to enforce certain roles and life-style choices (reflecting particular moral assumptions). Access to safe, legal abortion on demand was advanced as a prerequisite for the full and equal participation of women in society, for as Madeleine Simms of the first British reforming group, the Abortion Law Reform Association, put it: "no true state of equality can exist for women in a society which denies them freedom and privacy in respect of fertility control" (1981; 183).

The feminist claim that the regulation of abortion is intrinsically linked to attempts to control women is not so easily sustained in the Britain of today as it was in that of pre-1967. The 1967 *Abortion Act* provided that a pregnancy may be legally terminated by a registered medical practitioner where two doctors certify the existence of certain circumstances: either that the continuance of pregnancy would involve risk to the life of the pregnant woman, or of injury to her physical or mental health, greater than if the pregnancy were terminated; or that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped[4]. Since 1990, a time limit of twenty-four weeks has applied with exceptions allowing abortion after that time where termination is necessary to prevent grave, permanent injury to the physical or mental health of the woman; or continuance of a pregnancy threatens the life of the woman; or there is substantial risk that if the child is born it would suffer from such physical or mental abnormalities as to be seriously handicapped. The existence of these circumstances under the *Abortion Act* is a matter for the judgment of medical professionals. Over the past twenty-five years doctors' interpretation of the *Abortion Act* has become gradually more liberal and access to safe, legal

[4] The text of the *Abortion Act*, in its original form and as amended by s. 37 of the *Human Fertilisation and Embryology Act*, 1990, is set out in appendices 1 and 2 respectively. The Act was never extended to Northern Ireland, where the regulations governing the provision of abortion are still very restrictive (see chapter 5 below, p.105).

abortion services has, as a result, greatly improved.

Indeed, it seems that despite the efforts of the anti-choice groups, abortion is gradually slipping off the British political agenda. After repeated attempts to reform the law, the regime introduced by the *Abortion Act* was put again to the vote in Parliament in 1990, and the status quo it had established was largely endorsed. Currently the fiercest debates are waged not around the issue of whether women should have the right not to become mothers, but rather around how they must act once they have chosen maternity. Media attention and political debate seem focused not so much on abortion as on whether children should be fostered by lesbian/male gay couples or parents of a different ethnic origin to their own; the problems of single parent families; the use of reproductive technologies such as IVF to assist 'undesirable' (old, lesbian, poor, single, morally unsuitable) women to have children or whether such technology should be used to allow women to have children of a different ethnic make-up. Moreover, the responsibility owed to children is extended ever backwards through pregnancy, with more attention paid to the woman's conduct when pregnant[5]. And this discourse of 'responsible parenting' is not confined to women - rather the establishment of the Child Support Agency illustrates its extension to men (albeit that male responsibility is conceived of primarily in terms of a duty to contribute financially). In comparison, abortion increasingly seems a 'non-issue' with a status quo as regards access to abortion services firmly established and largely accepted.

The apparent depoliticisation of abortion in Britain paints quite a different picture from that which can be seen in the USA. There, it is not unknown for doctors working in abortion clinics to arrive at work wearing bullet proof vests[6] and the availability of safe legal abortion hangs in the balance or, better, hangs like a pendulum, liable to swing violently as a result of fine shifts in the composition of the Supreme Court. Moreover, the fact that the justices

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[5] Here there is also an overlap with abortion in terms of heated discussion as to the rights and wrongs of foetal sex selection (Morgan; 1988) or the abortion of handicapped foetuses: the 'responsible mother' is one who wishes to give birth to a healthy child, who accepts certain constraints on her conduct in order to do so, and will abort a foetus should it prove to be 'defective' (McNally; undated).

[6] See *The Guardian*, 9 May 1994. This follows the shooting of an abortion clinic doctor by an anti-choice activist.

are political appointments, and the significance their position on abortion will have for the President's choice, enhances the construction of abortion as a matter of politics. The fiery rhetoric of American radical feminist writers such as Andrea Dworkin (1983) and Catharine MacKinnon (1983a, 1983b, 1990) seems to gain some credence when the regulation of abortion is so explicitly a political matter. For MacKinnon:

"the availability of abortion frames, and is framed by, the extent to which men, worked out among themselves, find it convenient to allow abortion - a reproductive consequence of intercourse - to occur. Abortion will then, to that extent, be available" (1983a; 28).

"[W]hen convenient to do away with the consequences of sexual intercourse (meaning children), women get abortion rights. Women can have abortions so men can have sex...In this light, the theme of the laws of sexual assault and reproduction is male control of, access to, and use of women" (1990; 1300-1).

In MacKinnon's account, the state and law are seen as profoundly implicated in perpetuating male control over women. They are wholly pervaded by male power: their foci and uppermost objectives are seen as essentially male rather than capitalist or class-based and they oppress women through a legitimation and enforcement of the male view of the world[7]. The regulation of abortion forms a central part of this picture.

MacKinnon's analysis has been much criticised within the United States[8], but it transfers still less happily to the English context. In England and Wales, I will argue, abortion has increasingly shifted from the political 'public' realm into the 'private' sphere, where it is constructed as a matter for the discretion of the medical profession. This recodification as a technical problem to be discussed by experts, which has become increasingly clear in recent years (see especially chapters 6 and 7) has defused the most fierce debates around it. It seems that a status quo has been established, and those who continue to kick against it - be they pro- or anti-choice - are cast as marginal extremists. Given the current state of provision

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[7] "The demarcations between morals and politics, the personality of the judge and the judicial role, bare coercion and the rule of law, tend to merge in women's experience. Relatively seamlessly they promote the dominance of men as a social group through privileging the form of power - the perspective on social life - feminist consciousness reveals as socially male" (1983b; 655-6).

[8] For a critical response to MacKinnon's early writings on abortion, see especially Joffe (1984) and Petchesky (1984).

of abortion, if abortion is still a political issue then this political dimension is increasingly well concealed.

In the pages that follow, I will examine some aspects of the regulation of abortion in England and Wales from 1967 onwards. The thesis which I will seek to sustain has several interconnected strands. I will argue that abortion has been constructed as primarily a medical matter to the occlusion of other accounts and perspectives. This has had a substantial impact on the law which, in the last thirty years, has moved from a system of criminal prohibition to a decentralised network of medical control. The medicalisation of its regulation has led to an apparent depoliticisation of abortion, defusing political conflict and controversy surrounding it. However, despite this appearance of depoliticisation, abortion remains very much a political issue: the regulations governing its availability are underpinned by quite specific, discernable values which reflect particular attitudes to women and a clear value judgment as to who should control female fertility. Further, the regulation of abortion continues to serve as a focal point for the deployment of power over women. I will contend that whilst the medicalisation of abortion law has had substantial benefits for ensuring women's access to abortion services, it also poses substantial problems for that access, and that these have been inadequately addressed.

To support this thesis I will examine some particular sites and modes of the operation of power in the regulation of abortion. My focus will be on law, yet it will be broader than many previous legal analyses of the regulation of abortion. First, I take law to be more than a series of rules and judgments. Law is also a privileged site for dispute and contestation, and an "authorised discourse" with a significant influence on popular opinion (Eisenstein; 1988; 4, Smart; 1989, 1990a; Gordon; 1984; 109). It is crucial to think in terms of the values which underpin the law and which are perpetuated through it. Secondly, I wish to place more emphasis on medical regulation (and the interaction between the medical and legal regimes). Typically discussion of the regulation of abortion has begun with a study of the law. Medical practice, if discussed at all, is considered as a secondary level of control, determined by this framework. On the contrary, it seems to me that in practice law follows medical

developments, adopting and adapting norms and standards which have evolved at this level[9]. This is seen repeatedly: in the 1967 *Abortion Act*, the 1990 *Human Fertilisation and Embryology Act* and throughout the relevant jurisprudence. In this sense, it will be seen that medical norms have 'colonised' legal regulation, and a focus on medical practice and medical control, as it is operated at this local level, is essential for an adequate understanding of how access to legal abortion is regulated. Consideration of medical practice is also relevant in that, as will be seen below, problems of access to abortion currently seem to lie more at this level, than at the level of legal prohibition.

I will begin this analysis, in the next chapter, with some consideration of the statute which partially decriminalised abortion in Britain, the 1967 *Abortion Act*. I will argue that the regulations introduced by the *Abortion Act* cannot be adequately understood in abstraction from a context of gendered power relations. In chapter 2, then, I will look at the motivation underlying the partial decriminalisation of abortion in 1967 and locate it within a general shift towards 'governmentality' and the subtle, more decentralised operations of power detailed by Foucault (1979a). In an analysis of the reasons for which abortion was decriminalised in 1967, I will question the accuracy of the received representation of the Act as a 'permissive' piece of legislation. Rather than being seen as a loosening of power and the carving out of a greater free space for female reproductive autonomy, I will argue that the Act should be understood as a "taking charge of life" and consequent adoption of more continuous, regulatory and corrective mechanisms (Foucault; 1979b; 143-4). The Act is a landmark in the medicalisation of the law, and shows the close relationship between such medicalisation and the institution of a network of medical control over women.

It is important, however, that the *Abortion Act* should not be understood just as part of a general (genderless) shift towards a different mode of government. In chapter 3, I indicate the importance of viewing this reform within a context of gender, outlining the clearly

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[9] Currently, it is perhaps possible to see this same process even more clearly in those countries which have recently decriminalized, or are in the process of decriminalizing abortion. In Belgium for example, the recent decriminalisation of abortion has legitimised long-standing medical practices (Marques-Pereira, 1993, Berer; 1993; 38). Likewise, the Swiss law looks set to be reformed on the basis of medical developments (see Rey; 1994).

gendered constructions of the woman seeking abortion which underlay the reform and justified the need and suitability of the particular strategy of power which was brought to bear. The very nature of the 'peripheral subject' (the woman seeking abortion) to be regulated, legitimates and grounds the need for medical control and supervision over her. Thus, while the reform may be seen within this general movement toward 'governmentality', it is necessary to remember that this describes a broad brush stroke which maps a multiplicity of interconnecting fine techniques of control which operate to construct different (gendered) subjectivities.

I then move, in chapter 4, to a consideration of the 'operational context' of the *Abortion Act* - the level of medical regulation. The Act is seen to have carved out and legitimated a broad area for the free exercise of medical discretion. Here I take a closer look at the workings of medical practice in the case of a request for a termination, in order to determine whether and how one can see power as being deployed over women. Here, I rely on the work of medical sociologists such as Kathy Davis and Ann Oakley. I argue that although there is clearly an increasingly liberal attitude within the medical profession towards requests for terminations, the regulation of abortion remains nonetheless a site which provides a particular opportunity for the deployment of power over women. I argue that the relationship between a doctor and a woman approaching him/her for a pregnancy termination is pervaded with power. The patient approaches the doctor as a lay person to an expert, (s)he is the object of knowledge which the doctor must locate within a medical framework, to understand, to classify and to treat. This perceived need for medical control is reinforced when the patient is a woman, and even more so when she is a woman seeking abortion. With regard to abortion, I will identify four analytically distinguishable operations of power, which I call *technical* control, *decisional* control, *paternalistic* control and *normalising* control.

In the following two chapters, I shift the focus to the interaction between the legal regulation and this 'contextual' medical regime. Here the appearance of depoliticisation resulting from medicalisation of abortion law is thrown into relief. In chapter 5 I take a fresh look at some of the relevant decisions which the British courts have made in this area. What becomes clear is the tremendous respect and deference for medical opinion, and an unwillingness on the part of judges to 'second-guess' or supervise the exercise of medical opinion under the *Abortion*

Act. Abortion is constructed as a medical event and the doctors' power to define is accepted and reinforced, with other accounts pushed to the margins. This depoliticises the judicial decision which can be legitimated with reference to scientific truth. Judges intervene only to correct excesses or substantial departures from 'good medical practice' (a standard determined by the medical profession) in such a way as to legitimate the normal run of such practice. Whilst judicial reluctance to interfere with medical discretion has, in other areas of law, led to infringements of women's bodily autonomy and provoked feminist criticism, it is here seen to have worked to the advantage of women seeking to terminate a pregnancy. For example, women have been protected from claims for injunctions to restrain abortions brought by their sexual partners or parents[10]. I argue that this highlights a peculiar difficulty of the situation which feminists face with regard to the medical control of abortion. The principled arguments against such control (and its implicit paternalism), are in conflict with considerations of the practical and concrete benefits it has provided (and the security which it may continue to give) on the level of entrenching and extending women's access to abortion services. However, I hope to show that whilst doctor and woman acting in conjunction are relatively well protected from outside challenge, it may be that women are less well protected within the medical relationship itself.

The same tension regarding the medical control of abortion emerges equally clearly in chapter 6, where I move on to consider the most recent statutory development regarding abortion: s.37 of the *Human Fertilisation and Embryology Act*. A most significant feature of the Parliamentary debates surrounding the reform is their near complete medicalisation and the marginalisation of other knowledges or ways of structuring dispute. Thus it seems that whilst the pro-choice movement has been successful in fending off the various attacks made on the 1967 Act, ground may have been lost with regard to popular assumptions about abortion (Science and Technology Sub Group; 1991; 147). From this point the agenda becomes set within an essentially medical framework and the issue of what is at stake in abortion debates centre essentially around the medical development of the foetus to the exclusion of broader social issues. Moreover, the acceptance of a medical framework further entrenches and

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[10] See *Paton v Trustees of BPAS and another* [1978] 2 All ER 987, *C and another v S and others* [1987] 1 All ER 1230, *Re B (a minor)*, *The Independent*, May 22, 1991 (Family Division), discussed in chapter 4, below.

legitimates the medical control of abortion and would stand against any initiative to claim decisional control for women.

In chapter 7 I seek to illustrate some of these arguments through consideration of the decision to license the 'abortion pill', RU486, for use in Britain. Here I will examine both the debates surrounding its introduction (in and outside of Parliament) and the regulations introduced to control its use. The fact that RU486 was licensed for use in the UK with a minimum of public debate is again illustrative of the extent to which abortion has become viewed as a primarily medical phenomenon and the resulting depoliticisation. In the United States, the introduction of RU486 has been a far more explicitly political matter, with importation of the drug restricted under Presidents Bush and Reagan. On his election to the presidency, one of Bill Clinton's very first actions was to lift this import ban: a highly symbolic gesture. In Britain, on the other hand, the drug was licensed with a minimum of controversy and media attention, but within a framework of medical control which is even tighter than that required for surgical terminations. Emphasising again that the depoliticisation is only apparent, I will also argue that what debate occurred concerning the introduction of RU486, although played out in a largely medical rhetoric, can only be understood within the context of a struggle over the control of abortion (and female fertility). Likewise, only fears regarding who will control abortion can explain the stringent regulations introduced to govern the drug's use. Also important here is some consideration of how drugs like RU486 may help to redefine abortion, or to challenge commonly held assumptions about it, and how they may put back onto the agenda the perceived links between technical and other forms of medical control.

In my concluding chapter, I will attempt to draw together the strands of my argument in order to offer some thoughts on the implications of the medicalisation of abortion law. One tension which will run through my thesis is an awareness that medicalisation has simultaneously brought both advantages and disadvantages. Whilst helping to secure women's access to the provision of abortion services, it will also be seen that most of the problems which women now face in obtaining such services relate to matters of medical control, rather than legal prohibition. This, of course, poses the problem of how feminists are to respond to medicalisation and medical control.

A Note on Power/Control[11]

Before going on to the main body of my argument, I would like to pause for a moment to specify what I intend by 'power', an infamously elusive and slippery concept (Lukes; 1992; 1) and to say a few words about the theoretical basis for the arguments that I want to make. In particular, as I hope to derive some insights from the work of Michel Foucault, it is appropriate to provide a (brief) idea of his work on power and how I will be using it.

Foucault rejected a view of power as nothing more than command or prohibition deriving from certain central loci such as the state. Rather he argued that modern society is characterised by the spread of a more productive, disciplinary form of power which provides procedures for training and coercing bodies, by way of hierarchical observation, normalizing judgment and the examination. The diffusion of various disciplinary mechanisms throughout the social body is synonymous with the formation of what Foucault calls 'the disciplinary society'[12]. Behind the formally constituted egalitarian juridical framework of modern society, Foucault identifies a foundational network of micro-powers or disciplines. The formal legal and political structures of the society are seen to be predicated upon relations of power which both guaranteed a 'submission of forces and bodies', yet evade and undermine the formally constituted juridical limitations on the exercise of power. The operation of power here becomes increasingly closely related to the formation of knowledge. This is related to the disciplinary transformation of institutions into apparatuses within which methods for the formation and accumulation of knowledge began to be employed as instruments of domination: modern society is a "society of normalization, a society governed less by legal rights than by the authority of the human sciences" (Foucault; 1980b; 107).

Seen in this light, the recasting of abortion as a matter for medicine acquires a particular

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[11] I will use the words power and control interchangeably.

[12] As Barry Smart points out the concept of disciplinary society should not be understood as referring to the realisation of a programme for a *disciplined* and orderly society, but to the diffusion of disciplinary mechanisms throughout the social body, to the process by which the disciplines eventually constituted a general formula of domination (1988; 91).

significance. Science - and especially medicine - has a special role in justifying a particular type of power, and making its exercise seem logical and neutral (Foucault; 1980b; 107). Scientific knowledges can legitimate and depoliticise, providing grounds for making what might otherwise be an inherently political decision seem neutral or commonsensical. Medicine has played a pivotal role in establishing and legitimating the techniques essential to such power: it is within medical knowledge that the individual first became knowable as such and it is by identifying individual anomalies medically that the technologies of bio-power are in a position to supervise and administer them. Within medicine, the operation of power becomes justified by the patient's own 'best interests'. Medicine and medical knowledge occupy an important place in several of Foucault's studies. In *Madness and Civilisation*, he notes the entry of the medical personage who utilises surveillance and judgment, and who is a pivotal figure in the arrangement which inaugurated the emergence and development of a medical knowledge of the mind as an almost autonomous branch of knowledge. Later, *The Birth of the Clinic* reveals the formation of the individual's body as an object of scientific medical examination and analysis. Although these works predate Foucault's explicit consideration of power, he later tells Alessandro Fontana and Pasquale Pasquino that: "[w]hen I think back now, I ask myself what else it was that I was talking about, in *Madness and Civilisation* or *The Birth of the Clinic*, but power?" (1980c; 115).

In his 1979 Tanner lectures, Foucault linked his ideas on disciplinary forms of power with the increasing governmentalisation or "governmentality" of Western society from the eighteenth century onwards. He argued that the same style of analysis which had been used to study techniques and practices addressed to individual human subjects within particular, local institutions could be addressed to techniques and practices for governing populations of subjects at the level of a political sovereignty over an entire society. These links between the macrophysics and microphysics of power developed his earlier idea of 'biopower': the explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations (1979b; 140-1). Methods of power and knowledge here "assumed responsibility for the life processes and undertook to manage them" (1979b; 144). In these lectures, Foucault describes forms of power exercised over subjects as members of a population, within which issues of individual sexual and reproductive conduct interconnect with issues of national policy and power. Through statistics, the phenomenon of population

was shown to have its own regularities, such as birth and death rates, characteristic ailments, age profiles, social groupings and so on, knowledge of which allowed it to be 'managed' more efficiently. Government became more 'pastoral' with a concern for the welfare of the population and a range of new tactics and techniques of power emerged. Implicated here are social welfare programmes which, in aiming to provide for basic individual needs, instigate new, decentralized modalities of control, which operate through state-sanctioned experts (social workers, doctors, psychiatrists, child care experts, teachers and so on). These are empowered to function as 'parallel judges' able to dispense justice at the local level, after a close and minute examination of the individual case in hand. Political problems are thus recast in the neutral language of science, and then are debated and managed by specialists. Power is legitimated here by expert knowledge, and operates through surveillance, normalisation and judgment with the individual constructed as a subject for study and observation. Power develops at the micro level of such practices and is subsequently colonised, extended, overlaid and entrenched by more global forms of domination such as law. The regulation of abortion can, I hope to demonstrate, be usefully viewed as one site within such a broader network of control.

CHAPTER 2: THE ABORTION ACT (1967): A PERMISSIVE AND LIBERATORY REFORM?

"Britain has been magnificently hypocritical, maintaining that in general abortion is wrong, but fitfully turning a blind eye when the law is interpreted so as to allow abortion for a variety of reasons...the result has been to squeeze the law so hard, and make it look so ridiculous, that reform of some kind is now in sight. The authorities' inability to stop illegal abortion brought the law into contempt for a hundred years...".[1]

"[i]t is generally accepted that the law relating to abortion is widely disregarded, and that stricter enforcement would be difficult, and not necessarily a deterrent when women are desperate, and prepared, if no help is available, to operate upon themselves with instruments or drugs. Legal sanctions do little more than provide an abortionist with incentives to avoid detection, and so drive the offence underground to an extent where a small fragment of 1 per cent of abortionists is detected. On the other hand illegal abortion is associated with deaths counted in hundreds each year, and causes ill-health and serious damage to many women. Modest estimates of illegal operations range between 50,000 and 100,000 annually, and the figure of a quarter of a million has authority. It may appear that the present law drives abortion into the most undesirable and dangerous channels, without eliminating it".[2]

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[1] Paul Ferris (1966; 14).

[2] Bernard Dickens (1966; 165).

1. INTRODUCTION: A PERMISSIVE REFORM?

"The 1960s saw a tidal wave of permissive indulgence, homosexual as well as heterosexual. One-parent families, a huge boom in contraceptives, a crusade for sexual indulgence in whatever form, became accepted" (Morgan in Thompson; 1993; 137).

According to Benjamin Disraeli: "permissive legislation is the characteristic of a free people" (Davies; 1975; 13). It seems to me that this citation from Disraeli may provide a useful heuristic device for outlining the argument which I wish to make in this chapter. I will claim that it is the logic of this statement which also underlies our received understanding of the *Abortion Act*. If Disraeli is to be believed, then it seems self-evident that the restriction of criminal controls over abortion introduced in 1967, was characteristic of a newfound freedom for women. However, it seems to me that in Disraeli's statement, as in this account of the *Abortion Act*, freedom emerges as no more than a space for action created by the absence or limitation of repressive (criminal) legislation. One is free only in the sense of being free from one particular manifestation of (repressive) power which emanates from the state; other forms of power are ignored and no room is left for analysis of the *quality* or type of freedom which one may exercise. The opening citation taken from a speech of David Steel, taken from the Parliamentary debates leading to the introduction of the 1967 Act, reveals another aspect of its introduction - the medicalisation of the regulation of abortion, the desire to bring women seeking termination into contact with doctors, and a more subtle, decentralised form of power.

Here, however, I am perhaps getting ahead of my argument, and before going any further, I should set out in more detail exactly what I mean by 'permissive'. The Oxford English Dictionary defines permissive as: "[h]aving the quality of permitting or giving permission; that allows something to be done or to happen; not forbidding or hindering. In modern use freq.: tolerant, liberal, allowing freedom, *spec.* in sexual matters; freq. in phr. *permissive* society." A permissive measure is thus one which permits or tolerates certain behaviour, which limits the potential of external bodies to intervene in the life of an individual to correct or to punish certain acts, especially in sexual matters. Further, here I am taking permissive as having the more specific meaning of describing something which loosens control over sexuality and reproduction, and which contributes to the constitution of a 'private' sphere where sex (and its potential reproductive consequences) can be enjoyed free from external interference, regardless of the (lack of) procreative intention of the participants. The aim of this paper will

be to assess how far the *Abortion Act* fits within this definition, and thus how far it can be seen as heralding a newfound freedom for women.

In this chapter I will use the more expansive definition of power to which I alluded in chapter 1. This view sees power not merely (or even primarily) as a repressive force deployed by various central institutions, but rather as diffuse, productive and capillary, as a "complex strategical situation", or omnipresent "multiplicity of force relations" (Foucault; 1979b; 92-7). One particular benefit of this model is that whilst not denying the existence of central loci of power, it redirects attention away from centralised and legitimate forms of power and focuses more on techniques which have become embodied in local, regional material institutions (Foucault; 1980b; 97), here particularly on medical practices. My aim here is not be to deny the importance of the state - indeed a central focus of the analysis of this chapter will be the mapping of state attempts to gain control over abortion. However, I do want to oppose the idea that power *derives* from the state. As Michel Foucault has said:

"the state is not simply one of the forms or specific situations of the exercise of power...in a certain way all forms of power relation must refer to it...not because they are derived from it;...rather because power relations have come more and more under state control...that is to say elaborated, rationalized, and centralized in the form of, or under the auspices of, state institutions" (1982; 224).

The *Abortion Act* represented a liberalisation of the draconian terms of ss. 58 and 59 of the *Offences Against the Person Act*, 1861 (see below, pp. 19-20). It took English statute law from a near total ban on the performance of abortions, to a system whereby terminations might be performed in certain circumstances given the approval of two doctors. Hence it would seem self-evident that the *Abortion Act* must be seen as a permissive measure and one which was liberatory for women, in the sense that it decreased repressive criminal controls and hence facilitated a greater degree of individual (especially female) autonomy in sexual and reproductive matters. Henceforth, it seems, a woman would be guaranteed a greater degree of privacy, autonomy and freedom in her decision to terminate a pregnancy. The vast majority of commentators have accepted this interpretation (Lapping; 1970, Hindell and Simms; 1971, Davies; 1975), which fits neatly with a prevalent tendency to assume a rather linear notion of progress with regard to the law. In such a perspective, masculine bias in law is seen as a kind of lingering anachronism: something which has been gradually eroded and

(so the story goes) which will continue to be worn down, until the day that perfect equality/gender neutrality is achieved. Such a vision accords with a broader, often unstated view of society, and state power within that society - society is not (yet) perfect, but it is gradually getting better, the standard of living is always rising, people are healthier and wealthier than they were in the past, and the individual is gradually accorded more rights and more liberty as s/he achieves more protection from infringements into her/his private life. For an analysis of the *Abortion Act*, this rather linear concept could only state the *Abortion Act* to be an advance, albeit one which did not go far enough: the point is now to extend it. For example, Madeleine Simms writes:

"the 1967 *Abortion Act* was a half-way house. It handed the abortion decision to the medical profession. The next stage is to hand this very personal decision to the woman herself" (Simms; 1985; 94).

Moreover, this vision of the *Abortion Act* as a permissive measure fits neatly into a powerful and dominant story which has been told about the late 1960s in the UK. The latter half of the 'Swinging Sixties' are remembered not only for their permissive social mores, but also for the influence of these values on social policy, and the introduction of increasingly liberal, permissive legislation and humanising reform. A Labour government, headed by Harold Wilson, was voted into power in 1964, and having secured a larger majority of seats in 1966, it embarked on a substantial programme of social reform. The voting age was lowered to 18 (1969), divorce was made easier (1969), access to contraception was facilitated (1967), the death penalty was largely abolished (1965-9), a more liberal attitude was taken towards the censorship of plays (1968) and homosexuality was decriminalised, albeit in very restricted circumstances (1967). Some commentators have described these reforms in extravagant terms. Christie Davies (1975), for example, assesses such measures as signalling a shift to a new and more permissive Britain. The reform of the legislation governing abortion was a central piece of this programme[3] and the dispute over abortion reform was cast in this light,

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[3] Although the *Abortion Act* results from a Private Member's Bill introduced by a young, Liberal MP, David Steel, it is clear that it could never have succeeded without Government help. This was provided, firstly in the form of drafting assistance and, secondly more importantly, the granting of extra Parliamentary time. Between 1952 and 1967 there had been five previous attempts to reform the law (sec footnote 9 below), all of which had been talked out and failed for lack of time.

becoming constructed as a contest between enlightenment and obscurantism. The *Abortion Act* was heralded as the victory of 'forward looking minds over the prisoners of the past'[4], as a crucial step in the process of women's emancipation[5], and as a permissive measure which liberalised, humanised and modernised the previous law. Christopher Price, one of the reformers' whips, claimed that the Bill had come forward because of the pressure of public opinion, due to

"millions of women up and down the country...saying, 'We will no longer tolerate this system whereby men lay down, as though by right, the moral laws, particularly those relating to sexual behaviour'"[6].

This construction of the *Abortion Act* as permissive has provided the basis for both the liberal approbation and the conservative criticism which greeted its passing. Conservative fears of the likely result of the liberalisation of abortion law were expressed as long ago as 1939, when the Birkett Committee (an inter-departmental committee appointed by the Minister of Health) had concluded that abortion should be available only on medical grounds. To provide it at the woman's request would only aggravate the disturbing trend of the decline in the birth rate and "prove an added temptation to loose and immoral conduct" (Brookes; 1988; 125). The Act has thus been seen as a measure which promotes promiscuity[7]. This sentiment was

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[4] The first Abortion Law Reform Association conference found that abortion was not a struggle between women and men, but between "the prisoners of the past and forward looking minds" (ALRA Conference, 15 May, 1936, in Brookes (1988; 95)).

[5] H.C. Deb Vol. 750 Col. 1372, 1967 (13 July). Here again the *Abortion Act* seems to fit in with other contemporary measures. The *Matrimonial Property Act* laid down that women's work whether inside or outside of the home should be considered as a contribution towards buying the family assets, when they came to be divided on divorce. The *Equal Pay Act* (1970), introduced by Barbara Castle during her time as Secretary of State for Employment and Production, laid down the principle of same wages for same work. The *Divorce Act* (1969) established the right of a couple to have a divorce after two years apart where both partners wanted it, or five years' separation where one partner did not agree. The *Family Planning Act* (1967) provided for the provision of family planning facilities on the NHS.

[6] Price, H.C. Deb Vol. 750 Col. 1372, 1967 (13 July).

[7] In introducing her (failed) reform bill in 1965, Renée Short to explicitly refutes any correlation between liberalisation of abortion and an increase in promiscuity. H.C. Deb. Vol. 714, Col. 254, 1965 (15 June). However, many MPs still voiced connections between the

still very much present in the late 1960s. In his book, *The Nameless*, published the year before the *Abortion Act* was passed, Paul Ferris wrote:

"one often meets the feeling that abortion, like contraception, is the thin end of a decadent wedge, a dangerous device to make sex easy for all. The trouble with protectives (says this argument) is that they can be bought by promiscuous bachelors as well as by prudent husbands. Similarly, even those who favour a more liberal attitude to abortion may be inhibited by the thought that any conceivable system short of one founded on explicit moral sanctions, can be used by tarts as well as by tired housewives" (1966; 10-11).

The Lamp Society of Bebington issued a broadsheet which contained the following text:

"WANTED: for loitering with intent to murder innocent, unborn Children, a black-hearted monster going by the name of Abortion Bill, and last seen in the House of Commons where it was harboured, supported and assisted by a large number of M.P.s...If this Bill is not defeated it will be the beginning of the end of traditional Christian morality in this country. It will be followed by attempts to make divorce easier than at present and to legalize homosexuality - even to the extent of legal homosexual 'marriages'. There is no doubt whatever that once Abortion becomes legal there will be moves on foot for the sterilization of the unfit, and the killing of the sick and old and the socially useless..." (cited in Hindell and Simms; 1971; 89).

Liberals, however, welcomed the perceived permissive character of the reforms. Brian Lapping purports to identify a common theme running throughout a great many of the "civilising measures" introduced during these years: the right to privacy. He writes that

"[t]he Abortion and Family Planning Acts sought to ensure the right to privacy of a man and a woman who chose to make love. If they did not want to seek the public acknowledgement and approval of their conduct, called for by having a baby, these new measures helped to protect their privacy" (1970; 218).

One precision which must be made is that it is necessary to distinguish between the *aims* of the legislation and its *effects* in practice. Although in the course of the thesis it will become

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two, e.g. William Deedes, H.C. Deb. Vol. 732, Col. 1092, 1966 (22 July). John Corrie who introduced a Bill to try and restrict the *Abortion Act* criticised the National Abortion Campaign (which defended the 1967 Act) asserting that: "[t]here is an organization called NAC who want the law even more promiscuous than it is now." (The John Corrie Special, Radio Clyde, 15 July 1979 in Feminist Review, 1980; 66).

evident that there is a wide gulf between these two levels, I would contend that on both to view the *Abortion Act* as a permissive measure which decreases the deployment of power over women is a partial vision. In this chapter and the one which follows it, I shall be focusing on the aims of the legislation; in subsequent ones, I will go on to assess how the regime which it foresees operates in practice. Here, I will give an account of the partial decriminalisation of abortion in the UK in the 1967 *Abortion Act*, and to examine the arguments expressed in favour of reform. I will begin by (briefly) sketching the background to the *Abortion Act* by way of an overview of the development of the law and medical practices until 1967 (section 2), before going on to an assessment of the reasons presented for reform - the problems that the Act aimed to address (section 3). My claim here is that the *Abortion Act* was actually a measure which was largely motivated by a desire to facilitate a closer control over the 'private' sphere, rather than one which sought to delineate a space for autonomous female action. In a third section, I take a fresh look at the form of the regulation which the *Abortion Act* introduces in the light of the preceding analysis (section 4), before going on to present some tentative conclusions (section 5).

2. THE DEVELOPMENT OF THE LAW UNTIL 1967: "A REFORM WHOSE TIME HAD COME"[8]

a) Statute law

Abortion was an area where reform seemed long overdue. Inside and outside of Parliament, there was widespread desire for change and modernisation. Indeed in the 15 years preceding the introduction of the *Abortion Act* 1967, there had been no fewer than five parliamentary initiatives aiming at reform[9]. The *Offences Against the Person Act*, 1861, which governed the regulation of abortion, was widely criticised as anachronistic and archaic. It provides that:

s.58 Every woman being with child, who, with intent to procure her own miscarriage shall

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[8] This is how Madeleine Simms of the Abortion Law Reform Association (ALRA) described the *Abortion Act* (1985; 83).

[9] The attempts at reform were introduced by Joseph Reeves MP (House of Commons, 1952); Lord Amulree (House of Lords, 1954); Kenneth Robinson (House of Commons, 1961); Reneé Short (House of Commons, June 1965); Lord Silkin (House of Lords, November 1965). For more discussion of these initiatives, see Dickens (1966; 123-31).

unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony...

s.59 Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour...

These sections contained no time limit, made no distinction between abortions early and late in pregnancy[10] and contained no explicit exception for therapeutic abortion. A time limit was later read into the *Offences Against the Person Act* by virtue of the *Infant Life (Preservation) Act*, 1929. The *Infant Life (Preservation) Act* had not been introduced in order to deal with abortion. Rather it was intended to close a legal loophole, revealed in a observation by Talbot J. at Liverpool Assizes[11], whereby the killing of the foetus/baby in the actual process of being born was covered neither by the *Offences Against the Person Act* (which foresaw an offence only where miscarriage was procured) nor by the law of murder. Thus, where a baby was killed during the process of (spontaneous) birth, but before being fully separated from the body of the pregnant woman, no offence was committed. The *Infant Life (Preservation) Act* introduced the offence of child destruction, s.1(1) prohibiting the destruction of a child capable of being born alive, making an exception only for the case where its destruction was carried out in good faith for the purpose of preserving the life of

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[10] Previously English law had distinguished between abortion before and after quickening. This had been the position in common law, and was enshrined in statute in the first statute regulating abortion, *Lord Ellenborough's Act* 1803, which made abortion a felony in the case of abortion after quickening, but only a misdemeanour where it occurred before quickening. The distinction was removed by the *Offences Against the Person Act*, 1837, which established the substantial form of the modern law (see Smith and Hogan; 1988; 366). Quickening was the point at which the foetus was believed to become ensouled i.e. when the soul entered the body. It also marked the point when the woman might feel the first stirring inside her. Quickening was believed to occur at around 12 weeks, although this was believed to be earlier for a male foetus than a female one.

[11] Cited by Lord Darling in the House of Lords debate, see Grubb (1990; 149).

the pregnant woman[12]. The Act included a rebuttable presumption that this capacity for life was acquired at 28 weeks of gestation. This limit was read into the *Offences Against the Person Act* (and later the *Abortion Act*) as prohibiting abortion after this time, except where the additional requirements of the *Infant Life (Preservation) Act* were also fulfilled[13].

b) Medical practice and jurisprudence

However, access to legal abortion prior to 1967 was not so restricted in practice as it might appear from a reading of the statute. Medical practitioners had long had some room for manoeuvre in the prescription and performance of abortions and the decision in *R v Bourne* (1938)[14] had given explicit judicial approval to the exercise of medical discretion for therapeutic terminations. Dr Bourne had aborted a girl of fifteen who had been raped by a group of soldiers. Rather than basing his case on an appeal to humanity, he defended himself on grounds of good medical practice, asserting that the girl's mental and physical health might have suffered had the pregnancy continued. Macnaghten J., who presided over the case, linked the 1861 and 1929 statutes, and ruled that the burden rested on the crown to satisfy the jury that the defendant did not procure the miscarriage of the girl for the purpose of preserving her life. He reasoned that although these words were contained in the *Infant Life (Preservation) Act* and not in the *Offences Against the Person Act* (under which Bourne was charged), that they were implied in the latter by the presence there of the word "unlawful" (which logically presupposed that in certain circumstances abortion must, on the contrary, be lawful). He told the jury that they should take a broad view of what was meant by preserving the life of the mother:

"[i]f the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequences of the continuance of the pregnancy will be to make the woman

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[12] This exception reflects the second purpose of the Act: to legalise the operation of craniotomy - crushing the impacted foetal skull, inevitably causing foetal death - which was widely practised to save the life of the pregnant woman before caesarian section became commonplace.

[13] The *Abortion Act* and *Infant Life (Preservation) Act* were explicitly 'uncoupled' by s.37(4) of the *Human Fertilisation and Embryology Act* (1990). See chapter 6 for more discussion of this reform.

[14] [1938] 3 All ER 615.

a physical and mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that honest belief, operates, is operating for the purpose of preserving the life of the woman."[15]

In 1948, *R v Bergmann and Ferguson*[16] clarified this decision. Here, the judge held that it was not relevant whether Dr Ferguson (the psychiatrist who had certified the need for termination) held a *correct* opinion as to the existence of such grounds for termination, so long as it was *honestly held.* This was emphasised again by *R v Newton and Stungo*:

"use of an instrument is unlawful unless the use is made in good faith for the purpose of preserving the life or health of the woman. When I say health I mean not only her physical health but also her mental health. But I must emphasise that the burden of proof that it was not used in good faith is on the crown"[17].

Thus, as long as the doctor acted in good faith, therapeutic abortion was legal. Indeed, even before the *Bourne* judgment, it is clear that abortions had been performed by doctors for therapeutic purposes, according to criteria established by themselves (Keown; 1988; 78). Provided that practitioners abided by professional ethics, there seems to have been little risk of prosecution[18]. A 1884 report in *The Lancet* commented that the strongest evidence should be forthcoming before a doctor was brought to account for carrying out the operation or even for the death of his patient, for "[e]ven if a medical practitioner is known to have procured abortion, the presumption is that it was done in the legal exercise of his calling" (in Francome; 1986; 19).

The combination of a climate of social reform with very restrictive legislation (and wide variation in medical interpretation of it) formed the backdrop for the introduction of the 1967

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[15] [1938] 3 All ER 615 at 619.

[16] [1948] 1 Brit Med J. 1008

[17] [1958] Crim LR 469; [1958] 1 Brit Med J. 1242.

[18] The bringing of a case against Dr Bourne should not really be seen as an exception to this as he actively courted his prosecution, informing the police of the operation himself and inviting them to arrest him (Bourne; 1962). Of the four doctors involved in the other two cases mentioned above, the only conviction who was clearly acting outside the terms of what was accepted to be good medical practice (see chapter 5, pp. 105-9 on these cases).

Abortion Act, which decriminalised the operation of some abortions when authorised and performed by qualified medical practitioners.

3. THE NEED FOR REFORM

I have argued above that the *Abortion Act* has been widely represented as a permissive measure. Having also given a brief account of the development of the law, I will here argue that the aims of the legislation were not primarily permissive (i.e. the law did not aim to provide more space, free from external intervention, where women could exercise sexual and reproductive autonomy). I will not attempt to provide a unitary account of the motivations of all who sought reform. The *Abortion Act* represents the outcome of struggles between different groups expressing competing interests and opinions. It is important not to deny the agency or the vital role of the women's campaign groups - such as Abortion Law Reform Association - who fought for reform. However other factors were also important, and some of these have already received some consideration from other writers. In particular, attention has been paid to the influence of medical groups (Keown; 1988), the contribution of illegal abortions to high figures of maternal mortality, concern and sympathy for the situation of women facing unwanted pregnancy, an unequal application of the law (with a thriving private sector in the provision of abortion) and the lack of a well organised opposition[19]. However, like much interest group analysis, frequently accounts have posited state and law as neutral sites for struggle. Here, I want to achieve a shift of balance or focus between these different factors: in particular I want to also introduce consideration of a government interest in managing the social problem of abortion, and in bringing under control a situation of widespread illegality and de facto female resistance to the law. Below I group the motivations for reform which I believe to have been the most important into two major categories - factors relating to a) the protection of medical discretion and autonomy and b) a desire to bring women out of the backstreets and into contact with their GPs. The former of these has already received some attention (see especially Keown; 1988) and so will be covered only briefly here. The latter has, I believe, been largely neglected.

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[19] The Society for the Protection of Unborn Children (SPUC) was launched only on 11 January, 1967 (Lovenduski; 1986; 52).

a) Protection of Medical Autonomy and Discretion

A first category of concerns which influenced the development of the *Abortion Act* was the desire to entrench and protect medical autonomy and to delineate a space for the exercise of medical discretion. Groups representing the interests of the medical profession exerted considerable influence on the development of the *Abortion Act* (as indeed they have done with earlier and later abortion legislation)[20]. Keown notes that none of the major medical bodies opposed reform as such, but that the profession was firmly opposed to any reform which compromised clinical freedom either by taking the final decision out of the hands of the doctor or by specifying the indications for abortion too exactly (1988; 87). In the late 1960s, many prominent members of the medical profession were opposed to what they saw as the intrusion of the law into the sphere of medical power (i). Moreover, the situation of semi-legality of many abortions left them in a position of uncertainty with regard to potential prosecution (ii). There were also feelings of anger and resentment amongst many that whereas some doctors desisted from performing any abortions, their colleagues in the higher echelons of the profession collected large fees for doing so (iii).

i) Restriction of professional autonomy

There had long been resentment within the medical profession that the law should restrict their freedom to act in the best interests of their patients. John Keown (1988) argues that the desire to protect professional autonomy was central to the position adopted by the various groups. This led medical profession to call for the law to ensure the elimination of abortion by untrained and 'unskilled personnel'[21] and to oppose any rigid codification of the indications for abortion which might lead patients to expect a right to termination where given circumstances were met (see below).

ii) Fear of prosecution

There seems to have been very little real risk of prosecution of a qualified medical practitioner who performed abortions prior to 1967 so long as he/she acted in conformity with

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[20] Keown (1988) clearly shows this influence on the gradual statutory restriction of laws against abortion from 1803 to 1861, the shaping of the *Abortion Act* and its defence from subsequent threat of restriction.

[21] See the 1966 report of the Medical Women's Federation (Keown; 1988; 95).

medical procedure (see footnote 18 above). This was especially true after the case of *R v Bourne* had clarified the operation of the law. As Hindell and Simms (1971; 14) relate, however, for the medical profession the law remained both fragile and ambiguous, granting only "a tenuous and ill-defined right to induce abortion"[22]. It was fragile in the sense that *Bourne* seemed to have carried the law far beyond the intention and the letter of the statutes, and because this decision was made in a lower court and might have been overruled if a case went to appeal. The law was ambiguous in that so much seemed to rest on whether the doctor could establish that he/she had terminated a pregnancy in good faith and that it was his/her honest opinion that unless he/she had done so the consequences would have been grave. Many practitioners remained reluctant to carry out terminations for fear of prosecution (Harvard; 1958, Ferris; 1966). Harley Street doctors would take precautions to 'cover their backs', obtaining a second opinion, normally from a psychiatrist who would testify to the effect of continuing a pregnancy on the woman's mental health. Other less wealthy doctors would operate in semi-clandestinity. Their secrecy could be taken as a sign of bad faith and it was they who were more open to prosecution. Moreover, doctors were restricted from charging those fees they would have liked, given that to demand a very high fee might also be taken as a sign of bad faith (Ferris; 1966, Harvard; 1958; 609)[23].

iii) 'Legal', private abortions

Large numbers of abortions of dubious legality were occurring in the private sector for those women who could afford them (Jenkins; 1960, Ferris; 1966, Greenwood and Young; 1976, Hindell and Simms; 1971). Francome notes that as long ago as 1880, some doctors were carrying out legal abortions on comparatively wide grounds (1986; 18). He estimates that in 1966, 15,000 pregnancies were terminated in the private sector and 5,700 in the National Health Service (1986; 27). In her minority opinion to the Birkett Report, Dorothy Thurtle noted that it was not difficult "for any woman of moderate means to find a medical man willing to relieve her of an unwelcome pregnancy regardless of the state of her health" (in Brookes; 1988; 124). It seems that by the late 1960s, a 'legal' termination was available to

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[22] Royal Medical Association's memorandum on therapeutic abortion (1966), cited in Hordern (1971; 9).

[23] *R v Newton and Stungo* [1958] Crim LR 469; [1958] 1 Brit Med J. 1242.

any woman who had a certain amount of persistence and the necessary 100 or so guineas to pay for one[24]. This provoked allegations of social inequality in the operation of the law[25]. For example, introducing his own (failed) attempt to reform the law in 1961, Kenneth Robinson said:

"[i]t is a perfectly simple matter for anyone who has sufficient money to get a pregnancy terminated today by a qualified medical practitioner on the flimsiest of medical grounds...This leads in the simplest possible terms to a situation in which there is one law for the rich and one law for the poor. If there were no other arguments for amending the law, I submit that is a very powerful one"[26].

This perceived social inequality and failure to prosecute senior obstetricians and gynaecologists who collected large fees for performing terminations, also provoked resentment amongst their more junior colleagues. One doctor told the Birkett Committee that "patients for whom I have without difficulty refused to evacuate the uterus have had the operation performed in London" (Simms; 1980; 1).

b) Bringing Women From the Backstreets to the GP's Surgery

i) Reducing maternal mortality

The major aim of the pressure group most active in pushing for reform seems to have been to bring some relief to the suffering of those women who experienced unwanted pregnancy. The formation of the Abortion Law Reform Association in 1936 had been provoked by the plight of women who had previously faced risky back street abortions, and who had often suffered serious physical complications as a result of having them[27]. Official estimates

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[24] Although the price could rise even higher than this. Ferris notes that: "where the surgeon considers that a woman, her husband or her lover can afford more, the fees go up. Hearsay puts them as high as £400 or £500, though the highest I heard anyone admit to was £250 - 'If they can afford to pay,' he said, 'I have no hesitation in jacking up my fee'" (1966; 103).

[25] For example, the telling title of Alice Jenkins' (1960) book on abortion: *Law for the Rich*.

[26] Robinson, H.C. Deb. Vol. 634 Col. 858, 1961 (10 February).

[27] For an account of the formation of the ALRA, see Jenkins (1960), Hindell and Simms (1971), Greenwood and Young (1976) and Brookes (1988).

showed that 35-40 women died each year as a result of botched abortions, but unofficial sources guessed at a far higher figure[28]. The partial decriminalisation of abortion was thus an essential step in the progression towards a more enlightened, humane and sympathetic approach to the situation of women facing unwanted pregnancy and a recognition that, in certain circumstances, it is cruel and unreasonable to expect women to carry such a pregnancy to term. The Parliamentary debates preceding the introduction of the 1967 Act are littered with tragic examples of women who have died either during illegal abortions or as a result of being forced to continue with an unwanted pregnancy, and who leave families behind them. A particularly distressing account is given by Lena Jeger MP, who relates the story of an "honest young woman" who was refused a termination on the grounds that "she did not seem quite depressed enough". Forced to continue with the pregnancy, the woman's depression following the birth of the child was so great that she killed it. She was sent to Holloway prison, and her other five children were put into care[29]. The desire to improve the situation of women facing unwanted pregnancy was not translated into a desire to give women greater autonomy, however. Rather, as is shown in the next chapter, these women were not seen as sufficiently stable or rational to make important reproductive decisions. Whilst the reformers believed that women seeking abortion had been wrongly stigmatised as criminals, they represented them as victims who needed help and guidance (see chapter 3).

The difficulty of legally terminating a pregnancy was implicated in the sustaining of high maternal mortality figures, which had consistently refused to improve in line with other health statistics. Indeed, by 1966 illegal abortion had become the chief cause of avoidable maternal death (Brookes; 1988; 133, Oakley; 1984) at a time when four women in a thousand died for reasons relating to maternity (Jenkins; 1960; 47). According to Mason (1990; 105), pathologists of the period taught that in cases of the unexpected death of a young woman,

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[28] Ferris reports the official annual death rate but argues that many death certificates were disguised to conceal abortions in order to protect the good name of the family (1966; 73-5). The Birkett Committee quoted figures of 411-605 deaths per year associated with abortion (this also includes non-criminal terminations). Dickens puts the number of deaths from criminal abortions in excess of 200 per year (Dickens; 1966; 113) and Williams hints at a still higher figure (1958; 194).

[29] Jeger, H.C. Deb, Vol. 749, Col. 977-8, 1967 (29 June). Other examples will be found in the following chapter.

pregnancy should be suspected until its existence was positively disproved[30]. Recognition of this problem was not new to the 1960s. As long ago as 1935, the first woman MP, Lady Astor, had told the House of Commons that: "a high percentage of maternal mortality is due to attempted abortion...We, as a House of Commons and as a Nation, must face up to that fact today" (Simms; 1980; i). An influential paper, published in the same year, reached the same conclusion:

"[a]bortion is increasing in frequency, and the chief factor responsible for subsequent morbidity and mortality is illegal interference with pregnancy, the interference being usually determined by poverty. The law has failed to prevent the self-induction of abortion, and the problem, which is one of preventive medicine, must be reviewed from this aspect, consideration being given to the changed economic and social conditions of the present day" (Parish; in Simms; 1981; 175).

It was these same concerns for maternal mortality which had led to the establishment of the Birkett Committee in 1939. Its brief was:

"to inquire into the prevalence of abortion and the present law relating thereto and to consider what steps can be taken by more effective enforcement of the law or otherwise to secure the reduction of maternal mortality and morbidity arising from this cause" (Brookes; 1988; 105)[31].

ii) The threat to the family

The related threat to the family was another powerful argument for reform. Many examples are given in the Parliamentary Debates of cases where the family had suffered as a result of losing the wife/mother who was its central focus and binding force. The abortion reformer, Joan Malleson wrote:

"it happens that with the invalidism or death of these mothers, the family disintegrates; for around their health and their capacity to tend the children the whole home revolves: and therefore these mothers are the very last who should be permitted to jeopardize their well-

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[30] Likewise, Francome relates that at the beginning of the nineteenth century, women of childbearing age were routinely examined for a blue line on the gums which was indicative of lead poisoning (1984; 33, 1986; 19).

[31] This followed directly from the 1937 Report on Maternal Mortality which had recommended the further study of various subjects including "abortion with special reference to the influence which it may exert on maternal mortality and morbidity and future childbearing" (Brookes; 1988; 105).

being" (1938, cited in Jenkins; 1960; 37).

This loss of mother/wife might result from the woman's death following unsafe, illegal abortion. It also might result from the suicide of the woman faced with an unwanted pregnancy (Jenkins; 1960; 76-7)[32]. Equally, the effective 'loss' of the mother might be caused by the additional strain which she faced in having another child - particularly a disabled one (see chapter 3, p. 56). The thalidomide tragedies of the early 1960s had contributed to the creation of a greater public sympathy for women seeking abortion. As Dr. John Dunwoody told Parliament:

"my belief is that in many cases today where we have over-large families the mother is so broken down physically and emotionally with the continual bearing of children that it becomes quite impossible for her to fulfill her real function, her worthwhile function as a mother, of holding together the family unit, so that all too often the family breaks apart, and it is for this reason that we have so many problem families in many parts of the country"[33].

David Owen outlines the same problem - the woman facing an unwanted pregnancy is

"in total misery, and could be precipitated into a depression deep and lasting. What happens to that woman when she gets depressed? She is incapable of looking after those children, so she retires into a shell of herself and loses all feeling, all her drive and affection"[34].

iii) Back street abortions: a consistent flouting of the law

Dickens concludes his (1966) book on abortion and the law with the assertion that: "the present law drives abortion into the most undesirable and dangerous channels, without eliminating it" (Dickens; 1966; 165). This is symptomatic of the widespread agreement which had been reached by the late 1960s, that the regulation of abortion was a failure. This was not measured entirely - or even primarily - in humanitarian terms, but rather in functionalist ones: the regulation was unpopular, ineffective and constantly flouted. As such, an important reason which was advanced for the partial decriminalisation of abortion in the UK was the need to take control of a situation where "the administration of the law has broken down

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[32] In the House of Lords Debates, Lord Strange argues that "nearly every woman in this condition [of unwanted pregnancy] would be in a state bordering on suicide." (Strange, H.L. Deb. Vol. 277, Col. 1235, 1966 (23 October).

[33] H.C. Deb. Vol. 732, Cols. 1098-9, 1966 (22 July).

[34] Owen, H.C. Deb. Vol. 732, Col. 1115, 1966 (22 July).

[and] it is neither respected nor obeyed"[35]. The Birkett Committee had reported in 1939 that: "[w]e are satisfied that the law in this matter is freely disregarded among women of all types and classes." Speaking thirty years later to the House of Commons, Roy Jenkins, then Home Secretary, was in agreement. He argued that the present regulation was unable to deal with the problem. A decriminalisation would serve to bring unwanted pregnancy and abortion within the ambit of a medical control, where it might thus be more effectively monitored:

"the existing law on abortion is uncertain and is also, and perhaps more importantly, harsh and archaic and...is in urgent need of reform...How can anyone believe otherwise when perhaps as many as 100,000 illegal operations per year take place, that the present law has shown itself quite unable to deal with the problem?...the law is consistently flouted by those who have the means to do so...it causes many otherwise thoroughly law-abiding citizens to act on the fringe, or perhaps on the wrong side of the law. As the Minister responsible for law enforcement, I believe that to be a thoroughly bad thing"[36].

Illegal backstreet abortions were certainly not a new phenomenon. The *British Medical Journal* had reported in 1868 that in

"the more infamous quarters of London...clues...have been offered to us by persons who have reason to believe that, among the more abandoned classes of women, there exists a secret understanding as to the persons and places where abortion is practised as a daily trade" (in Francome; 1986; 16).

However, media reporting and the growth in public awareness had made it increasingly hard to ignore the occurrence of widespread illegal abortions. It was impossible to judge accurately how many illegal abortions per year were performed, but estimates ranged from 10,000 to 250,000 (Dickens; 1966; 73)[37]. Indeed, according to Jane Lewis, working class women viewed abortion as a natural and permissible strategy (1984; 17). The Birkett Committee found that

"many mothers seemed not to understand that self-induced abortion was illegal. They assumed it was legal before the third month, and only outside the law when procured by

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[35] McNamara, H.C. Deb. Vol. 732, Col. 1124, 1966 (22 July).

[36] Jenkins, H.C. Deb. Vol. 732, Cols. 1141-2, 1966 (22 July).

[37] The Birkett committee estimated 54,000 p.a. (Jenkins; 1960; 33), Hordern (1971; 2) says 120,000-175,000.

another person" (cited in Lewis; 1984; 17).

Prosecutions for illegal abortions represented just the very tip of this iceberg[38], with convictions numbering an average of around 50 per year (Williams; 1958; 192). The practice of prosecuting only the abortionist and not the pregnant woman was long established (Williams; 1958; 146)[39]. As with all 'victimless crimes', offences were hard to detect. The police were largely tolerant of the activities of abortionists unless they were forced to act - for example, if a woman died during or following an abortion (Simms; 1980; 5) or where she was brought to the hospital with serious complications such as a septic abortion or perforated uterus. From their point of view, abortion cases were time consuming and awkward, since the pregnant woman, who was generally required as a witness, was naturally reluctant to bring evidence against the abortionist who had relieved her of an unwanted pregnancy (Hindell and Simms; 1971; 37, Brookes; 1988; 133, Jenkins; 1960; 33-4). As one police officer related:

"it is gratitude to the person who has relieved them of an unwanted burden that keeps the victims of abortion silent. For this type of help, gratitude wells up in the heart to subdue every other sense. Even when dying they hug their secret gratefully, refusing to divulge the name of the person who has brought them to this impasse" (Williams; 1958; 190).

Moreover, the public were often unwilling to help with enquiries. David Steel, introducing the *Abortion Act*, gives the example of a 24 year old woman found dying in a North London street following an illegal abortion. He quotes from the *Evening Standard*:

"[a]fter hearing from the police that they had been unable to find out where the abortion took place, the St. Pancras coroner said: 'We are up against a blank wall of unwillingness to know and unwillingness to talk'".

Ferris cites several interviews with police officers who spoke of their reluctance to prosecute abortionists: one superintendent told him: "we know there's lots going on, but we don't

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[38] There were 62 prosecutions for illegal abortions in England and Wales in 1966, 28 of which resulted in prison sentences (Mason; 1990; 105) and 71 in 1967 (Cavadino; 1976; 63). As Glanville Williams (1958) points out, this represents less than one prosecution for every 1,000 criminal abortions.

[39] See the case of *R v Mills* [1963] 1 QBD 522, [1963] 1 All ER 202, following *R v Scully* (1903) 23 NZLR 380. See also the case of *Peake* (1932) 97 JPN 353.

prosecute unless we're forced to" (1966; 92). Ben Whitaker in his (1964) book, *The Police* writes of the same phenomenon:

"some police, particularly in poorer areas, have a certain amount of sympathy for the altruistic abortionist, and tend to ignore his activities unless some tragedy or trouble occurs" (Dickens; 1966; 77).

In the rare cases where charges were brought juries were unwilling to convict, probably as a result of popular sympathy with the plight of the woman.

Many of the backstreet abortionists commanded huge popular support, especially where they were known to have acted through sympathy for the woman rather than for pecuniary reasons (Ferris; 1966; 88, Simms; 1981; 179, Brookes; 1988; 140). Simms reports that the funeral of a well known abortionist, Dr Daniel Powell of Tooting was attended by women from all parts of the country. When Dr Powell had been prosecuted, his patients had collected the money for his defence. One detective who had been on his trail for some years, said: "he was a great hearted and fearless man whose work was directed by the highest motives" (Simms; 1981; 173-4). Hindell and Simms (1971; 38-9) likewise relate the case of William Tellam, who was sentenced to three years' imprisonment for carrying out illegal abortions in his surgery. Instead of being regarded as a villain, Tellam was a kind of hero figure, and eighteen thousand people signed a petition asking for clemency in his case. Dora Russell, founder of the Abortion Law Reform Association, wrote of his prosecution in *The Guardian* that:

"[o]ur inhuman and obsolete law against abortion has now claimed a fresh victim in one of the best and ablest medical men practising in Penzance...It is tragic that even a skilled practitioner who comes to the help of women pregnant and desperate, is liable to disgrace and punishment" (Hindell and Simms; 1971; 39).

Brookes reports several other cases where patients collected petitions in support of doctors convicted for performing abortions[40].

[40] 10,000 patients signed in support of Dr Sumatapalage Gunewardene; 2,739 in support of Dr Charles Bikitsha; and 1,100 for Dr Hanratty (Brookes; 1988; 140-1).

In such a climate of mass illegality and popular resistance to enforcement of the law, a partial and controlled decriminalisation of abortion had much support in Parliament. Even the staunchest opponents of the abortion agreed that some kind of reform was needed[41]. No doubt this was inspired in part by compassion for the plight of the woman, but more important was the clear need to bring this situation of widespread illegality and de facto female resistance under control. Steel, in introducing the second reading of his Bill, emphasised that: "[w]e want to stamp out the back street abortions, but it is not the intention of the Promoters of the Bill to leave a wide open door for abortion on request"[42]. The *Abortion Act* aimed to abolish backstreet abortion by granting registered medical practitioners a legal monopoly on the termination of pregnancy (Keown; 1988; 159). This would install the medical profession as the gatekeepers or 'parallel judges' who could grant or refuse access to termination according to how deserving an individual case was felt to be. Importantly, it would also enable abortion to be located in hospitals where it could be monitored, and make possible a system of registration whereby details of the woman and the reasons for allowing her abortion could be registered. Moreover, to decriminalise abortion in controlled circumstances would make it visible and enable its incidence to be mapped. 'Liberalisation' was thus proposed and accepted (at least in part) to bring under control a situation of mass illegality, and to ensure that the incidence of abortion might be more closely monitored.

4. THE PERCEIVED BENEFITS OF REFORM

The model of legislation adopted in the *Abortion Act* clearly reflects those aims which are discussed above. The *Abortion Act* would a) permit women seeking termination to be brought under a closer medical control, b) safeguard medical autonomy and discretion, and at the same time c) render abortion visible and enable it to be monitored and mapped by way of a system of registration, and provisions regulating where terminations might be performed.

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[41] See Wells, H.C. Deb. Vol. 732, Col. 1080, 1966 (22 July); Deedes, H.C. Deb. Vol. 732, Col. 1091, 1966 (22 July); Hobson H.C. Deb. Vol. 732, Col. 1132, 1966 (22 July); Braine, H.C. Deb. Vol. 747, Col. 455, 1967 (2 June).

[42] Steel, H.C. Deb Vol. 732, Col. 1075, 1966 (22 July).

a) Bringing women under medical control

The *Abortion Act* is fundamentally underpinned by the idea that reproduction is an area for medical control and expertise and that the doctor is the most appropriate expert to deal with abortion. This reflects not merely a belief in his/her technical expertise, but also the notion that the doctor is in the best position to observe the woman, assess her needs and interests, and take charge of her situation (see chapter 4). Moreover, the doctor is seen as taking on many of the pastoral functions previously associated with the priest: he is a guardian of the social body and a bastion of moral values[43]. Peter Mahon M.P. reminds the House of Commons that: "it would be as well if we applauded the work of some of these men to keep our homes and families and the country right"[44]. The *Abortion Act* accords clear moral authority to the doctor, in that it is he/she who has the final decision regarding abortion. There is nothing commonsensical about the decision to grant such power to doctors (medical experts), when one remembers that the vast majority of abortions are desired for social rather than medical reasons. The power given to doctors here far exceeds that which would accrue merely on the basis of a technical expertise.

A very clear construction of the typical doctor appears within the debates which, as will be seen in the next chapter, stands in strong contrast to the figure of the pregnant woman. The doctor is a male figure[45] who is perceived as the epitome of maturity, common sense[46],

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[43] This function of the doctor as a source of moral authority is detailed by Foucault in both *Madness and Civilisation* and *Birth of the Clinic*. In the former he notes that the introduction of the doctor into the asylum was based more on his moral authority than on his medical knowledge: "his absolute authority in the world of the asylum...insofar as, from the beginning, he was Father and Judge, Family and Law - his medical practice being for a long time no more than a complement to the old rites of Order, Authority and Punishment" (1989a; 272, see also 1980d).

[44] Mahon, H.C. Deb. Vol. 747, Col. 502, 1967 (2 June).

[45] Doctors are referred to as "medical men", "professional medical gentlemen" and "professional men". They are always referred to as "he" within the 1966-7 debates. William Deedes notes that "the medical profession comprises a great diversity of men" Deedes, H.C. Deb. Vol. 732, Col. 1092, 1966 (22 July); and Jill Knight says that "the GP is a skilled man" H.C. Deb. Vol. 747, Col. 482, 1967 (2 June) See also, Knight, H.C. Deb. Vol. 749, Col. 931, 1967 (29 June). Jenkin, H.C. Deb. Vol. 749, Col. 967, 1967 (29 June); Hobson, H.C. Deb. Vol. 747, Col. 531, 1967 (2 June); Hogg, H.C. Deb. Vol. 747, Col. 946, 1967 (2 June).

responsibility and professionalism. He is a "highly skilled and dedicated"[47], "sensitive, sympathetic"[48] member of a "high and proud profession"[49], which acts "with its own ethical and medical standards"[50] displaying "skill, judgement and knowledge"[51].

It was hoped that mere contact with this responsible and reassuringly male figure might dissuade the woman from seeking to terminate a pregnancy - the need for an abortion often being posited here as a direct consequence of her own hysteria and derangement, rather than a rational decision reflecting a reasoned assessment of her concrete situation. The rule of the doctor would be one of responsible control[52]. This point is made repeatedly in the Parliamentary Debates, for example in my opening citation from the Bill's sponsor, David Steel: "if we can manage to get a girl such as that into the hands of the medical profession, the Bill is succeeding in its objective"[53]. Steel picks up on this same argument in the Parliamentary debates at the time of Human Fertilisation and Embryology Act (1990), where he relates that doctors have told him that they now have the chance to see women before they abort and to discourage them from doing so. One told him that:

"[o]ne of the effects of the 1967 legislation has been that people will come to his surgery and discuss abortion with him, whereas pre-1967 they would not have done so and he would have lost control of what was happening, and the patient might have ended up with a back-street abortion or going into a private clinic"[54].

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[46] Steel, H.C. Deb. Vol. 747, Col. 463, 1967 (2 June)

[47] Mahon, H.C. Deb. Vol. 750, Col. 1352, 1967 (13 July)

[48] Raglan, H.L. Deb. Vol. 274, Col. 591, 1966 (10 May)

[49] Lyons, H.C. Deb. Vol. 732, Col. 1090, 1966 (22 July)

[50] Steel, H.C. Deb. Vol. 747, Col. 464, 1967 (2 June).

[51] Hobson, H.C. Deb. Vol.747, Col. 531, 1967 (2 June).

[52] For example, Steel, H.C. Deb. Vol. 732, Col. 1076, 1966 (22 July); H.C. Deb. Vol. 750, Col. 1348, 1967 (13 July); Owen, H.C. Deb. Vol. 732, Col. 1116, 1966 (22 July); Dunwoody, H.C. Deb. Vol. 732, Col. 1096, 1966 (22 July).

[53] Steel, H.C. Deb. Vol. 750, Col. 1349, 1967 (13 July).

[54] Steel, H.C.Deb. Vol. 171, Col. 210, 1990 (24 April).

David Owen echoes the same sentiment later in the 1966-7 debates, noting that:

"[i]f we allow abortion to become lawful under certain conditions, a woman will go to her doctor and discuss with him the problems which arise...he may well be able to offer that support which is necessary for her to continue to full term and successfully to have a child"[55].

The same argument also arises in the academic literature, with Glanville Williams asserting that:

"[a]n important medical result of legalizing abortion would be that it would enable the patient to take proper professional advice. It is, of course, always open to a doctor to dissuade his patient from the operation by pointing out any harmful effects that he thinks it may have" (1958; 203-4)[56].

The *Abortion Act* would serve to get women into the hands of the medical profession, who can take control of the situation.

b) Medical Autonomy

The law aims to protect medical autonomy and discretion rather than to grant substantive rights to the woman, even where she is in the most extreme circumstances envisaged by the reformers. The severely depressed mother of five, described by Lena Jeger (see p. 27 above), still would have no right to a termination. Rather, the regime introduced by the *Abortion Act* offers the qualified doctor (and only derivatively his/her patient) a valid defence against the *Offences Against the Person Act* for certain terminations, where these have been medically authorised and performed[57]. This is important in that the law serves to grant woman and

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[55] H.C. Deb. Vol. 732, Col. 1116, 1966 (22 July). See also Steel; H.C.Deb. Vol. 732 Col. 1076, 1966 (22 July). Bernard Dickens makes the same point as an argument for reform (1966; 133).

[56] Compare this also with the remarks of Simone Veil, opening the debates which preceded the legalisation of abortion in France: "[a]lthough the bill before you takes into account an existing state of affairs, although it allows the possibility of termination of pregnancy, this is the better to control it and, as far as possible, to dissuade women from it" (Allison; 1994; 231).

[57] Thus, s.1(1) provides that "a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion formed in good faith" [that certain

doctor together some rights against the state, but grants the woman no right to privacy or autonomy vis-à-vis the doctor. The decriminalisation of abortion entrenched the doctors' control of abortion and marked the legal recognition of the era of the doctor as the 'parallel judge' who could exercise power more quickly and effectively than a state-centred apparatus.

The clear desire to avoid giving any substantive rights to women is most clearly illustrated by the debates centring around whether the *Abortion Act* should carry a 'social clause' (whereby the need for abortion might be established with regard to socio-economic factors), and a clause allowing abortion in case of rape or incest. Steel's original *Medical Termination of Pregnancy Bill* did carry such clauses, clause 1(c) allowing doctors to authorise abortion where: "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" and clause 1(d) where "the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape".

These clauses were, however, opposed by all of the major medical bodies, who felt that women might interpret them to mean they had a *right* to demand abortions where the circumstances outlined were met (Keown; 1988; 87). For example, the Royal Medico-Psychological Association warned that:

"[s]pelling out in detail when a doctor should or should not have the right to induce abortion, even if the legislation is cast in permissive terms, would have the effect of introducing an element of coercion in the sense that in each defined situation the patient might reasonably expect the doctor to acquiesce and the role of the surgeon or gynaecologist would be reduced that of a technician carrying out an objectionable task" (Keown; 1988; 89)[58].

As a result of pressure from medical groups, the two clauses were subsequently removed.

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conditions are fulfilled].

[58] See Keown (1988) for the same objections from all the other major medical bodies: the British Medical Association (90); the Royal College of Obstetricians and Gynaecologists (93); and the Medical Women's Federation (95). That a doctor should not be forced to carry out a termination when he/she does not wish to do so is also enshrined in s4 of the *Abortion Act* which provides for the possibility of conscientious objection to providing treatment under the *Abortion Act* except when the operation is necessary to save the woman's life or to prevent grave, permanent injury to her health.

It was argued that in case of rape or incest, abortion would already be available under other provisions, notably the risk to the woman's mental health. To remove the clause would mean that women would not feel they had an automatic right to termination in these circumstances, and would minimise the risk of their fabricating stories of rape in order to qualify for abortion[59]. Hindell and Simms comment:

"David Steel, the medical profession, and the Government were propounding the view that the law must not be made too clear lest the public read it and began to demand their rights. Much better to leave it vague and fuzzy so that doctors would have total discretion in the matter of abortion and so that patients would be unable to argue" (1971; 185).

The social clause was likewise removed and was replaced with a wording which, whilst allowing social and economic factors to be taken into account, made it absolutely clear that they should be evaluated by the doctor and not the woman herself. Thus, under s.1(2), the doctor is now authorised in determining whether continuance of pregnancy would involve such risks to life or to mental and physical health as are specified in s.1(1) to take account "of the pregnant woman's actual or reasonably foreseeable environment"[60]. This ensures that socio-economic factors are assessed only in so far as they are subject to assessment by a doctor and that the doctor, rather than the woman herself, thus remains the ultimate judge even with regard to such factors.

c) The possibility to monitor the incidence of abortion: notification and regulation of premises where terminations might be performed

Another perceived advantage to the strict medical control was that abortion might be made more visible and hence more easily monitored and controlled. S.1(3) of the *Abortion Act*

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[59] The idea that the women might fabricate charges is put forward several times in the Parliamentary Debates (see chapter 3, pp. 60-2), and also in the Birkett Report which suggested that in a great number of cases, "girls and women made the allegation of rape falsely" (Brookes; 1988; 117).

[60] Compare this to the formula put forward by the Royal College of Obstetricians and Gynaecologists (RCOG) who suggested that the law might also provide that the practitioner could take into account such circumstances, whether past, present or prospective as were in the doctor's opinion relevant to the physical or mental health of the woman or of the child if born (Keown; 1988; 92) and the joint report of the RCOG and British Medical Association which argued for a subclause which had almost exactly this wording (Keown; 1988; 97).

provides that any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of state, or in a place approved by either for the purposes of the section[61]. Henceforward, abortions would be performed only in hospitals or specially licensed premises. The *Abortion Act* also paves the way for a system where doctors might be made responsible for notifying the performance of abortions, so that their incidence might be better measured and recorded. Under s.2, there is a duty for the Minister of Health (or the Secretary of state for Scotland) to ensure that any practitioner who terminates a pregnancy must provide to the Ministry of Health (or Scottish Home and Health Department) "such notice of the termination and such other information relating to the termination as may be so prescribed". Under s.4(1) of the Abortion Regulations[62], the operating practitioner is required to notify the abortion to the Chief Medical Officer, within seven days. This makes possible the yearly publication of statistics by the Office of Population Censuses and Surveys (OPCS), recording the number of abortions, reasons for performing them, the number of foreign women having abortions in the UK, the method of abortion, the number of weeks of gestation, whether women are married or single, how many children they have already, whether the abortions are performed on the NHS or in private clinics etc. Moreover, these statistics enable comparisons with similar foreign data. A 'dark mass' of unknowable female criminality is brought into the open and isolated in the bodies of individual women where it can be contained and controlled. The problem of abortion is changed from one of widespread and unquantifiable dev*iance*, to one of isolated, identifiable and treatable individual dev*iants* (see chapter 3).

5. CONCLUSIONS

"I don't want to say that the state isn't important; what I want to say is that relations of power, and hence the analysis that must be made of them necessarily extend beyond the limits

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[61] S.1(4) provides that this restriction shall not apply when a registered medical practitioner is of the opinion, formed in good faith that termination is immediately necessary to save the life, or to prevent grave, permanent injury to the physical or mental health of the pregnant woman. S.1(3) was amended in 1990 to allow the relevant authorities to approve simultaneously a "class of places" for the performance of terminations where performed primarily by the use of medicines.

[62] S.I. 1968 no 390, issued the same day as the *Abortion Act* came into force.

of the state...because the state for all the omnipotence of its apparatuses, is far from being able to occupy the whole field of actual power relations, and further because the state can only operate on the basis of other, already existing power relations. The state is superstructural in relation to a whole series of power networks that invest the body, sexuality, the family, kinship, knowledge, technology and so forth." (Foucault; 1980c; 122).

In this chapter, I have marked a shift in the modality of state attempts to bring women seeking to terminate pregnancies under control. Here focusing on the aims of the *Abortion Act*, I have taken issue with the common representation of that law as an essentially permissive measure which envisages a loosening of power over abortion, reproduction and (women's) sexuality. In such a light, the *Abortion Act* has been seen as both interpretative and constitutive of the development of a private sphere where sex may be enjoyed free from public interference and regardless of the (lack of) procreative intention of the participants. I have challenged this representation in arguing that whilst the *Abortion Act* has undoubtedly facilitated women's access to safer, legal terminations, it also represented a new way of striving to reach a certain social and political end: notably to increase control over a situation of widespread illegality by implementing a more subtle deployment of power over women and a more efficient way of managing this 'private sphere' of sexuality. Women's sexuality has in one sense been rendered more, not less, visible by the passing of the *Abortion Act*: in that their 'private' sphere of action is now open to extensive examination by doctors (as will be seen in chapter 4).

The problematisation of the connection between seemingly humanising reform and a loosening of power which has underpinned this chapter owes a debt to the work of Michel Foucault which I outlined in my introduction. Foucault has written that the reduction in penal severity in the last 200 years has long been regarded in an overall way as a quantitative phenomenon: "less cruelty, less pain, more kindness, more respect, more 'humanity'" (1991; 16). He argues, however, that these changes are also qualitative in nature, representing a new - more efficient - strategy in the deployment of power. Foucault's (1979a) work on 'governmentality' details the emergence of 'the population' as the new target of government. This ushered in social welfare policies and new forms of control aiming less at sporadic and spectacular interventions, and more at a fine and continuous surveillance and modification. In this light, the *Abortion Act* can be seen as part of a shift in political rationality in the 1950s and 1960s, with reforming legislation reconstructing modes of control. An important aspect

of the modern era, for Foucault, is the proliferation of small-scale 'legal' systems and "parallel judges" - of psychiatric and psychological experts, doctors, educationalists and members of the prison service - all fragmenting and sharing in the power to punish (1991; 21).

It is my contention that the passing and subsequent operation of the *Abortion Act* can be viewed as part of this process. The *Abortion Act* undoubtedly served in one way to lessen a particular modality of direct state control over abortion, by taking certain terminations out of the ambit of control of the criminal courts[63]. However, in the same process, indirect (medical) control was greatly enhanced and power was extended over the woman's 'private' sphere of action. Through the *Abortion Act*, the doctors, as 'parallel judges', are officially accorded the power to judge the woman and then to decide whether she should have the possibility of an abortion, or whether she should be denied relief and made to face the 'punishment' of being forced to continue with an unwanted pregnancy. Within the regulations introduced by the *Abortion Act*, women are decriminalised in order to be pathologised[64], to be judged not by the judiciary but by the 'parallel judges' of the medical profession. The partial decriminalisation of abortion corresponded with a finer deployment of power by way of a colonisation of existing lines of medical control and a legitimation, entrenchment and extension of those lines. Further, there is an attempt to make use of these lines, by way of the notification procedure and the control of premises, to monitor the incidence of abortion[65].

How far then is the *Abortion Act* a 'permissive' law? And, recalling Disraeli's words that

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[63] Although, as has been seen above, attempts to prevent or control abortions by way of the criminal law had proved a visible failure.

[64] See the following chapter for some examples of the way in which the figure of the woman seeking abortion is 'pathologised' and constructed as in need of medical control.

[65] In terms of the *effects* of the legislation, it will be seen in subsequent chapters that this attempted colonisation of medical lines of control was in many ways unsuccessful. It seems likely that the notification procedure is not always taken seriously by doctors with significant under reporting of abortions performed, see Walsworth-Bell (1992) and *Abortion Review*, Winter 1992, no. 46. In particular, the judiciary are largely unwilling to police medical action under the 1967 Act (see chapter 5).

"permissive legislation is the characteristic of a free people", how far does it symbolise a new degree of freedom for women? There can be no doubt that the *Abortion Act* is a piece of permissive legislation if "permissive" is interpreted to mean the carving out of a sphere of freedom from direct and repressive criminal law controls. In this sense the *Abortion Act* partially fits within the first part of the Oxford English Dictionary's definition: "having the quality of permitting or giving permission; that allows something to be done or to happen; not forbidding or hindering". The *Abortion Act* is thus permissive in providing doctors (and derivatively women) with the possibility to terminate a pregnancy without fear of prosecution. It does not permit women to terminate a pregnancy, however, rather it allows them to approach doctors to request such permission. Fitting the *Abortion Act* into the second part of the definition given by the Oxford English Dictionary is still more problematic: "in modern use *freq.*: tolerant, liberal, allowing freedom, *spec.* in sexual matters". The question which is then raised is how far and in what sense the *Abortion Act* gives women freedom in sexual (and I would add in reproductive) matters? This in turn raises a more fundamental question: what do we mean by freedom? Is freedom just the space left by the absence of restrictive criminal controls? The more expansive definition of power which I outlined in the introduction would imply an answer in the negative. It would point to the would need to take account of medical power over women within the 'private' sphere, and hence necessitate a closer analysis of the possible deployments of power at this level (as will be provided in chapter 4). If the *Abortion Act* is seen as representing not a lessening of control, but rather a shift in the modalities of control towards a finer means of deploying power, the kind of freedom which women can exercise under it becomes more problematic, and in need of further analysis.

CHAPTER 3: THE ABORTION ACT (1967) AND ITS 'PERIPHERAL SUBJECT'

"I believe that we must attempt to study the myriad of bodies which are constituted as peripheral subjects as a result of power"[1].

"There are women who suffer from illnesses, which...will...make her less able to bear the burdens of motherhood...There is the case of the woman who is in prison, serving a long term commencing between the beginning of the pregnancy and the time at which she will give birth. Obviously that woman is inadequate to be a mother of a child. There is the persistent offender, or the shop-lifter, and there is the mother who has in the past been found guilty of neglecting or ill-treatment of her existing children. These are some of the cases I have in mind. There is the drug taker or the alcoholic. I am sure the right reverend Prelate (the Bishop of Exeter) would not suggest that such a mother is a fit person to be in charge of children. There is the woman who already has a large family, perhaps six or seven children...There is the question of the woman who loses her husband during pregnancy and has to go out to work, and obviously cannot bear the strain of doing a full day's work, and looking after a child. There is the woman whose husband is a drunkard or a ne'er-do-well, or is in prison serving a long term, and she has to go to work. These are the cases I have in mind"[2].

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[1] Michel Foucault (1980b; 98).

[2] Lord Silkin, introducing his (1966) Bill to the House of Lords, in Hindell and Simms; (1971; 150).

1. INTRODUCTION

In the previous chapter I argued that it is mistaken to view the 1967 *Abortion Act* as a wholly permissive piece of legislation, a lessening of control over women's sexuality and fertility. I suggested that it should rather be viewed within the terms of the movement towards governmentality described by Michel Foucault (1979). The *Abortion Act* was revealed as motivated, inter alia, by the state's desire to take control of a situation of widespread illegality and to 'manage' the problem of unwanted pregnancy more efficiently. In this sense the *Abortion Act* stood as an official recognition that abortion should be removed from the ambit of repressive criminal prohibition and relocated in the sphere of medical control. The modality of control adopted reflects certain assumptions of the nature of the deviance (and deviants) to be regulated: within this shift, I suggested, women seeking termination were decriminalised in order to be pathologised. In this chapter, this idea will be developed. My concern will be to 'flesh out' the subject who is to be regulated through legislation dealing with abortion, to analyse how she has been constructed within law and how this construction serves to legitimate and perpetuate a certain model of control. This will serve to emphasise that although it is useful to locate *Abortion Act* within this general movement towards governmentality, it cannot be adequately understood without consideration of gender, as clearly gendered constructions of the subject to be regulated (the woman seeking abortion) underpin the model of reform adopted.

Foucault has written that the individual is both an effect of power and an element of its articulation:

"[t]he individual is not to be conceived as a sort of elementary nucleus, a primitive atom, a multiple and inert material on which power comes to fasten or against which it happens to strike, and in so doing subdues or crushes individuals. In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual, that is, is not the *vis-à-vis* of power; it is, I believe, one of its prime effects. The individual is an effect of power, and at the same time, or precisely to the extent of which it is that effect, it is the element of its articulation. The individual which power has constituted is at the same time its vehicle" (1980b; 98).

The various discourses around the problem of unwanted pregnancy (of which the law is one) have operated to construct a particular female subjectivity for the woman seeking termination

which stands both as an instance of power (the production of a 'true' account of her nature), and as a site for its exercise. This subjectivity is dynamic - the construction of the woman who would seek to terminate a pregnancy has not remained constant. Here, I will argue that the *Abortion Act* is clearly predicated upon a particular understanding of the nature of the woman seeking to terminate a pregnancy. It is one frozen moment in the development of this subjectivity, and one which continues to have important effect today.

In analysing the way that the female subject is constructed in law, I concentrate on the debates leading to the introduction of the 1967 Act, as played out in Parliament. It is beyond the scope of this work to explore the exact relationship between the content of Parliamentary debates, and the final text of a debated statute. To say that the law is the product of debate within Parliament is obviously simplistic, not least because any new bill is presented in draft form before ever coming under discussion (the text of the *Abortion Act* derives in large part from David Steel's original draft of the *Medical Termination of Pregnancy Bill*). Neither do I seek to deny the impact of extra-Parliamentary groups - and in particular in this case, the Abortion Law Reform Association and the medical profession - on the formulation of statute. That this influence was considerable should be clear from the previous chapter. Rather, I content myself with a minimum assertion, that Parliamentary debates are in some way indicative of the predominant social discourses around the concept of woman which form the context within which the *Abortion Act* was conceived, and a slightly more ambitious suspicion, that more than this, the statements made by M.P.s in this context provide particularly important and powerful "telling instances" of this social and political discourse (Fitzpatrick; 1987; 120).

In this more ambitious sense, it seems to me that Parliament provides a particularly significant arena for debate. This is not merely because of the inevitable relationship between the debates and the formulation of statute. Further, what is especially significant about Parliamentary debates is that speakers are inevitably particularly aware that what they say (especially on a topic of popular interest such as abortion) will be recorded, read and maybe even reported in newspapers. As such, there is every incentive to speak to the spirit of the times, to try to tap into and give voice to a broader popular morality. For example, I do not believe that all of those active in the debates shared the vision of those women seeking

abortion as somehow deviant and aberrant which I will discuss below. Madeleine Simms was a founding member of the Abortion Law Reform Association, which spearheaded the campaign for the decriminalisation of abortion. In 1971, in a book coauthored with Keith Hindell, she notes that the reformers did consider the situation of the ordinary woman who simply did not want to give birth, and that one wing of the reform movement did feel there was a need for abortion for all on request. They acknowledged, however, that politically this idea was far too radical to gain public acceptance and parliamentary approval. It was obvious throughout the reform campaign that they would only be able to carry the country with them if they concentrated on the hard cases (1971; 25)[3]. It seems to me that this gap between private opinions and political (public) discourse may make the public discourse more rather than less significant. Even when the reformers believed in the right of all women to choose abortion, and that unwanted pregnancy was not merely a problem faced by marginal women on the fringes of society, they recognised that the most effective way to achieve a partial decriminalisation of abortion was through the exploitation of these stereotypes which played upon popular constructions of the kind of woman seeking abortion. Parliamentary speeches represent more than the feelings of the individual speaker: the more effectively a political discourse manages to capture broad based social assumption, the more it will carry its audience and the more effective it will be[4].

In this chapter I begin by drawing out the way that the pregnant woman seeking abortion is constructed within these debates by bringing together dispersed comments of M.P.s to present

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[3] Similarly, Paul Ferris notes the very real need for caution on the part of the reformers: "[a] constant danger for abortion-law reformers, as it used to be for advocates of birth control, is that they should appear to be condoning immorality. This is why their propaganda plays up the unwanted pregnancies among married women, and says as little as it can about the thousands of single girls who have abortions. It is easier to make a respectable case in public for the weary mother of half a dozen children than for a girl of eighteen who slept with two men last week. The reformers' dilemma lies in the risk that any system which makes it easier for the mother of six to have an abortion is liable to be applied to a promiscuous teenager" (1966; 154-5).

[4] An interesting later example of this is David Alton's choice of rhetoric in Parliament in the 1988 and 1990 debates (discussed in chapter 6 below, p. 140). Although in his (1988) book, Alton gives priority to religious and moral arguments (starting the chapter on abortion by quoting Mother Theresa), in Parliament he relies far more on medical knowledges to found his arguments.

a more unified account of the sort of general assumptions about the 'type' of woman whom the legislation must address: what kind of woman would seek to terminate a pregnancy? (section 2). I then examine how these constructions and the assumptions upon which they are predicated are reflected in the text of the *Abortion Act* itself (section 3).

2. IMAGES OF THE ABORTING WOMAN

From my reading of the Parliamentary debates which preceded the passing of the *Abortion Act* of 1967, three major strands of narrative emerge, purporting to describe the 'type' of woman who would want an abortion. The accounts view this woman as peripheral: a marginal and deviant figure who stands against a wider norm of women who neither need nor desire abortion. The accounts which are given in Parliament reflect a strategic deployment of knowledge on the part of both the proponents and opponents of decriminalisation, and on a broader level, reflect images of women that were (and to a greater or lesser degree still are) predominant in other social discourses. The typifications adopted are extreme - they are predicated partially on stereotypes, and partially on real and concrete examples which continually recur within the debates as leitmotifs to become generalized as representing the reality of the woman who seeks abortion.

Two important constructions of woman used within the debates may be broadly (though not always consistently) identified with the reformer/opponent split. Thus, I would argue, whilst the reformers represent the woman who would seek to terminate a pregnancy as an emotionally weak, unstable (even suicidal) victim of her desperate social circumstances, the conservatives view her as a selfish, irrational child. This schema is inevitably a simplification and imposes a unity and coherence which is doubtless lacking, but nonetheless it is useful in understanding and highlighting the way that women are represented in the debates. In view of Carol Smart's timely warning that it is important to analyse how the female legal subject is constituted in classed and raced as well as gendered terms (1992; 10), this distinction might productively be analysed in terms of class. In this sense the poor, working class woman fits the model of the unstable and desperate "multi-child mother"[5] who will have to resort to a

[5] Lyons, H.C. Deb. Vol. 732, Col. 1089, 1966 (22 July).

cheap and dangerous abortion in the back streets should legal relief be denied her. On the other hand, the rich, educated middle class (working) woman is open to charge of selfishness for choosing to have a career rather than raise a child and choosing abortion when she can afford to have a child.

Here I will go on to outline three images of femininity that were presented in the debates: the woman as minor (a), the woman as victim (b), and finally an image advocated by proponents and opponents of reform alike, woman as mother (c). In the following section (section 3), I will go on to address how these assumptions have been incorporated into the 1967 Act.

a) woman as minor

The conceptualisation of women as minors, is often to be found in the narrative of the opponents of abortion (although normally in their accounts the central place would be ceded to the foetus). Here, the woman is posited as a minor in terms of immaturity or underdevelopment with regard to matters of responsibility, morality, and even to her very femininity or 'womanliness'. Her decision to abort is trivialised and denied rational grounding, being perceived as mere selfishness: she will abort, "according to her wishes or whims"[6], for example, in order to avoid the inconvenience of having to postpone a holiday. She is immoral for being sexually active for reasons other than procreation; she is irresponsible for not having used contraception, and now for refusing to pay the price for her carelessness; she is unnatural and 'unwomanly' because she rejects the natural outcome of sexual intercourse for women: maternity. There is a hint that one day she will come to realise the error of her ways and want children, yet may be unable to have them as a result of the abortion[7].

Jill Knight, a Conservative M.P. and one of the leading opponents of reform, plays heavily on the idea of the woman as selfish and irresponsible within the debates leading to the 1967 Act. She reveals an image of women seeking abortion as selfish, treating "[b]abies...like bad

[6] Mahon, H.C. Deb. Vol 750, Col. 1356, 1967 (13 July).

[7] See for example the comments of Knight, H.C. Deb. Vol. 749, Col. 932, 1967 (29 June); Glover, H.C. Deb. Vol. 749, Col. 971, 1967 (29 June).

teeth to be jerked out just because they cause suffering...simply because it may be inconvenient for a year or so to its mother"[8]. She later adds that "[a] mother might want an abortion so that a planned holiday is not postponed or other arrangements interfered with"[9]. The ability and willingness of the woman to make a serious decision regarding abortion, considering all factors and all parties is dismissed. Rather (like a child) she will make a snap decision for her own convenience. The task of the law is thus perceived essentially as one of responsibilisation: if the woman seeks to evade the consequences of her carelessness, the law should stand as a barrier. Knight argues that allowing women to take the 'easy way out' encourages them to be irresponsible:

"[p]eople must be helped to be responsible, not encouraged to be irresponsible...Does anyone think that the problem of the 15-year-old mother can be solved by taking the easy way out?...here is the case of a perfectly healthy baby being sacrificed for the mother's convenience....For goodness sake, let us bring up our daughters with love and care enough not to get pregnant and not let them degenerate into free-for-alls with the sleazy comfort of knowing, 'She can always go and have it out'"[10].

By forcing her to continue with the pregnancy then, the law will seek to ensure that the pregnant woman will be more responsible in the future (an application of the old adage that she has made her bed, and now must lie in it). As one M.P. comments with regard to whether abortion should be allowed to a fifteen year old girl: "one needs to think twice before one removes all the consequences of folly from people"[11].

The woman who seeks abortion is also seen as morally immature, and hence undeserving of help. Simon Mahon asks who is to be given priority in terms of treatment: is it the "feckless girl who has an unwanted pregnancy from time to time" or the "decent married woman who is awaiting investigation or treatment for sterility?"[12] The use of this rhetorical trick which

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[8] Knight, H.C. Deb. Vol. 732, Col. 1100, 1966 (22 July).

[9] Knight, H.C. Deb. Vol. 749, Col. 926, 1967 (29 June).

[10] Knight, H.C. Deb. Vol. 732, Col. 1101, 1102-3, 1966 (22 July).

[11] Maude, H.C. Deb. Vol. 732, Col. 1121, 1966 (22 July).

[12] Mahon, H.C. Deb. Vol. 749, Col. 1046, 1967 (29 June).

opposes the "feckless girl" to the "decent married woman" serves to emphasise that the girl is not only feckless but is also indecent and unworthy of respect. Such juxtapositions form a recurrent theme in anti-choice discourse. Prof. Jeffcoate (an implacable opponent of the *Abortion Act*, and subsequent President of the Royal College of Obstetricians and Gynaecologists), speaking after the decriminalisation of abortion, asked:

"[i]s it right that the promiscuous girl, who has not troubled to practise contraception should have priority over the decent married woman who has been waiting perhaps twelve months for admission for investigation of sterility?" (in Kitzinger; 1978; 366).

In more recent years, as Smart has noted, the construction of women seeking abortions as immoral and self-interested has become more dominant, and the extent of their guilt is compounded by placing them alongside a growing recognition of the problem of infertility. She asserts that:

"[t]he juxtaposition of images of women who want children, but cannot have them, with (misconstrued) ideas of the woman who gets pregnant carelessly and then, apparently equally carelessly, terminates her pregnancy, creates an antipathy towards the latter" (Smart; 1989; 148).

Several participants in the Parliamentary debates give voice to an implicit assumption that it is morally wrong for women to make a distinction between sex and procreation - women should not indulge in sex, if pregnancy is not desired. William Deedes makes these sentiments clear in expressing his concern that: "science and its little pill will enable so-called civilised countries to treat sex more and more as a sport and less and less as a sacrament in love, a divine instrument of procreation"[13]. Perhaps the single most telling quotation here comes from David Steel himself, defending a clause to allow abortion in cases of rape[14], which was eventually dropped after debate in Parliament, for reasons that were discussed in chapter 2 (pp. 37-8), and will be further developed below (pp. 60-2). He states:

"[m]ost honourable Members would agree that to have a woman continue with a pregnancy which she did not wish to conceive, or in respect of which she was incapable of expressing

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[13] Deedes, H.C. Deb. Vol. 732, Col. 1092, 1966 (22 July).

[14] The clause sought to allow abortion to "a pregnant woman being a defective or becoming pregnant while under the age of 16 or becoming pregnant as a result of rape".

her wish to conceive, is a practice which we deplore, but the difficulty is to find an acceptable wording which will enable termination to be carried out following sexual offences of this kind but which does not allow an open gate for the pretence of sexual offences"[15].

What is startling here is Steel's correlation of "a pregnancy which she did not wish to conceive" with conception following rape. Steel fails to imagine that the vast majority of requests for abortion will be for pregnancies that the woman did not wish to conceive[16]. In using this argument to justify abortion in cases of rape, he implicitly equates consensual intercourse with desired conception. Wanting sex equals wanting pregnancy equals wanting motherhood.

b) woman as victim

The second narrative account strongly present in the Parliamentary debates is that of woman as a victim of poverty and harsh social circumstances. This construction is typically that of the reforming forces, where the woman and her social situation enjoy a far more central place. The reformers here seek to capitalise on the public sympathy for women facing unwanted pregnancy, given the highly restricted access to legal abortion for poorer women, and the well known consequences of backstreet abortions as described in chapter 2. Newspapers, magazines and books had reported horror stories of backstreet and self-induced abortions, and as David Steel noted in the debates, in the years preceding the introduction of the *Abortion Act*, an average of thirty women per year were dying at the hands of criminal abortionists[17]. Further, the well publicised thalidomide cases had contributed to public sympathy for the woman carrying a handicapped foetus.

The image of the woman seeking abortion here draws her as "not only on the fringe, but [as] literally, physically inadequate" (Greenwood and Young; 1976; 76). She is presented as

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[15] Steel, H.C. Deb. Vol. 730, Col. 1075, 1966 (22 June).

[16] Although, of course, it is possible that in certain circumstances a woman might wish to conceive and subsequently change her mind, it is difficult to believe that this is the norm rather than the exception.

[17] Steel, H.C. Deb. Vol. 750, Col. 1350, 1967 (13 July). This is presumably based on the official statistics of 35-40 deaths per year, which I cited in chapter 2. As I explained there, there is every indication that the real figure was far higher, see footnote 28.

distraught, out of her mind with the worry of pregnancy (possibly because she is young and unmarried, but normally because she already has too many children). She is desperate, and should the doctor not be able to help her, her potential actions are unpredictable (suicide is discussed)[18]. Her husband is either absent or an alcoholic, her housing situation is intolerable. She is at the end of her tether simply trying to hold the whole situation together. As Madeleine Simms, of the Abortion Law Reform Association (ALRA), later wrote: "[i]t was chiefly for the worn out mother of many children with an ill or illiterate or feckless or brutal or drunken or otherwise inadequate husband that we were fighting" (1985; 81).

Lord Silkin was one of the most eloquent exponents of this narrative, and he had many opportunities to develop it during the passage of his own Bill in the House of Lords[19]. The following letter to him, which he read to the House of Lords during the second reading of his own Bill in 1965 provides a typical and tragic illustration of the woman to be helped, as envisaged by the reformist forces:

"Dear Lord Silkin, I am married to a complete drunk who is out of work more than he is in. I have four children and now at 40 I am pregnant again; I was just beginning to get on my feet, and get some of the things we needed. I've been working for the last three years, and cannot bear the thought of that terrible struggle to make ends meet again. I've tried all other methods that I've been told about; without success, so as a last resort I appeal to you - please help me if you possibly can" (cited in Hindell and Simms; 1971; 80).

The same kind of image is also repeatedly drawn in the House of Commons, where one M.P. speaks of "the mothers with large families and the burdens of large families very often with low incomes"[20]. Another describes the illegal abortions he knows of:

"I have represented abortionists, both medical and lay. I have, therefore, met the 30s. abortion with Higginson's syringe and a soapy solution undertaken in a kitchen by a grey-faced woman on a distracted multi-child mother, often the wife of a drunken husband. I have also come across the more expensive back-bedroom abortion by the hasty medical man whose

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[18] See for example: Strange, H.L. Deb. Vol. 274, Col. 1235, 1966 (23 May).

[19] By mutual agreement with the ALRA, Silkin dropped his Bill so that the reformers could concentrate on getting the Steel Bill through the House of Commons (see Hindell and Simms; 1971; 154).

[20] Dunwoody, H.C. Deb. Vol. 732, Col. 1096, 1966 (22 July).

patient returns to a distant town, there to lie in terror and blood and without medical attention"[21].

Even Bernard Braine, a vocal opponent of the Bill, accepts the image of the woman presented by the reformers:

"[t]he hope of the sponsors of the Bill is to change the law that many abortions which take place at the moment illegally - either in the back streets or, self-induced by some poor unfortunate woman, driven to desperation - shall be brought into the framework of legality"[22].

The woman who wishes to terminate her pregnancy is portrayed as someone who is not completely in control of her actions and who may be driven to madness if relief is denied to her. David Owen states that:

"[s]uch a woman is in total misery, and could be precipitated into a depression deep and lasting. What happens to that woman when she gets depressed? She is incapable of looking after those children so she retires into a shell of herself and loses all feeling, all her drive and affection"[23].

Here again, we see worries for the health of the woman related back to concern for the well-being of the family (see chapter 2, pp. 28-9). A more extreme example is the tragic story related by Lena Jeger, M.P. which I mentioned in chapter 2 (p. 27). An "honest young woman" with five children, recently deserted by her husband, who was refused an abortion because "she did not seem quite depressed enough". The woman was forced to continue the pregnancy, and her depression following the birth of her sixth baby was so extreme, that she killed the baby by throwing it on the floor. The woman was now in Holloway prison, the children in care[24]. Lord Strange notes that "nearly every woman in this condition [of unwanted pregnancy] would be in a state bordering on suicide"[25]. The woman's irrationality

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[21] Lyons, H.C. Deb. Vol. 732, Col. 1089, 1966 (22 July).

[22] Braine, H.C. Deb. Vol. 747, Col. 496, 1967 (2 June).

[23] Owen, H.C. Deb. Vol. 732, Col. 1115, 1966 (22 July).

[24] Jeger, H.C. Deb. Vol. 749, Col. 977-8, 1967 (29 June).

[25] Strange, H.L. Deb. Vol. 277, Col. 1235, 1966 (23 October).

is sometimes conceptually linked to her pregnant condition, as David Owen states, for example: "[t]he reproductive cycle of women is intimately linked with her psyche"[26]. This pathologises women, playing on the notion of female behaviour as dominated and controlled by biology, with women 'existing through their ovaries'[27].

This image of the desperate woman is emphasized by contrasting it with the cool impassive figure of the doctor (described in chapter 2, pp. 34-5). The doctor represents a calm, responsible, rational and reassuring male figure - everything that the woman is not.

c) woman as mother

The image of the woman as mother is appropriated in the cause of reformists and conservatives alike. Only in the 1990 debates do (some) M.P.s feel able to challenge the inevitability of maternity for all women[28]. In 1966-7, however, for the conservatives, the woman who rejects maternity is seen to reject the very essence of womanhood. Kevin McNamara provides a strong account of woman's maternal instinct:

"[h]ow can a woman's capacity to be a mother be measured before she has a child? Fecklessness, a bad background, being a bad manager, these are nothing to do with love, that unidentifiable bond, no matter how strange or difficult the circumstances, which links a mother to her child and makes her cherish it"[29].

This implicit assumption of woman as mother is further reflected in the consideration of her existing responsibilities to children and family (and an apparent inability to see her outside of this role of wife and mother). Jill Knight informs us that: "if it comes to a choice between the mother's life or the baby's, the mother is very much more important". This is not however, because the woman is more important in her own right, but rather because "[s]he

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[26] Owen, H.C. Deb. Vol. 732, Col. 1113, 1966 (22 July).

[27] The phrase belongs to Victor Jozé (1985) cited in Laqueur (1990; 149). See Thomson (forthcoming 1995) for an exposition of medical discourse concerning women in the nineteenth century, and the way that these perceptions connect with the regulation of abortion.

[28] See especially the speech of Theresa Gorman, cited at pp. 211-2.

[29] McNamara, H.C. Deb. Vol. 732, Col. 1129, 1966 (22 July).

has ties and responsibilities to her husband and other children"[30].

The reformists seek to capitalise on the idea of maternity as the female norm, rather than to challenge it. Madeleine Simms of the ALRA argued that it was precisely the woman with a fully developed 'maternal instinct' who might require an abortion. She pointed out that most women wished to have not more than two or three babies and were appalled if they found they were having more children than they believed they could adequately care for. Should they accidentally become pregnant, she argued, they would then seek an abortion because of their feelings of responsibility to their husband and family, and because of their maternal instinct towards their existing children (1985; 81). Likewise, another prominent reformer, Alice Jenkins wrote that: "the principal beneficiary under a new law would be the decent mother of a family who has as many children as she can cope with" (1960; 47). In the House of Lords, Joan Vickers reinforces these ideas and sums up sentiments which are often expressed or implicit in statements of other M.P.s when she notes that: "I think that most women desire motherhood. It is natural for a woman to want to have a child...It is only in extreme cases that a woman wants to terminate her pregnancy"[31]. In defending the need for a social clause (to allow abortion where the woman's social and economic circumstances are deemed inadequate) within the Act, Roy Jenkins argued that without the presence of such a clause, "many women who are far from anxious to escape the responsibilities of motherhood, but rather wish to discharge their existing ones more effectively, would be denied relief"[32]. Edward Dunwoody asserts in similar vein that in:

"many cases where we have over-large families the mother is so burdened down physically and emotionally with the continual bearing of children that it becomes quite impossible for her to fulfill her real function, her worthwhile function as a mother, of holding together the family unit, so that all too often the family breaks apart, and it is for this reason that we have all too many problem families in many parts of the country"[33].

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[30] Knight, H.C. Deb. Vol. 732, Col. 1104, 1966 (22 July).

[31] Vickers, H.L. Deb. Vol. 276, Col. 1108, 1966 (22 July).

[32] Jenkins, H.C. Deb. Vol. 732, Col. 1144, 1966 (22 July).

[33] Dunwoody, H.C. Deb. Vol. 732, Col. 1098, 1966 (22 July).

Dr Winstanley (Steel's close party colleague and medical adviser for the Bill) makes the related argument that women should be allowed to abort handicapped foetuses, because the woman who is forced to give birth to a handicapped child will seldom allow herself to become pregnant again[34]. Implicit here is an understanding of the role of law as being to protect and entrench motherhood, to encourage women to adopt the maternal role.

3. THE *ABORTION ACT*: A MORE SUITABLE MODEL OF CONTROL

In his concluding speech before the final vote, David Steel asserted that the *Abortion Act* (or as it then was the Medical Termination of Pregnancy Bill) is what a "reasonable man would regard as a reasonable statement of the law"[35]. Indeed, this impression of 'reasonable compromise' pervades much of what has been subsequently written on the Act. The Act is often depicted as a balancing act between two competing sets of rights: the right to life of the foetus versus the right to choose (right of self-determination) of the woman. However, as various commentators have argued, if the law aims to protect and entrench any rights it is not those of the woman (nor indeed those of the foetus) but rather those of the doctor (Fyfe; 1991, Berer; 1988, Clarke; 1990). I would argue that if the law has achieved any sort of compromise, it is by way of a reconciliation of the competing narrative accounts of the kind of woman who would seek abortion which I have outlined above. In this section, I aim to show how law has incorporated and entrenched certain aspects of these narratives, in working with certain assumptions about women's maternal role (section a), and the essential irresponsibility (section b) and sexual immorality (section c) of the woman who would seek to terminate a pregnancy. In its embodiment and entrenchment of these assumptions, the law itself (re)creates the peripheral, deviant subject which it will then seek to discipline and regulate. Equally it simultaneously reinforces the image of the good woman who does not seek to terminate her pregnancy and who provides the norm against which such deviance is to be measured.

a) An assumption of maternity as the normal role for women

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[34] Winstanley, H.C. Deb. Vol. 749, Col. 1059, 1967 (29 July).

[35] Steel, H.C. Deb. Vol. 750, Col. 1346, 1967 (13 July).

The assumption of maternity as the female norm is reflected both in terms of the very structure of the law and in specific provisions which allow abortion in cases where the continuance of a pregnancy would involve injury to the health of any existing children of the woman's family. The need for intervention is felt to be justified not merely on the basis of a woman's own health and well-being, but also by that of her family: "in the name of the responsibility they owed to the health of their children, the solidity of the family institution and the safeguarding of society" (1979b; 147).

As was seen above, the law regarding abortion functions in terms of a blanket ban (the *Offences Against the Person Act*, 1861) which renders abortion illegal. The *Abortion Act* offers a defence against this law where two doctors deem that the circumstances of the individual woman fall within the general categories which are laid out within section 1 of the Act. The decision to abort is not seen as an intrinsically acceptable one, as a choice which any woman could face at some time in her life. Rather, it is an option which may be justified only in certain cases by the individual circumstances (or inadequacies) of individual women, on the opinion of two doctors. Conceptually then, abortion stands as the exception to the norm of maternity. No woman can reject motherhood. The only women who should be allowed to terminate pregnancies are those who can do so without rejecting maternity/familial norms per se, in other words, those who have reasons to reject this one particular pregnancy without rejecting motherhood as their destiny in general. In this sense, women who are carrying the wrong sort of foetus, who have obligations to meet to existing children, or whose living conditions are at present inadequate for a child will be allowed by doctors to terminate a pregnancy. Likewise, it was felt that where the particular pregnancy was thrust upon the woman through rape or incest, the doctor should be free to authorise termination.

In this way, for example, section 1(1)(b) of the Act provides that abortion can be allowed where "there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped". Whilst clearly displaying eugenicist considerations[36], I feel that this clause can also be interpreted with regard to the

[36] There is much debate in Parliament on this issue, which revolves around the number of healthy foetuses which must be sacrificed in order to pick out damaged ones. This appears to give official sanction to the notion that the lives of the handicapped are of less value than

status of the woman. It was justified in part on the grounds that to force a woman to carry an abnormal child to term will discourage her from future pregnancy[37] and, as Dr Winstanley points out that "[i]n every case the duty of the medical practitioners should be, wherever possible to encourage aid and support the mother towards term with the pregnancy"[38]. The handicapped baby or child is not seen as being as desirable as a 'normal' one and does not feature in the romanticized family ideal. As Dr Winstanley says of the woman who has a higher than normal chance of giving birth to a handicapped baby: "this mother does not know whether she will get a baby which will make her very happy or one which will make her very sad"[39], Thus, the woman can reject this (abnormal) pregnancy without rejecting the whole institution of motherhood itself.

The woman's role as mother is again emphasised where s.1(1)(a) of the *Abortion Act* allows abortion where the continuance of a pregnancy "would involve...injury to the physical or mental health of...any existing children of her family". The woman is allowed to reject pregnancy in order to fulfill her existing responsibility as a mother more effectively. Here again, she is seen to reject one particular pregnancy, rather than motherhood itself. Indeed, she may reject this particular pregnancy in order to be a better mother to those children already in her family. This idea is still more clearly embodied in the wording of Steel's original *Medical Termination of Pregnancy Bill* which stated as a separate head for abortion: "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" (clause 1(1)(c)). It is perhaps worthy of note

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the able-bodied. For example, Peter Mahon, M.P. for Preston South: "It is argued that if a mother has a particular disease in pregnancy...there is a chance that her child will be deformed in some way. But *the real tragedy would be that a large number of perfectly normal unmaimed human lives are to be sacrificed for the sake of one who would be born with some physical deformity.* What kind of morality is that?" Mahon, H.C. Deb. Vol. 750, Col. 1358, 1967 (13 July), my emphasis. Likewise: "[s]urely it would be more reasonable to have the odd malformed child than to take the risk of killing a normal foetus." Galperin, H.C. Deb. Vol. 749, Col. 1065, 1967 (29 June). For a strong criticism by a disabled feminist of the provision of abortion for reason of foetal handicap, see Morris (1991).

[37] Winstanley, H.C. Deb. Vol. 749, Col. 1059, 1967 (29 June).

[38] Winstanley, H.C. Deb. Vol. 749, Col. 1055, 1967 (29 June).

[39] H.C. Deb. Vol. 749, Col. 1057, 1967 (29 June).

that the version which is eventually incorporated into the *Abortion Act* only allows termination on this ground where the woman already has children, where the original version included it equally where the child would be a woman's first. This may be seen to reflect the image of the overstrained "multi-child mother" who wishes to terminate one pregnancy in order to care better for her existing family. The image of a woman who simply does not want or cannot cope with any children at all is not present in these Parliamentary debates.

b) Female irresponsibility

Section 1(1) of the *Abortion Act* provides that:

"[s]ubject 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 two registered medical practitioners are of the opinion, formed in good faith...[that various conditions are fulfilled]".

The peripheral female subject conceived of within the *Abortion Act* is clearly treated as someone who cannot take decisions for herself. Rather responsibility is handed over to the reassuringly mature and responsible (male) figure of the doctor. Thus, the legislation here assumes that the doctor will be better equipped to judge what is best for the woman, even though he/she may never have met her before, and even though he/she may have neither knowledge of, nor interest in, her concrete situation. The entrenchment of such a construction in law is in a close relationship with the images of woman deployed in the debates. If the woman is distraught and irrational, then she is an unsuitable party to take such an important decision. Indeed she inevitably, by her very nature, lacks the necessary emotional *distance* to make such a decision in a considered way. Equally, if she is selfish and self-centred, intellectually and morally immature, portrayed as only considering her own needs, and giving no weight to other factors (such as the claims of the foetus) in her snap decisions, she is again incapable of making such an important choice. She is thus in need of the normalising control of the doctor to impose either calm and rationality or morality and consideration of others.

The power of doctors in the field of abortion is very often justified by the argument that abortion is essentially a medical matter. However, the actual decision whether or not a given pregnancy should be terminated is not normally one that requires expert medical advice, or the balancing of medical criteria. Further, the doctors' decision-making power is not here

contained within a narrow, limited medical field. In judging whether or not abortion could be detrimental to the mental or physical health of the pregnant woman or existing children of her family, "account may be taken of the pregnant woman's actual or reasonably foreseeable environment" (s.1(2)). The woman's whole lifestyle, her home, finances and relationships are opened up to the doctor's scrutiny, so that he/she may judge whether or not she is a deserving case for relief. This relates to the popularisation of the notion that social factors are inseparable from medical ones. Steel argues that:

"social conditions 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" (1971; 7).

This represents an ongoing expansion of the authority of the medical professional over an ever greater area of human life. As Foucault writes: "[t]he questions to be asked are innumerable; the things to be seen infinite" (1989b; 111).

It is also worth returning to the proposed rape clause, included in Steel's original bill, notable by its absence in British statute. Arguments for allowing abortion in the case of rape were dismissed for a combination of reasons, some of which I have already discussed (see chapter 2, pp. 37-8). First, despite widespread agreement that a woman who had been raped should be allowed to terminate any resulting pregnancy (Hindell and Simms; 1971; 185), it was felt that she would already have access to abortion under the law as it stood[40]. Secondly, as was noted in the previous chapter, medical groups opposed the inclusion of a clause which explicitly decriminalised abortion in case of rape, as they felt that this would lead women to assert a right to termination in that circumstance. Thirdly, it was argued that the woman could not be trusted to tell the truth about whether she has been raped. As one M.P. noted: "[w]e also know that a great many charges of rape are made which are quite unfounded and which are made for quite different motives"[41]. Bernard Dickens explains the decision not

[40] i.e. under section 1(1)(a) *Abortion Act*, 1967, continuance of the pregnancy would involve risk of injury to her mental health. There is also some contention as to whether abortion in case of rape might still be permissible on the basis of the pre-existing common law, and notably ***R v Bourne*** (see pp. 105-6). On the issue of whether *Bourne* was completely superseded by the *Abortion Act* see Smith and Hogan (1988; 372).

[41] Wells, H.C. Deb. Vol. 732, Col. 1086, 1966 (22 July).

to include a specific rape clause in that were it to be included: "women would have a stronger inducement to allege that an unwanted or embarrassing pregnancy had been imposed by rape." He goes on:

"This crime always poses problems of definition. The differences between rape and determined 'masculine' seduction can be fine, and the presence or absence of consent can sometimes be impossible to find conclusively. Further, a woman may provoke her own rape by finally withholding consent from a man who is unable to control the passion she has deliberately aroused. At present, charges of rape are occasionally found where a woman wishes to protect her reputation, for example, where she is unmarried, but the prospect of having the pregnancy terminated, without anyone having to be prosecuted or convicted, would be an attraction which some women might find hard to resist" (Dickens; 1966; 139).

Were it somehow possible for the verification of the occurrence of rape to fall within the competence of doctors, however, this might well have been sufficient for this clause to have survived to be included in the text of the *Abortion Act*: "if there were a way in which doctors could decide whether or not a lady had been raped, I would be content to allow the provision on rape to go in"[42], says one M.P.. An attempt to formalise in law such a requirement for medical verification was envisaged in Steel's original *Medical Termination of Pregnancy Bill.* A separate heading (s.1(1)(d)) allowed termination in the case of rape, with s.1(2)(4) providing that:

"[a] termination of pregnancy performed on the ground of rape shall require the certificate of a registered medical practitioner consulted by the patient freshly after the alleged assault that there was the medical evidence of sexual assault upon her".

Consideration of women's untrustworthiness in evidencing her own rape for the purposes of requesting abortion, forms an interesting parallel to the analysis offered in a recent article by Sheila Duncan. Duncan examines the requirement whereby the judge is obliged to warn the jury that it is unsafe to convict on the uncorroborated testimony of the rape victim, where the only evidence in a rape trial is her testimony[43]. Duncan notes that many justifications have been given of this warning, however she contends that:

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[42] Hobson, H.C. Deb. Vol. 732, Col. 1138, 1966 (22 July).

[43] However, the judge also has to point out that it is open to the jury to convict in the absence of corroboration if satisfied that the testimony is true.

"[a]t the root of them in respect of rape is the notion that the complainant in sexual matters may be falsely accusing the defendant as a result of a refusal to admit consent and accept responsibility for the sexual events which have occurred with the defendant".

She concludes that: "[t]he female Other is constructed as inherently untrustworthy" (1994; 16).

c) Female sexuality

The *Abortion Act* contains a strong moral element, distinguishing between categories of deserving and undeserving 'victims' of unwanted pregnancy. The former are allowed abortions, the latter denied them. This distinction works on the one hand with regard to whether or not intercourse was wanted and, on the other, with regard to whether the woman has a legitimate reason for changing her mind following conception - i.e. she did want to get pregnant, but now wants to reject this particular pregnancy (because of foetal handicap).

Although, unlike most other Western European statutes, the 1967 Act does not explicitly foresee abortion for cases of pregnancy resulting from rape or incest (for the reasons noted above), there are still lengthy discussions of this matter in Parliament which are informative with regard to perceptions of female sexuality. There was practically unanimous agreement that women should be allowed abortion in case of rape, although the clause which allowed it within the statute was deleted for the reasons discussed above, and notably that it "is already enshrined in the Bill as amended"[44] and women who were the victims of rape or incest would already be allowed abortion under the other provisions of the Act. Here then the woman who did not desire sex and hence did not make a distinction between sex and procreation should be allowed by doctors to terminate her pregnancy.

It have argued above that the provision with regard to handicap (s.1(1)(b)) is strongly influenced both by eugenic considerations, and the construction of woman as mother. This clause also, I would argue, bears some relation to constructions of women's sexuality, as it serves to provide a 'get-out clause' for good women who want to become pregnant (and thus do not commit the sin of making the fatal distinction between sex and procreation), but through no fault of their own happen to be carrying a foetus 'of the wrong sort'. The form

[44] Knight, H.C. Deb. Vol. 742, Col. 322, 1967 (1 March).

adopted by the legislation refuses to legitimate a disassociation of sex and procreation. Avoidance of procreation remains something which can only be justified by the inadequacies of a particular woman or a problem with a specific pregnancy.

4. CONCLUSIONS

"At the end of this catalogue of all the various kinds of medical conditions or adverse situations where abortion may be the best course, it may be asked if the reformers considered the woman who simply did not want to give birth to the embryonic child inside her...[I]t is an injustice to the well-adjusted, healthy woman that she cannot get the same relief from a pregnancy as her inadequate or overstrained, or unmarried, or rubella-infected, or incestuous sisters. One wing of the reform movement in fact did feel there was a need for abortion for all on request. They acknowledged, however, that politically this idea was far too radical to gain public acceptance and parliamentary approval" (Hindell and Simms; 1971; 24-5).

Deviance, like beauty, lies in the eye of the beholder. Quinney has written:

"crime is a definition of human conduct that becomes part of the social world...Criminal definitions in their official formulations...are the most powerful means of social control used to control actions which conflict with the interest of those who create these criminal definitions" (in Lacey et al; 1990; v).

However, law does more than draw lines between acceptable and unacceptable behaviour, in order to define dev*iance*. Law also constructs dev*iants*: it acts not on a pre-existing external, knowable individual, but itself (re)creates this individual, drawing upon and entrenching certain social assumptions and stereotypes. The aborting woman is given a particular subjectivity within the 1967 Act. She is identified as a peripheral subject with certain characteristics and inadequacies. In this sense, I have argued that the *Abortion Act* is predicated upon certain ideas of maternity as the female norm, female irresponsibility and emotional instability and implicit assumptions about appropriate female sexual morality. It is thus the woman's own nature which serves as a basis for legitimating the particular modality of normalising medical control adopted within the 1967 Act. The Act stands as a kind of snapshot of the times: a (re)construction of certain prevalent social female norms.

Women seeking abortion, more than any women, are 'hysterized', medicalised "in the name of the responsibility they owed to the health of their children, the solidity of the family

institution, and the safeguarding of society" (Foucault; 1979b; 147). Inherent female pathology is exacerbated by pregnancy. This redefining of 'woman' combined with a gradual redefinition of birth as a medical event, meant that medical control was the obvious 'solution'. Foucault writes of:

"a threefold process whereby the feminine body was analyzed - qualified and disqualified - as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practices, by reason of a pathology intrinsic to it; whereby, finally, it was placed in organic communication with the social body (whose regulated fecundity it was supposed to ensure), the family space (of which it had to be a substantial and functional element), and the life of children (which it produced and had to guarantee, by virtue of a biologico-moral responsibility lasting through the entire period of the children's education): the Mother, with her negative image of "nervous woman," constituted the most visible form of this hysterization" (1979b; 146-7).

With the construction of the woman seeking termination drawn in this way, medical control becomes the obvious solution. There can be no doubt that it is imperative to get such a woman into the safe hands of her GP, so that he/she can take control and 'manage' the problem in the best interests of the woman herself, her family and the broader society. "If we can manage to get a girl such as that into the hands of the medical profession, the Bill is succeeding in its objective", argues David Steel[45].

It is not only the aborting woman who is constructed in the 1967 Act, however. The subjectivity created here must be read alongside an implicit assumption of the 'normal' woman. The aborting woman is simultaneously the paradigmatic example and the antithesis of this female norm. In one sense she is its natural conclusion, standing as an extreme example of female instability and irrationality. In her attempt to deny maternity, the natural (and desired) destiny of the good woman, however, she is also its alter ego. In these senses, the female norm of the 'good woman' is simultaneously (re)constructed and enforced by the creation of her deviant sister.

[45] H.C.Deb. Vol. 750, Col. 1349, 1967 (13 July).

CHAPTER 4: ABORTION, REPRODUCTION AND THE DEPLOYMENT OF MEDICAL POWER

"Of course there is room for variation in opinion. All we can say is that we have to rely on the ethics of the medical profession to act in good faith. I accept that, just as there are bad Members of Parliament and clergymen, so there are bad doctors"[1].

"This new structure [of the clinic] is indicated - but not, of course, exhausted - by the minute but decisive change, whereby the question: 'What is the matter with you?' with which the eighteenth-century dialogue between doctor and patient began...was replaced by that other question: 'where does it hurt?', in which we recognize the operation of the clinic and the principle of its entire discourse"[2].

"[O]ne must distinguish between the purely technical activities of treatment and the social interaction and manipulation surrounding those acts...The former is clearly founded on medical science, that special knowledge of the profession which justifies its autonomy; the latter is not"[3].

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[1] Steel, H.C. Deb. Vol. 171, Col. 205 1990 (24 April).

[2] Michel Foucault (1989b; xviii).

[3] Friedson (1970; 342).

1. INTRODUCTION

In previous chapters I have argued that the *Abortion Act* represents a shift from a model of law based on prohibition to one which seeks to manage and regulate abortion by locating power in the hands of the medical profession. I have also suggested that a study of the regulation of abortion as a way of controlling women would be best to start by an examination of the workings of power "in its extremities" that is, at the level of medical practice, rather than in legitimate, regulated, central locations (such as the state) (Foucault; 1980b; 99). With this in mind, it is important to outline exactly how power can be deployed at the level of a request for a termination, and this will form the focus of the present chapter. This represents a shift from a focus on the aims of the legislation to consideration of its effects: an assessment of some of the operations of medical power in practice, following the introduction of the 1967 Act.

The analysis of this chapter will progress from the very general to the quite specific. First, I will deal briefly with the doctor-(female) patient relationship (section 2). Secondly, I will narrow the focus to look at the particular operation of this relationship in the case of reproduction (section 3). Lastly, and most specifically, I will analyse the way that power is deployed through the doctor-patient relationship in the case of a request for pregnancy termination (section 4). I will here distinguish between four deployments of power, which I describe as technical, decisional, paternalistic and normalizing control.

2. THE WOMAN AND HER DOCTOR

a) The Doctor-Patient Relationship

Medicine enjoys a very privileged position within modern society with a particularly strong claim of access to 'truth'. In a movement away from a narrow disease model of ill-health, the medical profession is capable of claiming jurisdiction far beyond that which it has traditionally enjoyed (Zola; 1972) and perhaps also beyond the confines of its basic technical competence, training and knowledge. Increasingly, the doctor increasingly takes responsibility for the patient's whole lifestyle.

Doctor and patient meet within the field of medical knowledge, where the doctor (by definition) speaks from a position of power and status. Medical statements cannot come from just anybody; their value, efficacy, even their therapeutic powers, and, generally speaking, their existence as medical statements cannot be dissociated from the statutorily defined person who has the right to make them, and to claim for them the power to overcome suffering and death (Foucault; 1989b; 51). The doctor is thus an expert with the whole body of medical knowledge behind him/her. The medical gaze is not the gaze of any observer, but that of a doctor supported and justified by an institution, and endowed with the power of decision and intervention (1989b; 89). The patient, on the other hand, is normally a lay person with access to medical knowledge only through the person of the doctor. As such, there is an inevitable and structural power dimension to any doctor-patient relationship (Roberts; 1985). This is more pronounced than in other expert/non-expert relationships (for example lawyer and client), as in the medical case the patient her/himself becomes the very object of study, and the doctor the one who can explain her/his illness and claim to understand her/him. Moreover, the basis of the authority of the doctor is the claim to overcome suffering and even death, which cannot be matched by other professionals. In this sense, the closest analogy might be to the power which was traditionally enjoyed by priests. Doctors are seen to hold powers over bodily health similar to the powers of the clergy over the soul: they are "a therapeutic clergy" or "priests of the body" (Foucault; 1989b; 32). Modern society has witnessed a shift from the centrality of religious knowledges to the new found pre-eminence of scientific rationality as the fundamental way of ordering and making sense of the world. In the case of understanding the human organism, medical science is now central[4]. The medical profession has taken over a large part of the function traditionally linked to the clergy as the guardians of social reality with a claim to identify abnormality, deviance and social disorder (Zola; 1977, Donzelot; 1979, Friedson; 1970): "[medicine] is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts" (Zola; 1977; 41). Doctors' credibility depends on their ability to make successful claims about the scientific value of their work and

[4] Indeed, medical science is fundamental in *constituting* the individual human organism, as Foucault showed medicine was the first to study the individual as such. Further as Foucault (1979b) and more recently Laqueur (1990) have argued, medical science is central to our understanding of the individuals as essentially coded male/female.

the way in which their medical knowledge is grounded in precise, accurate and reliable scientific information. The power of the doctor is to categorize and classify the patient within the medical framework (healthy/ill, normal/abnormal) and thus to claim the ability to understand, to treat and to cure.

Speaking of an inherent power dimension in the doctor-patient relationship, is not, however, to assert a straightforward and unilateral relationship of control of the individual doctor over the patient. Arney, in discussing the relationship between patient and doctor, draws an analogy with Foucault's work on the panopticon. Arney asks of the panopticon:

"[w]ho is in control? Certainly not the prisoner; but not the guards either. To speak of an agent of control in the panopticon is absurd since the machine is in control. As when a man walks a dog that carries its own leash in its mouth, neither party can claim to be in control. Rather the *situation is controlled* by the fictitious relationships created through history, in our case through the deployment of monitoring with its reformation of the doctor-patient relationship" (Arney; 1982; 231 - emphasis in original, see Foucault; 1991).

There is a power relationship *intrinsic* to the doctor patient relationship, which does not rely on the constant reassertion of authority by the individual doctor[5]. For both doctor and patient this is seen as the natural way of things[6]. Any challenge to the power basis in the doctor-patient relationship must therefore begin with a process of demystification. One step towards this is the recognition of medical discourse not as an abstract logical system, but as a specific cultural form (Foucault; 1989a, 1989b, Turner; 1987). Since these forms of rationality reside on a base of human practice and human history - since they have been made - they can be unmade (Raulet; 1983; 206).

b) The Case of the Female Patient

The power balance inherent in the doctor patient relationship can only be reinforced when it is overlaid by a (male doctor/female patient) gender relationship. First, women use health

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[5] "He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play simultaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault; 1991; 203).

[6] See Kitzinger (1978) for discussion of the medical training, and the argument that it is predicated on and serves to enforce and replicate this relationship of control.

services more frequently than men and are more subject to a routine, daily medical control (Roberts; 1985, Pfeffer; 1985, Davis; 1988a, Gardner; 1981; 130-1). Secondly, medical discourse constitutes women as *psychologically* and *socially* vulnerable and therefore in need of close medical surveillance, advice and guidance (Turner; 1987; 102, Scully; 1980; 14, see also, Ehrenreich and English; 1978, Showalter; 1987). Thirdly, the way that women are constructed within medical discourse often depicts them *biologically* as natural patients, at the mercy of their bodies or hormones (Turner; 1987; 109, see also Ehrenreich and English; 1978).

Medical involvement in the policing of female behaviour, and the restraint of potentially 'dangerous' feminine traits has been well documented. Medical texts have characterized women by irrationality, sexual passivity, and a desire for maternity (Martin; 1987, Scully and Bart; 1973, Merchant; 1980, Easlea; 1981) and various historical studies have demonstrated how doctors have acted to ensure female compliance with these constructions through such draconian measures as ovariectomies (Scully; 1980) or committal to psychiatric institutions (Smart; 1992c; 38)[7]. Further, in the late 19th century, the deployment of medical knowledge was integral to the attempts made to keep women in the home, through claims that studying outside it would damage their reproductive capacities (Ehrenreich and English; 1978, Thomson; forthcoming 1995). As one doctor put it: "[w]hy spoil a good mother by making an ordinary grammarian?" (cited in Thomson; forthcoming 1995).

Although the claims and methods of the medical science of more recent years seem (by and large[8]) far less dramatic, evidence of the same pattern of medical enforcement of appropriate female behaviour is still visible. Barrett and Roberts (1978) in their study of GPs and female patients, found that GPs and hospital specialists would often relate to women in terms of non-medical, social criteria in order to reinforce women's traditional social role (see also Roberts;

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[7] This was practised well into this century under the *Mental Defectives Act*, 1913, for unmarried mothers on the grounds of moral imbecility or feeble-mindedness.

[8] However, Hudson (1987) relates the case of a woman who developed obsessive behaviour as a result of living with a sadistic husband. The recommended medical 'cure' was to operate on her. Roberts (1985; 33) gives the example of another woman who, following an illness which consisted of a refusal to do any housework, was given a course of six ECT treatments and subsequently discharged as 'well' again.

1985).

"In consultation after consultation the GP smooths away the surface anxiety and adjusts the woman to the limitations of a life totally located in a home from which the children have moved away. In this respect the institution of medicine legitimates and endorses the status quo in relation to the position of women, and in so doing it fulfils an ideological function as an agency of disguised social control. We found that frequently doctors would use the authority of their medico-moral language to offer not neutral, clinical advice but a set of prescriptions based on the conventional wisdom of their own social milieu" (Barrett and Roberts; 1978; 42).

Likewise, Thomas notes that doctors are influenced by non-medical criteria in their determination of which contraception is suitable for which patient:

"[d]octor's perceptions of women's and men's contraceptive needs are based on assumptions about the social organisation of reproduction which support existing social and cultural norms" (Thomas; 1985; 63).

The role of the medical profession in policing and regulating women in line with certain norms of appropriate female behaviour thus has a long history. While doctors may have the role of "therapeutic clergy" for the whole of the population, their work is seen as doubly necessary with regard to female patients, who are characterised by an inherent pathology. This rests on a particular ideology of the nature of woman, her role and needs. It represents the double effect of medical relationship overlaid by conventional gender assumptions. The doctor-patient relationship is thus saturated with power: it is a relationship of expert/lay person, and the doctor with the full weight of medical science behind him/her has a strong claim to truth when he/she diagnoses and treats. This control relationship is reinforced when the doctor is male and the patient female.

3. MEDICAL CONTROL OF REPRODUCTION

"Nature is perfectly competent to bring without the assistance of man, a child into the world..Assist Nature! Can anything be more absurd? As though God in his wisdom...required the assistance of man" (Chavasse; 1832, cited in Oakley; 1984; 13).

"It is evident that the newborn outcome is controlled by events of multiple origins which take place even before conception. It can be seen that many of the factors can be attributed to genetic background and health as well as adolescence. These factors can be controlled in

part by parents, the government, and state or private agencies. Society certainly has a responsibility to develop programs in the community that can achieve this goal" (Roux et al. in Arney; 1982; 133).

Just over one hundred and sixty years ago, Chavasse dismissed the need for the medical supervision of childbirth. Since then, the perceived role of the doctor in the management of pregnancy has clearly undergone radical transformation, with the modern obstetric text clear in its assertion of the need for an appropriate program of surveillance and at times active intervention[9]. It is part of the common sense of the modern era that pregnancy and childbirth are too dangerous and important to be left in the hands of God, and must rather be taken in hand by man. This is of crucial importance to discussion of abortion, for as reproduction has fallen under medical control, so too has access to methods of *avoiding* birth by way of contraception and termination of pregnancy. The woman is seen to have the responsibility to actively embrace the medical help which she is offered in the interests of her own health and that of her family. When it is a matter of giving birth, the health of her foetus and her eventual child is dependent on her acceptance of medical control. The doctor becomes cast as the representative of foetal interests: the person objectively most able to ensure its well-being. In the case of a request for pregnancy termination, the doctor retains this role, becoming the agency responsible for ensuring that these interests are heard and weighed against those of the woman.

Reproduction is the singularly most important area where doctors operate control over women's lives (Oakley; 1981, 1984, 1986a, 1986b, Ehrenreich and English; 1978, O'Brien; 1981, Donnison; 1988, Arney; 1982, Roberts; 1981). Birth, a happening long controlled by women with help from friends, older women and midwives, has gradually fallen under a hegemonic medical control. Today, 98% of births in Britain take place in hospital and the number of births performed by caesarian section continues to increase (Bridgeman; 1993c).

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[9] For example, this extract from *Williams Obstetrics*: "[t]he widespread adoption of effective means for population control and consideration of their impact upon the well-being of current and future generations of offspring have logically accelerated interest in modalities for preserving and improving the health of the fetus and newborn infant...The health team providing care for the mother, fetus, and newborn infant currently must deal with an appreciably higher risk of unfavorable outcome unless an appropriate program of surveillance and at times active intervention is mounted" (cited in Arney; 1982; 137).

Whatever benefits the medicalisation of reproduction may have brought in the way of safety (and these are not undisputed[10]), it has also led to considerable erosion of women's autonomy. As reproduction has become more and more technologised, knowledge regarding it has become increasingly privatized, available only to the medically trained. This has provided the rationale for all sorts of reproductive decisions traditionally made by women (regarding pregnancy, contraception, infertility treatment[11] and abortion) to fall instead under medical control. Moreover, those doctors who try to provide a more woman-centred service and leave more choice to women as to how they wish to give birth, can face extreme hostility from their colleagues, as was clearly illustrated by the Wendy Savage case[12].

Ann Oakley provides the most thorough exposition of the medicalisation of reproduction in the British context (1981, 1984, 1986a, 1986b, 1987). She argues that this medicalisation is at once an aspect of the broader phenomenon of the medicalisation of daily life, and at the same time a specific exemplar and facilitator of the social control of women. She indicates two main stages in the medicalisation of pregnancy: its incorporation into medical discourse in the seventeenth and eighteenth centuries as a 'natural' state; and its gradual redefinition as pathology (Oakley; 1984; chapter 1, see also Ehrenreich and English; 1976; 15, Beech; 1985). With the definition of all pregnancies as potentially pathological, antenatal care obtained its final mandate which gave it an unprecedented degree of licence over the bodies and approved

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[10] Marjorie Tew has suggested that infant mortality was already in decline when obstetricians took over birth and that the increasing hospitalisation of birth, the focus upon abnormality and the employment of medical technology has actually slowed down the decrease in the infant mortality rate (in Bridgeman; 1993; 33, see also Gardner; 1981; 130).

[11] Most kinds of contraception and infertility treatments are available only on prescription from a doctor, who can frequently influence the patient as to which method is most suitable (Gillespie and Hubbard; 1986, Klein; 1989, Andrews; 1986, Roberts; 1981, Pollack; 1985).

[12] Wendy Savage was suspended from her post as Honorary Consultant in Obstetrics and Gynaecology to Tower Hamlets Health Authority in 1985 for alleged incompetence. In her (1986) book she forcefully argues that she was a victim of an ongoing power struggle about who controls childbirth. Her real crime had been to give women too much autonomy in the process. See also Young (1981), for an account of the difficulty of finding room to express female or feminist values within medicine.

lifestyles of women (Oakley; 1984; 2)[13]. Further, as the role of the doctor has become more central to birth, the role of the woman has become less so. Martin (1987) asserts that women have increasingly been seen only as machines, with the doctor as the technician who 'fixes' them:

"the dominant medical metaphors applied to women's bodies in menstruation, birth and menopause involve a hierarchical system of centralized control organized for the purpose of efficient production and speed. Medical attention usually is given when this system undergoes breakdown, decay, failure, or inefficiency" (Martin; 1987; 67)[14].

This medical 'take over' was no doubt more marked in the USA than in the UK. Notably, midwives were actually outlawed in the USA, which was not the case in the UK (Ehrenreich and English; 1976, Arney; 1982). Indeed, Arney notes that British obstetrics has accorded women a larger role in childbirth than is the case in the USA. He adds, however, that it might be more appropriate to say that obstetrics was organized so that it could pay attention to more aspects of the woman than simply the narrowly obstetrical ones (1982; 61). Arney discusses the expansion of the medical gaze through the person of the midwife who would select who was suitable for home or hospital confinement:

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[13] It seems that two basic innovations have been especially important in establishing this rationale of modern antenatal care: control of the timing of the onset of labour (Kitzinger; 1978) and the medical-professional claim to know what is going on inside the uterus better than the pregnant woman herself (Oakley; 1984; 27).

[14] This centrality of the doctor in the medical control of birth is reflected in the language which we use to describe it. Treichler (1990) points out the use of the verb 'to deliver' has changed in accordance with the growing medical control of birth. The construction traditionally used was: "she was delivered [i.e. liberated] of her child", which maintains the position of the woman as a subject. The present form, used from the 19th century onwards, of "he delivered her child" makes clear that it is a third party who is the one to have delivered or 'liberated' the child (Treichler; 1990; 129). Thus, she argues, technological and professional dominance is now enshrined within language - the birth process is now projected as interaction between doctor and foetus. This shift is also evident in medical textbooks which portray the woman as the "passive host" to the uterus (Martin; 1987; 59-61). One doctor explains that: "[n]ormal labor is the physiologic process by which *the uterus expels, or attempts to expel*, its contents...through the cervical opening and vagina to the outside world. Normal labor is characterized by periodic involuntary uterine contractions which produce gradual cervical effacement and dilation, as well as descent of the fetal presenting part" (in Treichler; 1990; 122).

"[t]he midwife's attention extended to the person, her beliefs, her concerns, and beyond her to the concerns of her relatives and to the environment in which she found herself. Midwives were instructed to select some women for hospital delivery for social reasons as well as for strictly medical reasons" (Arney; 1982; 61).

Rather than just seeking out and containing potential pathology, obstetrics turned its attention to developing systems of monitoring and surveillance of all birth. These mechanisms were originally expressly designed as part of a demographic policy to improve the quality of the nation in the years following the First World War, and reflected widespread fears triggered by the high infant mortality rate (Oakley; 1984). Whilst these fears may have subsided, the structures developed and the perceived need for them have survived. The medical control of pregnancy and birth is not limited to narrow medical considerations. Rather, every aspect of a woman's life becomes subject to the obstetrical gaze because every aspect of every individual is potentially important - obstetrically speaking (Arney; 1982; 154).

"Does [medical experience] not involve, because of the special attention that it pays to the individual, a generalized vigilance that by extension applies to the group as a whole?...One began to conceive of a generalized presence of doctors, whose intersecting gazes form a network and exercise at every point in space, and at every moment in time, a constant, mobile, differentiated supervision" (1989b; 19, 31).

The doctor then has come to be a key figure in a decentralized network of control.

The medicalisation of reproduction has received further legitimation from the perceived need to protect the foetus, and this has entrenched the development of techniques making it possible to see and monitor the foetus in utero. Whilst the figure of the woman fades into the background as the mere 'maternal environment' or 'grainy blur' at the edge of the image (Petchesky; 1987, Hartouni; 1991), the foetus itself comes to enjoy an increasingly central place as a separate candidate for medical attention. Despite their benefits for individual women, the new technologies (ultrasound, amniocentesis, in vitro fertilisation, electronic foetal monitoring, routine caesarian deliveries and in utero foetal therapies) also have the effect of carving out more space/time for obstetrical management of pregnancy (Petchesky; 1987; 64, Wells; 1993). Moreover, increasingly the major threat to foetal well-being is seen to be the

behaviour of the pregnant woman[15]. The idea of the doctor as the best representative of the foetus receives further legitimation from medical technology which gives him/her ever more knowledge about previously invisible processes within the woman's body. This also has implications for the regulation of abortion, in terms of entrenching the role of the doctor as the only one capable of representing the interests of the foetus (against those of the pregnant woman).

4. MEDICAL CONTROL OF ABORTION

I have so far sought to establish some very general points. First, I have shown that the doctor-patient relationship is saturated with power, that this is still further reinforced when the patient is a woman, and that this relationship has been used to regulate female behaviour and impose certain dominant norms. Secondly, I have demonstrated that reproduction is firmly established as a domain where medical control is seen as essential for the good of both woman and foetus/baby. Thirdly, I have argued that medical control of reproduction is established and legitimated by the development of the notion of pregnancy as pathology and the emergence of the foetus as a patient in its own right, with the doctor as the representative of its best interests. Now I will examine more specifically the operation of medical control and supervision in the specific case of a request for abortion. If I have dealt at length with more general questions of the medicalisation of reproduction, that is because this is the background against which the medicalisation of abortion must be viewed. As reproduction has fallen under medical control, so too have the means of avoiding it. Abortion is now legally and medically - even commonsensically - viewed as the exclusive province of the doctor, to the extent that, as Linda Gordon (1980; 515) has written, it is almost impossible to imagine an alternative legal context.

At the outset I would like to make two distinctions. Firstly, there will clearly be a difference between the experiences of women seeking access to state funded terminations and those who opt for abortions in the private sector (including the abortion charities, such as the British

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[15] See Petchesky (1987), Wells (1993). See Fortin (1988) for the spilling over of such ideas into the legal arena, chapter 5 below (p.100).

Pregnancy Advisory Service). In Britain, GPs operate as gatekeepers to other health services and NHS terminations are obtainable only if a woman's GP will agree to refer her to a second (hospital) doctor who must agree to perform the termination. Women who choose this course are much more likely to have some of the negative experiences described below, as there is no way of knowing the views of either GP or consultant in advance, and there is certainly no guarantee of sympathetic treatment. If women attend a specialist abortion clinic in the private sector, they are therefore less likely to meet with hostility. As the latter option is normally available only to those women who have the necessary £200-300 to pay for the termination, this inevitably introduces an element of class into the analysis, with the experiences of poorer women being more negative. Secondly, it is also important to distinguish between different categories of medical professionals - notably nurses, GPs and gynaecologists/obstetricians. There is some evidence that there may be significant differences of opinion regarding abortion between these groups (Hordern; 1971; 30, Homans; 1985; Simms; 1985, Farrant; 1985)[16].

In this chapter I will distinguish between four different levels of control: *technical* control of the actual performance of abortion operations (section a), *decisional* control over which women shall be permitted to terminate their pregnancies (section b), and *paternalistic* and *normalising* control (sections c and d) which may be exercised over women who request termination (regardless of whether they are granted access to it). This is an analytical distinction, designed to clarify the way that power operates at this level; there is some overlap between the categories in practice. Some of these 'types' of power have received more attention than others - in Britain the feminist call for abortion on demand has focused on decisional control, typically (although not invariably) assuming a medical retention of technical control.

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[16] Hordern indicates one possible reason for this when he cites a family doctor, who replied to a consultant gynaecologist that he was "much less likely to see at first hand, as do general practitioners, the day to day struggles of the ill-housed, impoverished mother of a young family, whose husband may be sick or unemployed or 'ne'r do well'. Has he really never read of a desperate, distraught mother driven to suicide, usually by gas poisoning - because she could not face another pregnancy? Often the mother who seeks an abortion has a truer conception of the dignity and sanctity of human life that those who preach the doctrine to her while rating the quality of her mental and physical life and her value to her family below that of a foetus less than 13 weeks old" (1971; 30).

a) Technical Control over the Performance of Abortions

No law expressly prohibits any unregistered or unqualified person from practising most types of medicine and surgery, unless such a person deliberately represents him/herself as being a registered practitioner, or as having medical qualifications. Along with the treatment of venereal disease[17], abortion is one of the few specified exceptions to this (Brazier; 1992; 11). Thus, although the technology involved in terminating a pregnancy is simple, under s.1 of the *Abortion Act*, abortion can only be legal "when a pregnancy is terminated by a registered medical practitioner". In a creative decision of the House of Lords, this has been interpreted as meaning that a doctor must remain in charge and accept responsibility throughout the termination. However where parts the procedure can, in accordance with good medical practice, be performed by auxiliary staff, the operation would still fall within the terms of s.1 of the Act, and such staff would be protected from prosecution[18]. The medical technical monopoly is more easily justified in some cases than in others. The most common form of early abortion - vacuum aspiration - is an easy and quick process with a very low rate of side effects[19]. Here, it is by no means self evident that such terminations could not be performed just as safely by trained lay personnel, nurses or midwives. Indeed, in practice, terminations by prostaglandins are already in large part performed by nurses rather than doctors. The decision of what method of termination is to be used also rests largely with the doctor rather than the woman herself. In Britain the favoured method for terminations in early pregnancy is that of vacuum aspiration, performed under general anaesthetic. The choice of general anaesthetic means that the majority of patients must stay one night in hospital.

Although doctors hold the monopoly of the right to perform abortions, they also benefit from a clearly specified right *not* to participate in the provision of abortion services for reasons of

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[17] Under the *Venereal Diseases Act*, 1917.

[18] *Royal College of Nursing v Department of Health and Social Security*, HL [1981] 1 All ER 545, discussed in chapter 5 below (pp.120-3).

[19] 5-10% of first trimester may be followed by minor complications of which the most common are infection and pain and bleeding due to incomplete evacuation. Many of these complications are self-limiting but up to 3% may result in hospital admission (Diggory; 1991).

conscientious objection, under s.4 of the *Abortion Act*[20]. This distinguishes abortion from all other treatments - there is no right to refuse to participate, for example, in the administration of ECT treatments. One important result of the right of conscientious objection is the extent of regional variation as to the possibility of obtaining an abortion on the NHS. In 1992 (the last year for which figures are available) around 50% of terminations in England and Wales were performed on NHS premises[21], whilst in Scotland, 90-99% of the demand for abortion was met by the NHS (Logan; 1994; 33). Moreover, there is a tremendous degree of regional variation within England and Wales: in North Tyneside, 93% of women have their terminations on NHS premises, compared with only 3% in North and South Birmingham, and just 1% in Dudley and Coventry. The statistics for the Birmingham area would seem to be the direct result of the hostility towards abortion of the consultant obstetricians and gynaecologists employed in the hospitals there and their right to exercise conscientious objection. Regulations have left it to the discretion of the consultant gynaecologist in charge of each hospital whether or not the hospital provides an abortion service[22]. Thus, two women in identical situations with the same reasons for seeking termination, but living in different parts of the country, are likely to receive different answers to their requests for an NHS termination.

The issue of technical control has been sharply thrown into relief by the decision to license the drug RU 486 for the provision of chemical abortions in Britain[23]. The Spring 1994

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[20] This right extends to doctors and nurses, not to administrative staff such as secretaries, see *Janaway v Salford AHA* [1988] 3 All ER 1051.

[21] Around 7.5% of terminations were performed in Agencies, but funded by the NHS, meaning that a total of 57% of abortions were funded by the NHS. This represents an increase on the figures for the previous year, when 45% of abortions were performed on NHS premises, with an extra 5% funded but performed elsewhere. All statistics are taken from the annual reports issued by the Office of Population Censuses and Surveys, and published by the Birth Control Trust.

[22] This may now be changing, as increasing power is given to administrators in purchasing services, see Paintin (1994b).

[23] See chapter 7. RU 486 (mifepristone) is an abortion drug, developed by a French company, Roussel-Uclaf. It is available in Britain up to the ninth week of pregnancy, and would seem to require far less expert medical control than any other method of abortion. A woman using this method of termination would not need anaesthetic, and can receive

edition of *Abortion Review* related that RU 486/PG abortions were now available in around 122 NHS hospitals and 16 private clinics, and this number should continue to expand[24]. As will be seen in chapter 7, despite the fact that RU 486/PG abortions have been marketed as easier and needing less control than conventional terminations, the procedure for the administration of RU 486/PG has been seen as leading to an *increase* in the level of medical supervision necessary. It is especially relevant to recall here that the performance of abortions is (in practice) a monopoly of certain - and not all - doctors. Although the proposal of the Royal College of Obstetricians and Gynaecologists (RCOG) that terminations should only be performed and authorised by or under the supervision of a consultant gynaecologist[25], was not incorporated into the *Abortion Act*, the law does provide that abortions must be performed in licensed medical premises (such as hospitals or clinics)[26]. This has greatly restricted the ability of some doctors - in particular GPs - to perform terminations. As will be seen in chapter 7, this is particularly relevant to the provision of RU 486/PG terminations, where the GP might otherwise administer the either one or both of the stages of treatment.

A particular instance of de facto resistance to this technical control of abortion by doctors, has been the emergence of small groups performing very early abortions by menstrual extraction[27] in the US. In the recent wave of fear that rights to abortion would be drastically

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treatment as an out-patient.

[24] Although reports suggest that doctors are still not well informed as to its availability, *The Independent*, 5 December 1992.

[25] Even though at that time there were only 460 of these in the country (MacIntyre; 1973; 127).

[26] Except in an emergency, under s.1(3) of the *Abortion Act*: "any treatment for the termination of pregnancy must be carried out tin a hospital vested in the Minister of Health or the Secretary of State under the National health Service Acts, or in a place for the time being approved by the said Minister or the Secretary of State".

[27] On or around the day that a woman expects to begin menstruating, the contents of the uterus are suctioned out by way of a cannula. This will lighten and shorten menstruation and, if an egg has been fertilised during the preceding weeks it will be removed at the same time. Menstrual extraction is also known as menstrual regulation or menstrual evacuation.

restricted there[28], a self-help guide to abortion by this means, *A Book of Women's Choices* (Chalker and Downey; 1992), was published. Menstrual extraction performed in small self-help groups would seem to be the most radical means of rejecting the technical level of medical control over pregnancy (and obviously the other levels of control discussed below would fall with it). Here there is no 'expert' in the group - all the women are at once practitioner and patient. There is no hierarchy and no privatized knowledge which is available to one but not all. However, menstrual evacuation has clear limitations. First, it is useful only in the very early stages of pregnancy, often before a woman would even know with any certainty that she is pregnant (although pregnancy tests are increasingly sensitive). Secondly, its legality is dubious even when performed within the limits set out in the *Abortion Act*[29]. Outside of such limits, menstrual extraction is clearly an offence under s.58 of the *Offences Against the Person Act*. Thirdly, it is to be assumed that many women would not wish to use this method, which implies an intimacy with one's own body and the bodies of other women, that might be unwelcome to many, and involves challenging a still strong taboo around menstruation. Finally, whatever the claims made by exponents of the method as to its safety, they also note that the method is riskier when the groups are less experienced in its use (Chalker and Downey; 1992; 129).

b) Decisional Control over Access to Abortions

Women have no positive legal right to an abortion. Rather they may *request* termination, and it is the medical professionals who must decide whether their request is founded with regard to the various criteria laid out by the *Abortion Act*. Where the doctor is not a conscientious objector, his/her personal position on abortion *should* in legal terms be irrelevant. However in practice this is far from the case. The opinions of doctors regarding abortion will - naturally enough - run the whole gamut of those opinions present in the wider British society

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[28] This fear has now somewhat abated following the election of Bill Clinton to the Whitehouse and the Supreme Court decision in *Planned Parenthood v Casey*, 112 S. Ct. 2791 (1992), which was less restrictive than had been anticipated.

[29] Tunkel (1979) discusses the case of Dr Goldthorp, who performed menstrual extraction within 10-18 days of a missed period. The DPP asserted that this was illegal. Subsequently the law officers (the Attorney General and Solicitor General) expressed the opinion that such a procedure would be legal only if performed in accordance with the terms of the *Abortion Act*.

from very liberal (favouring abortion on demand of the woman) to very restrictive (regarding abortion as unacceptable in any circumstances). The crucial difference here is that no other member of society is normally granted the right to impose their views over those of the pregnant woman. There is no doubt that even women whose situations would seem to fall well within the conditions foreseen in the law are refused abortions, because of the beliefs/attitudes of the individual medical practitioner approached. For example, Denise Winn cites the case of a 22 year old divorcee with two children, who had suffered a miscarriage five months previously, was pregnant again after her ex-husband forced her to have sex while he was drunk. She was refused an abortion by a NHS consultant (1988; 10). The wording of the *Abortion Act* is such that it allows a very liberal or very restrictive interpretation by those empowered to interpret it and grant or refuse abortion. In Britain, many medical practitioners have taken a very liberal interpretation of the Act and the result is that a woman is normally able to obtain a termination, if not on the NHS, then in the private sector. In the absence of a positive right to abortion, however, this may require some initiative on her part in order to find a sympathetic doctor where her own does not agree with her decision (and the funds to pay for it herself if necessary). This is likely to mean greater problems for certain categories of women, in particular young women, and women from ethnic minorities. Seema Daud asserts that illegal abortion is still prevalent within the ethnic communities, with cultural abortifacients being imported from 'back home'. These include bamboo sticks, or twigs of irritant plants (1993; 151).

The tremendous discretion left to doctors under the *Abortion Act* means that if a woman approaches her GP seeking to terminate a pregnancy, it is normally impossible for her to predict how her request will be received. The doctor may be supportive and helpful or moralising and judgmental. As was seen above, the GP has a right under the terms of s.4 of the *Abortion Act* not to participate in the provision of abortion on grounds of conscientious objection. Typically, he/she has no duty to refer the woman to a colleague with a different view of the matter[30]. What makes this especially problematic is that there is no way for

[30] There is, however, a statutory duty under s.4(2) of the *Abortion Act* to particiate in any treatment necessary to save the life or prevent grave permanent damage to the physical or mental health of the pregnant woman. See Smith and Hogan(1988; 373-4) for the same duty at common law, following *Bourne*. There may also be a duty to discuss the possibility of

women to know a GP's views on abortion before approaching him/her. A proposal that the *Abortion Act*'s conscientious objectors should be registered on a list which would be available to women, was rejected in 1990 on the grounds that it might lead to discrimination against them. The suggested amendment to the *Human Fertilisation and Embryology Act*, was sponsored by Labour's then front bench spokesperson on women, the late Jo Richardson, a stalwart campaigner for abortion law reform. She argued that the reform was essential to cut down on delays in the NHS:

"[o]ne of the problems is that doctors who have a conscientious objection to abortion tell women they are not entitled to abortions, when in fact they are. If a public register of doctors were available, women would not approach unsympathetic doctors and, as a result, get their abortions more quickly"[31].

The problem of delay is a serious one, and has been recently highlighted with regard to antiprogestin terminations (see chapter 7) which depend on a speedy referral. Women are often unable to choose this method of termination because their requests for abortion take so long to be processed. A study by the *Royal College of Obstetricians and Gynaecologists* found that in 1981, 16% of all terminations were carried out after 12 weeks, and that 2.3% occurred after 19 weeks (Alberman and Dennis; 1984)[32]. One thing which emerged clearly from the report was the delay between referral by the first doctor and the actual operation. Of those women aborting at 13-14 weeks, 25.6% had been referred by the ninth week, as had 16.8% of those aborting at 15-16 weeks. Even more worrying was the fact that over 20% of the women having their terminations between 20-23 weeks had been referred at 12 weeks, and 7% had been referred at 9 weeks. A Birth Control Trust report provides one particularly clear example of how delay can build up in the NHS:

"[a] separated woman, aged 27, went to her GP when her period was one week late. He told her she was too early and to return in four to five weeks. The pregnancy test took ten days

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amniocentesis with a view to abortion for women of over 35 (see Brazier; 1992; 308).

[31] *The Times*, 7 June 1990.

[32] The report identified four factors which contributed to delay: non-recognition of pregnancy, the decision to seek an abortion, locating and obtaining medical agreement and a clinic or hospital to carry out the operation and waiting for admission after agreement has been confirmed.

by which time she was around twelve weeks pregnant. Her GP then referred her to a consultant but the appointment was delayed because the consultant was on holiday. She was 15 weeks pregnant before she was seen. The consultant agreed to perform the abortion and told her he would admit her for the operation when possible. She waited for the appointment but nothing happened. After a while she phoned the hospital and was told that the doctor was away again. She told the hospital of her concern over the lateness of the pregnancy and was told she was now too late and they could not perform the abortion. By the time she found alternative help she was at least 21 weeks pregnant" (Chambers in Francome; 1986; 55).

According to Francome, some of the women whom he interviewed for his study of abortion practice believed that doctors can sometimes deliberately create delay in the hope that women will continue with their pregnancies:

"I went to my doctor and at first he said I wasn't pregnant. For a month I felt unwell and when I went back to him he said I was three and a half months and that I was too late for an abortion. I believe he said I wasn't pregnant on purpose. I continued with the pregnancy but had a miscarriage" (Francome; 1986; 55).

In cases of refusal, women must go to a private clinic, or one of the abortion charities, and thus lose the possibility of NHS funding (which is normally dependent on a referral from one's own GP). Francome cites a survey in Wessex in 1978, which showed that 16% of patients at the BPAS clinic had been refused NHS termination. However, he contends that women's decisions to 'go private' are not entirely a result of refusal but also reflect an unwillingness to face bureaucracy, delay and the uncertainty of how the doctor will decide (1986; 53). A recent survey of patients attending a London Pregnancy Advisory Service showed that three quarters of the respondents to a questionnaire, although not dissatisfied with the private care they had received, would have preferred NHS treatment had it been available (*Abortion Review*; Winter 1993).

The doctor is not legally entitled to allow abortion to any woman who asks for it without more ado - the one reported prosecution of a qualified doctor acting with the second opinion foreseen in the 1967 Act was of a doctor who took just such a view of the law[33]. Thus the law reinforces the element of decisional control, even should the individual doctor concerned seek to reject it, and it is clear that not every doctor would wish to do so. MacIntyre, in her

[33] *R v Smith* [1974] 1 All ER, 376, discussed in chapter 5 below (pp.110-2).

analysis of the views publically expressed by the medical profession in the months leading up to the *Abortion Act*, found near unanimity even in the Medical Woman's Federation that the decision should be made by the doctor although the pregnant woman would have the right to "state her case" (1973; 131)[34]. This control is seen as essential with regard to abortion for, as I argued in the previous chapter, the very nature of the woman who would seek to terminate her pregnancy would make her an unsuitable person to exercise self-determination.

An interesting illustration of the problem inherent in a law that demands that doctors act as gatekeepers, controlling access to abortion, is the case of London GP, Trisha Greenhalgh. Greenhalgh was approached by a pregnant woman of 38, who was married, with a large house and a nanny for her three children. She requested termination as pregnancy would interfere with her holiday plans. After counselling, Dr Greenhalgh felt unable to sign the referral form, but asked another GP at the practice, who did so. Dr Greenhalgh wrote:

"I am a feminist. I have marched and lobbied in support of a woman's right to choose, and I would do so again. But I am not a rubber stamp. I am a thinking and feeling professional and I must live with the clinical and ethical decisions I make" (British Medical Journal; 1992; 371).

A piece by James Campbell in the same issue of the British Medical Journal commented that

"doctors would not need to be confronted with difficult decisions of this type if the British law was amended to match the law in most developed countries...[which] allows women free choice of abortion during the first 12 weeks of pregnancy, and a reason does not have to be stated".

Thus, at present, even when a doctor feels that the decision of whether or not to terminate should rightly belong to the woman, he/she may not feel at liberty to repudiate all control of the situation. Indeed, legally speaking, he/she is not entitled to do so. Greenhalgh, although stating a commitment to women's right to choose, did not feel able to allow the woman absolute freedom of choice in these circumstances when the law still states the decision to be

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[34] One member of the MWF dissented , believing that the decision should belong to the pregnant woman. See also Tunnadine and Green: "if the doctor-patient relationship is a good one, the doctor is more likely to be in the best position to advise the woman on the most suitable course of action. *Only if she has confidence in him will she be inclined to allow him to take control*" (Tunnadine and Green; 1978; 180).

that of the doctor. The role foreseen for the doctor is not simply to "rubber stamp".

In leaving the decision to doctors, law leaves a free rein to the individual doctor's prejudice or opinion. In the exercise of the doctor's discretion, the age, ethnic origin, class background, or marital status of a woman may be deemed important (Aitken Swan; 1977, MacIntyre; 1977). Moreover, there is every indication, that the criteria used by doctors to decide who should have access to NHS abortions vary tremendously. MacIntyre notes that when examining statements made by the medical profession at the time of the introduction of the 1967 Act she was struck by the different rationales for decisions to refuse or to authorise terminations and how far these were on the periphery of medical knowledge. One doctor suggested that termination should be avoided for middle class women because they frequently consciously or unconsciously desire the pregnancy and, if they go to term. cement relationships with their own mothers. Another, however, considered an unwanted pregnancy worse for a middle class woman than for a lower class woman, whether married or not. He would therefore be more likely to allow a termination to the former even in the presence of less strong medical indications. MacIntyre concludes:

"[t]here appears to be an extremely wide variation in the factors likely to influence different doctors. What is clear is that idiosyncratic moral views or definitions of social and psychological reality are put into practice by doctors, and that this can have enormous implications both for individual women and society as a whole" (MacIntyre; 1973; 132).

It also seems clear that it is easier for certain groups of women to obtain abortions. According to Oakley, it is unmarried women with no children whose request for abortion is most likely to be unsympathetically interpreted; as a group they are most likely to have private rather than NHS abortions (Oakley; 1981; 92, see also McDonnell; 1984, MacIntyre; 1977). In MacIntyre's (1977) study of single, pregnant women it seems that students are deemed to have more of an interest and investment in their occupational careers than those already in the labour force in manual or white-collar jobs, and are thus more likely to be awarded abortions. Further, it is also significantly easier for women who have passed what is seen as the normal child bearing age to obtain abortion. An article in *The Times* reported that one in three pregnant women over the age of 40 is *automatically* offered an abortion by

their doctor[35]. Doctors have been documented as trying to 'weed out' 'defective' foetuses: Morgan (1990) has asserted that at the time of pre-natal testing for defects in the foetus, women are often asked for an undertaking to terminate should it prove to be affected[36]. Another report in *The Times* expressed the fear that doctors are putting pressure on women to have abortions in certain cases of foetal abnormality[37].

Wendy Savage relates the story of a West Indian single parent, whose gynaecologist refused to perform an abortion unless she cosented to sterilization concurrently. Whilst admitting that this is anecdotal, Savage argues that there is abundant published evidence that some doctors continue to press their ideas on women with regard to sterilisation. She points out that the rate of sterilization at the time of abortion has always been higher in the NHS than the non-NHS sector (1982; 294-5).

Further, decisional control makes it all the more easy for unsympathetic GPs to attempt to impede or hinder women seeking termination. Colin Francome suggests that sometimes doctors may deliberately create delay in the hope that the woman would be forced to continue with the pregnancy. For example, one of his interviewees relates:

"I went to my doctor and at first he said I wasn't pregnant. For a month I felt unwell and when I went back to him he said I was three and a half months and that I was too late for an abortion. I believe he said I wasn't pregnant on purpose. I continued with the pregnancy but had a miscarriage" (in Francome; 1986; 55).

Likewise one of the doctors in Isobel Allen's study illustrated the fact that speedy treatment is allied to a sympathetic attitude. He said:

"[t]hey're entitled to the benefit of the law. I've given up moral judgement. If it's for a reason like they have a heavy mortgage etc I forget to write sometimes. I say 'Too late, love, sorry. It's the hospital appointment system. You'll have to have the baby'" (in Cossey;

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[35] *The Times*, 15 April 1991.

[36] See Arney (1982; 183) for the same assertion with regard to the USA: "some doctors refuse to do amniocentesis unless the woman is willing to commit herself, before the test is done, to an abortion in case a defective fetus is found".

[37] *The Times*, 21 June 1989.

1982; 9).

Similarly, Dawn Primarolo told the House of Commons that:

"a young woman who went to see her doctor when she was two weeks pregnant. She did not know that her doctor was an anti-abortionist. The doctor was a man and he did not declare his conscience. By the time that young woman finally managed to get through the bureaucracy and to have the abortion that she had sought at two weeks, she was 22 weeks pregnant"[38].

The large quantity of data collected yearly with regard to terminations performed in England and Wales contains no information on how many women are refused NHS terminations[39].

The situation regarding delay is also greatly influenced by the views of senior obstetricians and gynaecologists and their level of commitment (or hostility) towards the provision of abortion services. Another Birth Control Trust report concludes that the areas which have been most successful in avoiding delay early terminations are those with interested and sympathetic gynaecologists (1987; 41). A survey conducted regarding abortion provision in Wessex Regional Health Authority found that twelve of its thirty-two NHS consultants had conscientious objections to abortion, and these consultants were directly responsible for the delays suffered by some Wessex women in obtaining abortion who, refused an NHS operation, turned to the private sector. Some districts in the Wessex RHA were served by only two consultants and if both had a major objection to abortion then NHS abortions were minimal in that district (in Cossey; 1982; 9). In 1990, the late Jo Richardson put this to the House of Commons:

"[i]n 1987, the consultant gynaecologist for Hexham told a Life conference that it was impossible - or almost impossible - to get a National Health Service abortion in Hexham. I wonder how late in pregnancy women in Hexham end up having abortions"[40].

The doctors' decisional control also makes it more difficult for a woman to resist the hostility or moralising lecture that she may encounter: she is very much a captive audience. Such

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[38] H.C. Deb. Vol. 171, Col. 247, 1990 (24 April).

[39] See Sackville H.C. Deb Vol. 209, Col. 605w, 1992 (17 June).

[40] H.C. Deb. Vol. Col. 1156 1990 (21 June).

evidence as exists of doctors availing themselves of the opportunity to air their views on the morals of the woman who has approached him/her to request a termination is largely anecdotal, and its occurrence is thus impossible to quantify. However, reports of such scenarios occur with such frequency in what studies there are of women's experiences of abortion that they must be taken very seriously (see especially, Winn; 1988, Neustatter and Newson; 1986; Cossey; 1982, Davies; 1991, Francke; 1980). The following examples are taken from interviews with women who have had abortions:

"The worst part was going to my doctor, who was very insensitive and cruel. My doctor refused flatly to grant a termination but offered a second opinion by another doctor. The second was a lady who still did her best to make me feel like a monster for wanting an abortion" (Davies; 1991; 69-70).

"[The gynaecologist] was horrid. He treated me like a piece of meat and then really told me off. He said he would only consider abortion at all because I had been depressed. I had to be grateful he would even condescend to see me. I felt so ashamed but, also, angry. That behaviour made me the more determined to go ahead." (Winn; 1988; 50).

"I didn't like her. She was trying to blame me for everything. She said I was wasting other people's money and the bed" (15 year old girl describing hospital doctor; Cossey; 1982; i).

"He was determined I was going to have the baby. He said '...then someone else who can't have babies can have your child'. It was a shock. My mum was upset and she's got heart trouble, and she said 'Don't I have any say in it?' and he said 'No' ...so we changed doctors" (14 year old girl talking about her GP; Cossey; 1982; i).

"Their moralising and obvious hostility...put me on the defensive. I'd used contraception responsibly for seven years...Although I had expected some resentment and a few nasty comments from anti-abortion staff, this sort of scaring tactic was hard to believe" (Cossey; 1982; 14).

"The GP was very rude. He basically said: "my wife had her first child at 19, so what's the problem?' I was living with a junkie at the time, in a squat in Bath" (*The Guardian*; 9 May 1994).

Some of the above examples might, of course, be characterized as instances of medical malpractice. The point is, however, that the current regulation of abortion leaves the woman with very little ability to resist such treatment - she is dependent on the goodwill of the doctor to secure access to a termination. Moreover, she has no recourse against a doctor who does act in such a way. Whilst the decisional control rests with the doctor, the woman seeking termination has the choice between risking submitting to this treatment, or seeking a

termination in the private sector. Obviously the possibility of taking the latter option depends on the woman's financial situation and her knowledge of the existence of such services. Whether or not an individual doctor grants access to abortion is based on his/her perception of the situation - the only control over the doctor being that his/her opinion must be formed in good faith: there is no requirement that the opinion be reasonable and judges are reluctant to supervise how the doctors will exercise this control (see chapter 5). Moreover, widespread social deference to medical authority makes it difficult for a woman to challenge a medical refusal for termination[41].

c) Paternalistic Control

In a work which focused on how a patient's initial presentation of complaints was diagnosed and treated in the course of consultation, Kathy Davis argues that the process is carried out not strictly on the basis of medical and scientific criteria, but is also tied up with the constitution of an asymmetrical gender relationship (1988a, 1988b). She speaks of the Janus quality of interviews, with GPs often being sympathetic and kind, but still making moral judgments or failing to take women's problems seriously: "it was precisely the intimate, pleasant quality of the medical encounter itself that made issues like power and control continue to seem like something else" (1988a; 48). Davis thus developed the concept of paternalistic control in order to understand the way in which power was being deployed in these encounters. She defines paternalism as:

"limiting the freedom of another person by means of well-meant regulations. In this way, benevolent intentions are combined with relations of power. The person in authority may restrict and coerce, but only for the good of the other...Paternalism...implies a relationship of asymmetry. The original model for a paternalistic relationship is that of parent and child" (1988b; 23-4, references omitted).

In abortion, where the legal regulation is overtly paternalistic, explicitly according the doctor the power to decide in the woman's best interests, this kind of power is especially significant. Moreover, as was seen in chapter 2, the woman seeking abortion is powerfully constructed as someone in need of this kind of control. The doctor's function is viewed as apostolic: to

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[41] On the acquiescence of women in the face of medical power, see: Roberts (1985), Gallagher (1987; 13), Cooke and Ronalds (1987), Kitzinger (1978). See Martin (1987), however, for instance of resistance.

guide the woman to the *correct* decision, one which will be objectively discernible to the trained doctor with access to medical knowledge. The doctor thus is better equipped than the woman herself to determine what constitutes her best interests. Thus, here I want to emphasise that even where the doctor is sympathetic and kind towards the pregnant woman, he/she may equally deploy power over her, influencing her course of action, rather than working to help her to make her own decision.

This interpretation of the medical relationship fully concords with the role of the doctor as foreseen in the Parliamentary debates which, as was seen above, was that of someone who would be able to reassure and support the woman, and encourage her to go ahead with the pregnancy. Paternalistic control may involve influencing a woman to continue (or equally to terminate) a pregnancy. Equally, it may be failing to tell her about some of the alternatives open to her - the doctor has more power over the 'agenda' of what will be talked about in the medical interview. The doctors in MacIntyre's study varied as to which options they would discuss with a woman. Some said they would present all women with all the possible alternatives (including abortion), some said they would mention the possibility of abortion only after ascertaining that the woman was not intending to marry, others said that they would discuss termination at all unless the woman herself raised the subject. One doctor told her:

"[s]he must bring up the subject of termination - I won't. I think if they'd like a termination they will bring the subject up - I don't want to put ideas into their heads" (MacIntyre; 1977; 75).

Further, doctors may put pressure on women, telling younger women that they must inform their parents (MacIntyre; 1977; 80, Cossey; 1982; i), or attempting to persuade reluctant women to tell their sexual partner. Several of the doctors in MacIntyre's study said that they favoured marriage as the best 'solution' to an unwanted pregnancy. One of them told her:

"[t]he majority of girls, those I've known since they were children, I manage to persuade them to get married. Girls from outside town, those I haven't seen previously - they're more difficult to persuade. Occasionally, girls do come in demanding termination but most can be talked out of it" (1977; 75-6).

Another had quite opposite views:

"[i]f they say, 'I'm getting married in September anyway' I ask if they *really* were intending

to - I'm enough of a rebel to say, 'Don't get married if it's just because of the pregnancy'" (MacIntyre; 1977; 76 - emphasis in original).

d) Normalizing Control in the Medical Interview

"In order to be able to offer each of our patients a course of treatment perfectly adapted to his illness and to himself, we try to obtain a complete, objective idea of his case; we gather together in a file of his own all the information we have about him. We 'observe' him in the same way that we observe the stars or a laboratory experiment" (Sournia; 1962; in Foucault; 1989b; xv).

There is also, I would assert, a fourth important deployment of power in the request for a termination of pregnancy, which goes beyond these three levels - this is the element of a normalising control exercised over women in the process of their request for an abortion. This 'type' of control is, of those described here, the least tangible and the most difficult to define coherently. Normalisation is the combination and generalisation of 'panoptic techniques': a process of insertion, distribution, surveillance and observation, which subsumes other forms of power (Foucault; 1991). Through constant observation, all those subject to control are individualized, and a body of knowledge about them is built up, with examinations producing dossiers and records containing observations about each individual.

"Not only has power now introduced individuality in the field of observation, but power fixes that objective individuality in the field of writing. A vast, meticulous documentary apparatus becomes an essential component of the growth of power" (1991; 190).

Details of the woman's abortion will be recorded in her medical records and also registered on notification forms which must be forwarded to the Chief Medical Officer (or the Secretary of State for Scotland). These reports enable the authorities to fix a web of objective codification, as more knowledge leads to more specification. This accumulation of documentation regarding individual women in a systematic ordering makes

"possible the measurement of overall phenomena, the description of groups, the characterization of collective facts, the calculation of gaps between individuals, their distribution in a given population" (Foucault; 1991; 190).

In the field of abortion, this is seen in the yearly publication of statistics which provide a wide range of information about which women have terminated pregnancies in the preceding

year. Thus we know reasonably accurately how many women of a childbearing age (15-44) will terminate their pregnancies in any given year, where they live, their marital status, age, how many children exist in their family, the grounds for performing the termination and so on.

A woman may succeed in obtaining an abortion referral from her GP, and have her pregnancy terminated, yet to achieve this she must still undergo a certain interviewing process. The strategy of the deployment of power which I want to capture here is that control exercised in the process of the medical interviews preceding an abortion, firstly the initial interview with one's GP preceding referral (or refusal of the same) and secondly, that with the obstetrician/gynaecologist. Here, there is the requirement 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. The very way that the law is phrased seeks to make every aspect of the woman's life and "actual or reasonably foreseeable environment" relevant to her application. Indeed, it imposes the medical surveillance and control as a duty.

A 1978 book entitled *Unwanted Pregnancy: Accident or Illness*, written by two doctors, provides a particularly interesting insight into how abortion interviews might serve as sites in a network of normalising power. The book provides a study of various women seeking abortion, with the aim of increasing the abortion counsellor's understanding of the 'illness' (sic) underlying these women's requests for terminations (Tunnadine and Green; 1978; 15)[42]. The doctors' information comes from a discussion group with other doctors each of whom would present to the group an account of each woman who approached them with a request for abortion. They present forty two case studies selected from the one hundred and forty seven women considered in their study. Here I will discuss just the first one by way of illustration of their approach.

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[42] This idea that a desire to terminate a pregnancy is an illness, reflects a common assumption that deviant behaviour in females often arises from psychological problems (see Smart; 1976; chapter 6). One might also think back to Oakley's assertion that pregnancy in itself has increasingly become seen as a state of pathology (1984; chapter 1).

The 'relevant' facts of the first 'case' (as they present them) are as follows: the patient, 'Angeline', was 26 and married with 3 children. At her first appointment, she said that she had become pregnant as the result of an accident, and had decided with her husband that she would have an abortion. Her doctor told her that she should make the decision for herself, but that he would make an appointment with a gynaecologist for her, and see her regularly in the meantime. At the next appointment, she came with her children. The third appointment was missed, and the fourth time she came without making an appointment. 'Angeline' had left home at 19, because of a bad relationship with her mother. She had recently seen her mother in the High Street, yet they had turned away from each other without speaking. She experienced a sexual coolness between the births of her first and second children, and had also complained at this time of a lack of energy. During the second pregnancy, she had rectal pain and, after the birth of her second child, the husband sent her to the doctor because of dyspareunia. Lack of finance forced the couple to move to a smaller house, she conceived again and towards the end of the pregnancy, she had a series of minor haemorrhages. After delivery the placenta was reported to be perfectly normal (Tunnadine and Green; 1978; 10-12). From these facts, the doctors draw the following conclusions:

"[i]t could be seen from the above that there are signs that Angeline was someone who had shown, at least over the last few years, an *inability to cope with her sexual life and her pregnancies*. She had *never really matured* and yet Angeline's GP attempted to get her to make her own decision. She had to decide what to do despite the evidence that she was *not a responsible or full-value woman*" (1978; 12, my italics).

Her GP was then criticized for having allowed 'Angeline' to take the decision regarding her abortion for herself.

Over and above the extremely negative picture of the woman seeking abortion painted by these doctors, I find two things particularly striking about this case study. The first is the extent of the detail which the examining doctor is able to report from the woman's life. Although he was criticised for his failure to really get to know the woman's situation, the doctor is still able to relate details of the couple's finances (why they had to move to a smaller house) and sex life. He even knows when 'Angeline' last saw her mother, and what the circumstances and outcome of the meeting were. All of this is seen as necessary and relevant in her request for abortion and yet is still deemed insufficient detail by the study.

If this is considered an insufficient knowledge of the woman's life, one can only wonder what degree of minute detail Tunnadine and Green would feel is necessary. I am reminded of the quotation from Sournia with which I opened this section:

"we gather together in a file of his own all the information we have about him. We 'observe' him in the same way that we observe the stars or a laboratory experiment" (in Foucault; 1989b; xv).

The woman is required only to be passive in terms of decision-making. However, as Douzinas and McVeigh point out (with regard to the medical interview in general),

"the patient is required to speak and to explain her relationship with the world (sexual, social, business etc)...the medical object becomes the speaking subject, the orator of the personal experience or relation of health" (1992; 20).

The second thing which particularly impressed me about this study is that the authors feel able to draw very radical conclusions from such information as they do have. The bad relationship between Angeline and her mother no doubt seemed particularly important to them, given the strong significance which they attach to the maternal relationship (1978; 181, 183). The "inability to cope with her sexual life and her pregnancies" is presumably inferred from the sexual coolness between the births of two of her children - perhaps it is also this that leads them to assert that she is not a "full-value woman". The conclusion of irresponsibility is possibly based upon the fact that 'Angeline' had difficulty in keeping her appointments (a fairly obvious alternative interpretation might be that as 'Angeline' has three children to care for she does not enjoy complete freedom with her own time). The doctors here consider the details of 'Angeline's' life to produce an authorized account of her reality - albeit one that may have precious little to do with her lived experience of it. Their account, moreover, has the stamp of medical 'truth'. I argued above that the power of the doctor is tied to his/her ability to understand, to classify, and then on this basis to treat. After a close surveillance, 'Angeline' is located within a conceptual framework, her problems identified and explained, her sickness understood, the correct treatment decided. In the normal course of events, the examining doctor will then go on (if the woman is referred for abortion) to register the abortion, with explanation for the contraindications which justify her referral. It is thus

his/her version of events which are officially recorded in state archives[43], and in the woman's medical records.

What is especially relevant about Tunnadine and Green's book is the light which it sheds on the medical method: the woman's life is put under the spotlight, her problem is located within a medical frame of reference, and the medical professional can thus claim the power to understand and to cure. This same process, I would argue is present even in the approach of the far more progressive Dr Greenhalgh (discussed above, p.84). Greenhalgh talks in depth to the woman seeking abortion, assesses her situation and then decides that a referral is unjustified. Despite her own liberal views on abortion, and the fact that she has marched in favour of a woman's right to choose, she cannot recommend a referral in this case. Her perception of her role is not that of a "thinking and feeling professional", rather than a 'rubber stamp'. The criteria may be different, the process is the same.

Several of the women in Sally MacIntyre's (1977) study were surprised and somewhat disconcerted by the amount of questions which their GPs asked regarding their pasts. As one woman concisely put it: "[w]hat does it matter what form of contraception we was using - it didna' work, did it?" (1977; 81). MacIntyre comments:

"[i]nformation about events and relationships in the past provided GPs with the major evidence by which they could typify the women and understand their circumstances. This could be resented by women wishing a simpler form of diagnosis and management, e.g. who wished confirmation of pregnancy and access to further services. Some saw questions about the past as prurient curiosity that had to be tolerated in order to obtain the required services, and as irrelevant to the management of their pregnancies" (1977; 81).

MacIntyre contends that GPs use the abortion interview to classify (single) women into certain categories, and these categories (combined with the GP's own views on abortion) influenced whether termination will be recommended. She identifies three ideal types: normal-as-if-married women (who would, of course, continue their pregnancies), nice girls who made mistakes (who would have abortions or surrender their babies for adoption) and

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[43] Section 2 of the *Abortion Act* provides that every abortion referral must be notified to the State, with such other information as required by the Minister of Health (for England and Wales) or the Secretary of State (for Scotland).

bad, promiscuous girls (who did not deserve abortion).

Other women haven spoken about these interviews as painful and unpleasant:

"[h]e kept asking questions about my boyfriend...very embarrassing questions which I wouldn't answer...he made my mum cry" (Cossey; 1982; i).

"I took great exception to being told off in a very condescending, humiliating manner. He wanted to know how long I'd known the man and asked what kind of relationship we'd have after this. I told him it was none of his business. He treated me like a stupid little girl. I was almost in tears and I was furious that he should have made me feel like this" (Cossey; 1982; 14).

Uncertainty as to how one's request will be received by doctors means that women may feel the need to convince doctors that they are justified in seeking abortion and thus are unable to really talk through their reasons for abortion in a way that may be helpful for them, or to voice any uncertainty or ambivalence about choosing abortion. This belies the idea that the GP's role is that of counsellor. The woman's awareness that the final decision rests with the doctor undermines any possibility of his/her acting effectively in this way (Hühn; 1992, Berer; 1993), even where this is how the GP views his/her role. Two of the women interviewed by Denise Winn, expressed this very clearly:

"I felt I had to express guilt to get a letter for an abortion, so the decision was made. I felt I couldn't have expressed reservations".

"I told the doctor that I was only 22, did shift-work, had no home and everything was chaotic. I think I was saying all that because I was basically going to ask for an abortion. So I was putting forward the negatives" (1988; 51, 47).

I do not want to overstate the existence of what I have classified here as 'normalizing' control. While this is built into the very structure of the medical interview, it's extent *will* vary from interview to interview. One factor which may minimise the woman's experience of this type of control might be simply that, given the current pressures on GPs in terms of the time they can spend with patients, he/she will not have a great deal of time to investigate the woman's situation fully, before making his/her decision as to referral.

5. CONCLUSION

I have argued that the relationship between a doctor and a woman approaching him/her for a pregnancy termination is pervaded with power. The patient approaches the doctor as a lay person to an expert, (s)he is the object of knowledge which the doctor must locate within a medical framework, to understand, to classify and to treat. This perceived need for medical control is reinforced when the patient is a woman, and even more so when she is a woman seeking abortion. With regard to abortion, this control operates firstly at the level of a *technical* control of the means of avoiding reproduction, secondly at the level of *decisional* control - policing who should (and who should not) be allowed the possibility of an abortion, thirdly at the level of *paternalistic* control (where the benevolent doctor still enforces his/her views through 'persuasion'), and lastly at the level of a *normalizing* control exercised in the medical interview over women seeking abortion.

If we accept with Foucault, that a claim to knowledge is always already an assertion of power, then it seems that as new and more complex techniques and medical knowledges are developed, this will inevitably enhance and enforce still further the medical control over women's lives. Oakley has warned, "[r]etention of absolute control over technical procedures is absolutely necessary for the survival of modern medical power" (Oakley; 1987; 46, see also Barrett; 1980; 168). Likewise, there is no guarantee that the removal of decisional control can by itself solve the problems posed by other forms of control: Davis' study shows paternalistic control as prevalent in doctor-(female) patient interaction regarding other medical matters (1988a). It is questionable, then, how easily the process of separating out the various strands of control, which I have here attempted on an analytical level, will be possible in practice.

It might be argued that state and law are neutral in this matter, with women's negative experience in access to abortion stemming from the hostility of individual medical practitioners. However, such official 'neutrality' serves to support the existing status quo and the power imbalance which characterises it. Law does more than this, however: it imposes the control of the woman as the doctor's responsibility. A doctor fulfilling the role foreseen for him/her by statute, will exercise all those forms of control described above. Those doctors

who do not - those who view their role as one of helping the woman to make her own choice for example - do so by attempting to step outside of this role.

A final point to bear in mind, is that this chapter has revealed some of the very negative consequences for women of the fact that control of abortion rests so firmly in medical hands. In the next chapter, I want to go on to examine the relevant case law in this area, and here we will see the other side of the coin - some of the positive aspects of medical control, and notably the strategic benefits which it has brought: protection against the power of third parties (such as parents and sexual partners).

CHAPTER 5: THE JUDICIAL PROTECTION OF MEDICAL DISCRETION

"I do not mean to say that the law fades into the background or that the institutions of justice tend to disappear, but rather that the law operates more and more as a norm, and that the judicial institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory"[1].

"Not only would it be a bold and brave judge who would seek to interfere with the discretion of doctors acting under the [Abortion] Act, but I think he would really be a foolish judge who would attempt to do any such thing, unless possibly, there is clear bad faith and an obvious attempt to perpetrate a criminal offence. Even then, of course, the question is whether that is a matter which should be left to the Director of Public Prosecutions and the Attorney-General"[2].

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[1] Foucault (1979b; 144).

[2] *Paton v British Pregnancy Advisory Service* [1978] 2 All ER, 987 at 992.

1. INTRODUCTION

As was seen in the previous chapter, the medical control of reproduction is a matter which has provoked a great deal of concern and an ever-expanding literature from feminist commentators. The role of the courts in protecting and entrenching such control has not escaped the attention of such writers, and judicial decisions provide important focal points for conflict in the ongoing struggle between advocates of medical discretion and those who are concerned to protect female bodily autonomy. In particular, the growth of the body of medical knowledge regarding the development of the foetus has already led to important social restraints on the autonomy of pregnant women, and worries have been expressed of the possible consequences of importing such knowledges are imported into law. In an article in the *Modern Law Review*, Jane Fortin has argued that it is only right that law should take account of such matters for: "[i]n most circumstances, the unborn child is much more likely to be harmed, not by a third party but by his [sic] own mother"[3]. The courts have so far refused to make the foetus a ward of court in order to protect it against the activities of the woman who is carrying it[4], but they have been prepared to take account of a woman's conduct during pregnancy, when considering the need to make a care order following the baby's birth[5].

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[3] Fortin continues: "[t]he expansion of biological and medical knowledge about the needs of the unborn child show that it is at its most vulnerable at the earliest stages of its gestational development and that foetal abuse or neglect at this time, may do serious and permanent structural damage. It is now well known, for example, that the excessive consumption of drugs or alcohol and the excessive smoking of cigarettes by the pregnant mother is hazardous to the health of her unborn child. There are many other sources of potential harm; safeguards are now commonly taken against unsuitable or inadequate maternal diet and workplace hazards such as exposure to radiation or harmful chemicals of various kinds" (1988a; 75).

[4] *Re F* [1988] 2 WLR 1288, [1988] 2 All ER, 193. The courts refused a local authority's application for an order to restrain a pregnant woman who was mentally disturbed, had a history of drug use and led a 'nomadic existence'.

[5] *D (a minor) v Berkshire County Council and others* [1987] 1 All ER 20. A woman who was a registered drug addict and had taken drugs throughout her pregnancy, gave birth to a baby born with drug withdrawal symptoms. The local authority obtained care and control of the child by order of the juvenile court on the grounds that, inter alia, the mother's abuse of her own bodily health during pregnancy had avoidably impaired or neglected the child's proper development, see Bainham (1987) and Fortin (1988b).

The aim of this chapter will be to discuss the case law dealing with various aspects of the regulation of abortion, and in particular to highlight the medicalisation of the jurisprudence in this area. However, it is important that this should be considered in the context of decisions in other areas of law in order to form a basis for the argument which I wish to make in this chapter: whilst all of the cases which I will consider below are strongly influenced by judicial deference for medical opinion, in the case law dealing with abortion, this may have had quite different results for considerations of women's bodily autonomy. Consequently, I will first sketch two of the more recent cases where medical discretion and female autonomy have come into conflict (section 2), before going on to examine in more detail some of the cases which have arisen with regard to abortion (section 3).

2. FEMALE AUTONOMY IN CONFLICT WITH MEDICAL DISCRETION

a) Re S *(Refusal of Medical Treatment)*[6]

S was admitted into hospital with the foetus in a position of traverse lie with an elbow protruding through the cervix. Doctors attempted to persuade her to have a caesarian section but, backed by her husband, she refused on religious grounds. The doctors applied to the courts for a declaration that they could lawfully perform the operation even in the absence of S's consent, the consultant surgeon testifying that it was a question of "minutes rather than hours" and that this was a "life and death situation". He maintained that S's baby could not be born alive in the absence of a caesarian operation and that S herself was in imminent danger of a rupture of the uterus.

The position in English law is that a caesarian section (like any operation) is saved from constituting an assault only by the patient's consent to it, and a mentally competent adult patient has every right to withhold consent. The position in this case seemed to be complicated, however, by a statement made obiter by Donaldson, MR in an earlier case, *Re T*[7], where he specified the only possible qualification to this principle might be: "a case in

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[6] Family Division, 12 October, 1992, NLJ 23 October, 1992.

[7] *Re T (refusal of medical treatment)*, NLJ 7 August 1992. This case concerned the legality of giving a blood transfusion to an unconscious patient who had previously refused her consent to such a process.

which the choice may lead to the death of a viable foetus" (1126)[8]. It is into this legal lacuna which *Re S* fits. Sir Stephen Brown, President of the Family Division granted the declaration as sought and the caesarian was performed. S's baby died shortly afterwards and her own condition was reported to be critical following the operation. In his reasoning Sir Stephen seems to go no further than noting that this point seemed to have been left open in *Re T*, judging the caesarian to be in the best *medical* interests, and stating (probably incorrectly) that an injunction would be accorded under U.S. jurisprudence[9]. As Derek Morgan quite rightly points out this should have been no more than the starting point for his deliberations (1992; 1448). It seems relatively clear, however, that the only possible legal basis for the decision can be the (medically determined) interests of the foetus.

Re S provoked a storm of discussion and protest[10]. Its precise effects in law remain uncertain, but its potential implications seem to be great. The case has been reported as the first time in English law that the rights of the unborn child have taken precedence over the rights of the pregnant woman to determine her treatment[11] and as establishing that a competent woman's absolute right to decide treatment could be overridden where the operation might save the child's life and would do the mother no harm[12]. As Morgan wryly adds in his commentary on this case,

"if non-consensual caesarian can be described as doing the mother no harm then it is difficult to imagine how other possible interventions to the benefit of the foetus could be refused" (1992; 1448).

The legal precedent remains, despite the fact that the ethical committee of the Royal College

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[8] Donaldson does not precise any legal basis for this one possible qualification.

[9] The judge refers to the case of *Re A.C.* (1990) A 2d 1235, where an order to perform a caesarian section was granted by a trial judge against the woman's wishes. However, he seemed to be unaware that the Court of Appeals had later overturned and roundly condemned the decision.

[10] See Morgan (1992), Young (1993), Bridgeman (1993b, 1993c) Wells (1993) and Draper (1993).

[11] *The Guardian*, 14 October 92.

[12] *The Times*, 14 October, 1992.

of Obstetricians and Gynaecologists have since decided that the life of the foetus should *not* give doctors grounds for overriding a woman's explicit refusal to undergo a 'caesarian section[13]. Further, as Allan Levy (1992) indicated: "[i]f the ruling was in the interests of the unborn child and recognises its rights, it could fuel the anti-abortion lobby and have unpredictable consequences"[14].

b) *Re W*[15]

Another controversial area and point of potential conflict between female autonomy and medical control is that of the ability of minors to give or withhold consent to medical treatment. In the case of *Re W*, the doctors of an anorexic 17 year old, who had expressed her wish to refuse medical treatment, were granted permission to force feed her. Jo Bridgeman mounts a strong critique of this judgment as "taking a paternalistic approach, based on the assumption that treatment recommended by the medical profession must always be in the patient's best interests" (1993; 69). For Bridgeman, this case highlights an illogical distinction in the law regarding the medical treatment of minors: whereas children are often now allowed to override parental wishes in *consenting* to medical procedures, they cannot override parental wishes in *refusing* to consent to such procedures[16]. Within the context of judicial respect for medical opinion, this distinction becomes easier to understand - in the first case the child is agreeing with the medical opinion, in the second she/he seeks to oppose it. The latter requires parental consent, the former not. This reveals the courts as essentially pro-treatment or at least as biased towards upholding the decision of the medical professionals involved.

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[13] *The Guardian*, 13 April 1994.

[14] *The Guardian*, 14 October 1992.

[15] The High Court judgment was reported as *Re J*, the Court of Appeal judgment as *Re W*, (*The Times*, 14 May 1992).

[16] Under *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 403, a child of under 16 with the necessary intelligence and understanding can consent to medical treatment; however she/he does not have the ability to refuse treatment. In the latter case, other parties (and notably parents) can give consent on her/his behalf, even when the child has explicitly refused consent to a procedure.

In the light of these two cases, it may not seem surprising that medical power has been perceived by feminist writers as such a significant threat to women's bodily autonomy. In these cases of conflict between woman and doctor, the judicial respect for medical discretion and prioritisation of medical opinion in defining a woman's best interests has facilitated a significant encroachment into women's bodily autonomy. Moreover, whilst these cases remain exceptional, it is impossible to know what practical day to day effect they have in weighting the power balance in the doctor-patient relationship still more heavily against the patient. Indeed, it is not an exaggeration to see this as a serious compromise of the consent requirement. What real meaning can a patient's consent to a procedure have, if she believes that if she withholds the consent, the doctor can secure a court order to authorise treatment without it?

3. THE MEDICAL CONTROL OF ABORTION

The medical control of abortion cannot be understood outside of the context of these other cases of judicial support for medical discretion. Yet for abortion, I would argue, the existing case law has a very different flavour. In the two cases discussed above, a woman's claim of bodily autonomy has come into conflict with her medically defined 'best interests'. In the cases dealing with abortion which I will discuss below, however, the woman normally approaches the court in conjunction with her doctor. Thus, in these cases, the same judicial prioritisation of medical opinion and reluctance to interfere with good medical practice has had far more positive results for women and their possibility to exercise some reproductive autonomy in deciding to terminate a pregnancy. Where problems may still occur, however, is when law is called upon not to protect the medical relationship from outside challenge, but to protect the woman within it.

First, I will address five series of cases involving the regulation of abortion which have been faced by the English courts: a) prosecutions for the unlawful procurement of miscarriage under s.58 of the *Offences Against the Person Act*, 1861, prior to 1967; and b) after 1967; c) applications for injunctions to restrain an intended abortion; d) the legality of abortions by medical induction and; e) cases of abortion where consent is problematic (where the pregnant woman is a minor or is mentally handicapped). Finally, I will address another case which

looks poised to enter the English courts: that of non-consensual abortion.

a) Prosecutions under s.58 OAPA: Prior to the 1967 Act

Even prior to the introduction of the 1967 *Abortion Act*, there were relatively few prosecutions for illegal abortion. As was noted in chapter 2, despite estimates of 10,000 to 100,000 illegal abortions per year, in 1966 there were 62 prosecutions, only 28 of which resulted in convictions entailing prison sentences. Further, very few of these prosecutions were of registered medical practitioners. Prosecutions before and after the introduction of the *Abortion Act* seem to be based on two criteria: whether the abortionist is a qualified doctor, and if so whether he/she was operating within the bounds of good medical practice.

i) R v Bourne[17]

Until 1967 the provision of legal abortion in Britain was ruled by *R v Bourne* and this still forms the basis for what abortions are performed in the six counties of Northern Ireland, where the *Abortion Act* does not apply[18]. In this case, a girl of 14 was pregnant as the result of being raped by a group of soldiers. Alec Bourne, a surgeon with a good reputation n openly performed an abortion in a London hospital without charging any fee. He was charged under s.58 of the *Offences Against the Person Act*, 1861, with unlawfully procuring an abortion. The *Offences Against the Person Act* provided no specific defence against this crime, however the judge, Macnaghten J., directed that the word "unlawfully" implied that there must also be certain circumstances in which abortion might be considered lawful. He argued that the scope of lawful abortion should be equated with the scope of lawful child destruction under the *Infant Life (Preservation) Act*. Thus, the jury were directed that in order for Bourne to be convicted, that the prosecution must prove beyond reasonable doubt that the operation was not performed "in good faith for the purpose only of preserving the life of the mother". Here Macnaghten, J. established a wide definition of life which was to form the

[17] 3 All ER [1938] 615.

[18] An amendment aiming to extend the *Abortion Act* to Norther Ireland was firmly rejected in 1990, by 267 to 131 votes. All M.P.s representing Northern Irish constituencies (all of whom are male) voted against the reform. As several of them commented, it was the first issue to unite them for some time. In 1990, 1,855 Northern Irish women travelled to Britain to terminate their pregnancies (OPCS figures).

basis of the performance of legal abortions for the next thirty years:

"if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequences of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that honest belief, operates, is operating for the purpose of preserving the life of the woman"[19].

According to his (1962) autobiography, Bourne had actually made the decision to bring such a case to court three years earlier when, to his anger, his house surgeon had walked out during a termination performed on a girl of a similar age. He himself informed the police of the operation, and it seems highly probable that he would never have been prosecuted were he not to have done so. His acquittal rests squarely on the fact that he is a qualified doctor. This is noteworthy in that at this time, no such distinction existed in statute as to the professional status of the abortionist (Hoggett; 1968; 256). In his summing up, however, the judge pointedly and repeatedly distinguished between the act of the professional abortionist and an operation openly performed by a qualified surgeon. He contrasted the case in hand with another which had come before the court earlier in the month. In the first case

"a woman without any medical skill or any medical qualifications did what is alleged against Mr. Bourne here...She did it for money. £2 5s. was her fee, and she came from a distance to a place in London to do it...She came, she used her instrument, and, within an interval of time measured not by minutes but by seconds. the victim of her malpractice was dead on the floor. She was paid the rest of her fee and she went away. That is the class of case that usually comes before the court. The case here is very different. A man of the highest skill, openly, in one of our great hospitals, performs the operation...as an act of charity, without fee or reward, and unquestionably believing that he was doing the right thing, and that he ought, in the performance of his duty as a member of a profession devoted to the alleviation of human suffering, to do it" (619)[20].

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[19] Cited approvingly in *Newton v Stungo*, Crim. L.R. [1958] 469, and *Bergmann and Ferguson*, BMJ 22 May 1948, 1008.

[20] And later at 617: "[this case] has nothing to do with the ordinary cases of procuring abortion to which I have already referred. In those cases, the operation is performed by a person of no skill, with no medical qualifications, and there is no pretence that it is done for the preservation of the mother's life. Cases of that sort are in no way affected by the consideration of the question that is put before you. In the ordinary cases, no question of that sort can arise. It is obvious that the defence could not be available to the professional abortionist". The same distinction is made once again at 621.

Indeed, it was the norm in such cases to distinguish between 'respectable' qualified medical providers of abortion acting within the bounds of good medical practice and unscrupulous, unqualified backstreet abortionists, operating for profit. Again, in the later case of *R v Bergmann and Ferguson*[21], a sharp distinction was made between unqualified people performing such operations and those lawfully engaged in the practice of medicine. Drs Bergmann and Ferguson were subsequently acquitted (not, however, before the former had attempted suicide). It seems, however, that this stark division between the altruistic medical practitioner and callous and greedy backstreet abortionist is far from representing the reality. It belies the fact that a great many of the qualified medical practitioners were actually making large sums of money from performing abortion (see Ferris; 1966 and chapter 2 above) and that at least some backstreet abortionists were motivated more by compassion and a desire to help a woman in trouble than by any financial motive. Sometimes these abortionists were women who had first terminated a pregnancy for a friend in trouble and frequently they charged very low amounts for their services. Moya Woodside (1963) interviewed 44 women who were in Holloway prison for the performance of abortions in the early 1960s. She found that although most knew abortion to be illegal, they did not feel it to be wrong. They asserted that they had acted out of "compassion and feminine solidarity" for women facing unwanted pregnancies and denied that financial gain was their chief motivation (1963; 100).

According to Andrew Grubb (1990; 152), *Bourne* marks the first (albeit primitive) regulation of abortion. Three factors are especially significant in the form of this regulation: first, the judge notes that only the medical profession can lawfully perform abortions; secondly, a doctor should act only when he has consulted some other member of the profession of high standing; thirdly, the judge distinguishes between paid and unpaid abortionists. As Grubb rightly points out, the bases for such requirements are not easily found in law, but they provide the first judicial confirmation of the ascendancy of the medical profession over any rivals it might have had in earlier times, whilst sketching some safeguards against possible abuse by doctors. This case clearly signals the lines which will be followed by the British courts in treating abortion as a medical procedure. Thus judicial confirmation of greater

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[21] Reported in the *British Medical Journal* (22 May 1948) 1008-9. This case would appear to extend the test as laid down in *Bourne*, demanding not that a belief be reasonable, but merely that it be honest.

access to abortion is integrally related to the tightening of an exclusionary medical monopoly over it.

ii) R v Newton and Stungo[22]

In this case a woman, Ms Smith was referred to Dr Newton by a psychiatrist, Dr Stungo, who deemed that, given her suicidal state, her pregnancy should be terminated. Dr Newton saw Ms Smith at 2.30, told her to think about it and come back at 5.30. When she returned, still requesting an abortion, he administered utus paste by way of uterine injection and sent her off to her hotel in a taxi. He charged Ms Smith a total of £75 for the operation, accepting the sum in cash in advance. He admitted that the fee was high, but explained that he had done this on purpose "to discourage her from having anything done". Ms Smith became ill the same evening and was vomiting continuously the following morning. Dr Newton examined her. Her condition continued to deteriorate and on the third day he claimed that he decided to send her to hospital, but that she declined. She actually went to hospital the following day. The prosecution claimed that the delay in sending Ms Smith into hospital showed gross negligence or an intention to conceal for as long as possible the fact that he had terminated her pregnancy. In the letter requesting her admission to hospital, Dr Newton stated the reason for admission as "incomplete abortion" but made no reference to the fact that it was he who had operated. Further, according to the registrar at the hospital, when Dr Newton phoned to check on Ms Smith's condition he explicitly denied that he himself had performed the abortion.

The respective verdicts delivered for the two defendants are instructive. Dr Stungo, who had acted in accordance with regular medical practice, and whose good faith was demonstrated by the low fee (of three guineas) which he had charged, was acquitted of being an accessory before the fact to using an instrument to procure a miscarriage under s.58 of the *Offences Against the Person Act*, 1861. Dr Newton, however, was found guilty both under this section, and also of manslaughter by unlawfully using an instrument to procure a miscarriage. He was sentenced to consecutive terms of two and three years' imprisonment respectively. Dr

[22] Crim. L.R. [1958] 469. See Harvard (1958) for more detail of the facts of this case.

Newton had not acted in accordance with good medical procedure. He had operated in his consulting rooms, without admitting Ms Smith to hospital, and without anyone else being present. He delayed in admitting her to hospital and then (apparently) lied about the fact that it was he who had terminated the pregnancy. Finally, he had charged an unusually large amount for performing the operation. The expert witness for the prosecution testified that where a patient was three months pregnant, the normal medical practice would be to keep her in hospital for five to seven days. He refused to recognise Dr Newton's actions as proper: indeed everything about them pointed to the fact that he was carrying out the operation clandestinely for profit. If he had charged a lower fee and had carried out the operation more openly, it is highly unlikely that he would have been convicted. Harvard writing of this case argues:

"in practice it is often found that a doctor who terminates pregnancy unlawfully will make certain departures from accepted medical practice in order to conceal the matter. Such is the integrity of the medical profession that abortions carried out under the accepted medical procedure are rarely, if ever, questioned, at any rate since the decision in *Bourne*" (1958; 607).

He goes on to conclude that this case has

"confirmed that the accepted medical indications for terminating pregnancy will be recognised as constituting the defence of necessity. Providing the operation is carried out in good faith for the purposes of preserving the life or health of the woman the doctors have nothing to fear" (1958; 613)[23].

b) Prosecutions under s.58 OAPA: after the 1967 Abortion Act

If there were few prosecutions before the *Abortion Act*, understandably there have been still fewer following its introduction. In fact, there has been just one reported conviction of a doctor operating with the necessary second opinion foreseen in the *Abortion Act*. One might have foreseen the possibility of more prosecutions - the Act explicitly refuses complete freedom of action to doctors, but rather allows them to perform abortions in the presence of specified indications. However the only requirement for the doctor in attesting to the condition of such conditions is that he/she reached his/her decision in good faith. There is no requirement that the assessment be a reasonable one. As Hoggett foresaw in the months

[23] See also the case of *R v Sumner* (1958) Glamorgan Assizes, discussed in Harvard (1958; 600).

before the *Abortion Act* came into force: "the availability of abortion will rather be governed by medical ethics than by legal requirement" (1968; 257). Later, Denning MR, in a judgment which is explicitly hostile towards the liberal provision of abortion, confirms this in asserting the impossibility of controlling the doctor's decision beyond the requirement for good faith. He states that the only limitations on abortion imposed by the *Abortion Act* are the requirement of a certificate signed by two doctors, that the abortion must be done in hospital or other licensed premises, and that it must be done by a registered medical practitioner[24].

Moreover, the courts have exercised only a minimum of supervision as to what constitutes good faith. In a frequently cited comment from the judgment in *Paton v BPAS*, Baker P notes that:

"not only would it be a bold and brave judge who would seek to interfere with the discretion of doctors acting under the *[Abortion] Act*, but I think he would really be a foolish judge who would attempt to do any such thing"[25].

The "discretion of doctors" is interpreted by the judge here very widely, as anything which does not include "bad faith and an obvious attempt to perpetrate a criminal offence". Even then, according to Baker P, it is possible that this matter may still be best left to higher judicial authority. Given the judicial reluctance to prosecute doctors in this matter, it is worth examining in some detail the only reported prosecution of a registered doctor operating within the 1967 Act.

i) R v Smith[26]

A woman of 19, who wanted an abortion, was sent to Dr Smith, a general practitioner, with a specialised practice in the termination of pregnancies. Dr Smith neither examined her internally nor enquired about her medical history but agreed to perform the operation on the

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[24] *Royal College of Nursing v Department of Health and Social Security,* 1 All ER [1981] 545, at 554.

[25] [1978] 2 All ER, 987 at 992. Cited approvingly by Donaldson, MR in *C v S* [1987] 1 All ER 1230, at 1243.

[26] [1974] 1 All ER 376, 1 WLR 1510, 58 Cr App Rep 106.

payment of a fee of £150 a week or so later. Their appointment lasted just 15 minutes, and he made no suggestion of the need for a second opinion or further inquiries. Eight days later, Dr Smith performed the abortion at a nursing home. The woman did not see any other doctor in the meantime, nor were any enquiries or investigations made about her. Further, there was some doubt as to whether the operation was carried out in accordance with good medical practice. In particular, she claimed that her anaesthetic was administered by a man who was later identified as a porter at the nursing home. Dr Smith was subsequently charged and convicted of illegally procuring a miscarriage under s.58 of the *Offences Against the Person Act*, 1861. It was held that he was not protected b the defence offered under the *Abortion Act*, as he cannot have been acting in good faith when he operated, having allowed himself no opportunity to form a *bona fide* opinion as to the balance of risks between termination and continuation of pregnancy. The Court of Appeal upheld the judgment.

The case is interesting for the light which it throws on the very liberal judicial interpretation of the limitations imposed on the medical profession by the 1967 Act. Scarman LJ summarizes the operation of the *Abortion Act* in the following way:

"[t]he Act, though it renders lawful abortions that before its enactment would have been unlawful, does not depart from the basic principle of the common law as declared in *R v Bourne*, namely that the legality of an abortion depends on the opinion of the doctor. It has introduced the safeguard of two opinions: but, if they are formed in good faith by the time the operation is undertaken, the abortion is lawful. Thus a great social responsibility is firmly placed by the law on the shoulders of the medical profession" (381).

However, this does not delegate total responsibility to the medical profession:

"[i]f a case is brought to trial which calls in question the bona fides of a doctor, the jury, not the medical profession, must decide the issue...By leaving the ultimate question to the jury, the law retains its ability to protect society from an abuse of the Act" (381).

Again, however, the only requirement is one of good faith.

The issue of the case became according to Scarman, LJ to determine whether or not Dr Smith had abused the trust placed in him by the Act of Parliament (383). As the judge in first instance had explained Doctor Smith's actions in his summing up:

"[the defendant] took the view that if any girl wanted her pregnancy terminated, that of itself was, if not entirely sufficient, a very powerful indication of the risk of injury to her mental health if the pregnancy continued being greater than if the pregnancy was terminated".

The verdict of the court reveals that to authorise abortion for no more reason than a woman's desire to have one was indeed an abuse. It seems from the judgments delivered in *R v Smith*, that if Dr Smith had examined the woman then there would have been no possibility for the judges to 'second-guess' his opinion. His failure here was that, objectively, there was no possible way in which his opinion could have been formed in good faith based on an assessment of the case in hand, as there was no possibility that a real assessment had been made. Rather he was prepared to provide a termination for any woman who had the money to pay for it. Other actions of Dr Smith's also indicated a failure to act in accordance with good medical practice: the doubt as to who applied the anaesthetic, the fact that their appointment was so short, his failure to inform the woman of the need for a second opinion and the size of his fee.

Significantly, the doctor's failure to act in good faith is evidenced by the fact that he did not act within the bounds of good medical practice. This standard is not met here because of his failure to exercise the level of medical control foreseen in law. Dr Smith advised the woman that she might have an abortion without any medical investigation or discussion of her social circumstances. His defence was that if any girl wanted her pregnancy terminated, that of itself was a very powerful indication of the risk of injury to her mental health. There is no suggestion that there was any danger to the woman's health as a result of Dr Smith's actions, however, his actions are an abdication of the role that Parliament had foreseen for him. Indeed, given the role of the doctor as envisaged in the Parliamentary debates as discussed in chapter 2 (see especially pp. 34-5), it is hardly surprising that the conduct of Dr Smith failed to measure up. Another doctor gave evidence to the court that:

"one would want to know as much as one could about the patient's general background and so on...Then there is the girl's own history, her past medical history, has there been mental illness in the family, one would expect to check that".

As Scarman, LJ summarises: "[h]e made it clear that in his opinion careful enquiries on a number of matters would be needed before an opinion could be formed" (382).

Thus, at least as it was seen in 1971, the discretion granted to doctors under the 1967 Act has one very important limit: it does not include a discretion to abdicate control and allow abortions indiscriminately, simply on the basis that the pregnant woman wants it (and is able to pay for it). Although some doctors may operate in this manner, they are expected to justify their decision in some other way. A minimum of control is demanded and will be enforced by the law. This would be a very minimalist level of control however - presumably a cursory medical examination would suffice. This is reinforced by the 1976 Regulations issued by the Minister of Health, which require the doctors to base their opinions on the woman's individual circumstances and to state whether they were formed after seeing the patient[27].

ii) Notification Forms and the 'Statistical Argument'

It is unlikely that the British courts will see a similar prosecution to the one described above. Now it seems to be widely accepted that some doctors are very liberal in their interpretation of the *Abortion Act.* In 1982, in an effort to tighten up the rules for legal abortion, the Department of Health and Social Security changed the abortion notification forms. The new forms made no reference to the environmental grounds[28] for termination of pregnancy. Rather, they demanded to know the main *medical* condition justifying abortion, whereas the previous form had specifically left a space for non-medical grounds[29]. Pro-choice doctors responded by answering with 'pregnancy' as the grounds justifying an operation. No prosecutions have been brought in these cases. Indeed such a prosecution would be extremely difficult as, under s.1 of the *Abortion Act,* an abortion is justified where there is risk to the woman, greater than if the pregnancy were terminated. It is generally agreed that where abortion is performed early in the pregnancy, statistically speaking, it poses less of a risk to the woman than carrying the pregnancy to term. A successful prosecution of a doctor in these circumstances would need to show that the doctor on trial did not honestly believe these

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[27] Abortion (Amendment) Regulations 1976 (SI 1976 No 15), see Grubb (1990; 152).

[28] S.1(2) of the *Abortion Act* which states: "[i]n determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment."

[29] See Hordern (1971; 275 - appendix 1) for a copy of the original notification form.

statistics to be valid, and so had failed to act in good faith (Brazier; 1992; 292). Thus, it would seem that abortions (at least where performed in the first trimester), can be freely available from a doctor who is prepared to accept the statistical argument. However this does not relieve doctors of their duty to make a comparison between the risks to the particular woman of continuing or terminating a given pregnancy: as was seen above the 1967 Act requires the doctor to make an individualised decision (see Grubb; 1990; 155).

What the courts have done in these cases is to actively protect and entrench the monopoly of doctors, whilst policing those marginal cases which did not fall within the bounds of good medical practice. This accords with a long tradition of leaving the regulation and control of medical practice largely to the medical profession (Kennedy; 1988; 5). As has been seen above, the courts act only in the most exceptional cases, and this serves to sanction and legitimate the 'ordinary' cases in which they do not intervene. Further, they confirm the legitimacy of day to day medical practice by adopting medical standards ('normal medical practice' or 'good medical practice') and punishing only those who deviate from it. Thus, in the interaction between the two systems (legal and medical), doctors can be held criminally liable when they deviate from what are thus essentially standards developed within the medical profession[30]. Judges constantly reiterate and reinforce the naturalness and correctness of the medical control of abortion and the autonomy of medical practice. This seems to neatly illustrate an argument made by Peter Fitzpatrick (forthcoming):

"[b]y intervening occasionally and to correct excess, law confirms the normal run of administration as the unexceptional, as 'the nature of things'. In their relation, there are indefinable but inevitable limits to what law can do about administration. The supervising judge will ultimately recognise and respect the bounds or the integrity of administrative expertise".

And as Grubb concludes:

"[t]here can be little doubt that the English judiciary has no desire to challenge, except in the most exceptional circumstances, the medical decision-making power conferred upon doctors

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[30] Compare this with the standard of medical negligence as established by *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at 121: "[a] doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art." Again the court must judge the actions of doctors against the standards of their peers.

by the Abortion Act 1967" (1990; 156).

The judicial recognition of the authority of these 'parallel judges' of the medical profession, has meant that doctors who decide to take a liberal interpretation of the *Abortion Act* are unchecked, and women's access to legal abortion is thus facilitated.

c) Injunctions to Restrain Abortion

Judicial reluctance to step within the area of discretion carved out for medicine can also be seen in cases where injunctions to restrain a proposed abortion have been requested. Such an injunction has never been granted in the UK, nor, to the best of my knowledge, in any other common law jurisdiction, with the one notable exception of the Canadian case of *Tremblay v Daigle.* Here, the judge at first instance granted the woman's sexual partner an injunction to prevent her proposed abortion, commenting that:

"[t]he child conceived but not yet born, regardless of the term that is given to his civil status, constitutes a reality which must be taken into consideration. It is not an inanimate object, nor anyone's property, but a living human entity, distinct from that of the mother that carries it, which two human beings have give existence to, which they procreated, and which, at first blush, is entitled to life and to the protection of those who conceived it"[31].

This case has since been overturned, however, and is hence bad law. There have been two well-publicised failed attempts to secure such injunctions from the UK courts.

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[31] (1989) 59 DLR (4th) 609, per Bernier JA, at 613. He continues: "[a] person who freely does an act must assume its consequences. Pregnancy is not in itself an infringement of the physical integrity of a woman, an interference with her body, but a function which is a fundamental part of her nature. The rule of nature is that a pregnancy must be carried to term. The right to voluntarily terminate it constitutes an exception to this general rule. To arbitrarily have recourse to this without reasonable grounds constitutes at any stage of a pregnancy an abuse of right. On the other hand, a woman is entitled to an abortion if there are reasonable grounds for doing this in the light of the stage of pregnancy. The further advanced the pregnancy, the more serious and peremptory must be the grounds...But when the interests of the mother are contrary to those of her unborn child, when she wishes to terminate her pregnancy in a situation where the public interest is not involved, it is unquestionably the right of the father, on serious and reasonable grounds, to oppose the abortion. This legal interest is based on the very fact of conception of which both the father and mother were the cause. It is his child as much as it is the mother's, neither more, neither less." See Graycar and Morgan (1990; 218-9) on this case.

i) Paton v Trustees of British Pregnancy Advisory Service[32]

Mrs Paton obtained the two necessary certificates from registered medical practitioners, which would enable her to have her pregnancy lawfully terminated under s.1(1)(a) of the *Abortion Act*. She did not consult her husband, nor was he consulted by the authorising doctors. Mr Paton opposed the foreseen abortion, arguing that he had a right to have a say in the destiny of his child. He applied to the court for an injunction restraining his wife from causing or permitting an abortion to be carried out on her without his consent. The Court refused the injunction on the basis that a husband had no right, enforceable either at law or in equity, to stop his wife having, or a registered medical practitioner performing, a legal abortion. The court refused to supervise the discretion of a doctor acting under the *Abortion Act* where there was no clear indication of bad faith.

Paton clearly illustrates the judicial attitude to the position of doctors acting within the 1967 Act. The judgments clearly show the role of medicalisation in depoliticising the judges' decision. The judges here explicitly deny the relevance of moral values stating an aim of applying the law, "free of emotion or predilection"[33]. The first question addressed by the court was whether the plaintiff had any right which was enforceable at law. The foetus was held to be incapable of having any rights of its own until born and having a separate existence from its mother (989). To have succeeded, the case must have rested on the rights of the father. As the illegitimate father can have no rights at all (other than those which he is explicitly accorded by statute), the claim would have had to have rested on his rights as a husband (990), but the court will not seek to enforce or restrain by injunction matrimonial obligations. Therefore, Baker P concluded that the husband cannot by injunction prevent his wife from having a lawful abortion within the terms of the *Abortion Act* (991). He dismissed the plaintiff's claim that if the doctors did not hold their views in good faith (which would be an issue triable by jury following *R v Smith*, see above), then the plaintiff might recover an injunction. Baker P held that it was unnecessary to decide this "academic question" because it did not arise in this case:

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[32] [1978] 2 All ER, 987.

[33] Per Baker, P. at 989. Cited approvingly in *C v S* [1987] 1 All ER 1230, at 1238.

"[m]y own view is that it would be quite impossible for the courts in any event to supervise the operation of the 1967 Act. The great social responsibility is firmly placed by the law, on the shoulders of the medical profession" (991).

He concluded that it was not and could not be suggested that the certificate was given by the doctors in other than good faith and that that was an end to the matter in law (991). He ended his consideration of English law with the now famous words (which are cited more fully above): "not only would it be a bold and brave judge...who would seek to interfere with the discretion of doctors acting under the 1967 Act, but I think he would really be a foolish judge..." (992).

The husband's action thus failed in the face of the broad discretion accorded to doctors working within the terms of the *Abortion Act*, and the refusal of the judges to police within this discretion. *Paton* was the first occasion that the courts were faced with making such a decision, and it was not self-evident that they would have found in such a way[34]. Furthermore, the case was taken all the way to the European Court of Human Rights, and so the decision is supported by the very highest authority[35]. It is not surprising, therefore, that few similar actions have been brought. Indeed, only one further attempt to obtain an injunction to restrain an abortion has been reported in the UK.

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[34] The decision goes against the prediction of an earlier article in the *Modern Law Review* which foresaw the necessity of consent, at least where the couple were cohabiting. O'Neill, and Watson argued that: "[i]t seems quite feasible that the court might hold, not only that it has a duty to protect the unborn child, but also that the child's father has a right to request that it do so. If sympathy ever guides a court in coming to its decision on law, such sympathy might well, in the case of an abortion apparently "on demand", guide the court towards a decision in favour of the father" (1975; 184).

[35] *Paton v UK* [1980] ECHR 408. The Commission (the preliminary screening body for the Court) held that the right to respect for family life cannot be interpreted so widely as to confer on the father a right to be consulted or to make applications about an abortion his wife intends to have performed. Grubb (1990; 157) has argued, however, that this case may not be the last word at this level, as the decision was narrowly expressed: Mrs Paton was only 8 weeks pregnant and the Commission made it clear that it was not concerned with balancing the rights of a mature foetus with those of the woman, for this was a case where the pregnancy was in its initial stages. Further, the Commission restricted its decision to cases where there is a 'medical indication' for abortion in the interests of the woman's life or health. For example, it specifically excluded from its consideration, abortions performed on eugenic grounds.

ii) C v S[36]

The case of *C v S* involved an application by Robert Carver, president of the Oxford University Pro-Life group, on his own behalf and as next friend of the 'child en ventre sa mère', for an injunction to restrain his pregnant ex-girlfriend, from terminating her pregnancy. Carver conceded that he had no locus standi based on a claim of biological paternity (this much was clear from *Paton*[37]). However, he argued that he had a sufficient personal interest to do so as the proposed termination would be a crime concerning the life of his child. Further he argued that the unborn child was a proper party to the proceedings since it was the subject of a threatened crime. Carver argued that the issue to be decided could be distinguished from that in *Paton*, given the gestational age of the foetus (between 18 and 21 weeks). This, he argued, meant that it was "capable of being born alive" and the act of aborting it would thus constitute the offence of child destruction under s.1(b) of the *Infant Life (Preservation) Act*, 1929. Carver defined "capable of being born alive" in terms of the ability to demonstrate real and discernible signs of life, namely a primitive circulation and movement of the limbs.

The judge at first instance refused to grant an injunction, holding that the foetus had no right to be a party and that the father had failed to establish that an offence under the 1929 Act would be committed if the termination was carried out. The father appealed to the Court of Appeal which dismissed the action, holding that although a foetus of between 18 and 21 weeks of gestation could be said to demonstrate real and discernible signs of life, the medical evidence was such that it would not be "capable of being born alive" within s.1(1) of the 1929 Act. This decision was reached by the court on the basis that the foetus would be incapable of breathing either naturally or with the aid of a ventilator - and that "capable of being born alive" also included some capacity for independent survival. Given that lung development does not occur until around 24 weeks of gestational development, capacity for life could not be presumed before that point. The House of Lord upheld the decision by

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[36] [1987] 2 WLR 1108, [1987] 1 All ER 1230.

[37] Indeed Mr Paton would have been in a stronger position to make such a claim as he was married to the pregnant woman, and thus would have been the child's legal guardian. Further, Baker clearly dismisses the possibility that the putative or illegitimate father could have any rights at all in such a case, *Paton v BPAS* [1978] 2 All ER 987, at 990.

refusing leave to appeal[38].

Thus the issue in *C v S* is essentially a medical one, and the task of the judges is to sift through medical evidence provided in the affidavits of "medical men, all of high reputation and great experience" (1235) to arrive at the correct definition of "capable of being born alive". Here the judge must take into account the "rapid, extensive and truly remarkable developments in medical science, not least in the field of obstetrics" (1238). The interesting thing about *C v S* is that, despite the very clear authority of *Paton*, Carver still thought that there was a possibility to obtain an injunction by challenging the received legal construction (i.e. the rebuttable presumption that viability is presumed to occur at 28 weeks, contained in the *Infant Life (Preservation) Act*, 1929) with the argument that it has been overtaken by medical technology and the production of expert medical witnesses to testify to this effect. The judge is then forced to step onto essentially medical territory, in weighing up different medical criteria for viability and choosing from amongst them. In so doing, he does indeed find that the limit of 28 weeks too high, but fails to accept the criteria (and the still lower time limit) proposed by Carver. The judge also weighs up the different medical definitions against pre-existing case law on the matter, and thus retains final authority for the law[39]. He adds:

"[i]t is not necessary for me, nor would I want, to try to decide on affidavit evidence in a somewhat limited sphere the answer, which baffles men and women with great scientific expertise, to a very profound question. I would, however, say that I am not greatly attracted

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[38] *C v S*, could no longer occur in the same form as s.37 *Human Fertilisation and Embryology Act* has specifically uncoupled the application of the *Abortion Act* from that of the *Infant Life (Preservation) Act* and introduced a fixed upper time limit of 24 weeks into the *Abortion Act* (except in the presence of some specified contraindications). It is worth noting that although Carver lost this case in the courts, he won it out of them: S felt unable to go through with the termination following all the publicity surrounding the case.

[39] The following cases were referred to (at 1239): *R v Handley* (1874) 13 Cox CC 79, a child was considered to have been 'born alive' when it existed as a live child, breathing and living by reason of its breathing, through its own lungs alone, without deriving any of its living or power of living by or through any connection with its mother. *R v Poulton* (1832) 5 C&P 329, 172 ER 997, even the fact of a child having breathed was said not to be conclusive proof of it having been in 'a living state'. In *R v Enoch* (1833) 5 C&P 539, 172 ER 1089 and *R v Wright* (1841) 9 C&P 754, 173 ER 1039, the judge directed the jury that to be alive there must be, in addition to breathing, a circulation independent of the mother.

to the very limited definition relied on by [the expert medical witness for the plaintiff] and I do not accept it as a realistic one" (1240).

Paton and *C v S* show the same reluctance on the behalf of the judiciary to supervise the doctors or to second-guess their decisions (other than in clear cases of bad faith or bad medical practice) as was seen in the other cases described in sections a) and b) above. As Sir Roger Ormrod, then a judge of the Court of Appeal and a qualified doctor stated in 1976:

"[a]bortion has become generally available, if not yet quite on demand, but subject only to the attitude of the surgeon concerned or of the clinic to which the woman is referred" (in Grubb; 1990; 154).

d) Protection of Medical Practice: Terminations by Medical Induction

Royal College of Nursing of the United Kingdom v Department of Health and Social Security[40]

The Department of Health and Social Security (DHSS) sent out a circular to regional and area medical officers and district nursing officers, dealing with abortions by medical induction[41]. In it they advised that it was not necessary for a registered medical practitioner personally to perform every action in the process, providing that he/she decided on and initiated the process and remained responsible for it throughout. The Royal College of Nurses (RCN) claimed a declaration from the courts that the advice given in the department's letter and annexes was unlawful in that nurses were not registered medical practitioners, and that the defence in s.1(1) of the *Abortion Act*, applying only when "pregnancy is terminated by a registered medical practitioner", was therefore not available to them.

Woolf, J., deciding the case at first instance, decided in favour of the DHSS, arguing that s.1(1) should not be interpreted narrowly. The RCN appealed to the Court of Appeal who

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[40] QBD, CA and HL [1981] 1 All ER 545.

[41] The procedure for abortion by medical induction is as follows: a doctor inserts a catheter into the woman's uterus and subsequent steps are carried out either in whole or in part by nursing staff, who may be responsible for connecting a pump to the catheter which would feed the prostaglandins into the woman, and monitoring the process which could take anything up to 30 hours. The prostaglandins serve to induce uterine contractions which will expel the foetus and terminate the pregnancy.

overturned the decision. In turn, the DHSS appealed to the House of Lords which (by a majority verdict of 3:2) reversed the Court of Appeal's decision[42], holding that the 1967 Act must be construed in the light of the fact that it was intended to clarify the previously unsatisfactory law, to broaden the grounds on which abortions might lawfully be obtained and to ensure that they were carried out with proper skill in hygienic conditions in ordinary hospitals as part of ordinary medical care and in accordance with normal hospital practice. Thus, in the words of Diplock, LJ:

"a registered medical practitioner...should accept responsibility for all stages of the treatment for the termination of the pregnancy. The particular method to be used should be decided by the doctor in charge of the treatment for termination of the pregnancy; he should carry out any physical acts, forming part of the treatment, that in accordance with accepted medical practice are done only by qualified medical practitioners, and should give specific instructions as to the carrying out of such parts of the treatment as in accordance with accepted medical practice are carried out by nurses or other members of the hospital staff without medical qualifications. To each of them, the doctor, or his substitute, should be available to be consulted or called on for assistance from beginning to end of the treatment" (571)[43].

There is almost a circularity to the logic here: doctors are legally authorised to do what doctors normally do. In fact, this is a clear statement of the judicial preference for self-regulation by the medical profession, and the development of standards for good medical practice to be determined within the profession. Accordingly, so long as a doctor prescribed the treatment for the termination, remained in charge and accepted responsibility throughout, and the treatment was carried out in accordance with his directions, the pregnancy was "terminated by a registered medical practitioner" for the purposes of the 1967 Act, and any person taking part in the termination was entitled to the protection afforded by s.1(1).

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[42] This case was thus decided by the narrowest of margins. As Smith writes in his commentary of it: "[f]ive judges answered the question in the negative and four in the affirmative - but as three of the four were sitting in the House of Lords, their opinion prevailed" (1981; 323).

[43] See also Woolf, J. at 553: "the registered medical practitioner must decide on the termination; the process must be initiated by him, and he must remain throughout responsible for its overall conduct and control in the sense that any actions needed to bring it to a conclusion are done by appropriately skilled staff acting on his specific instructions, but not necessarily in his presence, though he or another registered medical practitioner must be available to be called if required".

This case is notable for several reasons. What first struck me on reading it is the extent to which those judges who found for the DHSS are prepared to stretch an interpretation of the terms of the *Abortion Act* in order to reach an acceptable decision. The decision which the House of Lords eventually comes to is the common sense verdict and no doubt accords with "the obvious intention of the Act"[44], yet it is one that is squared with the actual wording of the statute only with great difficulty. When the doctor's actual involvement in the termination is limited to the insertion of the catheter - an act preparatory to the administration of the prostaglandins which cause the uterus to contract and expel the foetus - it involves a rather creative interpretation to see the doctor as terminating the pregnancy rather than the nursing staff who do everything else. Explicitly underlying this decision is a refusal to interfere with 'good medical practice'.

Liz Kingdom welcomed the final (House of Lords) verdict in the case, saying that had it upheld the Court of Appeal that this would have been "a setback to feminists' hopes that trained personnel other than registered medical practitioners might, in the future, lawfully terminate pregnancies" (1991; 53). However, whilst Kingdom is correct to state that this case does not represent a setback to such hopes, neither would it be right to see it as particularly advancing them[45]. It appears that the situation is now governed by the statement of Lord Diplock cited above. Whilst nurses are hereby authorised to do certain actions in this kind of termination, they can still do so only under the control of the doctor who retains the ultimate responsibility for the operation. This strict hierarchy of the relationship between doctor and nurses is thus reproduced in the legal assessment and the doctors' legal monopoly is reasserted. Especially telling here is Lord Keith's statement:

"I find it impossible to hold that the doctor's role is other than that of a principal; and I think he would be very surprised to hear that the nurse was the principal and he himself only an accessory" (575).

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[44] See Hoggett: "[t]he obvious intention of the Act is to protect not only the doctor but any person who takes part in an abortion, such as nursing and theatre staff, and any person who procures or supplies instruments or other abortifacients knowing that they are to be used "with intent to procure the miscarriage of any woman"" (1968; 254).

[45] The one area where I feel it *may* advance them is the liberalisation of the administration of drugs in antiprogestin terminations (see chapter 7 below).

The doctor's control of the process is thus enforced: it doesn't matter if it is the nurse who physically performs the actions necessary to bring about termination, so long as the doctor remains in control and instructs. As Montgomery comments on this case:

"[i]n order to justify the [Department of Health and Social Security's] position it was necessary to construe the actions of the nurses as being those of the doctors in the eyes of the law...their Lordships characterised the relationship between the two professionals as one in which the nurse is little more that the doctor's handmaiden" (1992; 145).

Kingdom raises a second interesting point with regard to this case: the fact that the catalyst which provoked this case was a departmental circular[46]. This highlights a trend in the regulation of abortion for decisions to be made at the level of administration/medical practice. As Kingdom notes, in the *RCN* case the use of administrative measures was consistent with improved abortion facilities. However in other cases it is not. Kingdom also cites the introduction of new notification forms which I discussed above (pp. 113-4). Pro-choice campaigners were concerned that the absence of any reference to the 'environment clause' on the notification form could influence the willingness of doctors to use that clause when authorising terminations. Resistance was situated within a concern that the forms heralded the removal of the basis for any future campaign for independent social grounds for abortion (Kingdom; 1991; 53).

The *RCN* case demonstrates again how the reluctance of law to interfere with medical discretion and good medical practice, can benefit women by protecting the provision of abortion services.

e) Abortion in the Absence of Consent: Minors and the Mentally Handicapped

Abortion - like any medical procedure - is only saved from constituting an assault by way of the consent of the patient. In certain cases this is problematic as the pregnant woman is not legally competent to consent, either because she is too young, because she is mentally handicapped or (as will be considered in the following section) in an emergency situation

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[46] In the Court of Appeal decision, Lord Denning criticised this, commenting that: "[i]f the Department of Health want the nurses to terminate a pregnancy, the Minister should go to Parliament to get the statute altered...that is the way to amend the law and not by means of a departmental circular" (557).

where she is unconscious. In such cases, difficult ethical and legal issues arise as to who is in a position to make the decision on her behalf. Since the case of *Gillick v West Norfolk and Wisbech Area Health Authority*[47], the courts have adhered to the principle that where the care and upbringing of a child was at issue, the court must treat the welfare of the child as the paramount consideration. In practice, very often the courts find that these best interests of the child accord with the opinion of the medical professionals involved.

i) Re B[48]

L, a schoolgirl of 12, was cared for by her mother until she was 18 months old. Since then she had been brought up by her maternal grandparents, but was in regular contact with her mother, who now had two other children living with her. L became pregnant and being informed of the pregnancy by her GP, the local authority initiated wardship proceedings and applied to have the pregnancy terminated. The Official Solicitor (who represented L), the maternal grandparents and the putative father of 16 all supported L, who was said to be "of normal intelligence and understanding" and who had been "constant" in her wish to have the abortion. Her mother, however, opposed the application, arguing that "it is not right to take the baby's life". Medical evidence was conflicting. Two obstetricians and gynaecologists said that L, who was small in build, was both physically immature and mentally inexperienced and although termination would be traumatic it was her best interests. A different prognosis was offered by two obstetricians and gynaecologists on behalf of the mother, who suggested that psychological effects might surface years after an abortion and there was also a risk of future premature births. In their view the risk of an abortion at this stage was higher than the risk of pregnancy. However, it seems that they were also clearly influenced by considerations other than the strictly medical, as they also argued that it was "wrong to kill the baby simply because it is inconvenient to have". Referring to *Gillick* (see p. 124 above), Hollis J. rejected the view that "it is wrong to kill the baby" as putting the

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[47] [1985] 3 All ER 403. In this case, the House of Lords upheld the right of doctors to give contraceptives and contraceptive advice to minors, even in the absence of parental consent. This case also established the principle that the ability of a child under the age of 16 to give her/his consent to medical treatment and advice depends on her/his level of understanding and intelligence.

[48] *The Independent*, 22 May, 1991 (Family Division).

interest of the foetus and not the ward of court as paramount. Having considered L's age, the wishes of all those concerned, the competing medical opinions and the view of the Official Solicitor, he asserted that it was clearly in L's best interests to have the pregnancy terminated since its continuance involved greater risk both to her mental and physical health.

One commentator has described this case as an important landmark in the continuing erosion of parental rights, complaining that it is now the medical profession who has the power to define what is in the best interests of the child:

"[t]oday, on medical matters, at least, parental rights seem relatively unimportant, and the medical profession apparently has the final say on any contested issue of the treatment of children...Is there any important respect in which a parent can hold out against medical orthodoxy when it comes to the treatment of a child and when the state has become involved?"[49]

Here, the adoption of the girl's best interests (as determined by her own doctors) accorded with her own wishes and the *Gillick* test. The medicalisation of the issue favoured a verdict which accorded with considerations of the girl's autonomy.

The English courts have never yet had to decide on a case where a pregnant minor opposes an abortion, when this is desired by her parents and recommended by her doctor. However, it has been suggested that the law as decided by *Re W* (see above) could lead to abortions being carried out by doctors with the consent of parents, despite the refusal of 16 or 17 year olds. Donaldson MR considered this possibility and stated (rather ominously) that although it might be possible as a matter of law, medical ethics would ensure that it was only the case if it were in the "best interests" of the young woman (see Bridgeman; 1993a; 80).

***ii) T v T and another*[50].**

The defendant was a woman of 19 who was epileptic and severely mentally handicapped. She was completely dependent on others. She became pregnant and termination of the

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[49] Alexander McCall Smith in *The Times*, 28 May, 1991.

[50] [1988] 1 All ER 613.

pregnancy was recommended by medical advisers on the ground that it was impossible for her to understand the concept of pregnancy or to cope with the difficulties and complications associated with that condition and that she would be incapable of providing and caring for a child. However, the defendant was unable to consent to abortion and sterilization procedures. Her mother applied to the court for a declaration that the proposed termination of pregnancy and sterilization would not amount to an unlawful act by reason only of this lack of consent. The court accordingly made a declaration of right because the circumstances were special and proper medical practice demanded that the operations take place. The court held that where there is nobody in a position to consent, that a medical adviser must consider what decisions should be reached in the patient's best interests[51].

iii) Re G[52]

In the case of *Re G*, this discretion and authority is again recognised. The case concerned a 26 year old mentally handicapped woman who was 17 weeks pregnant. Her doctors felt it desirable to apply to the High Court before terminating the pregnancy. However, Stephen Brown, President of the Family Division, held that it was not essential as a matter of practice to seek a declaration from the High Court before carrying out a termination of pregnancy on a mentally handicapped woman. The *Abortion Act* provided fully adequate safeguards for the doctors involved and it was not necessary that specific approval of the High Court should be a pre-condition for the termination of a pregnancy.

Here again, the judges accord the authority to the doctor to reach the decision which he/she believes correct in recognising her/him as the person most well placed to determine what constitutes the woman's 'best interests'. Once again the doctor is located as the appropriate expert to take a decision which is not merely a (narrow) medical one, but one involving far reaching social and ethical questions.

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[51] [1988] 1 All ER 613 at 621.

[52] Reported in *The Times*, 31 January, 1991.

f) Abortion in the Absence of Consent: the Unconscious Patient

A recent case has posed the possibility for conflict between medical paternalism and female autonomy in a particularly dramatic and tragic way. In March 1993, Barbara Whiten, a thirty-five year old woman, was in hospital for a hysterectomy to relieve a painful and chronic disease of the womb which she believed had left her unable to conceive. The operation was performed by a consultant gynaecologist and obstetrician, Reginald Dixon. During the operation, Mr Dixon noticed that Mrs Whiten's uterus was enlarged, one possible cause of this being pregnancy. He decided against delaying the removal of the womb so that a scan could be arranged in order to determine the cause of the swelling and (if due to pregnancy) to give Mrs Whiten the opportunity to decide whether or not she wished to go ahead with the operation. Rather, he removed ovaries and uterus and the next day informed her that she had been pregnant and that he had removed a healthy 11 week old embryo, stating this to be "the usual practice". Mrs Whiten, who had been trying to conceive for some years, was horrified. She complained that she had had the possibility of making her own decision taken away from her.

In a letter to Mr and Mrs Whiten, Mr Dixon said that he felt an emergency termination was justified on the grounds of Mrs Whiten's age, desire for a hysterectomy and history of depression. In a second letter he acknowledged that with hindsight he may have done better to have sewn up the abdomen and arranged a pregnancy scan. In this case, then, Mr Dixon has taken what, with the benefit of hindsight, seems (also to him) to be have been the wrong decision. Nevertheless, he has taken it in good faith and has acted within the grounds of what he considers to be "usual practice". The surgical services manager at the hospital told *The Guardian* that this was a sad and complex case, but that the doctors involved had "acted in good faith"[53]. In the course of their investigations of Barbara Whiten's complaint, the police uncovered a second similar case. A woman called Jane Henson told detectives that a trainee gynaecologist acting under the supervision of Reginald Dixon ignored her concerns that she might be pregnant and removed her womb in December 1991. After the operation Mrs Henson was told that she had indeed been pregnant[54].

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[53] *The Guardian*, 13 September 1993, see also Thomson (1994).

[54] See *The Observer*; 27 March 1994.

Both Mrs Whiten and Mrs Henson are currently preparing court actions, however their chances of obtaining legal redress are uncertain (Thomson; 1994). As was seen above, it is only the consent of the patient which prevents medical treatment from constituting an assault and in both of these cases, consent was obviously absent. However, Mr Dixon has two possible defences. First, there is the defence of tacit consent. The standard form which patients sign before undergoing surgery authorises:

"any procedure in addition to the investigation or treatment described on this form [which] will only be carried out if it is necessary and in [the patient's] best interests and can be justified for medical reasons".[55]

The doctor is only permitted to carry out further surgery without which the patient's life or health will be immediately at risk. There is also a second possible defence: necessity. In emergency situations, the doctor is justified in taking any necessary action to save life and to proceed without consent "with any procedure which it would be unreasonable, as opposed to merely inconvenient, to postpone until consent could be sought" (Skegg; 1974; 518)[56]. The crucial factor with regard to the success of both defences is whether the abortion was immediately necessary. Mr Dixon contends that it was, on the grounds of Mrs Whiten's mental state: her age, history of depression and desire for a hysterectomy. Although these arguments seem less than compelling, it is still highly possible that a court would find in his favour. To demonstrate that Mr Dixon's conduct was unreasonable, Mrs Whiten must show that the surgeon did not act "in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art"[57]. In practice, this means that Mr Dixon must produce some of his colleagues who are prepared to testify to the effect that what he did was not outside the boundaries of what other medical professionals accept to be reasonable. Again the essential test becomes one determined within the medical profession,

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[55] A copy of the standard consent form is included in Brazier (1992; 76).

[56] These two defences seem very similar, but in practice there is one important difference: in the first the burden of proof is on the patient to establish that the surgeon's assumption of consent was not reasonable, in the second, the burden of proof is on the surgeon to establish that the intervention was reasonable and necessary to save the life of the patient or to prevent grave and permanent injury to her health (see Brazier; 1992; 91).

[57] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 at 122.

and if many (or even some) doctors are operating with similar standards (even if such standards seem unreasonable or unacceptable to the broader public) then Mr Dixon is not liable.

The Crown Prosecution Service were also reported to be considering Barbara Whiten's case, but at the time of writing they have yet to decide whether to bring an action. In terms of a criminal prosecution, there is a possible action under the *Abortion Act*, as Mr Dixon has not complied with the terms of s.1 which foresee the need for the consent of two doctors. S.1(4) provides a defence for the doctor who terminates a pregnancy without such second opinion only in an emergency situation, where:

"he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman".

Again the legal outcome will rest upon Mr Dixon's opinion that this was an emergency operation. What is relevant is not whether the situation objectively constituted an emergency, but subjectively whether Mr Dixon believed in good faith that it did so (there is no requirement of reasonableness).

Barbara Whiten's story is an extreme and particularly tragic example of the effects of medical paternalism. Mr Dixon here feels justified in making a decision for Mrs Whiten as to whether or not it is best for her to continue with her pregnancy, and may be proved right in his contention that this falls within the bounds of "usual practice". The fact is that English law explicitly grants the authority to doctors to take important decisions regarding female reproduction - notably abortion - even when it is clear that these decisions are only rarely based on strictly medical criteria. Medical paternalism is not merely allowed by the law, with regard to abortion it is actively condoned and enforced. Such paternalism is thus within the bounds of 'good medical practice', and so the doctor is left beyond administrative reprisal (Mr Dixon has the support of his health authority and is not to be dismissed from his post[58]) and possibly judicial intervention. If this case proceeds, it will stage a confrontation between

[58] *The Times*, 12 September 1993, Thomson; 1994; 13.

women's autonomy and medical discretion that will be a test for English law. If no case is brought, then it would seem to illustrate my fear that the law is far more reliable in protecting the medical relationship from outside challenge than it is in protecting the position of women within it.

4. CONCLUSION

The breadth of the discretion which the judiciary accords to doctors is as clearly shown by the cases dealing with abortion, as it is in the cases of *Re S* and *Re W* which I discussed in the introduction to this chapter. In the abortion cases, however, I would contend that considerations of medical discretion have not impinged on women's autonomy. On the contrary, they have favoured it and have constituted a vital factor in the liberalisation of the provision of abortion. This has been shown in a variety of cases. First, the safety from prosecution which doctors enjoy as a result of judicial respect for medical discretion, has created a situation in which some doctors feel free to be increasingly liberal in the provision of abortion, even to the extent where those pro-choice doctors discussed above who specify "pregnancy" as the reason for termination have not been prosecuted. Secondly, the court's complete refusal to supervise the doctors' decision, beyond ensuring the existence of good faith, was an extremely influential factor in establishing that women cannot be prevented from terminating a pregnancy by the opposition of their sexual partners. Thirdly, in the *RCN* case the courts let considerations of good medical practice dictate a very creative interpretation of statute, hence ensuring the possibility of legally providing abortions by medical induction. Finally, in cases where consent is problematic, in the case of *Re B*, L was allowed to terminate her pregnancy in accordance with her own wishes, despite the opposition of her mother.

The argument which I am making here is not a principled justification (or still less an apologia) for the benefits of the medical control of abortion. I have argued above that such control rests on paternalism: a refusal to credit women with the necessary maturity, rationality and integrity to make their own reproductive decisions. It has also been clearly seen in previous chapters that such control has presented serious obstacles to the establishment of good provision of abortion services. What this analysis does do, however, is to highlight the

peculiar difficulties of the situation which feminists face with regard to the medical control of abortion. The principled arguments against such control must be weighed against the practical and concrete benefits it has provided (and the security which it may continue to give) on the level of entrenching and extending women's access to abortion services. In the case of abortion, the judicial deference for medical opinion has been so beneficial for women because they approach the courts in conjunction with their doctor, desiring the same legal outcome. The benefits for them arise from the legal refusal to look within the doctor's area of discretion, and the doctor-patient relationship. The last case, I discussed reveals the limits of this in terms of protecting women's autonomy. Here, like the cases of *Re S* and *Re W*, which I mentioned in the introduction, the woman stood in opposition to her doctor and problems arose when she sought to challenge the doctors' control. The story of Barbara Whiten provides an illustration of how this might also occur with regard to the regulation of abortion. It seems likely that, also in abortion cases, where the law has been effective at protecting the doctor-patient relationship from outside attacks, it is less useful at protecting female reproductive autonomy within it.

CHAPTER 6: THE HUMAN FERTILISATION AND EMBRYOLOGY ACT (1990): WINNING THE BATTLES BUT LOSING THE WAR?

"The outcome of voting on the abortion amendments to the government sponsored Embryology Bill was a massive defeat for the anti-abortionists, which poses a new stage in women's struggle for reproductive control. It decisively confirms the impact of the underlying trends in the position of women, and the political developments these make possible. Success in this most difficult abortion battle rested more than ever before on the tactical choices made by the Pro Choice movement. It is crucial that the left and the whole movement learns the lessons of these tactics and how the campaign was waged and won"[1].

"Political technologies advance by taking what is essentially a political problem, removing it from the realm of political discourse, and recasting it in the neutral language of science. Once this is accomplished the problems become technical ones for specialists to debate...Bio power spread under the banner of making people healthy and protecting them. When there was resistance or failure to achieve its stated aims, this was construed as further proof of the need to reinforce and extend the power of the experts...We are promised normalization and happiness through science and law. When they fail, this only justifies the need for more of the same"[2].

"We need to establish a principle that is related to the best medical practices. We should not have to debate the matter year in, year out but should place our trust in medical practitioners and give them a legal framework within which they can operate and which the public can understand"[3].

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[1] Anne Kane, coordinator of the Stop the Amendment Campaign (STAC) (1990; 19).

[2] Dreyfus and Rabinow (1982; 196).

[3] Doran, H.C. Deb. Vol 171 Col. 214, 1990 (24 April).

1. INTRODUCTION

In 1990, after fierce and protracted debates both inside and outside Parliament, the *Human Fertilisation and Embryology Act* was voted onto the statute books. The Act has three fundamental objectives: to provide a statutory framework for the control and supervision of research involving human embryos, to provide for the licensing of certain types of assisted conception, and to effect changes to the *Abortion Act* 1967. These changes are the first to be made to the Act since it came into effect, despite numerous previous attempts by way of Private Members' Bills, all of which were talked out of time[4]. As the reforms contained in the *Human Fertilisation and Embryology Act* were to be heard in Government time however, filibustering was now impossible and it was inevitable that, after nearly 25 years, the 1967 Act would be put once again to the vote. Although various additional amendments to the 1967 Act were suggested, the main point of contention was the upper time limit on abortion: pro-choice activists argued that the rebuttable presumption of a 28 week limit read into the Act from the *Infant Life Preservation Act*, 1929 should be maintained; anti-choice activists demanded that it should be reduced to 18 weeks[5]. The eventual outcome of the voting was widely hailed as a gain for the pro-choice movement. The upper time limit was reduced to 24 weeks, however this was not to apply in cases where the pregnant woman's life or health was seriously threatened by the pregnancy or birth, or when the foetus was seriously handicapped. In this chapter I want to look again at the reforms embodied in the *Human Fertilisation and Embryology Act*, and ask how far they can be seen to represent victory, and how far they should be assessed as loss. My contention will be that whilst the reforms undoubtedly represent the most recent in a series of political victories for the pro-choice campaign, on a significant level, they also represent a defeat.

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[4] These were introduced by Norman St John-Stevas (1969), Godman Irvine (1970), Michael Grylls (1973 and 1974), James White (1975), William Benyon (1977), Bernard Braine (1978), John Corrie (1979), Enoch Powell (1984), Ken Hargreaves (1985 and 1986), Alistair Burt (1987) David Alton (1988) and Douglas Houghton (HL, 1989). For more information on attempts to reform the *Abortion Act* between 1969-1982, see Keown (1988: 138-52).

[5] 18 weeks was chosen as the lowest limit for which might be realistically attainable - this reflects a strategy of cutting away 'salami' fashion at the law, gradually paring down the time limit on abortions.

It is important not to be alarmist. The victories which have been won over the past 25 years are not negligible and repeated attempts at restricting the 1967 Act have all failed. The reforms introduced to the Act by way of s.37 of the *Human Fertilisation and Embryology Act* in 1990 did not introduce radical changes in respect of the practice which existed prior to its implementation and, if anything, have liberalised the operation of the *Abortion Act*. There even seems to have been, at the time of the *Human Fertilisation and Embryology Act*, an undertaking by the anti-choice forces in Parliament that if the possibility of voting on reforms of the 1967 Act was given, that they would 'go away for a while' and not introduce more bills aiming to restrict the Act (see below, pp. 137-8). Thus the immediate future of the provision of abortion services in Britain seems doubly secure after 1990, the status quo assured.

Whilst avoiding alarmism however, one should also be careful not to succumb to complacency. In this chapter I will analyse the broader assumptions and constructions which underlie this development. My contention is that although feminists have won an important series of legal battles, there may still be a danger of losing the wider war of definition of what is really at stake in the issue of abortion (Science and Technology Sub Group; 1991; 147). Feminist strategies have long aimed at directing attention to broader social issues, and to situate abortion in relation to issues of contraception, sex education, welfare benefits and general discussion over women's sexuality and position in society. Such broader concerns, however, are becoming increasingly marginalised even within pro-choice discourse. 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. As Elizabeth Grice (1988) wrote in the *Sunday Times*: "[a]fter two decades of a woman's right to choose, the emphasis in debate has slid with a minimum of fuss towards the child's right to life". To accept an essentially medical framework for debate seems doubly dangerous given that, as has been seen in previous chapters, and as I will expand below (pp. 196-203) many of the problems faced by women seeking termination are related to medical control.

I will begin by considering briefly the Alton Bill (1988), a Private Members' Bill which received considerable public attention and which, despite its eventual failure, has been cited

for its importance in establishing a new agenda for discussion of abortion (Steinberg; 1991) and thus provides a suitable starting point. I then move onto my main focus of attention - the *Human Fertilisation and Embryology Act*, with particular reference to section 37 (amendments to the Abortion Act). Here, the acceptance of a medical framework as the only legitimate structure for discussion on abortion is clearly marked. Likewise a construction of the issue in terms of protection of the (essentially separate) foetus seems to have been largely accepted (or at least inadequately challenged) within Parliament. I will also discuss briefly the provisions of section 3 (prohibitions in connection with embryos), for their significance in fostering a discourse of foetal protectionism which may yet have an impact on the provision of abortion.

2. THE ALTON BILL (1988)

"What has happened to alter David Alton's chances of abortion reform where at least 12 others have failed is that life in the womb is not nearly so shadowy as it was 20 years ago" (Grice; 1988).

The Alton Bill was introduced into Parliament in October 1987 by a Private Member, the Liberal M.P. for Mossley Hill (Liverpool), David Alton. It received its second reading in the House of Commons on 22 January 1988, where it was passed by a majority of 296 to 251. The main provision of the Bill was a reduction in the upper time limit for legal abortion to 18 weeks with exemptions of up to 28 weeks only where termination was necessary to save the life of the woman or where the child was likely to be born dead or with physical abnormalities so serious that its life could not be independently sustained. A further exemption for women under eighteen years old who had suffered incest or rape was introduced at Committee stage. After vigorous campaigning by both anti-choice and pro-choice supporters, the Bill ran out of time at the Report Stage which follows Committee and failed without being put to the test of a final vote.

The Alton Bill forms the focal point of a fascinating series of essays published together in the book, *Off-Centre: Feminism and Cultural Studies* (Franklin et al; 1991). The contributors worked together as the 'Science and Technology Subgroup' (STSG) at the Centre for Contemporary Cultural Studies at Birmingham University and focussed on the importance of

science to recent debates about abortion in Britain. In a general conclusion to the essays, they assert that:

"despite the fact that the Bill itself was legislatively unsuccessful, the terms in which abortion was to be considered had been forged in a way which left little opening for women's needs or interests or for exploring reproduction as a social, not just a technological, biological or individual issue" (1991; 215).

One member of the group, Deborah Steinberg (1991) argues that although the Alton Bill ultimately failed in that it did not pass into law, it was successful in several respects in shifting the terrain of the meaning of abortion. Amongst the legacies of the Alton campaign which she lists is the increasing degree on reliance on medical/scientific knowledges to define abortion and it is this which will form the major focus of my discussion concerning the *Human Fertilisation and Embryology Act*. Thus the importance of the Alton Bill and its surrounding campaign should rather be seen in terms of the assumptions which it succeeded in establishing and/or further entrenching in the public consciousness. These assumptions were also fostered by the media coverage. Tess Randles contends that in the reporting of the progress of the Alton Bill, the media established a particular framework within which scientific knowledges were seen as structuring the debate. She argues that within the reporting of the Alton Debate, this consensual framework took the form of a "medico-moral rhetoric" which drew upon a fusion of Christian dogma and state-of-the-art medical technological knowledge. This resulted in the establishment of a seemingly 'consensual' framework for debate which invited 'objective' decision-making and 'rational' discussion (1991; 207)[6]. The STSG conclude:

"the debate focused on fetal viability as the established role of medical expertise in the adjudications surrounding abortion in Britain. In addition, the enhanced role of medical expertise went hand-in-hand with the harnessing of abortion rights to the technological capacities of modern medicine and an unquestioning faith in scientific progress. Prenatal diagnosis, technological systems for sustaining infants born prematurely and the technology which produces photo-images of fetuses were all invoked frequently during the Alton abortion controversy. In such circumstances, medical judgements and technical possibilities or limitations, not women's needs or lives, set the parameters of debate" (1991; 214).

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[6] See also McNeil (1991; 151) on press panics during the period of debate over the Alton Bill which reinforced the enhanced status of the foetus.

3. THE *HUMAN FERTILISATION AND EMBRYOLOGY ACT*: S. 37 (AMENDMENT OF LAW RELATING TO TERMINATION OF PREGNANCY)

The most recent prolonged Parliamentary discussions of abortion occurred in 1990, when certain reforms to the 1967 Act were introduced by way of s.37, *Human Fertilisation and Embryology Act*. Prior to this there had been no time limit in the *Abortion Act* itself, but an effective time limit on abortions had been read into it by way of the *Infant Life (Preservation) Act*, 1929, which made it an offence to destroy a "child capable of being born alive", and contained a rebuttable presumption that a child would be held to be "capable of being born alive" from 28 weeks of gestational development. In the *Human Fertilisation and Embryology Act*, the *Abortion Act* was specifically 'uncoupled' from the *Infant Life (Preservation) Act*, and a fixed limit of 24 weeks[7] was inserted into the former, with exceptions made for cases of serious risk to the pregnant woman's life or health, or in the presence of serious foetal handicap. These provisions did not greatly effect the operation of the 1967 Act - it had already become established medical practice to treat viability as occurring at around 24 weeks and not to provide terminations after this point (Hall; 1990, Murphy; 1991). If anything the provisions extended the circumstances in which abortion should be allowed, in allowing terminations up to birth in the case of foetal handicap. Murphy (1991) argues that in practice, this is the only real change introduced by the reforms.

Following the introduction of the *Human Fertilisation and Embryology Act*, it seems unlikely that there will be another challenge to the abortion law in the immediate future. There seems to have been an 'understanding' between the Government and anti-choice supporters within the House of Commons, that if the Government gave time for discussion of abortion and a re-evaluation of the working of the 1967 Act, that the anti-choice forces in Commons would 'disappear' for a while and cease their periodic attacks on the Act. In replying to a question as to how long was meant by 'a while', one of the most vociferous anti-choicers in Parliament, Anne Widdecombe answered:

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[7] One persistent point of imprecision in the law, is that it does not specify when the 24 weeks will be deemed to begin. As Murphy (1991) argues there are four distinct stages which may be argued to mark the critical date: date of the last period prior to conception (LMP); date of fertilisation; date of implantation; or when the embryo reaches two weeks old.

"[a]s to what is meant by "for a while", how long is a piece of string? A decent interval must mean just that. We, I or anyone may go to Government again to say that the House wants to take a decision on this matter and must do so, but if we simply get into the habit of coming back with a whole load of similar or different proposals, frankly we would not deserve the trust of Government, nor would I expect to receive it. Therefore, "for a while" means a decent interval"[8].

So far, at least, this promise seems to have been by and large respected[9].

All in all, the limited nature of the reforms introduced and the successful defence of the substance of the 1967 Act would seem to be an emphatic victory for the pro-choice camp. The time limit introduced was that which had already been widely adopted and would potentially effect a very small number of women - in 1988 (the last figures which were available at the time of the debates), only 22 abortions had occurred after 24 weeks[10], and under the specific exemptions in the new legislation, it seems likely that these would have been allowed in any case. The anti-choice M.P.s were even committed to 'disappearing' for a while. However, a close analysis of the Parliamentary debates and the actual form of the changes introduced presents a less happy aspect. In particular, I will argue that the debates display an unquestioning reliance on medical knowledges as the exclusive framework for approaching any question of abortion and an acceptance of the construction of the foetus as an essentially separate individual who must be protected from the pregnant woman. This construction is disturbing both with regard to future defence of the 1967 Act and in terms of how it might effectively block further progress towards liberalisation of the law. Here I will examine a) the medicalisation of the debate and b) the construction of foetal separation within the debates in more detail.

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[8] H.C. Deb. Vol. 171 Col. 199 1990 (24 April). An article in *The Times* (24.04.90), cited Widdecombe as promising a lapse in the Parliamentary Pro-Life campaign "at least until after the general election" (which eventually took place in April 1992).

[9] The exception to this was a Ten Minute Rule Bill introduced by anti-choice M.P., David Amess on 23 February 1993. The Bill (which stood no chance of being passed) opposed the use of sex selection technology.

[10] See *The Times*, 23 April 1990.

a) Medicalisation

Deborah Steinberg's argument that one legacy of the Alton Bill is the increasing reliance on scientific and medical knowledges, is wholly borne out by the *Human Fertilisation and Embryology Act* debates. First, the need for reform was introduced to the House of Commons as necessitated by "developments in medical and scientific practice". Virginia Bottomley, Minister for Health, presented the need for reform as a narrow and technical matter - not a political issue, but a matter of updating the existing law in line with medical developments:

"The Government have...[the] role of advising Parliament of ways in which changes over time and the recent developments in medical and scientific practices may have affected the existing law in ways in which Parliament should take account. It is in that context that the Government have considered the question of abortion time limits".[11]

Secondly, there is an ongoing struggle within Parliament as to who can claim the medical 'high ground' and who has the support of the various medical bodies. Thirdly, there is extensive reliance on medical sources and knowledges by both 'sides' of the debate, to the exclusion of other factors.

i) Use of Medical Knowledges

Anti-choice campaigners make use of medical knowledges both inside and outside Parliament and their literature increasingly relies on medically established facts to justify its claims. The following assertion, taken from a LIFE leaflet, is typical:

"[t]he unborn child is not part of [the woman's] body. He (or she) is a unique human being, genetically, physiologically, and organically distinct from both parents. Human life begins at conception - so from conception onwards the mother is carrying another human being. *Deny any of that and you deny the evidence of modern genetics and embryology*"[12].

Anti-choice M.P.s make similar use of medical knowledges. They relate gruesome 'medical facts' of the reality of abortions, give medical accounts of the development of the foetus[13]

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[11]H.C. Deb. Vol. 171 Col. 172 1990 (24 April), see also at Col. 175.

[12] In Life leaflet: "Abortion: A woman's right to choose?"

[13] See Braine, H.C. Deb. Vol. 171 Col. 217 1990 (24 April); Alton, H.C. Deb. Vol. 174 Col. 1206 1990 (21 June).

and cite letters from doctors and nurses who have been involved in abortion relating their experiences[14]. They based their main argument in the 1990 debates - that a time limit of 18 rather than 24 weeks was needed - on the assertion that a reduction of four weeks is no fair reflection of 23 years of advancement in medical science[15] and that it is necessary to legislate also for the future, which will no doubt bring technological advances which will lower the gestational age at which the foetus can be considered as viable outside of the womb[16]. David Alton argues:

"[t]wenty-three years ago, let alone 61 years ago, there was no ultrasound scanning of the type that I have described, no electrocardiograms for a foetus, and no appreciation of the complete sensory development of the unborn child or knowledge that the unborn baby feels pain...Given those quantum leaps in our knowledge, it is absurd to leave our laws in the dark ages"[17].

In this specific context, Alton treats the medical as the decisive factor in discussion of abortion and, marginalising other concerns, sees reform as the inevitable result of medical 'progress'. It is interesting to note that the rhetoric which Alton adopts in Parliament is very different from the terms which he uses to discuss abortion in his (1988) book, *What Kind of Country*. Here he opens the chapter which deals with abortion with a quote from Mother Teresa of Calcutta: "...[i]n destroying the child, we are destroying love, destroying the image of God in the world", and continues in a vein which gives moral and religious values priority over medical ones. From this, it seems that Alton believes (correctly, no doubt) that in order to voice his opinions in Parliament and be effectively heard within the debates, the most effective discourse is the medical. Likewise, it is noteworthy that another anti-choice M.P., the Reverend Martin Smyth, despite his vocation, makes use of medical, rather than religious, arguments within the debate[18].

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[14] See Alton, H.C. Deb. Vol. 171 Col. 228 1990 (24 April).

[15] Amess, H.C. Deb. Vol. 171 Col. 255 1990 (24 April).

[16] Kellett-Bowman, H.C. Deb. Vol. 171 Col. 175 1990 (24 April).

[17] Alton, H.C. Deb. Vol. 171 Col. 223 1990 (24 April).

[18] H.C. Deb. Vol. 171 Col. 241-2 1990 (24 April). The speech made by the Rev. Ian Paisley forms a notable exception to this, with heavy recourse to religious arguments, H.C. Deb. Vol. 174 Col. 235-9 1990 (21 June).

The defenders of the 1967 Act, who in 1966-7 had focussed on social factors and in particular on the desperate situation of the woman facing an unwanted pregnancy, in 1990 chose primarily to work within this medical framework. The arguments used by pro-choice M.P.s fall into three categories: the social, the feminist and the medical. The social aspect whilst not being completely ignored, has become increasingly marginal and now appeared in the form of (very) occasional references to sex education[19], family planning facilities[20], and the state of the National Health Service[21]. The use of feminist arguments in the debates is also much more evident than was the case in 1966-7. However, it is confined to a small group of M.P.s[22]. Moreover, it seems that the efficacy of the arguments is doubtful given the ability of anti-choice activists to subvert them (Steinberg; 1991; 181-2). David Alton, in particular, makes use of feminist rhetoric both in the House of Commons and in his book:

"[m]en will often use their sexuality in a way that demonstrates a greater sense of machismo than it does responsibility towards their partners. At the heart of the debate about contraception...is the need to recognise that when love and a sense of responsibility is removed from sexual relations, there will always be a tragedy. Sometimes that can result in men trying to pressurise women into what people often perceive as the quick fix of an abortion"[23].

Overwhelmingly, however, the rhetoric and framework adopted is medical.

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[19] Richardson, H.C. Deb. Vol. 171 Col. 186 1990 (24 April).

[20] Steel, H.C. Deb. Vol. 171 Col. 205 1990 (24 April), Primarolo, H.C. Deb. Vol. 171 Col. 248 1990 (24 April).

[21] Harman, H.C. Deb. Vol. 174 Col. 1136 1990 (21 June).

[22] The most clear use of feminist discourse is made by Theresa Gorman, H.C. Deb. Vol. 171 Col. 231 1990 (24 April): "[w]hat motivates those who persist in trying to amend a woman's right in these affairs is theology...Those motives form one of the deepest, most misogynous strands in human society. For centuries theologians; have equated sex with sin and celibacy with grace. They have regarded women as little more than flower pots in which future generations of children, preferably boy children, are reared."

[23] Alton, H.C. Deb. Vol. 171 Col. 221 1990 (24 April). See also, Alton (1988), where he quotes at length from Paula Conor of Feminists Against Eugenics, and Duffy, H.C. Deb. Vol. 171 Col. 252 1990 (24 April): "[f]ree and easy abortion is in the interests of men because it removes the problem of pregnancy, and women are well aware of that".

First, the defenders of the 1967 Act dispute the medical evidence of the anti-choicers. For example, Steel attacks Widdecombe for trying "to set herself up as a medical authority, greater than others on the time limit that the House should accept"[24]. Likewise, Dawn Primarolo argues that:

"[w]ith, perhaps, a few exceptions, hon. Members are not medically qualified. They are not consultants and they are not the best people to make medical decisions. We should recognise that"[25].

Implicit here, is the assertion of abortion as a purely medical matter and a corresponding claim as to who should be allowed to speak about it.

Further, pro-choice supporters make good use of medical knowledges and constructions to support their own arguments. Steel goes on later to cite an article in *The Lancet* (2 December 1989), which showed that 75% of gyneacologists preferred a limit of 24 weeks. He argues that:

"[i]t would be a great mistake for the House to set aside the opinion of established medical bodies on the issue of setting a limit of 18 weeks...We are not entitled to cast aside all these opinions as though they did not matter, or to pluck out of the air a figure that we think might be better"[26].

Here, the choice which he presents is one of either accepting medical judgment or of complete arbitrariness.

The same medical framework was adopted in press coverage of the issue. For example, the day before the voting took place, *The Guardian* (23 April 1990), ran an article which was described as "an attempt to summarise the arguments". It was entitled: 'Most doctors opt for 24-week limit' and began:

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[24] Steel, H.C. Deb. Vol. 171 Col. 201 1990 (24 April).

[25] H.C. Deb. Vol. 171 Col. 248 1990 (24 April).

[26] Steel, H.C. Deb. Vol. 171 Col. 204 1990 (24 April); see also Steel, H.C.Deb. Vol. 171 Cols. 206-7 1990 (24 April), Harman, H.C. Deb. Vol. 171 Col. 262 1990 (24 April).

"[t]here are few supporters for retaining the present 28-week limit, as the medical consensus is that babies are viable from 24 weeks, given the intensive care and technology of modern premature baby units..."

Thus the perceived framework within which the issue of abortion should be decided was essentially structured by medical knowledges.

ii) The Adoption of a 24 Week Upper Limit

The actual voting on the upper time limit in Parliament was done 'pendulum' fashion, swinging between the extremes in order to allow all opinion to be canvassed. The new clause drafted by the Government envisaged a time limit of 24 weeks, and various amendments were tabled to challenge this. The order and results of the voting were as follows:

18 weeks: 165 (for): 375 (against) = Majority of 210 against
28 weeks: 141 (for): 382 (against) = Majority of 241 against
20 weeks: 189 (for): 358 (against) = Majority of 169 against
26 weeks: 156 (for): 372 (against) = Majority of 216 against
22 weeks: 255 (for): 301 (against) = Majority of 46 against
24 weeks: 335 (for): 129 (against) = Majority of 206 for

It is, of course, tremendously significant that the time limit eventually accepted (by a majority of 206 votes) is that recommended by the Royal College of Obstetricians and Gynaecologists in a report which is often referred to in the Parliamentary debates[27]. The limit adopted is that of 24 weeks - the point when the foetus is deemed to become 'viable' - capable of sustaining independent life outside the womb. It seems conclusive that this limit recommended itself on these grounds. Patrick Wintow, political correspondent for *The Guardian* writes that:

"[m]any M.P.s appeared to have been swayed by the professional view of the Royal College of Obstetricians and Gynaecologists, the British Medical Association and many family planning organisations, all of which backed 24 weeks on the basis that the foetus is now considered viable at this stage" (1990).

The support for the lower limit of 22 weeks (defeated by only 46 votes) might be seen as

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[27] For example, Bottomley, H.C. Deb. Vol. 171 Col. 173 1990 (24 April); Clarke, H.C. Deb. Vol. 171 Col. 267 1990 (24 April). See also the references in the previous footnote.

a result of assertions that viability in some cases occurs below 24 weeks, with in extreme cases, foetuses as of little as 22 weeks in utero development having survived. However, as Harriet Harman informed the House of Commons:

"[t]he time limit of 24 weeks was not arrived at arbitrarily. When deciding on an abortion, doctors err on the side of caution and, in practice, a 24-week limit would mean something like a 22-week limit or even a 20-week limit...For the future, doctors believe that they can increase the chances of survival for babies after 24 weeks, but because of the insufficiency of development, they do not expect to be able to keep babies born at 22 weeks alive in the foreseeable future"[28].

Here then, viability takes on a force of its own, becoming accepted as the natural dividing line between those abortions which should (in some circumstances) be allowed by law, and those which should not. This construction completely obscures broader social issues (Franklin; 1991; 200, McNeil; 1991; 154). As McNeil writes, the adoption of viability as a dividing line:

"shifts the focus of decision-making away from women who, in opting for or against abortion, make complex evaluations of their particular circumstances and of the social sustainability of new life. Such decisions have little to do with what medical science can sustain technologically. Saying that it is theoretically possible to plug a 24-week-old fetus into life support apparatuses is very different from saying that you personally will take primary responsibility for supporting - in every sense - a child through to adulthood" (McNeil; 1991; 156).

The adoption of viability as the cut-off point for abortions has obvious attractions for pro-choice activists and has been put to effective political use in establishing a comparatively high upper limit. However, it also has limitations. The effect of the 1990 debates has been to entrench in the public - and Parliamentary - consciousness that abortion is permissible prior to viability, but should be forbidden after this point[29]. One letter to *The Times* goes so far as to argue that the destruction of the handicapped viable foetus is no longer a matter of

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[28] Harman, H.C. Deb. Vol. 171 Col. 262 1990 (24 April).

[29] It is important to remember here that prior to 1990 there was *no* such limit in the text of the 1967 Act, and that the notion viability read into it by the *Infant (Life) Preservation Act* was developed for very different purposes than those regulating legal abortion (see below, pp. 20-1).

abortion, but rather of euthanasia[30]. This is a notion which future campaigns may find hard to dislodge. Whilst the present state of medical science makes it impossible to sustain neo-natal life at much less than 24 weeks of gestational development for reasons of lung development, it is surely not inconceivable that this limit will be gradually pushed downwards (Rhoden; 1985)[31]. If this happens, pro-choice groups will face a particularly bitter struggle to try and separate out the legitimacy of abortion from the notion of viability. Even in the 1990 Commons Debates, anti-choice M.P.s in Parliament several times emphasised the need to 'legislate for the future' as:

"medical techniques are advancing so rapidly that, long before 20 years is up, we shall regard a termination within 20 weeks as ludicrous...By that time, medical techniques will be so good that a foetus will be viable much earlier than that"[32].

"Medical science will continue to advance, and more and more babies born prematurely will survive. Surely we should legislate for the future and not for the past"[33].

"we should take decisions that bear a relationship to the present situation but, having regard to the advances in medical science, to the situation that is likely to develop in the next decade"[34].

Although various commentators have suggested that it is unlikely that it will ever become possible to sustain neonatal life much below the 24 week limit, due to the limited lung development, this is still a point of concern.

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[30] *The Times* (2 June, 1990), letter from Nigel de S. Cameron, editor of *Ethics and Medicine*: "do our legislators truly intend the unborn to be destroyed well beyond viability, for any other cause than to save the life of the mother? The answer may, of course, be "yes"; and - if so - we will have moved from discussion of abortion to that of euthanasia."

[31] Nearly ten years ago, Stubblefield wrote that viability is occasionally possible at 23 weeks (1985; 161-2).

[32] Kellett-Bowman, H.C. Deb. Vol. 171 Col 241 1990 (24 April).

[33] Braine, H.C. Deb. Vol. 171 Col. 216 1990 (24 April).

[34] Braine, H.C. Deb. Vol. 171 Col. 215 1990 (24 April). See also Smyth, H.C. Deb. Vol. 171 Col. 241 1990 (24 April); Clarke, H.C. Deb. Vol. 171 Cols. 264, 267 1990 (24 April); Amess, H.C. Deb. Vol. 171 Col. 255 1990 (24 April); Alton, H.C. Deb. Vol. 171 Col. 223 1990 (24 April).

Moreover, it is also important to bear in mind that the notion of viability contained in the Abortion Act is not an entirely medical concept, but is rather a legal reconstruction of the same. From a medical viewpoint, it is impossible to fix one clear time limit at which viability will be achieved, rather viability will be achieved at a different stage of development depending on the individual foetus. It is the law with its particular need for a precisely defined point (prior to which abortion is legal, after which illegal), which has provided this particular construction of viability. Hence, whereas medically speaking different foetuses will achieve viability after different periods of gestational development, the law introduces a fixed period for the purposes of certainty and precision. As a legal construction, viability may be subject to judicial as well as medical erosion. There are already some indications of the potential for such a trend in the courts. Whilst in *C v S*[35], viability was seen as requiring the capacity of breathing either naturally or with the aid of a ventilator and surviving for a reasonable period, there may be some authority for a less restrictive test in *Rance and another v Mid-Downs Health Authority and another*[36]. Under *Rance*, a foetus was deemed "capable of being born alive" if when it was born, it was capable of living and breathing through its own lungs without any connection to its mother. No requirement of sustaining life for a reasonable period was specified. *Rance* was hailed several times in the 1990 Commons debates as establishing a lower gestational age of viability. For example, Anne Widdecombe relates that:

"Mr. Justice Brooke said, 'No the point at which a child is capable of being born alive is the point at which it can survive independently of its mother, even if only for a short period.' If we take that as a definition, we are no longer talking about 22 weeks - we are talking about something substantially lower"[37].

Jurisprudential erosion of the time limit envisaged in the concept of foetal viability can have no immediate effect on the provision of abortion, as the 1990 Act foresees a fixed time limit of 24 weeks and explicitly 'de-couples' the Abortion Act from the *Infant Life (Preservation) Act* 1929 which uses the concept of 'capable of being born alive'. However, the threat may

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[35] [1987] 1 All ER 1230.

[36] [1991] 1 All ER 801.

[37] H.C. Deb. Vol. 171 Col. 191 1990 (24 April).

be posed in case of abortion once more being debated in Parliament. If *Rance* is followed and this lower age of viability becomes accepted as the correct legal construction (of this medical event) then this might have possible repercussions in future Parliamentary debates.

A more immediate cause for concern with increased medicalisation is that this can only further serve to entrench medical control of abortion. The more abortion becomes viewed as primarily (or exclusively) a medical phenomenon, the more it seems inevitable that it must fall into the sphere of authority of doctors to maintain both the technical and decisional control which I outlined in chapter 4 (and thus the possibility to continue to exercise paternalistic and normalising control). The medical control of abortion is very much accepted within the debates, with the majority of pro-choice M.P.s emphasising that this is a decision that should be made by the woman in conjunction with her doctor[38]. In the 1990 debates, two amendments which addressed the medical control of abortion were tabled. The first, tabled by Conservative M.P. Emma Nicholson, which sought to allow abortion on request for up to twelve weeks of pregnancy, was not selected to be put to the vote. The second, tabled by Harriet Harman, sought to allow women to have abortion for up to twelve weeks with the approval of only one doctor. Pro-choice M.P.s argued very much in terms of reducing the number of late abortions, by facilitating procedures[39], but eventually was defeated by 228 to 200 votes.

b) Foetal Separation

"The fact that the unborn child is physically dependent on its mother prior to birth need not lead to the assumption that it has no relevant separate existence..." (Fortin; 1988; 82).

The other worrying trend highlighted during the *Human Fertilisation and Embryology Act* debates is an acceptance of the foetus as a separate individual. This is no doubt closely

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[38] Gorman, H.C. Deb. Vol. 171 Col. 232 1990 (): "I would far rather trust the woman and her medical adviser [to decide]"; Primarolo, H.C. Deb. Vol. 171 Col. 248 1990 (24 April): "[a]bortion is a medical decision and a woman's choice"; Nicholson, H.C. Deb Vol. 171 Col. 250 1990 (24 April): "up to 12 weeks the mother's wish, in conjunction with her general practitioner's decision, should be sufficient to allow her an abortion".

[39] See for example Richardson, H.C. Deb. Vol. 171 Col. 187 1990 (24 April), Nicholson, H.C. Deb. Vol. 171 Col. 250 1990 (24 April).

linked with the medicalisation of the debates, for medical discourse itself increasingly reflects such assumptions[40]. In recent years a number of feminist writers on both sides of the Atlantic have started to point with concern to the developing doctrine of foetal autonomy (Gallagher; 1985, 1987, Petchesky; 1987; Steinberg; 1991, Franklin; 1991, Hartouni; 1991) - 'foetal patienthood if not foetal personhood' (Petchesky; 1987; 64)[41] - and concomitant "fetalization" (Franklin; 1991) of the abortion debate. The fear expressed is that the development of technologies such as ultrasound, which have increasingly rendered the foetus visible to the outside world have opened up a Pandora's box of ills which may yet have very far reaching consequences. The visual symbols produced by such techniques have a particularly powerful purchase in a society so oriented to the visual, and in the current context of continued battles and fierce political debates over abortion their political importance is not to be under-rated. Combined with an increasing medicalisation of the debate and even greater primacy accorded to medical knowledges, these developments have resulted in an entrenchment of the centrality of the foetus in the abortion debates and the emergence of discourses of foetal protectionism and foetal rights (see Gallagher 1985).

The conceptualisation of the foetus as an individual, separate from the body of the pregnant woman dates back as far as the Old Testament, possibly even beyond[42]. What is novel is the increased possibility of relying on medical rather than religious knowledges to ground this construction. In 1989, SPUC spent £60,000 on producing half a million full-colour postcards showing a 'baby' (foetus) of 18 weeks gestational development sucking its thumb, and three million colour leaflets "showing the baby's humanity in words and pictures". The latter were delivered to three million homes[43]. Although this campaigning tactic is not new, it is becoming increasingly effective due to the invention of techniques which allow the

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[40] See Arney (1982); Petchesky (1987); Martin (1987).

[41] See also Gallagher (1985) and the contributions to Franklin et al. (1991). Franklin (1991) has written that the concept of 'foetal personhood' is both ontological and teleological in that it focuses on not only the foetus' present status, but also its human potentiality.

[42] Joyce Outshoorn cites the Book of Jeremiah: "Before I formed you in the womb/I knew you/and before you were born/I consecrated you" (1992; 1).

[43] Information from SPUC leaflet, "White Flower Sunday".

photographing of the foetus *in utero*. These images emphasise all that is baby-like about the foetus - like a baby, it is shown as existing whole and separate from the body of the pregnant woman. The danger of such images in enhanced by their stamp of photographic 'fact' or 'truth' (Petchesky; 1987). Petchesky writes: "foetal imagery epitomizes the distortion inherent in all photographic images: their tendency to slice up reality into tiny bits wrenched out of real space and time" (1987; 62). She cites Barthes in order to argue that the appearance of the photographic image as a 'mechanical analogue of reality', without art or artifice, obscures the fact that the image is heavily constructed, or 'coded', it is grounded in a context of historical and cultural meaning (1987; 62).

Petchesky, writing with regard to the U.S.A. notes that the new foetal imaging techniques (such as ultrasound and in utero photography) have constructed the foetus as hanging in a void, like an astronaut dangling in space. Barbara Katz Rothman has similarly observed that:

"[t]he fetus in uterus has become a metaphor for 'man' in space, floating free, attached only by the umbilical cord to the spaceship. But where is the mother in that metaphor? She has become empty space" (1986; 114).

The construction of the tiny yet intrepid 'space hero' hanging fearlessly in 'his' void is present in the 1990 debates. The use of the space imagery is striking in this comment taken from the debates:

"[t]he stark and dreadful import of abortion is that what nature has successfully - in spite of all hazards - launched into the orbit of life, human hands seek deliberately to arrest and destroy in mid-trajectory. To make such a terrible intervention in the course of nature demands compellingly good reasons. The further the foetus has got off the ground, so to speak, the more vital it is that human intervention should be geared to assisting and upholding, not to arresting and destroying"[44].

Thus the debates have succeeded in combining two seemingly conflicting constructions of the foetus - the image is of a "little creature...a human being not yet born, yet with all the hope and expectation of life"[45], vulnerable yet intrepid, already embodying all the characteristics of a true individual.

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[44] Alison, H.C.Deb. Vol. 174 Col. 1180 1990 (21 June).

[45] Braine, H.C. Deb. Vol. 171 Col. 217 1990 (24 April).

What is worrying here is the failure of the pro-choice movement to actively counteract the construction of foetal separation on a political level (Petchesky; 1987; 58). The power of the visual image is being exploited solely by the anti-choice groups, and remains largely unchallenged by activists on the other side. This is emphasised by the strategy adopted by the Society for the Protection of Unborn Children (SPUC) during the Parliamentary debates preceding the *Human Fertilisation and Embryology Act.* SPUC sent each M.P. a plastic replica of a foetus at 20 weeks of gestation. Although various M.P.s expressed their distaste at this strategy as "obscene"[46] and "a gross act of bad taste"[47], not one commented on what for me is the most worrying aspect of this tactic: that the foetus is represented in total abstraction from the body of the woman that carries it. It emphasises everything that is baby-like and vulnerable about a foetus and hides the essential difference from a baby - whilst the baby is separate and can be independent of its mother (at least if someone else cares for it), the foetus is not and cannot be. The representation of the foetus as a free-floating and separate entity embodies a fundamental deceit, and one which has been inadequately contested.

One anti-choice M.P. commented:

"[w]hen I opened my parcel I found a legitimate and graphic piece of campaigning, because nobody disputes that is what a 20-week old foetus looks like. *If somebody had been able to produce medical evidence that this was a grotesque mock-up that was totally inaccurate and grossly misleading, it would have been the most obscene piece of campaigning that anyone could indulge in.* However nobody has suggested that. When I was in the Post Office yesterday an hon. Member came in, took his parcel, opened it, and threw it in the bin. I could not help thinking that this is what happens to many foetuses"[48].

Worryingly, no one in the House of Commons challenged Cormack to suggest that this in abstracting the foetus from the body of the woman, this "graphic piece of campaigning" was indeed a "grotesque mock-up" and "totally inaccurate and grossly misleading" and indeed, that it should not only be *medical* evidence that has the authority to challenge it. The failure to

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[46] Doran, H.C. Deb. Vol. 171 Col. 213 1990 (24 April).

[47] MacKay, H.C. Deb. Vol. 171 Col. 243 1990 (24 April).

[48] Cormack, H.C. Deb. Vol. 171 Col. 208 1990 (24 April), my emphasis.

dispute this essential deceit in SPUC's representation of the issue, reflects a startling unconscious acceptance of the construction of abortion as revolving essentially around this free-floating foetus and what rights are to be attributed to it. Once the woman is abstracted from the equation in this way, then SPUC are already half-way to proving their argument and central claim that there is a negligible difference between a foetus in the last stages of gestational development and the newborn baby.

Such an assertion is made to the House of Commons by Anne Widdecome:

"[a]t the moment, a child in an incubator can be kept alive, loved and cherished with all the resources of medical science being devoted to saving it, while a child of identical age and identical gestation in the womb has no rights and can be destroyed. There is something wrong with a law which allows that degree of inequity between *two individuals who are exactly the same except that we can see one and we cannot see the other*...we must bring about a situation in which there is at least equality. At present, we have a law which states that *a child who is seen is protected but that a child at an identical stage who is not seen is not protected*"[49].

Widdecombe's assertion that there is no difference between these two situations totally ignores the pregnant woman's role, her needs and her interests. In concentrating attention entirely on the foetus, the essential difference between the two situations (that one is occurring inside a woman's body) is hidden. She is challenged by Emma Nicholson, a vocal pro-choice advocate. However, Nicholson makes no mention of the total absence of consideration of the pregnant woman in Widdecombe's argument, rather, she notes that:

"[t]he hon. Member for Maidstone (Miss Widdecombe) talked of identical babies whose only difference at 20 weeks was that one was visible and the other invisible to the naked eye. That is not true because the baby invisible to the naked eye may be hideously deformed and if born and brought to life, may face a future of unimaginable suffering. It may be visible to the naked eye through modern machinery and perhaps it can be kept alive, despite its wretched existence for many years"[50].

Having implicitly accepted the central importance of the foetus and the absence of any consideration of the pregnant woman, Nicholson adopts the terrain set out by Widdecombe

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[49] Widdecome, H.C. Deb. Vol. 171 Col. 192 1990 (24 April), my emphasis.

[50] Nicholson, H.C. Deb. Vol. 171 Col. 249 1990 (24 April).

and uses an essentially eugenicist argument to argue against her, asserting that the essential difference in the foetus which we cannot see is that it may be handicapped.

Steinberg argued that a eugenic dimension to the abortion debate would be a further legacy of the Alton Bill, with Anti-Alton M.P.s relying on the limitations of prenatal diagnostic technology in discovering foetal abnormality, in order to justify the continuing legality of 'late' abortions (1991; 187). It would obviously not be true to assert that the eugenicist rhetoric only appeared at the time of Alton, its presence is also clearly discernable in the 1966-7 debates (see p. 57-8, especially footnote 36). However, Steinberg is right to indicate an increased reliance on this kind of argumentation on the part of the pro-choice supporters post-1988. She points to some of the problems caused by the adoption of eugenicist rhetoric which fails to challenge the adversarial construction of abortion, with central place accorded to the status of the foetus, but rather implicitly supports and entrenches this premise. Women are seen as having the 'right' to 'late' abortions only on a special case basis, where the status of the foetus so allows. Here, once again, the high moral ground is ceded to the anti-choice, with pro-choice supporters seen as pitted not only against the foetus, but also against the disabled. In his book, David Alton demands:

"[w]hat does it say about a society that snuffs out a life that is not deemed to have worth because of disease or disability? Ask the next disabled person you meet whether they are glad to be alive" (1988; 174).

It is interesting, nonetheless, to note the seeming success of this rhetoric in that since 1990, women are now theoretically allowed abortions *until birth* in the presence of a serious foetal handicap.

In practice, medicalisation of the debates and the increasing importance of foetal separation are integrally related and mutually supporting. As medical knowledges become more important in the abortion debate, the issue of the (medically determined) status of foetal life becomes increasingly central. As the status of foetal life becomes increasingly central, the place of medical knowledges and the authority of medical experts becomes ever more entrenched. This is the vicious circle into which feminist campaigns must now break. Moreover, as I argued in chapter 4, developments in other areas of obstetrics and gynaecology

- have equally led to the emergence of the foetus as a separate patient with the doctor the best placed to represent its interests. This conceptualisation of the medical role equally serves to reinforce the notion of the doctor as the appropriate expert to also wield such authority in cases involving a request for abortion.

4. THE *HUMAN FERTILISATION AND EMBRYOLOGY ACT*, S. 3 (PROHIBITIONS IN CONNECTION WITH EMBRYOS)

s. 3(1) No person shall:
a) bring about the creation of an embryo, or
b) keep or use an embryo,
except in pursuance of a licence.

s. 3(3) A licence cannot authorise
a) keeping or using an embryo after the appearance of the primitive streak.

Although, it is impossible here to deal with the other provisions of the *Human Fertilisation and Embryology Act* (1990) in anything like the level of complexity which they deserve, it is important to include some mention of them here in so far as they may yet prove relevant to the abortion debate[51]. The *Human Fertilisation and Embryology Act* follows a report, commissioned by the Government and headed by Mary Warnock (1984), and is clearly informed by much of the analysis contained within it. Much of the moral argument regarding embryo research within the debates centred on 'personhood' (Morgan and Lee; 1991; 4) the idea being that one particular point may be chosen at which we can say that someone becomes a 'person', or entitled to receive the respect owed to a person. The position which Warnock appears to have held however is that there is no absolute point at which a person appears and has moral status, but that a person emerges as a gradually present moral entity and one which becomes possessed of more and more rights as a juridical person. Indeed, Warnock explicitly denied the need to fix on one point at which personhood could be said to begin and has been criticised for this (Fortin; 1988; 54, Lockwood; 1985). For Warnock, then, to make particular legal or political decisions, we have to select a point or a series of points. The solution she proposes with regard to embryo research was to choose a cut off point of fourteen days, with some limits as to what research could be done on embryos before

[51] For an excellent, detailed commentary on the Act, see Derek Morgan and Robert Lee (1991).

that point.

The recommended cut off point of fourteen days took as its reference point the emergence of the primitive streak, which "marks the beginning of individual development of the embryo" (Warnock; 1984; 11.22). Warnock notes that taking such a time limit had the added advantage of being also consonant with the views of those who favoured the end of implantation stage as a limit (1984; 11.22). The primitive streak appears as a heaping-up of cells at one end of the embryonic disc on the fourteenth or fifteenth day after fertilisation (1984; 11.5). Until this time, it is argued, the cells of the embryo are undifferentiated in terms of which will become the placenta and the embryo proper (Franklin; 1991; 198-9) and this is also the latest stage at which identical twins can occur. As Jo Richardson asserts in Parliament: "[the fourteen day limit] is a well known chronological event and that is why the Warnock committee chose it. It is a particular stage in the development of a human being"[52]. The *Human Fertilisation and Embryology Act* follows Warnock's recommendation in taking the appearance of the primitive streak as the upper time limit on embryo research.

It is important also to note that the explicit linking of abortion and embryo research by the inclusion of this section in a statute dealing with "human fertilisation and embryology" shows how far abortion is accepted as revolving around the biological status of foetal life[53]. This assumption is reflected and has been entrenched in the reporting of these issues in the media, with developments in the debates around abortion and embryo research consistently reported in the space of the same article. This can only have compounded the perceived connections between the two in the public consciousness. The most consistently pro-choice of the quality newspapers, *The Guardian*, reported the forthcoming Parliamentary debates under the title: "MPs to vote on two life issues" (23 April 1990). The problem faced in the two cases appears to be parallel - to choose one cut-off point after which the embryo/foetus is to be subject to a certain regime of protection. The solution adopted is also seen as parallel and resting upon a point of biological development (which may or may not be constructed in

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[52] Richardson, in *The Guardian*, 24 April, 1990.

[53] See Brazier (1988; 9) for discussion of the invocation of abortion in the arguments used by opponents and proponents of research.

terms of a fixed period for reasons of legal clarity)[54]. The comments of Kenneth Clarke (then Secretary of State for Health) show how the debates have further compounded the understanding of the two issues as essentially linked:

"I was not instinctively attracted to the idea of debating the abortion law at the same time as discussing the introduction of law on embryo research. Even in the past month or two I have genuinely changed my mind, and today's debate has confirmed that. These subjects are so closely related that this is a suitable opportunity for the House to have a day at the end of which it can come to a conclusion, which should last a long time, on the time limits and future operation of the 1967 Act and its relationship with the Infant Life (Preservation) Act"[55].

The two matters are, however, in another sense quite different - one is dealing with the control of medical research, the other with women who wish to end unwanted pregnancies. The commonality which exists is provided by a focus on the status of the conceptus, with this narrow medical/biological issue seen as the determinate factor in both regulation of embryology and abortion. This obscures consideration of any broader social factors and of women's needs.

A worrying note for feminists is that once the crucial question is defined as the status of the conceptus and the need to protect it from third parties (doctors or women), it may seem inconsistent to offer this protection at such different stages in foetal development. The linking of embryology and abortion provides fuel to anti-choice activists, who were not slow to point out the incongruity of protecting the conceptus from medical research at 14 days, yet not protecting it from abortion until 24 weeks.

"It seems illogical that such an illustrious committee [the Warnock Committee] should strongly condemn any experimentation on embryos after 14 days of growth, due to the possibility of pain, when, since 1967, over two million embryos, the majority with fully intact central nervous systems, have been fragmented by curettage/suction or forcibly expelled

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[54] It is interesting to note that s.37 (dealing with abortion) chose to adopt a fixed period of 24 weeks, thus translating a medical event into a fixed period to meet the (legal) requirement for precision and certainty. However, s.3 (dealing with embryo research), wrote the biological event itself (the appearance of the primitive streak) into the statute.

[55] Clarke, H.C. Deb. Vol. 171 Col. 265 1990 (24 April).

prematurely, a practice not only condoned but vociferously defended by society"[56].

Similar arguments were also heard both in Parliament - "[i]s it not illogical of Parliament to provide protection for human embryos from two weeks on, yet not be concerned for the future of that pre-embryo at 18, 20, 24, 26 or 28 weeks?"[57] - and, to a lesser extent, in academic literature. Fortin, writing before the introduction of the *Human Fertilisation and Embryology Act*, argues that the legislative changes recommended by the Warnock Committee would, if implemented, result in a situation where:

"the law might contain greater protection for the very early embryo *in vitro*, through controls on experimentation and restrictions on the period permissible for keeping the embryo alive, than the abortion law contains for the more developed foetus" (1988a; 55).

She suggests an alternative approach based on Michael Lockwood's distinction between human organisms, human beings and persons. In Lockwood's view the foetus only becomes a human being when the brain has developed to a certain extent at around ten weeks (1985; 10). On this basis, Fortin recommends a common upper limit for both experimentation on embryos *in vitro* and abortion on demand[58].

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[56] *The Times*, 24 July 1984. A letter to *The Times* (17 July 1991) responding to a letter calling for a review of NHS referral procedures, which had been signed, inter alia by Mary Warnock, made the same point: "[t]hose who consider abortion as an option in the "management of pregnancy", a social service rather than a killing must deny the right of the unborn. So perhaps those three members of the Warnock committee, including the chairman herself, who now so earnestly propose a "fully comprehensive abortion service", might ponder upon why they sat for so long and moralised so earnestly upon the rights of a mere 14-day-old embryo".

[57] Duffy, H.C. Deb. Vol. 171 Col. 252 1990 (24 April). See also Alton, H.C. Deb. Vol. 171 Col. 223 1990 (24 April).

[58] After ten weeks she suggests that the abortion law would be improved by the insertion of a direction requiring those involved in any abortion decision relating to a foetus of more than ten weeks development, to consider its particular stage of physical and mental development, with a view to assessing its claim to continued life, as opposed to the claims of the pregnant woman. Fortin envisages that compliance with such a requirement in cases of this kind could be ensured by the participation in the abortion decision by a fourth person, who would have to ensure that the claim of the foetus to continued life is balanced against the claim of the woman.

The aims of provisions regarding control of embryo research are obviously not condemnable in themselves. The issues involved are complex and difficult and I have not attempted to address the ethical merits of the legislation, nor indeed of the research it seeks to regulate. There are no easy, 'correct' answers to such questions. However, the problem which I have sought to highlight here is that of whether recognition of foetal rights may foster a climate of foetal protectionism which eventually leads to an infringement of women's reproductive autonomy.

5. CONCLUSIONS

"Abortion is, in the first order, something done to fetuses/'unborn children', and only secondarily (at most), a procedure women undergo" (Steinberg; 1991; 180).

The developments outlined above and the underlying assumptions which inform them, are both indicative and constitutive of a changing climate which could have negative implications for women's access to abortion. Whereas the courts and legislator have as yet resisted the extension of foetal rights where they would infringe on the application of the *Abortion Act*, the potential for such extension remains and is grounds for some concern. Whilst the pro-choice forces have been successful in defeating various attacks on the provision of abortion enshrined in the 1967 Act, considerable ground has been lost in popular assumptions about abortion (STSG; 1991; 147). From this point the agenda becomes set within an essentially medical framework and the issue of what is at stake in the abortion debate centres essentially around the medical development of the foetus to the exclusion of broader, social issues. What seems to me to be still more worrying, however, is that the acceptance of a medical framework further entrenches medical control of abortion and stands against any initiative to claim decisional control for women. There is something startling in the fact that M.P.s would vote to allow abortion of handicapped foetuses until birth, yet refuse to allow abortion in the first twelve weeks on the authority of one doctor (as opposed to two). I have argued in the preceding chapters that it is medical control which now provides the most significant challenge to women's access to abortion, yet it is precisely this which remains unaddressed (see especially chapters 4 and 5).

In chapter 3, I argued that the construction of the woman seeking abortion was crucial to the

form taken by the regulations introduced in the 1967 *Abortion Act*. The importance of the construction of woman in earlier debates was no doubt due in part to a greater focus on social factors. Now, with a near exclusive focus on medical factors, the situation of the woman is pushed to one side and the foetus attains a greater centrality. Its construction as a small and vulnerable 'unborn child', divorced from the body of the woman, and pitted against her in an essentially adversarial relationship serves to legitimate the role of the doctor (backed by the State) to protect the foetus and represent its interests against those of the woman.

CHAPTER 7: THE REGULATION OF ANTIPROGESTIN TERMINATIONS

"These projections of absolute autonomy and independence of women is the reason why so many fight so hard against it...An anti-progestin drug could develop in the future in such a way that sudden decisions could be put into effect, so that spontaneous contacts from which no consequences are desired would become increasingly devoid of risk of pregnancy. This would likely change the behaviour of women entirely around reproduction and their sexual behaviour. They would be in a position to act and react like men, meaning they would, in every single case, be able not to let the consequences of sexual intercourse take place. I am convinced that in this framework the intensity of the reaction to this new drug becomes intelligible. More autonomy with regard to decisions in matters of reproduction and fertility always triggers fear"[1].

"Mifegyne has been developed within both the spirit and the letter of the law. In the UK, its usage as an abortifacient is strictly within the provisions of the Abortion Act 1967. This provides for the legal termination of pregnancy when clinically necessary and approved. The Mifegyne/prostaglandin in combination can therefore only be administered to women who fulfil the requirements of the 1967 Abortion Act. Usage is confined specifically to those hospitals and clinics approved and licensed under the Act for the termination of pregnancy. it is administered there only under medical supervision and only to women who agree to the treatment schedule. Mifegyne is therefore not available for general sale, nor through chemists nor on family doctors' prescription...The supply of Mifegyne is strictly controlled by Roussel. It is available only to those hospitals and clinics which have received instructions in its use and which conform to Roussel's specific conditions of supply"[2].

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[1] Ingeborg Retzlaff (1993; 24).

[2] Roussel UK Company Statement, 1 June 1993, *RU486 (mifegyne, mifepristone): Background on the Medical Abortifacient Licensed in July 1991 for Use in the UK.*

1. INTRODUCTION

In the preceding chapters I have sought to demonstrate that the construction of abortion as primarily a medical matter has had a substantial impact on the law which, in the last thirty years, has moved from a system of criminal prohibition to a decentralised network of medical control. This medicalisation has increasingly led to an apparent depoliticisation of abortion, defusing the conflict and controversy surrounding it. The extent of this depoliticisation in the 1990s was illustrated in the last chapter. However, despite this appearance, I asserted that abortion remains very much a political issue: the regulations governing its availability are underpinned by quite specific, discernable values which reflect certain attitudes to women and a clear value judgment as to who should control female fertility. Moreover, it was seen (in particular in chapter 4) that the regulation of abortion continues to serve as a focal point for the deployment of power over women. Whilst the medicalisation of abortion law has had substantial benefits for ensuring women's access to abortion, it also poses substantial problems for that access. In this chapter, I would like to illustrate these arguments by way of an examination of the decision to license RU486 for use in Britain.

Whereas in the USA a storm of controversy has surrounded the drug (Chicoine; 1993, Lader; 1990, Ricks; 1989), in Britain, RU486 was introduced with a minimum of discussion. This has prompted one commentator to compare the British and US situations in the following terms:

"[t]he NHS's distribution of RU 486 to any woman who qualifies for it is convincing evidence that in Great Britain equitable access to health care is more important than political pressures brought to bear by a vocal minority" (Chicoine; 1993; 111-2).

The characterisation of the availability of RU486 as 'NHS distribution to any woman who qualifies for it' is obviously mistaken, and this will be clearly seen below. However, this analysis is interesting in indicating once again the difference between the more explicit politicisation of abortion in the USA, where the direct effect of political pressures brought to bear by identifiable individuals and groups is clearly visible (see p. 165 below).

Having first offered a brief introductory sketch of RU486 (section 2), I shall go on to discuss reactions to the decision to license it for use in Britain (section 3). Although the political

significance of the debate as played out in Parliament (and to a lesser extent, outside it) was obscured by a focus on competing medical evidence as to the relative benefits of the drug, I will argue that such depoliticisation is more apparent than real: fears regarding the control of abortion are the only convincing way of explaining the opposition to the drug amongst anti-choice activists. Surprisingly, such fears also go some way to explaining opposition to the drug amongst pro-choice activists. This seems to present a paradox: how can it be that both those in favour of restricting and extending women's self-determination oppose antiprogestins for this reason? I seek to explain this with reference to the models of medical control which I developed in chapter 4. In a fourth section, I address another apparent paradox: given the seeming simplicity of the antiprogestin procedure, why has this resulted in a stepped up regime of supervision and control? Finally, I shift from an examination of the present regulation of antiprogestins to an assessment of their potential to offer new ways of challenging the medical control of abortion (section 5).

2. BACKGROUND

a) The Development of RU486

RU486 is an anti-hormone drug or, more specifically, an antiprogestin. Its action is to bind to the progesterone receptors in the woman's uterus in order to block the production of progesterone and thus impair the womb's ability to hold onto a fertilized egg. The womb lining breaks down and the embryo is lost in the bleeding which follows. In order to improve its efficacy, RU486 has been combined with prostaglandins (PG), drugs which act to induce uterine contractions[3]. Subsequent research has combined varying doses of RU486 with different types of prostaglandins administered either orally, as intramuscular injections or as vaginal suppositories. The formula which proved most successful and which has since been adopted in Britain is that of a first application of 600 mg of RU486 (3 tablets), followed 36-48 hours later by a 1 mg gemeprost (synthetic prostaglandin) vaginal suppository. This

[3] Since 1970 prostaglandins have been used to initiate labour and to interrupt pregnancies. Initial optimism about their use was soon dampened by disappointing success rates and serious adverse effects on the women who have used them (see Klein et al; 1991; especially chapter 4). However, the dosage of prostaglandins used in an RU 486/PG abortion need be only 10-20% of that used in prostaglandin only abortions and consequently the side effects are much less severe (Baird; 1990).

combination has a 94-7% success rate[4]. In the cases where abortion is not successfully induced, the woman will have a surgical abortion, normally by vacuum aspiration.

RU486/PG was first released onto the (French) market in September 1988. Distribution was suspended the following month by the manufacturers, Roussel Uclaf, amidst fears of an economic boycott by Catholic and anti-abortion groups and pressure from Hoechst, its principal shareholder. It was, however, swiftly reintroduced following the intervention of the French Minister of Health, Claude Evin, who maintained, in a phrase that has since become famous, that RU486 was the "moral property of women" (Nau and Nouchi; 1988). By the end of 1992, 25% of all women terminating pregnancies in France were choosing to do so by way of RU486/PG (Reproductive Health Matters; 1993; 123). Roussel Uclaf, however, has shown a marked reluctance to distribute the product in other countries, and has declared itself unwilling to apply itself for a licence to market the drug, seemingly preferring to wait to be asked to apply by the relevant government (Kingman; 1989; 7)[5]. At the time of writing, only Britain and Sweden have followed France in licensing the drug, although negotiations are underway for the Netherlands, some other Scandinavian countries (Söderholm; 1993; 37) and the USA. However, as yet, a comparatively low number of abortions have been performed in Britain using RU486/PG[6], and many GPs seem still to be unaware of the availability of RU486/PG. This greatly limits the number of women who can use this method, as quick referrals are an essential prerequisite for its use.

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[4] Rodger and Baird (1987) UK Multicentre trial (1990), Baulieu (1993), Baird (1993; 5), Aubeny (1993).

[5] Roussel Uclaf list the following factors as prerequisites for a decision to apply for a product licence: abortion must be legal, the right to abortion must be accepted by public, political and medical opinion; the request must be made by official and medical bodies; the distribution circuit must be very strictly controlled; approved clinics must exist; a suitable prostaglandin must be available on the market; a strict medical follow-up of the patient must be part of the clinical protocol (Roussel release; 29 July 1992). See Thoss (1993) and Retzlaff (1993) for the problems this has caused regarding the possible introduction of RU486 in Germany.

[6] Roussel estimate 10,000 (this figure excludes the women who used the drug during its trials in the UK). The method is available in 122 (of 265) NHS hospitals and 16 (of 74) non-NHS abortion clinics, *Abortion Review*, Spring (1994) no. 51.

b) RU486/PG Compared to Conventional Abortion Techniques

In terms of effectiveness[7], complications[8], cost[9] and the experience of the women who have used it[10], RU486 seems comparable to other early abortion techniques. It does however have some differences. One disadvantage is that, as will be seen below (pp. 174-7), an RU486/PG abortion takes more time than a surgical abortion, requiring two days or more, and three trips to the clinic/hospital. This delay can be distressing for the woman, and for this reason, a French gynaecologist involved with trials for RU486, Annie Bureau, has suggested that RU486/PG abortions are not suitable for all women (USPDA; 1990; 8). This has, on the other hand, also been cited as a positive part of the RU486/PG experience: "RU gives women time to separate themselves from the pregnancy which they are giving up" (USPDA; 1990; 17). A pamphlet issued by the Swiss Union for the Decriminalisation of Abortion (USPDA) reports on the possibility to:

"transform the termination experienced as a failure into a positive reflection on one's fertility and sexuality. The time taken allows the event to sink in better, as part of the continuum of the life of the woman" (1990; 17).

It is easy to imagine, however, that many might find the delay distressing and prefer the

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[7] Cameron and Baird (1988), UK Multicentre Trial (1990), Rodger and Baird (1987), Baulieu (1993), Baird (1993), Aubeny (1993).

[8] Rodger and Baird (1987). Common side effects include bleeding, abdominal pain and cramping and possibly some nausea, vomiting or diarrhoea from the prostaglandin. Antiprogestins have the advantage of being non-surgical, requiring no anesthesia and putting women at no risk of perforation, damage to the cervix or infection from instruments. There has been one reported death resulting from an RU486/PG abortion: a thirty-one-year-old French woman, in her 13th pregnancy died of cardiovascular complications resulting from the prostaglandin administered in conjunction with RU486 (*The Lancet*, 20 April 1991; 969). Clinical tests have not revealed any long term health effects on women who have used RU486/PG, and predict that such effects are unlikely to appear given the short time women are exposed to the drug.

[9] Henshaw (1994; 42) puts the cost of an RU486/PG in-patient termination at £340, as compared to £375 for a surgical termination. These figures relate to the NHS, and are higher than for the non-NHS sector.

[10] See Baird (1993; 6), Templeton (1993; 26d), Urquhart and Templeton (1988, 1991), Furedi (1994), Henshaw (1993), Brewin and Bradley (1989) and Glasier (1993; 14). Some women's experiences of the method are examined in more detail below.

speed of a surgical termination. This delay between the two stages of the abortion also means that it may be difficult to fit RU486/PG terminations into existing hospital schedules, which often allocate certain days of the weeks to performing terminations (Lloyd; 1993; 3, Baird; 1993; 6, Stewart; 1994; 16). Antiprogestins do have one major advantage over other methods of termination: they can be administered to the woman as soon as she knows that she is pregnant and has decided that she wants to have an abortion. For a surgical abortion a woman has to wait until at least 6 weeks from her last menstrual period There seems to be some public consensus that early abortion is morally preferable to late abortion (Francome; 1991), as well as being safer, and often psychologically easier for the pregnant woman. One woman who had had an abortion using antiprogestins said that she chose it for this reason:

"I decided to choose the medical method because I could undergo the abortion much faster that if I had opted for a surgical abortion. I can't remember how many weeks it was, but, when I was told, it seemed quite horrific - the amount of time I would have had to have waited to have seen a gynaecolgist" (Furedi; 1994; 43).

From the evidence available it would seem, on balance, that antiprogestins have proved as safe as other methods of performing abortions, and may be a preferable alternative for some (but not all) women. As with any new development, it is necessary to proceed with caution, and especially important to carefully monitor for any possible long term effects. However, most pro-choice commentators have come out cautiously in favour of the possibility of RU486/PG abortions and many women's groups are currently lobbying their governments and Roussel Uclaf for RU486 to be made available in their countries.

3. THE BRITISH LICENSING OF RU486

In Britain, with some few exceptions, it seems that reactions to the drug have split down the traditional pro- and anti-choice lines. Here I want to make two main points about these reactions: first, the level of opposition to RU486 in Britain was relatively slight and the majority of arguments against the drug operated within a medical framework (a), however underlying reactions to the drug are hopes and fears regarding the control of abortion (b).

a) Medicalisation of the Political Debate

First then it is important to note that the introduction of antiprogestins did not provoke huge

controversy in Britain. In the United States, the debate surrounding antiprogestins has been far more explicitly political and far more acrimonious. The decision to make RU486 available there was explicitly influenced by party politics: RU486 was opposed by both Presidents Reagan and Bush, who stopped all research on it at the National Institute of Health and forced the Food and Drug Administration (FDA) to put the pill on the proscribed list, blocking its entry into the country. Moreover, one Republican representative, Robert Dornan, unsuccessfully introduced legislation aiming to prohibit RU486, and to prevent its approval by the FDA (Lader; 1990; 21). One of the first actions of Bill Clinton (three days after assuming responsibility as President) was to authorise the Minister of Health to approve testing of the drug within the United States, with a view to granting it a product licence[11]. Claudia Mancina describes this act as: "undeniably solemn and binding, corresponding to a precise political line, assumed not only by Clinton but by the Democratic Party as a whole" (1993).

In Britain, conflict over the drug has not been constructed as a matter for party politics. Opposition to it has been far more muted, but has been present nonetheless: a largely unsuccessful and low profile campaign was launched by the anti-choice groups, and the drug was debated in Parliament, although only after the decision to grant it a product license for the British market had already been taken. Product licences are granted by the Minister of Health following advice from the Medical Control Agency (MCA) and RU486 was licensed on 1 July 1991, ten months after an application had been submitted[12]. The fact that RU486 was licensed in Britain without any preceding discussion of the issue can itself be seen as a result of the fact that abortion is here again constructed as a medical rather than political issue - the decision was taken outside of the political arena on medical and economic criteria (safety and potential savings to the NHS). Discussion of the issue in Parliament was initiated by Kenneth Hind (Secretary of the All Party Parliamentary Pro-Life Group).

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[11] It also seems likely that the FDA's initial import ban on the drug was a direct result of pressure brought to bear by four US Congressmen, see Chicoine (1993; 94-5).

[12] This provoked allegations that the drug had been 'fast-tracked', this period being substantially shorter than the normal 17 months: Winterton, H.C. Deb. Vol. 195 Col. 894 1990 (22 July); Braine, H. C. Deb. Vol. 195 Col. 888 1990 (22 July); Hind H. C. Deb. Vol. 195 Col. 885 1990 (22 July).

The pro- and anti-choice split is clearly seen in the Parliamentary debates following the granting of a product licence to RU486, where the lines of opponents and proponents of abortion are drawn clearly, with Jo Richardson joining the Under Secretary of State for Health in speaking in defence of the granting of the product licence, and Kenneth Hind, Bernard Braine and Ann Winterton speaking against it[13]. However, the rhetoric adopted by the latter three is quite different in emphasis from that normally used, focusing on considerations of the health of the pregnant woman with only scant mention of the foetus. The arguments do not explicitly consider how the drug will effect women's control over their fertility. Rather M.P.s phrase their arguments within an essentially medical framework. Anti-choice M.P.s argue that: "women in their dilemma may be subjected to [RU486]"[14] with long term dangers to their health, and long term costs to the NHS[15]. This is countered by pro-choice M.P.s and government ministers who assert the safety of the antiprogestin termination ("nothing could be simpler and safer than that"[16]), the saving to the NHS[17] and the extra choice for women and doctors[18].

This focus on arguments concerning women's physical health marks a shift in the anti-choice rhetoric. One could not be thought overly cynical for seeing this concern as a strategy for attempting to block the introduction of the pill, and for believing that the real motivation for so doing lies elsewhere. This move is also interesting in providing further illustration of the shift in anti-choice rhetoric to a concentration on the medical, already evident in the Parliamentary debates at the time of the Alton Bill and the *Human Fertilisation and*

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[13] The exception to this is Campbell-Savours MP who, although a member of the Life lobby, spoke in favour of the pill as a means of preventing later abortions.

[14] Bernard Braine, H.C. Deb. Vol. 195 Col. 890, 1991 (22 July). Note the construction of the traumatised and misguided woman, who needs to be protected from abortion.

[15] See Hind, H.C. Deb. Vol. 195, Cols. 884-7, 1991 (22 July); Braine, H.C. Deb. Vol. 195, Col. 888-892, 1991 (22 July); Winterton, H.C. Deb. Vol. 195 Cols. 895-6, 1991 (22 July).

[16] Richardson, H.C. Deb. Vol. 195, Col. 892, 1991 (22 July).

[17] Richardson, H.C. Deb. Vol. 195, Col. 893, 1991 (22 July).

[18] Richardson, H.C. Deb. Vol. 195, Cols. 892, 894, 1991 (22 July); Thurnham, H.C. Deb. Vol. 195, Col. 897, 1991 (22 July); Dorrell, H.C. Deb. Vol. 195, Col. 899, 1991 (22 July).

Embryology Act (see chapter 6). Again, both sides of the debate in Parliament increasingly make use of medical rhetoric and knowledges as the best way of putting across their arguments. This shift in focus away from the foetus also offers some support for an argument that I shall make below: antiprogestins make it more difficult for the anti-choice movement to rest their arguments on considerations of a foetus which cannot be constructed as a recognisable 'baby' at this stage of gestational development (see pp. 182-4). And again the anti-choice run into problems in adopting medical rhetoric, as they fall open to challenge for lack of medical expertise[19]. Moreover, they face specific problems in that the weight of medical opinion stands against them. In an attempt to justify their opposition to the research claiming to have established the safety and efficacity of the RU486, anti-choice M.P.s imply that the tests done have not been scientifically objective, as they have often been financed by Roussel or have involved at least one Roussel scientist[20].

b) Understanding Opposition to Antiprogestins

It is abortion as an end rather than the means used to achieve it which has been the traditional focus of political dispute. The introduction of vacuum aspiration as an alternative to dilation and curettage (D&C) terminations provoked no debate. Moreover antiprogestins only work early in the course of a pregnancy, and this should be a factor to recommend them to everyone. Why then did antiprogestins encounter any opposition? In this section, I shall be looking in particular to the perceived need for medical control to explain opposition to the drug.

i) Anti-Choice Groups

The anti-choice campaigning groups have fought antiprogestins on all fronts, maintaining a more traditional line of argumentation, as well as seeking to deploy medical knowledges:

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[19] "I am surprised that lay persons should so question the work of the Medicines Control Agency, which is held in the highest regard and undertook proper testing" Thurnham, H.C. Deb. Vol. 195 Col. 897, 1991 (22 July).

[20] See Hind, H.C. Deb. Vol. 195 Col. 884 1991 (22 July). M.P.s make similar accusations of partiality on the part of the French government's decision to licence the pill, given that they own a 36% share in Roussel: Braine, H.C. Deb. Vol. 195 Col. 888 1991 (22 July); Winterton, H.C. Deb. Vol. 195 Col. 895 1991 (22 July). See also SPUC (undated), *RU486: Update and Implications*.

"[w]e believe [RU486] will be physically and psychologically damaging to the women who take it" (Nuala Scarisbrick, administrator of Life, in Prentice; 1990; 4);

"[w]e see it as a return to the days of backstreet abortions, except that dirty knitting needles and caustic soda will be replaced by dangerous chemicals" (Keith Davis, national campaign co-ordinator, Life in Lees; 1991);

"[t]here will be more pressure on women to have abortions" (Scarisbrick in Prentice; 1991); "[RU486 is] chemical warfare on the unborn"[21].

Also present in some statements is an undercurrent of the need for abortion to be unpleasant as a deterrent to those women who take the decision to terminate a pregnancy too easily, and here the clearer expression of fears of the control of abortion emerges. Phyllis Bowman (director of SPUC) said:

"[w]e want to see the abortion law tightened up in this country and this drug is going to make people think it's easy to have one. We're against this philosophy of making abortions easier and easier" (Moorhead; undated; 1).

SPUC's expert on RU486, Catherine Françoise, comments:

"[y]ou take a tablet to get rid of a headache. You take a tablet to stop getting pregnant. And now you take a tablet to get rid of a child...Terrifyingly, some people now talk of the death and destruction of the tiny unborn human life by a powerful chemical steroid as being more convenient" (Sapsted; 1991; 41).

A more extreme reaction comes from the U.S. where a pro-life congressman stated that:

"proponents of abortion want to replace the guilt suffered by women who undergo abortion with the moral uncertainty of self-deception...[W]ith the 'death pill', the taking of a pre-born life will be as easy and as trivial as taking an aspirin" (Ricks; 1989; 92).

Several commentators have raised the possibility that it is the belief that the abortion pill will make abortion less unpleasant which has created the hostility towards it. Dall'Ava Santucci asks "are they suggesting that women need to suffer to stop them 'reoffending'?" (1988, see also Ricks; 1989, Cook; 1990, Sapsted; 1991).

Underpinning the anti-choice opposition both inside and outside of Parliament would seem to be certain worries about the issue of control. If the technical aspect of having an abortion

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[21] SPUC leaflet, *A Dose of Lies: False claims about RU486, the Abortion Drug.*

becomes as easy as 'taking an aspirin' (and this construction implicitly carries with it the images of self-treatment and even self-diagnosis), how is it to be controlled? This, I believe, is the real motivating force behind anti-choice opposition to antiprogestins. Whereas some feminists have long advocated the practice of self-help terminations by menstrual extraction (see chapter 4, pp. 79-80), antiprogestins seem to bring the possibility of self-induced abortion much closer to reality. Abortion by menstrual extraction relies on women who have experience with the method, working as part of a group, with access to certain equipment. More importantly, menstrual extraction presupposes the acceptance of a level of intimacy with one's own body and with the bodies of other women, that would be difficult for many. Menstrual extraction would be less acceptable to many women than antiprogestins. As in the image conjured up above, it sounds as easy as taking an aspirin. So the introduction of RU486 seems to strike at the very basis of medical control of abortion - the level of technical control. Antiprogestins seem to embody the potential to render doctors redundant, and their monopoly untenable. One gynaecologist involved with the French trials for RU486 enthused that antiprogestins are revolutionary, as for the first time the doctor

"loses his/her primordial role. (S)he contents him/herself with saying if there is or is not a contraindication to taking RU and to overseeing the development of the abortion from a distance" (Aubeny; 1991; 33).

She goes on to argue that RU486 will lead to the disappearance of hospitalisation and any invasive procedures, and the possibility for women to take control of their own abortions, as it is their own action which will bring about the abortion (1991; 33). If this is true then anti-choice fears seem well founded.

As will be seen below, however, the present regulation of RU486 in those countries where it has been introduced is strict, so the hopes expressed by feminists such as Elisabeth Aubeny have little prospect of realisation. However, her ideas do present exactly the kind of image that seems to underlie the fears of the anti-choice activists. Opposition to the pill does seem for the most part to reflect the (internationally) expressed idea that RU486 may 'privatize' abortion. A leader in the *Daily Telegraph* referred to RU486 as "abortion on request"[22].

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[22] 21 July 1991. Cited by Richardson, H.C. Deb. 1991 Vol. 195, Col. 892, 1991 (22 July).

The American Journal, *The New Republic*, carried an article which described RU486 as

"enabl[ing] women to perform abortions privately at home...a woman could take RU-486 safely and privately very soon after missing her period without ever knowing whether she was actually pregnant" (Kaye; 1986).

These ideas have been summed up in *The New Scientist*:

"[w]hat is different about RU486 is that it offers women throughout the world a technique that not only promises many advantages over surgery, but could also give women greater autonomy in choosing when and where an abortion was to be performed. These advantages, it seems, are precisely where the problem lies" (reprinted in NAC; undated; 10).

These fears have also been raised specifically in connection with one of the amendments introduced by s.37 of the *Human Fertilisation and Embryology Act* which gives the Secretary of State the power to authorise classes of places for the administration of such drugs (as opposed to having to issue individual licences, as is the case for other forms of termination, see pp. 186-7 below). Anne Widdecombe noted in the Houses of Commons that:

"[this amendment] gives the Secretary of State powers to enlarge the classes of premises that will be licensed. I believe that that is merely a paving measure - even if it is not intended as such - for self-administered home abortion"[23].

It seems that opposition to antiprogestin terminations is underpinned by fears regarding the implications for control over abortion - that too much control may ultimately come to rest in the hands of the pregnant woman. After all, "[h]ow could a state control swallowing?" (Goodman in Klein et al.; 1991; 29).

ii) Pro-Choice Reactions

"If this is a private and de-medicalized abortion experience, then the word 'private' has lost its definitional moorings" (Klein et al.; 1991; 112).

The majority of pro-choice supporters, who have expressed an opinion, seem to have come out in favour of the decision to license RU486 for use in Britain. In particular, both the National Abortion Campaign and the Birth Control Trust supported this move. Given the fears of the anti-abortionists that antiprogestins might result in freer access to abortion, this

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[23] Widdecombe, H.C. Deb. Vol. 174 Col. 1193, 1990 (21 June).

is not surprising. What is perhaps more puzzling is the idea of pro-choice opposition to antiprogestins. Although there has also been some evidence of feminist opposition to RU486 in Europe[24], this has originated mainly in the USA, where there is a stronger school of feminist thought which is unequivocally anti-technology/anti-medical power. Arguments which have been made against the pill is that it is less safe than conventional methods of early pregnancy termination such as vacuum aspiration, that it has as yet been inadequately tested, that women are being used as guinea pigs for industry and that the long-term effects of the drug will remain unclear for many years (Aktionsforum MoZ et al.; undated, Klein et al.; 1991, Raymond; 1991). These arguments are similar to those made by anti-choice M.P.s in Parliament (although in Parliament, specific opposition was expressed to the fact that it was *British* women who were being used as guinea pigs[25] and the dangers of long term effects were expressed not only in terms of dangers for women but also in terms of cost to the NHS).

The arguments put forward by those feminists who have proved hostile towards the licensing of the drug also focus in part on control - that whereas RU486/PG terminations have been presented as involving a detechnicalisation and loosening of medical control, in fact quite the converse is true. Klein et al. put their claim strongly:

"[i]n reality, the RU486/PG abortion method increases, rather than decreases the lack of privacy and the lack of women's control over the abortion experience. The only different about an RU486/PG abortion is the *rhetoric* of control which hardly matches the *reality* of strict and prolonged medical supervision. Measured by the number of doctor's visits, and the duration of time from visit one to visit three, or four (at which point the woman is back to square one of conventional abortion), we are talking about a non-private, extensively medicalized, and complicated abortion method" (Klein et al.; 1991; 29 - emphasis in original).

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[24] Aktionsforum et al. (undated), Raymond (1991). At the 1992 International Planned Parenthood Federation conference on medical abortion services (see Newman; 1993; 45) and the 1992 European Network for Women's Right to Abortion and Contraception conference, such opposition seemed to be most loudly voiced by Dutch feminists, who have reservations as to what antiprogestins can do to improve abortion services in the Netherlands, which would seem to be superior to those in Britain.

[25] Hind, H.C. Deb. Vol. 195, Col. 888, 1991 (22 July); Braine, H.C. Deb. Vol. 195, Col. 889, 1991 (22 July), Winterton, H.C. Deb. Vol. 195 Col. 895 1991 (22 July), Amess H.C. Deb. Vol. 195 Col. 898 1991 (22 July).

Whilst this criticism originates from outside Britain, it seems to be no less applicable here, and indeed has been advanced in much the same form in an article in *Spare Rib*, by one of the book's authors, Janice Raymond (1991). It is this seeming paradox - that worries regarding control are central to both pro- and anti-choice opposition to the drug - which I attempt to untangle in the following section regarding the regulation of antiprogestin terminations.

4. ANTIPROGESTINS AND PARADOXES OF MEDICAL CONTROL

I have argued above that the appearance of detechnicalisation offered by antiprogestin terminations has fuelled controversy at the introduction of RU486 and has drawn the lines between its opponents and proponents. Although arguments have been framed primarily in terms of medical safety, I have maintained that opposition has been motivated in large part by the fear that RU486 will give more control to women. Equally, where putting more control into the hands of women is seen as a positive thing, this has served as an argument in favour of antiprogestins.

In the UK, Roussel Uclaf, doctors involved in the trials of RU486 and politicians alike, have all been at great pains to dispel the idea that RU486 will contribute to increasing women's control over termination. In Parliament, every M.P. who spoke to support the introduction of RU486 emphasised that it would have to pass through the *Abortion Act* in the same way as other kinds of termination, and would be subject to exactly the same level of medical control:

"[RU486's] 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"[26].

"We are discussing a method of abortion. As it should be seen clearly as an abortion method, its use must be governed by the provisions of abortion legislation, and principally the *Abortion Act*. My right hon. Friend the Secretary of State has made it clear that he is

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[26] Richardson, H.C. Deb. Vol. 195 Col. 892, 1991 (22 July). See also Thurnham, H.C. Deb. Vol. 195, Col. 897, 1991 (22 July); Clarke, H.C. Deb. Vol. 174 Col. 1199 1990 (21 June).

licensing the drug only for use in conditions that are clearly set out in law - that is to say, that the prospect of an abortion must be agreed to by two doctors. It must be on defined grounds within the terms of the Act, it must be in licensed establishments - there is no question of it being available for use in unlicensed establishments by general practitioners"[27].

"To maintain safety you require extremely close medical supervision."[28]

"Usage is confined specifically to those hospitals and clinics approved and licensed under the Act for the termination of pregnancy. it is administered there only under medical supervision and only to women who agree to the treatment schedule. Mifegyne is therefore not available for general sale, nor through chemists nor on family doctors' prescription...The supply of Mifegyne is strictly controlled by Roussel. It is available only to those hospitals and clinics which have received instructions in its use and which conform to Roussel's specific conditions of supply"[29].

All of this would seem to support Klein et al. and other feminists who have opposed the introduction of antiprogestins in their assertion that RU486 does not challenge the medical control of abortion. What particularly angers them is that RU486 has been extensively represented as an essentially demedicalising procedure which will give more control to women whereas they contend that, on the contrary, it actually extends and entrenches medical control:

"[a]ll of the researchers and clinicians agree that RU486 will *never* be given without this medical management, yet they speak out of both sides of their mouths in simultaneously stating that RU486 gives women more control over abortion. The kind of medical supervision that RU486 requires is not physician oversight from afar, but a *highly medicalized treatment regimen* which is multi-stepped, time consuming, and for many women, pain-producing and long-suffering" (Raymond; 1991; 35).

Klein et al. give the following example of the contradictions in the way that the drug has been presented, citing the pill's inventor, Emile-Etienne Baulieu who, in the space of one article, writes both that: "...RU486 could be a prototype of the second generation of ways of giving women more control of their fertility" and also that "it should be given under strict medical

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[27] Dorrell, Under-Secretary of State for Health, H.C. Deb. Vol. 195, Col. 899, 1991 (22 July).

[28] Allan Templeton, Professor of obstetrics and gynaecology at the University of Aberdeen, who headed the British trials of RU486, in Klein et al.; 1991; 29.

[29] Roussel Uclaf, company statement, 1 June 1993

supervision in specialized centers" (in Klein et al.; 1991; 25). Whilst for Klein et al. these two statements form a clear contradiction, I feel that it may be more usefully viewed as an apparent paradox which might be untangled with regard to the different forms of medical control which I outlined in chapter 4. Antiprogestin abortions fall squarely within the terms of the *Abortion Act*, and are subject to all the same regulations as surgical abortions. As such, decisional control remains firmly in the hands of the medical profession: a woman seeking abortion will still need the certification of two doctors that her situation falls within one of the categories laid out in s.1 of the 1967 Act. What may be more interesting are the implications for technical, paternalistic and normalising control.

a) Technical Control

As was noted above, antiprogestins seemingly have the potential to detechnicalise the provision of abortion: their administration does not require the same level of training as a surgical abortion (although expertise will be necessary as back up cover in case of complications). At present, however, it is true that in an important sense, as Klein et al. (1991) contend, antiprogestins serve to medicalise (rather than demedicalise) abortion. The increased medical control which forms the focus of Klein et al.'s critique is represented by increases in a basic level of technical control: the woman requires more visits to hospital/clinic (i) and, like other terminations, the procedure must be performed at specifically authorized medical centres, under medical supervision which is, if anything, closer than that required for surgical terminations (ii). One can add to this that the supply of the drug is very closely controlled (iii) and is subject to an extra level of administrative regulations introduced by the Secretary of State for Health (iv). So contrary to fears often expressed in the months preceding its introduction, RU486 will not be available over the chemist's counter without prescription, or with a prescription signed by a doctor. Neither will it be possible for the woman to take the drug to use 'in the privacy of her own home'. Even the enthusiasm of Elisabeth Aubeny (cited earlier as foreseeing the doctor as losing his/her primordial role) is dampened sufficiently for her to admit that "the price paid for [RU486] is the increased medicalisation of medical terminations for women" (1991; 34).

i) Number of hospital/clinic visits

Once a woman's request for termination has been granted, she will face three visits to the

hospital/clinic where the termination takes place as opposed to one visit for a surgical termination (Jones; 1994; 21)[30]:

* the woman will be referred to a licensed clinic where she will be physically examined and given a pregnancy test. The number of weeks since her last menstrual period will be ascertained, either from information that the woman can provide, or, in cases of doubt, by other means such as ultrasound. RU486 is available only within the first nine weeks of pregnancy[31]. The woman's medical history will be screened for contraindications to the use of RU486/PG[32]. If there are none, she can be given RU486 in the form of three pills of 200 mg each. Roussel specify that these pills must be swallowed in the presence of doctor. Most women will start to bleed the following day.

* Between 36 and 48 hours later the woman must return to the clinic to receive the prostaglandins which will complete the abortion. In Britain, this is administered by way of vaginal suppository, which is believed to be safer than injection. The woman will stay at the clinic for the next 4-6 hours. Most (up to 90%) abort there; a small number will abort after leaving the clinic.

* The woman must return several days later for a medical examination to make sure the abortion is complete and to monitor if she has experienced any side effects. Bleeding similar to a heavy period usually lasts from 7-12 days. With an RU486/PG termination, there is a 4% chance of incomplete abortion. In such cases, the woman will need to undergo a surgical

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[30] In France, where the law imposes a week long waiting period between the woman's request for termination and the medical procedure to induce it, the number of visits necessary will be at least four.

[31] In France the treatment is available only until 7 weeks. This would seem to follow indications of reduced efficiency of the treatment after this time: see, for example, Templeton (1990), UK multicentre trial (1990).

[32] Women who cannot use RU 486/PG include: those who have been receiving long-term corticosteroid therapy, those who have a blood clotting disorder, those with chronic adrenal gland failure, those with an ectopic pregnancy, those who have any contradiction to prostaglandins, women over 35 and heavy smokers. Some studies have also suggested that women who are overweight should be excluded (see Klein et al, 1991, 34-7).

termination (normally by vacuum aspiration)[33].

There was some initial confusion as to what stages of the antiprogestin termination come within the term 'treatment' (per s.1(3) of the 1967 Act) and must therefore take place in a hospital or approved place. This point has since been clarified in a Department of Health circular:

"[a]s with any other treatment for termination of pregnancy, both stages of this method (antiprogesterone tablets followed by prostaglandin pessary 36-48 hours later) must be administered in an NHS hospital/NHS Trust hospital or in one of the places approved by the Secretary of State under Section 1(3) of the 1967 Abortion Act, as amended, and specifically authorised to use this new method"[34].

Therefore both antiprogestin and prostaglandins must be given in accordance with the restrictions imposed by the 1967 Act. This interpretation is not one which would be self-evident from a reading of the legislation as only in a very few cases will the antiprogestins themselves provoke the termination: they might could rather be seen as a pre-treatment, with the second stage (prostaglandins) being responsible for causing the termination. This interpretation is the one which imposes the closest medical control. However, administration on an out-patient basis is in accordance with the *Abortion Act*, even in the small number of cases where the woman actually aborts outside the clinic.

The third foreseen visit (for check-up) to the hospital or clinic is not a requirement when the woman has a surgical abortion. In the latter case, the check up can be done by her GP or at a family planning clinic or advisory centre. David Baird, who is professor of reproductive endocrinology at the University of Edinburgh and who participated in many of the UK trials involving RU486, writes that if it will not be possible for the woman to come back for this check up, medical termination will not be offered to her (Baird; 1993; 5). He contends,

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[33] In France the woman is made to sign a form agreeing to have a surgical termination, should the medical one fail. This reflects concern that the treatment may be teratogenic. Although there is no such legal requirement in Britain, David Paintin advises that prior to the treatment that it should be certain that the woman understand and agree that in the event of failure the pregnancy must be terminated by another method (1994a; 11).

[34] Department of Health, PL/CMO (91) 9, PL/CNO (91) 4, issued by the Chief Medical Officer.

however, that in medical terms this is not always necessary, if you search for the products of conception by examining the woman vaginally before she leaves the hospital[35]. David Paintin (Emeritus Reader in Obstetrics and Gynaecology at St Mary's Hospital Medical School in London) comments that:

"[t]he development of medical services both within and outside the NHS is being restricted by prescribing rules, Department of Health regulations and the legal requirement to provide abortion within an NHS hospital. Clearly some regulation is necessary for patients' safety in relation to the use of drugs and the organisation of non-NHS facilities. But many of the regulations have been imposed for political reasons because ministers who are in charge of health and pharmaceutical manufacturers fear the small, but vehement, anti-abortion lobby" (1994b; 48).

ii) Medical Surveillance

Secondly, regulations ensure a closer level of medical surveillance over the woman while she is actually at the clinic/hospital. It is specified by Roussel that RU486 must be taken in the presence of the prescribing doctor. Further, the woman must be observed for at least two hours following administration of the drug and Roussel's conditions for issuing the drug prescribe that throughout the time a patient is on the premises a doctor must be present (not a requirement for surgical terminations). It seems that this level of control is unsupported by medical needs. Marge Berer argues that:

"[i]n the vast majority of cases, neither a gynaecologist nor a hospital setting...is required, as long as back-up is at hand in the few cases where something goes wrong" (Berer; 1993b; 16, see also Lloyd; 1993).

The regulations imposed by the Department of Health and Roussel may seem excessive not only in terms of medical need, but also in terms of the existing law. Following the case of *RCN v DHSS*, it would seem that where the initial examination of the woman is done by doctors, pills could probably be handed over by a nurse acting under the doctor's supervision. As was seen in chapter 5, terminations are included within the terms of the *Abortion Act* where, per Diplock, LJ: "a registered medical practitioner...[accepts] responsibility for all

[35] Although he does feel that a follow up visit is necessary for post abortion counselling and contraceptive advice (1993; 6).

stages of the treatment"[36]. Accordingly, so long as a doctor prescribed the treatment for the termination, remained in charge, accepted responsibility throughout, it seems that the pregnancy would be "terminated by a registered medical practitioner" for the purposes of the 1967 Act, and any person taking part in the termination would be entitled to the protection afforded by s.1(1). This does not imply the need for a doctor to be present on the premises, to be the one who gives the woman the pills or supervise her following administration, so long as there was cover provided in case of an emergency. Indeed, in the *RCN* case, Woolf J noted *obita dicta* with explicit reference to the future possibility of chemical terminations that:

"the registered medical practitioner must decide on the termination; the process must be initiated by him, and he must remain throughout responsible for its overall conduct and control *in the sense that any actions needed to bring it to a conclusion are done by appropriately skilled staff acting on his specific instructions, but not necessarily in his presence,* though he or another registered medical practitioner must be available to be called if required"[37].

This would suggest that it is probable that a far less strictly controlled regime would still meet the existing statutory requirements. Again, restrictions on access to antiprogestin terminations are not so much caused by statutory prohibition, as by the administrative and medical regulations governing their use.

iii) Supply of RU486

There is a very tight control over the supply of the drug and to whom it may be given. Roussel are proud to claim that they can trace every individual pill from the factory through the hospital or clinic to the GP prescribing it. Each package of three RU486 tablets is labelled with three numbered stickers. One sticker goes on factor records, the second is retained in the hospital or clinic pharmacy, and the third goes on the woman's medical chart. It must be possible for the doctor or hospital pharmacist to account for all labels at any time. Roussel refuse to supply the drug unless doctors from a clinic attend a training seminar in its

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[36] *Royal College of Nursing of the United Kingdom v Department of Health and Social Security*, 1 All ER [1981] 545, at 571.

[37] Ibid. at 553, my emphasis.

use. Further, they make detailed specifications as to how drugs must be stored, delivered and, if for any reason they are unused, returned[38]. One U.S. doctor who requested a pack of RU486 as a last attempt to save a patient with advanced breast cancer, was requested to return the drug, when she eventually died before using it (Chalker and Downey; 1992; 220). These provisions speak clearly to fears that a black market may develop in the drug, and that it may thus become available outside of strict medical supervision.

iv) Ministry of Health Regulations

The Minister of Health has issued some special regulations regarding the use of antiprogrestins which would also seem to imply a tightening rather than loosening of medical control (see Jones; 1994; 20). First, outside of the NHS, antiprogestins are available only to women who live within one hour's travelling time of the clinic. This regulation is important as it serves to exclude non-resident women from using the drug. According to Chalker and Downey, provisions limiting the drug to British nationals were requested by Roussel (1992; 21), presumably to avoid further publicity of women travelling to the UK in order to receive early abortions. However, Marie Stopes clinics have now declared that they are able to offer early medical abortion to women from overseas, provided they are prepared to be treated on an in-patient basis and return to the clinic one week later for a check-up[39]. Secondly, it seems that antiprogestins may only be offered if the woman agrees for her own GP to be notified[40], and he/she must be left sufficient time to respond with anxieties about the proposed treatment. Thirdly a GP (not necessarily the woman's own) must agree to provide overnight cover. This is intended to ensure medical supervision following the termination.

With regard to the current regulations governing the use of antiprogestins then, it seems that

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[38] See Roussel release: *Conditions of Supply for Mifegyne (Mifepristone).*

[39] *Abortion Review*, Spring (1994), no. 51.

[40] There seems to be some confusion on this point. The Department of Health states that there is no requirement that the woman be referred by her GP, rather the relevant procedure is rather that the woman must demonstrate that she has medical cover for follow up (letter to Lloyd, 26 April 1993). However, it seems that (at least some) clinics are applying this to mean that they must inform her GP (for example, Paintin; 1994a; 10).

basic technical control of the abortion procedure has been tightened, despite some evidence that such a degree of control is neither medically nor legally necessary. It seems likely that this very potential to demedicalise or detechnicalise abortion is responsible for the concrete *increase* in control, as it is this seeming potential of the drug which has fostered the fears surrounding its introduction, and led to the build up of bureaucracy. However, the foundations of such control seem less solid in this instance. Medical control of abortion is legitimated by the appearance of necessity to ensure safety: the promise that only the medical professional can promise health. With antiprogestins it may become apparent that these two levels are out of step, and the medical monopoly seem untenable.

c) Paternalistic and Normalising Control

Whilst antiprogestins increase the level of basic technical control and medical surveillance over abortion, they may nonetheless be important at the level of making women feel more in control of their own abortions as the procedure depends more on their own active participation. As a leading feminist gynecologist involved in the French trials leading to the introduction of the abortion pill there noted "with the abortion pill the woman isn't hospitalised or even undressed and at the moment of the abortion" (Bureau; in Simmonot; 1993b). Although women have to go through the same interviewing process to secure authorisation for their terminations, this may nonetheless have a significant effect on their experience of the abortion, and their relationship with the medical professionals involved in it. All ten of the women in Chantal Birman's (1989) study reported that their relationship with the medical profession was different and more positive than in the case of a surgical termination. Two women attributed this to the fact that they were part of a trial to test the drug and consequently things were better explained. Three others, however, asserted that the relationship was really different because they themselves were taking charge. One even talked of 'collusion' with the doctor. Further, three of them noted that it was an advantage not to be so much at the mercy of the doctors who "often want to make women suffer because they are usually against abortion and they inflict abortion as a punishment" (Birman; 1989; 8). Another woman cited by Chalker and Downey compared her RU486 termination with an earlier abortion: "[t]his time, I felt like I was in control, and taking the pills felt so much safer than having anesthesia and having some doctor poke at you with instruments." (1992; 211).

Abortion is also symbolically removed from medical control in that women are normally alone when they abort. Janet Callum relates her impression of a French clinic where women were having RU486/PG abortions:

"[s]ome women felt that because there was no instrumentation, RU-486 was gentler and less intrusive, and they also appreciated not having to disrobe and lie down before a stranger. I observed women sitting quietly in a room together, reading magazines and talking. Occasionally one would excuse herself, walk into the bathroom and within about five minutes, emerge, her abortion completed. All expressed a profound appreciation at being 'in control', and several watched with rapt attention as the technician examined the products of conception (undated; 6)[41].

According to another study, the women who opted for medical termination were distinguished by their desire to be in control (Bachelot et al; 1991; 38, see also Sapstead; 1991; 41). Elisabeth Aubeny studied seventy five women who had used this method of abortion. She notes that:

"[a]ll emphasize the responsibility that they have to take...Instead of being passive as they are in vacuum aspiration, they manage their own abortions. By taking the tablet, the woman acts to trigger the process and supervises evacuation at home. In the vacuum technique, a doctor is in sole control. A woman can be virtually absent if she chooses general anesthesia. But RU 486 fits the needs of responsible patients who can cope by themselves, as many women want to do" (cited in Lader; 1990; 54)[42].

Whilst RU486 may lead to a present increase on the level of technical control, it simultaneously (paradoxically?) may increase the woman's feeling of power and this may effect the nature of her relationship with the medical professionals she encounters - if not her GP, then the consultant who will be responsible for her termination. Further, RU486 may also have the potential to challenge the technical level of medical control of abortion in the future. As I have argued above, it is perceptions of this possibility which has provoked the fears motivating anti-choice opposition to it and led to the very tight regulation of the drug.

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[41] The privacy might, also be experienced as a more negative thing. Birman notes that "by increasing the sense of individualism, RU 486 may well make the women's isolation and solitude worse, at a time when they are battling with a painful and harrowing situation." (Birman; 1989; 8).

[42] Not all women will experience such control as a positive thing. One woman told Dr Aubeny that: "[y]ou see everything that takes place and that's difficult, I would have preferred the doctor to have taken complete charge of everything" (in Lader; 1990; 55).

5. POTENTIAL FOR CHALLENGING MEDICAL CONTROL

"Today, a strictly controlled pill, taken at hospital. But tomorrow, will it always be possible to exercise such a control?" (Aubeny; 1991; 34).

In chapter 6, I discussed the perceived need to protect the foetus from the pregnant woman, and the appointment of the doctor as the appropriate expert to represent the foetus' interests. This is closely related to the construction of abortion as an essentially medical event, requiring specialised knowledge and the idea of the woman as too irrational or irresponsible to be in control of her own termination. Whilst not wanting to overstate the importance of antiprogestins, I believe that they do have the potential to effect the abortion debate positively by challenging at least some of these assumptions (sections a and b). Further, antiprogestin terminations may yet provide an extra impetus for streamlining medical procedures in a way that would further loosen medical control and improve women's access to early terminations (sections c and d).

a) 'Foetal protectionism' and antiprogestins

Early abortions were traditionally seen by women as 'bringing on a late period' and various products were advertised in newspapers and magazines in this way. Antiprogestins to a certain extent recreate this image of abortion. Berer writes that RU486 fulfills women's need when facing an unwanted pregnancy: to get a period (1993b; 18). Commentators have described the final stage of the antiprogestin termination as "a heavy period which expels the fertilised egg" (Sapsted; 1991; 41), calling RU486 "an 'unpregnancy pill', a non-surgical means of menstrual regulation, or an 'MR drug'" (NAC; undated; 11), or the "latest contraceptive miracle" (Halpern; undated; 8). Coulet reports that some French women requesting antiprogestin terminations have described RU486 as "the drug which brings periods back" (1993; 20), and Couzinet notes that:

"[m]any women think of it as an induction of a menstrual period. Compared with classical abortion, the procedure is so much better tolerated emotionally by women" (in Cahill; 1987; 7).

The abortion debate in the UK seems to have centred very much on the status of the foetus and its (non) personhood. An important anti-choice strategy has been to focus attention on

fully formed foetuses in later pregnancy, and much of their campaigning literature contains images of the developed older foetus. As has been seen, one anti-choice success of the 1988 Alton Bill campaigns was to shift attention onto 'late' abortions (Steinberg; 1991). Antiprogestins, on the contrary, focus on early pregnancy. Abortion becomes more clearly part of a continuum which also includes contraception - the line between the two starts to blur, especially given that RU486 is in pill form and works in a way similar to the "morning-after" pill (Outshoorn; 1990, see also Murphy; 1991). Baulieu describes his invention as a 'contragestive', ("to diffuse the strength of the word abortion"), arguing that it falls between abortion and contraception (Baulieu; 1993; 4, 1991). In an article which examines the ethical implications of antiprogestins, Cahill argues that this is one of the more worrying implications of the drug:

"the line between abortifacient and contraceptive methods of birth control is obscured by rhetoric designed to make the drug more acceptable to those who already accept contraception prevention" (1987; 7).

However, what Cahill's argument conceals is that a clear line drawn between abortion and contraception is not a natural or inevitable boundary, but is itself historically specific and socially constructed, dating from the 1920s (Brookes; 1988; 6). What changes with antiprogestin terminations is the following: with surgical abortion, the pregnant woman has to wait until at least 6-8 weeks from her last menstrual period before the termination can take place. This gap has served to separate the two categories of abortion and contraception, keeping them distinct in both public consciousness and law. Indeed, British law has failed to provide any explicit distinction as to where contraception ends and abortion begins, a grey area long existing between the two[43]. Antiprogestins seem to have bridged this gap, to form a continuum between forms of contraception which prevents the egg from being fertilised (e.g. condom, spermicides, diaphragm, female condom), those which may prevent fertilisation or implantation (combined pill), those which may prevent implantation, or may dislodge the implanted embryo (IUD), and antiprogestins which cause the womb to shed its lining and hence the implanted embryo. Sara Ricks suggests that the similarity between the functioning of antiprogestins and an IUD is strong: both interfere with the nurturing uterine environment

[43] See Tunkel (1979), Douglas (1991; 95-6), Kennedy (1988; chapter 3). Ricks (1989; 72) makes the same point with regard to U.S. law.

sufficiently to prevent the continuation of pregnancy, and to induce menstruation (1989; 80).

This has already been noted as a problem for the anti-choice movement in the United States, where National Right to Life Committee president, John Wilke noted that: "[w]e're really very simplistic, visually-oriented people, and if what we destroy in there doesn't look human, then it will make our job more difficult" (Kaye; 1986; 5). Richard Glasgow, education director for the U.S. National Right to Life, writes:

"[s]ince opinion polls show that the public supports contraception but is deeply split over abortion, proponents of RU-486 are eager to tie it to the former. Moreover, if RU-486 becomes identified in the public's mind with contraception, then right-to-life opposition to the drug could be portrayed as 'reactionary' and 'out-of-touch' with the mainstream of Americans" (Halpern; undated; 9).

Also in Parliament, there seemed to be some confusion as to the nature of antiprogestin terminations, with one (anti-choice) M.P. referring to the drug as a "morning-after pill"[44]. Indeed, the first claim that the Society for the Protection of the Unborn Child (SPUC) seek to challenge in their leaflet on RU486, is that "RU486 brings on a menstrual period or natural miscarriage"[45].

b) Demystification of abortion as a specialised medical event

The role of the doctor in the medical termination changes from active to a more passive one. The doctor becomes a background figure, needed to supervise and step in if anything goes wrong. It seems to me that although the basic technical and bureaucratic control of abortion is currently greater in the case of antiprogestin terminations, that this control somehow becomes somehow emptier and more artificial - it depends much more on stringent rules and bureaucracy than on accepted medical need. This is reflected in that in practice, doctors do not always strictly abide by the rules. Baird writes that:

"[d]uring the administration of the mifepristone, minimal supervision is required, and although the manufacturers tell us that the woman should be observed for two hours, in practice after the swallowing of the tablets the patient is allowed to leave after five to ten minutes. In the

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[44] Campbell-Savours, H.C. Deb. Vol. 195, Col. 898, 1991 (22 July).

[45] SPUC, *A Dose of Lies: False Claims about RU486, 'The Abortion Pill'*.

UK we have to administer these tablets in a licensed premises or in an NHS hospital. There is really no medical reason for this. This is purely a product of the legal requirement for termination of pregnancy" (1993; 5).

Logan (1994; 34) describes how a significant part of the RU486/PG termination is carried out by nurses: they administer the prostaglandin and do the vaginal examination with speculum. Likewise, Jones (1994; 22) notes: "[t]he use of mifepristone has enabled other doctors to distance themselves form the practice of abortion by leaving the work to nurses or junior medical staff." It would seem to be just as safe for a nurse, midwife or trained lay person to administer both courses of treatment, given access to specialised medical help in case of need. This means that the traditional justification for the need for medical technical control - safety - would no longer ring true here. Antiprogestins seem then to offer greater future potential for arguing for safe abortions, performed by trained lay personnel with medical personnel necessary only as backup.

c) Challenging Referral Procedures

A letter in *The Times* (9 July 1991) shortly after the UK licensing of RU486 called for a review of the existing referral procedures of the NHS[46]. As the letter points out, in the NHS in England and Wales, only 21% of all abortions are performed within the first nine weeks of pregnancy, because of the lengthy procedures in some area health authorities. The signatories argue that the introduction of early medical abortion, which can be used only until nine weeks from the woman's last menstrual period, provides the NHS with an exceptional opportunity to review its referral procedures so as to provide a fully comprehensive abortion service. Thus the importance of antiprogestins here is to provide an impetus for existing referral procedures to be expedited in order to make their use a possible option. This is an administrative matter and so has the advantage of not having to put abortion back onto the Parliamentary agenda[47]. Some excellent examples in the UK already exist to show how successful a streamlining of referral procedures can be (see Glasier; 1993).

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[46] Signed inter alia by MPs, members of the Birth Control Trust, Mary Warnock and Janet Radcliffe Richards.

[47] In this sense the response from Bernard Braine MP was incorrect when he accused the signatories of the letter as "by implication...calling for a change in the law to allow abortion on demand" (*The Times*, 17 July 1991).

A more radical step would be to propose again the streamlining of referral procedures in Parliament. As was seen above (chapter 6), in the 1990 Parliamentary debates, the amendment tabled by Harriet Harman which sought to allow a woman to have an abortion following referral by just one doctor (as opposed to two) failed by a slim margin of only 28 votes. Harman argued for this amendment in the name of a speeding and streamlining of NHS procedures. As antiprogestin terminations are dependent on an early referral, their existence within the NHS might provide one more argument for such an amendment in future debates and thus swing the balance[48]. Claims that women should have the absolute right to elect to terminate early pregnancies might benefit in the same way. It is unlikely, however, that these issues will again receive Parliamentary time in the near future.

d) Licensing of Other Premises

Under the terms of the *Abortion Act*, s.1(3)(a) (introduced by s.37(3) of the *Human Fertilisation and Embryology Act*, 1990), the Secretary of State has power to authorise the use of specified abortifacient drugs in classes of places other than NHS hospitals. Although ministers have said that they have no immediate plans to make use of these powers[49], as this amendment was introduced specifically by the government, the possibility of future licensing of other premises is obviously already on the agenda[50]. This might mean that GPs' surgeries and eventually family planning clinics could be licensed to supply either the first or both courses of treatment. This would be beneficial for women, given that typically one will live nearer to a GP than to a hospital/clinic. It also has a broader significance in driving a wedge

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[48] In a study conducted by Victoria Hartnell (1993), two thirds of the 156 women included had requested abortion before 63 days of gestation, but only 17% actually had their abortion within 63 days. The average delay between request and referral from GP was two days, and from referral and operation was 20 days. Hartnell concludes that strong arguments exist for clinics dedicated to pregnancy termination as more efficient and effective and having lower long term complication rates.

[49] Dorrell, H.C. Deb. Vol. 195, Col. 899, 1991 (22 July), letter of 9 March 1993 from Department of Health to Leonora Lloyd.

[50] "A question was asked earlier about what type of premises would be used for administering such a drug. It is possible that the pill could be administered in a GP's surgery under the supervision of a registered medical practitioner. The patient would still have to return two days later to be given the pessary", Clarke; H.C. Deb. Vol. Col. 1199 1990 (21 June).

into the power of the hospital doctors who, as was seen in chapter 4, have a de facto monopoly on the provision of NHS terminations: it is this regulation that the abortion must be performed on specially licensed premises which restricts the number of doctors who can perform abortions.

David Bromham (senior lecturer in obstetrics and gynaecology at St James' Hospital, Leeds) has suggested that family planning clinics might be particularly suitable for the provision of antiprogestin terminations (1994; 14, see also Baird; 1993; 6). The desirability of extending permission for treatment to be administered there or at GPs' surgeries will depend on the results of clinical trials and on medical opinion about the safety of such a move. If thought desirable, achieving this would depend on the political will of the Minister of Health (Colvin; 1990)[51]. Given the current composition of the Government, the likelihood of such political will existing is probably limited. One Scottish organisation recently asked the Scottish Home and Health Department whether it could set up an abortion service in Edinburgh where women who presented for abortion to a large family planning clinic could be given the RU 486 in that clinic and then admitted 48 hours later to the hospital for the administration of the prostaglandins. This would have meant that the family planning clinic would have had to have been recognised by the Secretary of State for Scotland as an approved place for termination of pregnancy. The Scottish Home and Health Department were reluctant to allow this to happen, for reasons which according to Glasier are political: namely "they do not want to rock the boat" (1993; 15).

6. CONCLUSION

Klein et al. argue that "RU486/PG represents the epitome of a reproductive politics that makes no connection to the sexual politics of women's lives" (1991; 120). This is true in the sense that any kind of abortion does not address the wider social (sexual) context within

[51] If the Minister failed to take such action in the face of overwhelming evidence that it would be medically safe to do so, it might be possible to challenge his decision in public law if it could be shown that he was exercising his discretion wholly unreasonably and against overwhelming evidence. Ministers have a wide discretion however, and courts are reluctant to overrule their discretion (Colvin; 1990; 20).

which women get pregnant. The availability of abortion is only ever part of the story and it can only be one part of a feminist politics of reproduction. However, in another sense, Klein et al. are also wrong. Antiprogestin terminations may connect with women's needs and perceptions in important ways. In particular, the availability of such an early method of abortion may have a positive effect on a woman's experience of her abortion. Further, whilst antiprogestins are indeed a method which currently entail a tighter level of technical control, this control seems in an important way to be more 'hollow' in that it is more dependent on rules and bureaucracy and less on a commonly perceived medical need. This increased technical control seems to be a result of fears generated by the seeming potential of antiprogestins to strike at the basis of this technical power.

Here it has been seen that the decision to license RU486 for use in Britain had little of the explicit political significance of the same measure in the USA. What debate occurred here was rather cast within an essentially medical framework. Despite this, however, I argued that the dispute which existed could only be adequately understood within a context of control and dispute as regards who should make reproductive decisions. Moreover, whereas RU486 was introduced with comparatively little controversy and contestation, it has been introduced only within a rigid framework of medical control and supervision. This is hardly a situation of "NHS distribution of RU 486 to any woman who qualifies for it", as it was enviously described by the US commentator whom I cited in the introduction to this chapter.

CHAPTER 8: CONCLUSIONS

"What I mean is this: in a society such as ours, but basically in any society, there are manifold relations of power which permeate, characterise and constitute the social body, and these relations of power cannot themselves be established, consolidated, nor implemented without the production, accumulation, circulation and functioning of a discourse...We are subjected to the production of truth through power and we cannot exercise power except through the production of truth"[1].

"Yet law remains a site of struggle. While it is the case that law does not hold the key to unlock patriarchy, it provides the forum for articulating alternative visions and accounts. Each case of rape, sexual abuse, domestic violence, equal pay, and so on provides the opportunity for an alternative account to emerge. This account may not emerge in court (indeed it would be silenced there), nor in the media, nor in the formulation of reformed legislation, but it can and does emerge in women's writing and feminist groups...These resistant discourses are growing in power, and it is often law that provides a focal point for the voice to be heard"[2].

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[1] Michel Foucault (1980b; 93).

[2] Carol Smart (1989; 88).

1. SYNOPSIS: "INTO THE HANDS OF THE MEDICAL PROFESSION"

In chapter 1 I laid down a thesis which I sought to sustain in the pages which followed. I have argued that the shift from a model of law based on criminal prohibition to a decentred network of medical control has (re)cast abortion as a narrow medical matter. Whilst it is true that threats to the 1967 Act remain both in the form of periodic attacks in Parliament, and the emergence of more militaristic, anti-choice tactics outside it, increasingly it seems that a status quo has been broadly accepted and within this abortion has become established as a matter for medicine rather than politics. This depoliticisation is real to the extent that important decisions regarding the provision of abortion have been shifted out of the public arena and left in the hands of medical professionals. However, I have argued that nonetheless abortion remains an important political issue. This is true both in terms of the values underpinning the existing rules governing the availability of abortion, and also in the sense that the regulation of abortion provides particular sites and modes for the deployment of power over women. It seems to me that in Britain the most serious problem currently facing a pro-choice politics is the relative powerlessness of women in the face of medical authority and the problems which stem from this.

In chapter 2, I began my study of the law regulating abortion with some consideration of the statutory basis for legal terminations in Britain. I located the 1967 *Abortion Act* within the terms of the broad shift to 'governmentality' described by Foucault (1979a), as a tactic of management, surveillance and control of the population. In this instance, this is instituted through the medical profession who operate as 'parallel judges', able to offer a close evaluation of every individual case. I argued that, far from representing a straightforward loosening of power over women or being motivated by a desire to extend female autonomy and self-determination, the *Abortion Act* was actually in part motivated by a desire to regain control of a situation of mass, de facto resistance to the law and to assert a medical monopoly over the control of reproduction. The form of legislation adopted operates to fulfil these aims, strenuously avoiding the granting of substantive rights to women seeking abortion and passing almost total control to the medical profession. The Act represents a shift from a legal regulation based on criminal prohibition, to one based on a decentralized network of medical control over women. This is not to deny that the 1967 Act represented a gain for women,

but rather to note that it simultaneously grounded a particular modality of power over them.

Foucault has contended that the new visibility of the population achieved through tactics of governmentality succeeded in constituting the individual for the first time as a 'case study', an object of inquiry and a new target of power. In chapter 3, I examined the 'peripheral subject' (re)constructed within the *Abortion Act*. The woman seeking abortion was constructed in terms of irrationality and instability: as either a selfish minor or a downtrodden and deranged victim of circumstance. Her very nature renders her unsuitable to make her own reproductive decisions; her inherent pathology grounds the need for the calm, rational and responsible figure of the doctor to take control of the situation. She is inherently in need of normalising medical supervision. The statute avoids challenging the notion of maternity as the female norm, rather abortion is only permitted when an exception can be made to this general rule. The constructions of unwanted pregnancy as an instance of individual pathology and of abortion as a wholly medical event have been integrally connected with the extension of a network of medical control.

In chapter 4, I moved from a focus on the spirit of the legislation to a consideration of how the medical control over abortion actually functions in practice. In an attempt to provide a more differentiated model of power, I distinguished between: technical control (the medical monopoly over the performance of legal abortions); decisional control (the doctor decides who shall have access to abortion); paternalistic control (the sympathetic doctor imposes his/her own views) and normalizing control (the doctor has access to details of the woman's 'private' world, and the power to locate her in a broader framework of understanding in order to produce an authorised account of her reality). It was noted that some individual doctors have attempted to minimise the extent of this control over women, seeing the woman's desire for a termination as grounds enough for authorising it. In leaving control of abortion in the hands of the medical profession, women's access to abortion services becomes dependent on doctors' discretion. In practice this has had significant and enduring negative consequences for such access.

The medicalisation and medical control of abortion have been entrenched and extended by law. Whilst not denying that abortion has medical aspects, I criticised the fact that the

colonisation of law by medical knowledges has operated to the exclusion of other accounts and perspectives. The courts both accept and reinforce the medical control of abortion - and hence medical power over women - as was seen in chapter 5. The jurisprudence displays a clear judicial deference to medical authority and itself illustrates the influence of medicalisation, making use of medical constructions. As the law becomes dependent on medical concepts and definitions (e.g. viability), or creates its own constructions based on its perceptions of medical reality (e.g. good medical practice) then expert medical witnesses are necessarily drawn into the courts to guide judicial interpretations. Judicial respect for medical authority has not been entirely negative for women: it was significant here that medical control of abortion has in many ways served to protect, rather than to impinge upon, female autonomy. The law operates to protect the medical relationship from outside challenge. Where it is less useful is in protecting women within this relationship - this has been seen in cases such as *Re S* and *Re W*. In terms of the regulation of abortion, the case of Barbara Whiten has staged a confrontation between medical discretion and female autonomy to provide a challenge which, at the time of writing, the law has yet to answer.

In chapter 6, I examined section 37 of the *Human Fertilisation and Embryology Act*, 1990 in the light of the broader assumptions which underlie it. I argued that the reforms introduced by this section display the same tension with regard to medicalisation as the case law: although they have been widely greeted as a pro-choice victory, on another level they also constitute a defeat. In this sense I argued that the framework for debate has shifted away from a broader social framework which includes discussion of women's circumstances and needs to a predominantly medical framework, focusing on the (medically defined) status of the foetus. I highlighted two specific problems. First, I argued that the Parliamentary debates display a worrying assumption of foetal separation which has remained largely unchallenged. Secondly, whilst the acceptance of abortion as an area of medical knowledge has helped to defend the ambit of the 1967 Act, and to secure a comparatively high upper time limit for terminations of 24 weeks, it cannot but have contributed to the climate which saw the failure of proposed amendments which sought to loosen medical control over access to abortion and allow women greater autonomy in early pregnancy.

In the final chapter, I looked at antiprogestins (available in Britain since July 1991) and the

legal and medical framework which has been established to regulate their use. I argued that what discussion there was about the decision to license RU486 for use in Britain was conducted primarily in medical terms and this obscured the drug's political significance and contributed to the relative lack of controversy which greeted its licensing for the British market. However, I also contended that such depoliticisation remains an appearance and not a reality: whilst phrased in medical terms, the reactions of pro- and anti-choice groups can only be understood within a context of an ongoing struggle over control of women's fertility. Further, I noted that although RU 486/PG terminations were initially seen as a way of de-medicalising abortion, their introduction has resulted in an increased degree of medical control and supervision. I sought to explain this with regard to the different models of control outlined in chapter 4. I argued that the regulations governing the use of antiprogestins were a reaction to fears regarding the potential of the drug to decrease medical control. Over and above these regulations, however, I argued that RU 486 may yet have significant potential for challenging certain aspects of medical control and medicalisation.

In the light of this analysis, it seems clear that the medicalisation of abortion has served to largely remove it from the public sphere, whilst also greatly influencing what discussion of it remains within that sphere. However, it is still relevant to view the regulation of abortion in Britain as a political issue. This is true in two senses. First, the existing legal rules governing the availability of abortion were predicated on the desire to establish a network of control capable of regulating both abortion and the women who seek it, whilst safeguarding the medical monopoly over it. This is seen in terms of the statute (chapters 2, 3 and 6), the judicial protection of the medical monopoly (chapter 5), and in the administrative rules and regulations, as was seen particularly in discussion of antiprogestin terminations (chapter 7). Secondly, the form taken by the regulations ensures that women are constantly vulnerable to medical power: the element of control inherent in the doctor-patient relationship is entrenched and extended (chapter 4).

However, a rather different model than such as that suggested by Catharine MacKinnon (1983a, 1983b, see p. 4) which focuses on violence or coercion is essential for such an analysis. The model of power which has emerged in this work is one not of state prohibition,

but a more regulatory model: a shifting and decentralised network of medical power, the operation of which is justified by specific gendered constructions of the nature of the woman seeking to terminate a pregnancy and the expert knowledge of medical professionals. Legal regulation stands not in opposition to this medical regulation, but functions in a symbiotic relationship with it, adopting medical knowledges and norms, legitimating and entrenching a sphere of medical discretion. The operation of power has been largely concealed in that the encoding of abortion law in medical terms contributes to a growing appearance of depoliticisation - abortion becomes a site for scientific knowledge and expert control. This serves to protect the status quo, with the legal framework for such medical control, and the exceptional judicial intervention serving to legitimise the normal run of medical practice and control. As Dreyfus and Rabinow comment:

"[p]olitical technologies advance by taking what is essentially a political problem, removing it from the realm of political discourse, and recasting it in the neutral language of science. Once this is accomplished the problems become technical ones for specialists to debate" (1982; 196).

Although law retains ultimate authority for itself, its power is deployed only in exceptional cases.

Abortion activists on both sides of the political fence have embraced medicalisation, working within the medical framework and adopted medical knowledges and rhetoric where this has seemed the most effective way of influencing the political debate and legislation. Anti-choice activists have used medical knowledges very effectively, using medical accounts of the physiological development of the foetus and photographs which purport to show it at an advanced stage of pregnancy. The pièce de résistance of this genre is the (largely discredited[3]) pseudo-scientific film, *The Silent Scream*, which purports to show an ultrasound imaging of a twelve week foetus being aborted. Narration is provided by Dr Bernard Nathanson, "sober, bespectacled, leaning professorially against the desk", providing medical

[3] A panel of New York medical experts have contested the scientific validity of the film, on the grounds that, inter alia, the frantic movements of the foetus are caused by the speeding up of the film and that the size of the foetus as it appears in the film is nearly twice the size of a normal twelve week foetus (Petchesky; 1987; 60-1).

authority for the images (Petchesky; 1987; 59, see also Hartouni; 1991; 36-7). Likewise, in chapter 6, I noted that in 1989, SPUC produced half a million full-colour postcards showing a 'baby' (foetus) of 18 weeks gestational development sucking its thumb, and three million colour leaflets "showing the baby's humanity in words and pictures". I argued that although this is not a new campaigning tactic, its power has been increased due to the invention of techniques which allow the photographing of the foetus *in utero*. Advanced medical technology is used to produces an image which emphasises all that is baby-like about the foetus - like a baby, it is shown as existing whole and separate from the body of the pregnant woman. This mirrors the shift in the political debate, which I argued above has come to revolve around the (medically defined) status of the foetus, with the pregnant woman completely occluded. The anti-choice movement has also produced expert witnesses to testify to a medically proven form of illness following termination: 'post-abortion trauma' or syndrome. This has the object of a recent private Commission organised by anti-choice M.P.s under Lord Rawlinson[4] and a repeated subject of Parliamentary questions by anti-choice M.P.s[5]. Anti-choice M.P.s have also tabled many Parliamentary questions dealing with various other medical aspects of abortion. To take January of 1993 alone, David Alton requested information on the links between abortion and chlamydia[6], infertility[7] and spontaneous miscarriages in subsequent pregnancies[8], maternal deaths[9], how often it was necessary to give blood transfusions following abortion[10], the incidence of perforations and

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[4] Members of the Commission include David Alton, Margaret White and Catherine Françoise. See National Abortion Campaign (1993b) and *Abortion Review*, Spring 1993, no. 47.

[5] Alton, H.C. Deb. Vol. 209 Col. 603w 1992 (17 June), Spink, H.C. Deb. Vol. 212 Col. 69w 1992 (19 October).

[6] H.C. Deb. Vol. 217 Col. 477w 1993 (22 January).

[7] H.C. Deb. Vol. 217 Col. 813w 1993 (28 January).

[8] H.C. Deb. Vol. 217 Col. 813w 1993 (28 January).

[9] H.C. Deb. Vol. 217 Col. 722w 1993 (27 January).

[10] H.C. Deb. Vol. 217 Col. 477w 1993 (22 January).

ruptures of the uterus[11] and the procedures for reporting of physical complications following abortion[12].

Nevertheless, it seems that the weight of medical opinion in Britain is in favour of allowing abortion (within certain medically controlled circumstances and limits) and that, on balance, medicalisation has led to a facilitation of women's access to abortion. Britain was among the first Western countries to legalise abortion and the medical framework adopted by the law helped to minimise potential political controversy. Since 1967, doctors have grown increasingly liberal in the provision of abortion and the courts have refused to check this development. Specialist non-NHS clinics have been established in areas where (senior) NHS doctors are less liberal and block the performance of abortions in 'their' hospitals. Administrative attempts to restrict the number of abortions (for example where the Department of Health altered notification forms to omit reference to the woman's environment) seem likewise to have been unsuccessful (see chapter 5, p. 113). Britain has a relatively high upper time limit for abortion, which was enshrined in statute in 1990 because it coincided with viability (primarily a medical event). Finally, that antiprogestins arrived on the British market with only minor protests preceding their introduction, testifies to the extent to which abortion has come to be seen as an essentially medical, rather than political, matter.

2. WHAT'S WRONG WITH MEDICALISATION?

Given that medicalisation has brought such obvious gains, why would one seek to challenge it? Although it has been seen above that medicalisation has in many ways served to improve and protect women's access to abortion, it has also become clear that it presents two integrally connected but nonetheless analytically distinguishable problems. First, there is the problem of the medical framework itself: in the same way that the adoption of a rights framework for debate has been criticised for the marginalisation of consideration of broader social issues, so crucial to earlier pro-choice campaigns, so too has the pre-eminence of

[11] H.C. Deb. Vol. 217 Col. 698w 1993 (26 January).

[12] H.C. Deb. Vol. 217 Col. 536w 1993 (25 January).

medical knowledges and the acceptance of a consensual medical framework for debate. As the law has been colonised by medical knowledges, other understandings of abortion have been excluded from it (section a). Secondly, this acceptance of a medical framework seems to make any possibility of loosening the medical grip on the control of abortion appear ever more remote and thus contributes to the maintenance of the concrete problems which stem from such medical control, outlined in chapter 4 (section b).

a) Marginalisation of non-medical factors

The first problem which I want to raise here with regard to medicalisation echoes that which some feminist writers have outlined with regard to the use of rights discourse in abortion debates[13]. Whilst feminist commentators have recognised that the language of rights has been useful and politically empowering for the women's movement (as for many minority groups), recent years have seen an increasing degree of unease with regard to its invocation. The use of rights in the formulation of claims has been criticised for a number of reasons including its focus on individuals as opposed to social structures (Himmelweit; 1988; 42, Kingdom; 1991; 62) and on narrow legal solutions rather than wide-ranging social reform. Thus, if and when such rights are attained, this can present a problem as solved (Smart; 1989), although history clearly shows that an improvement in women's formal legal position does not automatically lead to an improvement in women's social and economic position (Kingdom; 1991; 47). I would argue that medicalisation poses similar problems. Furthermore, the analysis of this thesis would suggest that, certainly at the Parliamentary level and to a large extent also within the rhetoric of the campaigning groups, the rights discourse is being superseded by the use of medical discourse and a deployment of medical knowledges (see especially chapters 6 and 7).

As Carol Smart has contended, law has a particular claim to truth which is indivisible from

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[13] See especially Liz Kingdom (1985, 1991, 1992); Carol Smart (1989); Sue Himmelweit; (1988); Lucinda Finley (1983) and Ros Petchesky (1984a). For a defence of the use of rights, see especially Adelaide Villmoare (1991); Martha Minow (1989) and Patricia Williams (1988). Joyce Outshoorn (1992) has argued that this preoccupation with rights may be a peculiarly Anglo-American one. She cites the very different formulation of claims by the German and Dutch women's movements, which focus more on control over one's body (1988; 207).

its expression of power, operating not simply in its material effects (judgments), but also in its ability to disqualify other knowledges and experiences (1990a; 5). This gives great significance to the colonisation of law by medical knowledges. The 1967 Act marked a landmark victory for the medical discourse or paradigm, constructing abortion as falling primarily within the sphere of medical, rather than - say - moral or religious authority (as in Ireland), or as a matter of the conflict between a woman's right to privacy and the state's interest in protecting foetal life (as in the United States). This victory has been consolidated in more recent years: the medicalisation of abortion has become so grounded in our commonsense perception of it, that it is now difficult for many even to imagine an alternative legal context to that of medical control (Gordon; 1980; 515). In this sense a clear evolution between the Parliamentary debates of 1966-67 and those of 1990 has been seen. Whilst the former contain much discussion of women and broader social factors, the latter are characterised by their strong medical focus (see chapters 2, 3 and 6). The acceptance of abortion as something which falls within the realm of the medical has become so firmly entrenched that any voice wishing to make itself heard in the debates is under pressure to adopt medical discourse. Neatly illustrating this, Fyfe reports a comment made to her: "how can you do any research on abortion, you've never studied medicine!" (1991; 169).

One example of the ability of medical knowledges to disqualify other accounts was seen in chapter 6 with the adoption of 24 weeks as the upper time limit for abortion in 1990. As was seen this rested on the significance attributed to the medical construction of 'viability' and the assertion that any other cut off point would simply be "arbitrary". As I asserted above, to accept this one factor of viability as the decisive cut off point ignores women's complex decision making and awareness of broader social considerations. As Maureen McNeil argues, the adoption of viability as a dividing line:

"shifts the focus of decision-making away from women who, in opting for or against abortion, make complex evaluations of their particular circumstances and of the social sustainability of new life. Such decisions have little to do with what medical science can sustain technologically. Saying that it is theoretically possible to plug a 24-week-old fetus into life support apparatuses is very different from saying that you personally will take primary responsibility for supporting - in every sense - a child through to adulthood" (1991; 156).

Other examples were found in the jurisprudence. In chapter 5, I discussed the case of *C v*

S, which concerned Robert Carver's attempts to prevent his pregnant ex-girlfriend from terminating her pregnancy. The major issue to be debated in court was neither S's situation, nor her claim to self-determination and how that can be weighed against Carver's interests. Rather the legal issue was constructed as a narrow medical one, again revolving around the point of viability and the boundaries of medical discretion. Again, this led to a favourable (legal) result for S, however the tremendous political importance of the decision is defused. The legal problem to be decided is encoded in medical terms.

The process of focussing a debate is inevitably also one of narrowing it: any way of formulating a question equally occludes other possible formulations. This is an essential process for law, which is not able to deal with infinite complexity. It must simplify and reduce an issue to manageable proportions before it can begin to deal with it (Teubner; 1983; 249). However, whilst it is not 'wrong' to view abortion as a medical phenomenon, other important ways of conceptualising it are obscured by the dominance of the medical framework. I would contend that the current statute does more than simply omit consideration of social factors. Rather, as was seen in chapter 3, by its very structure, the law focuses attention onto what is *different* and medically (broadly construed) significant about the particular woman's situation. Abortion is illegal: the question is what is peculiar about this woman or this pregnancy that should justify its performance? This obscures consideration of much of what has been central to feminist accounts of abortion: what may be *similar* in the situation of women which contributes to the existence of unwanted pregnancy[14]. Even in so far as the *Abortion Act* does take account of social factors (in that the doctor can take account of the 'woman's actual or reasonably foreseeable circumstances'), these are individualised, reconstructed as exceptions which are particular to the situation of the individual woman and only by virtue of this fact gain their medical (and hence legal) relevance. As was seen in chapter 5, this is true even where doctors make their recommendation for termination on the grounds of the so-called 'statistical argument'[15]: they

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[14] Compare this with the French law, as drafted by Simone Veil, which foresees that legal abortion should be accompanied by a coherent policy on contraception, abortion and improved education, see Allison (1994; 230).

[15] I.e. statistically speaking, to continue a pregnancy poses greater risk to the woman's health than an early termination.

are required to take an individualised decision (see p. 114). It remains implicit in the law that women should only be allowed to have abortions if they fit into one of the 'abnormal' categories: if they are somehow distinguished from the 'normal' family oriented, maternal woman with a normal pregnancy.

In dealing with social problems which particularly affect certain individuals, the makers of public policy have always to make a choice, or to strike a balance, between dealing with the problem on a social level (through welfare measures, preventative campaigns) and on an individual level (through treating the individual, criminal sanctions, individual benefits etc.). For example, unemployment can be seen as social, structural problems: for whatever reason, there is inevitably a class of people in our society who are without work. Alternatively, it can be seen as an individual problem: the individual is unemployed because s/he is under skilled or insufficiently motivated. The way in which unemployment is conceptualised has vital implications for how we seek to deal with it. If it is due to structural factors, it is only by addressing these that unemployment will be eradicated or mitigated. If it is because of an individual fault, then effort must be directed at the individual. In fact, our system of welfare benefits rests on a dual conception which incorporates aspects of both of these viewpoints: accepting the inevitability of unemployment and hence the need to pay benefits, but at the same time introducing carrot and stick measures to encourage the individual into the labour market, or schemes to enhance her/his chances within it.

Central to feminist writing on abortion has been an emphasis on the broad, structural factors which contribute to the incidence of unwanted pregnancy and which make abortion more than an individual matter - a refusal to abstract the issue of abortion from the context of women's concrete situation(s) in society. Such writings have raised not merely individual, medical considerations (are the requirements for abortion justified by this case history?) but also reflect the more general, social issues involved in discussion about unwanted pregnancy. The problem of understanding abortion has thus been one of simultaneously grasping both individual and social factors, of understanding that abortion is at once a decision arising from intimate and personal circumstances, yet at the same time is influenced by important structural givens which relate to the particular situations of women in a given society at a given time. As Petchesky writes, the nature of reproduction is simultaneously social *and* individual,

operating both at the core of social life, as well as within and upon women's individual bodies (1984a; 2).

Socialist feminist writers like Ros Petchesky in the USA and Liz Kingdom in Britain have suggested that pro-choice campaigns might be usefully reformulated with a focus on women's needs (Petchesky; 1984a) or circumstances (Kingdom; 1992). Within these general categories they would include the need to consider such matters as the availability of safe and efficient contraception; sex education; the difficulty for women to take control of their own sexuality and refuse intercourse where it is not desired; social pressures such as stigma attached to mothering outside of marriage; financial and economic considerations; and the massive loss of freedom experienced by individual women on having a child (see Petchesky; 1984a; 1-21). Within the present, medicalised legal construction, the essential problem is one of how far doctors' freedom to terminate pregnancies should be legally controlled. Once some provision has been made in this direction and an acceptable 'compromise' reached, the problem seems solved, the State's responsibilities fulfilled. When the problem is relocated within the context of women's lives, the issue becomes one of unwanted pregnancy and attention is uncomfortably refocused onto problems which are less easily (and cheaply) addressed: poor child benefits, lack of childcare facilities, inadequate social provision for the physically and mentally handicapped, failure to provide adequate sex education and contraception and, above all, women's lack of control in sexual relations and hugely disproportionate share in the costs and responsibilities of childcare[16]. Medicalisation (and the casting of law in medical terms) has aided the apparent depoliticisation of abortion by structuring debate in such a way that attention is not focussed on such factors.

b) Entrenchment of Medical Control

The acceptance of a medical framework for debate works against any loosening of medical control: the more abortion becomes seen as a medical decision, the more difficult it becomes to see this decision as one which fundamentally belongs to women rather than doctors. In 1990 M.P.s voted to maintain a relatively high upper limit in the law and in certain instances

[16] One might also think here of the costs that childcare imposes on individual families (even in the exceptional cases of two or more adults genuinely sharing childcare responsibilities) as opposed to costs borne by the wider society.

(including in cases of foetal handicap) they voted that abortion should be allowed until the moment of birth, in this respect marking the *Abortion Act* amongst the most liberal of Western abortion statutes (see chapter 6). At the same time, M.P.s refused to allow abortions prior to 12 weeks either on request or where authorised by only one doctor, retaining the strictest medical control and situating the *Abortion Act* amongst the least liberal of Western abortion statutes. This voting pattern is consistent, however, if one locates it within this context of medicalisation and medical control. Law leaves a broad scope for medical discretion, but this implicit acceptance of abortion as a site of privatised, expert, medical knowledge can only have contributed to the failure of the proposals to loosen such control in early pregnancy. Likewise, antiprogestins were licensed for use in the UK on the basis of repeated assurances that they would be issued only through the most strictly controlled medical channels. As a result, women in Britain may have the possibility to use this method, but only within very the tight limits of a cumbersome, highly medicalised system of supervision and control (see chapter 7). The licensing of RU486 thus widens the medical choices open to women acting in conjunction with their doctors, but allows the exercise of this choice only under an even tighter medical control.

It has been evident that medical control of abortion brings its own attendant problems, and these were outlined in chapter 4. It remains true that one's chance of obtaining NHS funding for a termination is dependent on where one lives, and the bias of the senior doctors in local NHS hospitals. Further, it seems that there is little control over how women will be treated by the GP and hospital workers they encounter in their attempt to obtain an NHS termination. There are also problems of underfunding which are integrally linked to the power of senior hospital doctors. Finally, whereas the woman acting in conjunction with her doctor is comparatively well legally protected against outside interference (by State or third party), it seems that she has less protection against her doctor (see chapter 5). In practice, this resulted in a situation where women who are sufficiently knowledgeable to approach a clinic, and who have the necessary money to fund their own terminations, will have access to safe, legal abortion, normally in a more sympathetic environment. The same is not necessarily true for younger women, women of minority ethnic groups or others who are lacking the same resources in terms of money and knowledge of how the system operates. The entrenchment of medical control leaves women's access to termination as discretionary, and the treatment

which they receive as dependent on medical goodwill. Inevitably, the worst consequences of the this will fall upon the most vulnerable groups of women. With the possibility of obtaining NHS funding for a terminations dependent on geography, and the likelihood of a sympathetic reception from one's GP largely a matter of luck, it seems to me that the most pressing problem now facing a feminist politics of abortion is that of medical control.

3. CHALLENGING MEDICALISATION AND MEDICAL CONTROL: THE ROLE OF LEGAL REFORM

The above analysis raises a clear problem for a pro-choice politics. It seems that the most effective way of protecting and entrenching women's access to abortion services has been to embrace an essentially medical framework, deploying medical knowledges and constructions. This is a language and argumentation which seems to have been most effectively 'heard' within the existing legal structures and which is least susceptible to challenge or dispute. To phrase claims in the language of medical need also serves to depoliticise them, giving an appearance of neutrality. However, it is difficult to see how medical knowledges can be deployed without reinforcing the construction of abortion as essentially a medical phenomenon, thus marginalising other accounts and entrenching the idea that control should rest in medical hands. Moreover, addressing medical power is especially difficult given the form that it takes and the fact that its operations are often barely apparent: only in the most extreme cases can such power be understood in the terms proposed by writers such as MacKinnon as coercion or violence against women. Its operation is rather grounded in medical knowledge, and the medical claim to define the patient's best interests. For abortion, moreover, such power is grounded not only by the notion of the doctor as the expert most able to help the pregnant woman, but equally by the idea that he/she is most in touch with the interests of the foetus, and by his/her construction in other areas of obstetrics and gynaecology as the 'foetal protector' (see pp. 74-5).

The problem of the power imbalance inherent in the medical relationship is not confined to discussion of abortion, however in this instance it is still more acute. Confronted with an unwanted pregnancy, the doctor may be hostile to the woman's request and decide not to authorise her termination. And only for abortion (and some infertility treatments) does the

doctor have the right to refuse to treat on the grounds of conscientious objection. On a general level, patients' representation groups have fought for certain legal structures and procedures which aim to restrict medical discretion and to protect the patient. Academic commentators have likewise called for a statute to lay down the rights of patients (Montgomery; 1992; 94ff.) or for the transformation of John Major's *Patients' Charter* into more specific, enforceable rights (Longley; 1993; chapter 5). What is perhaps not evident, however, is how far law is capable of addressing such operations of medical power and how far the acquisition of legal rights is sufficient for ensuring women's access to abortion services. In the remaining pages, I would like briefly to assess how useful recourse to law can be in this instance. I will very briefly outline some of the potential legal reforms which might serve to improve the position of the 'patient' within the specific case of the regulation of abortion (a). I will then go on to question whether law is the most effective way of addressing the problems which have been highlighted above. Should legal reform provide the basis for feminist campaigns in this area? Or would a focus on medical practice be more beneficial (b)? In a final section, I will return to consideration of legal reform as a focal point for feminist campaigns, this time from a slightly different perspective (c).

a) Legal Reform

Various possible legal reforms have been suggested as ways of improving the power imbalance within the medical relationship or giving women some legal protection within it.

i) Giving women more autonomy in (early) pregnancy.

The central demand of the woman's movement (and, in particular, the National Abortion Campaign) has been that women should be credited with the responsibility and maturity to make their own reproductive decisions, and thus should be entitled to authorise their own terminations. Doctors should be seen as technicians, who will perform the terminations as and when women request them. This would obviously have a significant effect on the power relationship between the woman seeking abortion and her doctor, not only in terms of removing his/her decisional control, but also lessening the potential exercise of paternalistic and normalising control. Women are currently vulnerable to the exercise of such power as a result of being dependent on the doctor for a referral. Recognising this decision as one which belongs fundamentally to all women would also focus attention on abortion as a

collective issue, involving all women rather than just a marginal and deviant minority.

Such a reform has at least two shortcomings. First it leaves doctors' technical control (and the problems which stem from it) intact. Secondly, it has little possibility of success in the current political climate. Amendments suggested in 1990 attempted far more limited measures: to give women more autonomy in early pregnancy and even these were unsuccessful (see chapter 6, p. 147). The limiting of these demands to the first twelve weeks of pregnancy was no doubt designed to maximise support - opinion polls have consistently shown that a greater number support a 'woman's right to choose' when this is confined to the first trimester (Francome; 1991). Moreover, elective termination in early pregnancy is now the norm in Western Europe. Such reforms might be achieved by limiting the doctor's responsibility under the *Abortion Act* to certifying that the pregnancy had not exceeded a certain number of weeks. Another measure, and one which came close to succeeding in 1990, was to remove the requirement of a second signature, and to thus allow women to decide in conjunction with just one doctor. This was narrowly defeated (by 228 votes to 200). I noted that the introduction of antiprogestins provides one more argument in favour of such reform (pp. 185-6).

ii) The problem of conscientious objectors

A still more recent initiative was the Abortion Clinics (Access) Bill introduced into Commons in May 1993 by Harry Cohen M.P.[17]. The Bill was introduced at a time of concern at arrival in the UK of 'Operation Rescue' and more militaristic, US style tactics on the part of anti-choice activists, and its main thrust was the prohibition of interference with and intimidation or harassment of clients or employees entering abortion clinics. However, the Bill also contained a clause which put the onus on general practitioners to inform women what sort of counselling is available and might be helpful to them. Such a requirement might provide a small step towards attempting to address the power imbalance within the medical relationship, refusing to allow the doctor complete agenda-setting power, and giving the woman greater information. Statute could provide that a doctor, acting as a conscientious objector under the Act would not be able simply to refuse a woman's request for abortion but

[17] See H.C. Deb. Vol. 225, Cols. 241-4, for the Bill's first reading.

at that point would have to inform her of the reason for such refusal and refer to her a colleague who is not a conscientious objector. This would protect doctors who wished to exercise their right to conscientious objection, whilst mitigating the impact of this on the women who approach them for terminations. An alternative to this was a suggested amendment to s. 37 of the *Human Fertilisation and Embryology Act*, 1990 which foresaw that doctors wishing to exercise their right to conscientious objection under s. 4 of the *Abortion Act* would have to register on a list which would be available to women before approaching a GP. This was rejected, seemingly on the grounds that it might lead to discrimination against doctors who hold such views. The utility of any such changes is again limited, however, unless introduced in conjunction with a loosening of doctors' decisional control as suggested in i) above. Under the current legislation the doctor can, without claiming to be a conscientious objector, still block the woman's request: the power to certify whether the conditions laid down in s.1 of the *Abortion Act* are fulfilled remains his/hers.

iii) Increasing the number of individuals who are legally entitled to perform terminations. As was seen in chapter 4 (p. 77), abortion is one of the only specified cases where treatment must be performed by a registered medical practitioner. This technical control has been important in grounding the other types of medical power seen in chapter 4. Doctors' decisional control over access to abortion services and the authority which enhances their paternalistic and normalising control is closely tied to their technical expertise and control of the performance of abortions (Barrett; 1988; 168, Oakley; 1987; 10). The question which now arises is whether this technical monopoly should be removed, and (early) abortion governed in the same way as any other medical operation: i.e. that it is not illegal, unless the practitioner holds him/herself out as having skills or qualifications which he/she does not. A first problem and area for closer investigation would be the possibility of ensuring the safety of women seeking termination. Again, however, such a reform would have no chance of success at the present time.

There may, however, be a possibility for challenging doctors' monopoly of technical control over terminations, by allowing them to be performed within established medical structures by a wider group of individuals. It has been seen that prostaglandin terminations are already largely performed by nurses, with the doctor in a largely background, supervisory role

(chapter 5, footnote 41). I have also argued that antiprogestins may in the future provide a basis for a larger number of people to be able to perform terminations: the most obvious first step would be to allow the administration of the first stage of treatment by GPs in their surgeries or in family planning clinics. This kind of potential extension was clearly in the minds of ministers in 1990, when Geoffrey Howe proposed an amendment which now allows the Secretary of State to authorise classes of places to carry out terminations (see chapter 7). If antiprogestins continue to prove safe, their administration might also be entrusted to a broader group in the future, with the doctor fading into the background as merely providing cover in case of emergency. Increasing the number of potential providers loosens the medical monopoly. Also, it would have a significant effect on the power context were the abortionist to be a nurse or midwife rather than a doctor. The executive board of the American College of Obstetricians and Gynaecologists has just recommended that non-physicians be trained to do abortions in 'collaborative settings alongside physicians' - at present nearly all states have laws which, like the *Abortion Act*, limit the performance of abortions to trained medical practitioners[18].

b) Non-Legal Reform

However, whilst the above proposals accept a focus on legal reform as the most effective means of achieving change, it is by no means clear that this is the case. Neither is it clear that the acquisition of legal rights would be sufficient to secure women's access to abortion. It seems to me that those reforms which have even the slightest chance of success in the current political climate would be seriously limited in their impact. It remains a dilemma for feminist campaigns that once enacted, legislation is in the hands of individuals and agencies far removed from the values and politics of the women's movement. It is thus never possible to know with any certainty what effect a certain reform will have in practice. This has led Carol Smart to warn feminists to beware the "siren call of law". Even where feminists are critical of law, she argues, we are all too often seduced by it, attempting to use it

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[18] Abortion Review, Spring 1994 no. 51. Unlike the UK, US law contains no specifications to *where* terminations may be performed. This means that the potential of RU486 to privatise abortion becomes much more real. Doctors will be able to perform terminations in their surgeries. This has obvious advantages in a country where abortion clinics have become such focal points for dissent.

pragmatically in the hope that new law or more law might be better than the old law (1989; 160). Whilst this does not lead Smart to the conclusion that law must remain unchallenged (and I shall come back to this below), it does suggest that it is important not to resort unproblematically to law. It is possible that other (non-legal) strategies might be more useful.

Something which has emerged clearly during this thesis is the importance of medical practice. Indeed, it has been seen that legal developments have often followed changes at this level, rather than vice versa: not only in the sense that medical groups have had an important influence on the development of legislation, but also that the judiciary has adopted medically determined standards of 'good practice' in judging medical conduct, and the law has become ever more dependent on medical concepts and knowledges. As such, it may be that the authority of medicine is more significant than the precise content of legal rights. It is medical practice which will have the greatest influence on the availability of abortion, in terms of doctors' willingness to perform and authorise terminations, and their treatment of the women who approach them.

That the acquisition of legal rights may be insufficient to address such problems can be seen in the French situation. French law grants women the right to define themselves as in a 'situation of distress' and thus to authorise their own abortions within the first twelve weeks of pregnancy. All French women have the right to have such terminations funded by the State. However, women are still dependent on doctors for the performance of such abortions, and this combined with the low time limit foreseen by the law and public spending cuts, means that 65% of abortions in the Paris region are privately funded and 5,000 French women travel abroad each year (to Britain or the Netherlands) to terminate their pregnancies (Simonnot; 1993a, 1993b, see also Allison; 1994). The situation of practical access to abortion would thus appear to be worse in France than it is in Britain, despite the more liberal statutory provisions regarding early termination. Joni Lovenduski and Joyce Outshoorn argue that the effects of abortion legislation are far less important than a network of good medical facilities. They point to the examples of Sweden and the United States, both countries with liberal legislation. In Sweden, the scrupulous provision of adequate facilities makes access to abortion a reality for women. In the United States, on the other hand, access to abortion is often severely restricted (1986; 4, see also Ketting and van Praag; 1986). It is particularly

important to think about how improvements can be made at the level of medical practice.

i) Deprivatisation of knowledge.

An important aspect of the medicalisation of reproduction is the privatisation of knowledge - knowledge regarding reproduction in general has become concentrated in medical hands. One priority is a deprivatisation or proliferation of knowledge: an attempt to readdress the power imbalance inherent in the medical relationship, by strengthening the position of the 'patient' within it. Greater awareness of the practical realities of access to abortion, of reproductive biology and of different abortion techniques are essential here. This has long been part of feminist strategies: it is the aim of books such as the Boston Health Collective's *Our Bodies; Ourselves*, and more recently *A Book of Women's Choices* (see chapter 7, p. 80). The idea is that knowledge will strengthen women and lessen the power imbalance within the medical relationship, reversing the process of the privatisation of knowledge. This is especially important where women have least knowledge and are thus most vulnerable: for example, young women and ethnic minority women - especially those who do not speak English. The most effective way to reach such women may be (as a first step) through public information campaigns, better and earlier sex education in schools and well-women clinics (see Gardner; 1981, Cooke and Ronalds; 1987).

ii) Exploiting and supporting elements of resistance within the medical profession.

The medical profession consists of different groups and individuals, and instances of resistance to the hegemonic medical control over abortion have also come from *within* it. A few noteworthy doctors have been amongst the leading campaigners who have fought for women to be allowed more control. Many more, at the grass roots level, have allowed women to make their own reproductive decisions, and have viewed their role as one of facilitating such choices. Especially important is the fact that non-NHS charitable clinics developed precisely to oppose the monopolistic power of senior gynaecologists who were in a position to deny the possibility of NHS terminations in the hospitals which they control. These clinics have provided inexpensive terminations and have guaranteed a more sympathetic reception and a more woman-centred service. Thus, the situation of practical access to abortion has improved over the last 30 years in no small part because of the actions of some doctors and sections of the medical profession who have done much to try to further women's

reproductive autonomy, taking as starting point the need to listen to women (and often being very much marginalised within the profession for so doing[19]). As such, both the greater education of doctors and the support of such clinics remain important.

c) A Return to Law: Challenging Medicalisation and the Construction of Alternative Visions

However, an appreciation of the limits of law reform and a recognition of the importance of medical practice is not in itself an argument that one should abandon the law as a site of struggle. As I argued above, the law regulating abortion cannot be understood only in terms of its concrete, material effects but must be seen also in terms of its importance as an institutionalised and formalised site of power struggles, with a power to prefer certain accounts, to define and to disqualify (Smart; 1989, 1990a). Moreover, law does not merely reflect reality, it also contributes to constructing our perception of it. Law lies at the root of some of the most commonplace assumptions which people make in ordering their daily lives (Gordon; 1984; 109). Equally, it will have influence on doctors: it is surely true that the more liberal provisions of the *Abortion Act* contributed to doctors' changing attitudes towards abortion. Smart has thus argued that feminists *do* need to engage with the law, maintaining that it is precisely law's power to define which must become the focus of feminist strategies: it is in its ability to offer a redefinition or alternative truth that feminism offers political gains (Smart; 1989; 164-5). Law operates as an important "authorised discourse" which silences women by privileging other accounts of reality (Eisenstein; 1988; 4, Smart; 1989, 1990a). Engagement with the law is thus important as a process of the public formulation of claims and alternative visions (Smart; 1989, Drakopoulou; 1994).

In this thesis, I have attempted to show the specific understanding which has been fostered by the law: abortion is seen as a medicalised phenomenon, with the doctors as the natural experts to manage this problem and the women who seek it, by virtue of the very fact that they wish to terminate a pregnancy, seeming in need of medical supervision and support. The possible legal reforms outlined above (section a) are not in themselves sufficient for

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[19] As the Wendy Savage case clearly demonstrated, see Savage (1986), and footnote 12, chapter 4, above.

countering the problems of medical power and ensuring women's access to abortion. However, the challenge they pose to the current status quo in terms of their reconceptualisation of women, women's role in society, abortion and the medical relationship is important. Indeed, in this sense, the challenge they pose to the status quo is radical.

In the 1960s, abortion law reformers spoke in powerful and angry terms of the hypocrisy of a law that effectively allowed abortions for the rich but not to the poor, the latter being forced to choose between unwanted maternity or the danger of the backstreets. Today, with improved access and an apparent depoliticisation of abortion, such tones are muted and alternative accounts of abortion are often lacking. Abortion law remains a particular site of conflict for definitional struggle. However, what seems to have become central to such dispute is the definition of the conceptus - as foetus or baby, embryo or 'unborn child', fixing one point where it can be said to acquire humanity (Albury; 1993, Dworkin; 1990, Williams; 1994)[20] and increasingly, medical science has been accepted as the final arbiter of this point. The attribution of one status to the foetus, of one point whereby its rights can be seen to override those of the woman is, however, only one possible construction of the crucial issue of what is at stake in the abortion debate. It is important to dislodge the foetus from its central place in the debates and to reintroduce consideration of pregnant women and their lived experiences. The introduction of broader, social circumstances will implicitly involve a challenge to the medicalisation of the debates, and a (re)emphasis of knowledges other than the strictly medical. It will also require a challenge to the way in which the female subject upon which the law is currently predicated is to be constructed (see chapter 3).

Arguably the most powerful speech in the 1990 debates, came from the New Right Conservative M.P. and vocal advocate of abortion rights, Theresa Gorman. Gorman refused the medical framework and rather attacked those who oppose abortion:

"What motivates those who persist in trying to amend a woman's right in these affairs is

[20] Noonan sums this up concisely: "[i]s the foetus a person? If so, then any interference at any point of the pregnancy constitutes murder. Is the fetus simply part of the woman's body? If this is the case, then the woman has a prior claim to treat an unwarranted intrusion into her lifespace as an 'invasion' and forcibly reject it" (1985; 8).

theology...These motives form one of the deepest, most misogynous strands in human society. For centuries theologians have equated sex with sin and celibacy with grace. They have regarded women as little more than flower pots in which future children, preferably boy children, are reared. Time and again we hear people pay lip-service to a woman's rights in this, yet when it comes down to it they legislate to give priority to the rights of the foetus that she carries...The concept of a woman having a right to control her sexuality, let alone enjoy it, is anathema to them...If the Pied Piper of Mossley Hill [David Alton] had his way, he would lead the House and the country back to the time when women were the victims of their sexuality - perpetually pregnant, physically worn down, old before their time, unable to find time to develop the other talents with which they were born and always subservient to a man and to the demands of the family...This is supposedly a liberal society and we should accord to the women of that society the maturity and ability to make decisions about such matters for themselves"[21].

Whilst anti-choice M.P.s increasingly deploy medical argumentation, Gorman here asserts that their underlying motivation is actually religious or moral - hence she implicitly challenges its relevance. She insists on a repoliticisation of abortion, relocating it within a context of (male) power over women's lives. However, this speech, where a pro-choice position is overtly informed by feminist arguments, remains the exception rather than the rule in Parliamentary debates[22]. Moreover, outside Parliament, the pro-choice movement has a low profile. Compared with the anti-choice groups, its membership is very small, and it operates on a tight budget (Lovenduski; 1986). Its strategy has been essentially one of reactive campaigns, with a capacity to mobilise large numbers of women only when the 1967 Act is challenged. The pro-choice movement is, in one sense, a victim of its own success: the establishment of a status quo which seems to ensure relatively good access to safe, legal abortion. However, in the absence of a more pro-active stance on the part of the pro-choice movement, it is difficult to see how medical power can be effectively challenged.

4. CONCLUSIONS

In this thesis, I have described the *pre-eminence* of medical knowledges, the consequent *marginalisation* of other accounts and *shift* to a medical model of control. The choice of terminology has been deliberate - it is not a question of the complete replacement of religious,

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[21] Gorman, H.C. Deb. Vol. 171, Cols. 229-33, 1990 (24 April).

[22] Indeed, as I noted in chapter 6, it is perhaps anti-choice MPs who have made the greater use of explicitly feminist rhetoric in Parliament (see p. 141).

moral and social discourses by the medical, but rather a matter of the gradual readjustment of the balance between them and recodification of the law in these terms. I have here expressed concern that such medicalisation has been inadequately challenged, and that its pre-eminence has been established on the basis of the occlusion of other accounts. At the same time, I have recognised the problems and dangers inherent in challenging it.

Diane Munday, an early and active member of the Abortion Law Reform Association, was recently interviewed in an article commemorating 25 years of the entry into force of the Abortion Act. She expresses her sadness that

"Britain, which pioneered abortion legislation, now lags behind the rest of Europe where abortion on request in the first three months of pregnancy is available in 13 countries. Here, 'rigid' legal requirements remain in place, which led to many abortions being carried out much later in pregnancy than necessary" (Hunt; 1993).

Various factors are implicated here including the one which Munday goes on to highlight: the existence of a well-organised and active anti-choice campaign. Whereas pro-choice activists and academics have been most alert to the risks posed by the anti-choice groups, the church or the state, however, less attention has been paid to the problems posed by the highly medicalised model of British abortion law. Women have, in effect, been delivered "into the hands of the medical profession". Whilst medicalisation has helped to extend access to abortion, such access remains tightly grasped in the deadlock of medical control and this is an essential focal point for a pro-choice politics.

Medicalisation has been the greatest strength of the British abortion law (depoliticising the extension of women's access to abortion services and hence defusing political conflict), and its greatest weakness (leaving women dependent on medical discretion and good will). Smart has written that law is often an important focal point against which resistant voices can be raised (1989; 88). The current regulation of abortion and the situation of practical access to it gives a much clearer focal point for opposition to the anti-choice groups. In this sense it is important for feminists to make explicit the gender politics which underlies the current regulation of abortion: to argue that who controls abortion *remains* a deeply and inherently political matter. It is political because it concerns how women are able to live their lives and

control their own fertility, and this is a choice of fundamental importance in terms of how we wish to order our society. If the law regarding abortion is to be improved, I feel that it is essential for the feminist movement to take a more pro-active stance towards it. An essential part of this is to challenge the basic assumptions underlying the current regulation of abortion: the medicalisation and the construction of woman seeking abortion which underpin it. This inevitably involves an attack on the status quo.

APPENDIX 1

THE ABORTION ACT, 1967[1]

1967 Chapter 87. An Act to amend and clarify the law relating to termination of pregnancy by registered medical practitioners. [27 October 1967]

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows: -

Medical Termination of Pregnancy

1. (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 two registered medical practitioners are of the opinion, formed in good faith -

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

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

(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or Secretary of State.

(4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Notification

2.-(1) The Minister of Health in respect of England and Wales, and the Secretary of State in respect of Scotland, shall by statutory instrument make regulations to provide-

(a) for requiring any such opinion as is referred to in section 1 of this Act to be certified

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[1] Taken from Hindell and Simms (1971, appendix 2, 249-53).

by the practitioners or practitoner concerned in such form and at such time as may be prescribed by the regulations, and for requiring the preservation and disposal of certificates made for the purposes of the regualtions;

(b) for requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination and such other information relating to the termination as may be so prescribed;

(c) for prohibiting the disclosure, except to such persons or for such purposes as may be so prescribed, of notices given or information furnished pursuant to the regualtions.

(2) The information furnished in pursuance of regulations made by virtue of paragraph (b) of subsection (1) of this section shall be notified solely to the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department respectively.

(3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations under subsection (1) of this section shall be liable on summary conviction to a fine not exceeding one hundred pounds.

(4) Any statutory instrument made by virtue of this section shall be subject to annulment in pursuance of either House of Parliament.

Application of Act to visiting forces etc.

3. omitted

Conscientious Objection to Participation in Treatment

4.-(1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

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

(3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

Supplementary provisions.

5.-(1) Nothing in this Act shall affect the provisions of the Infant Life (Preservation) Act 1929 (protecting the life of the viable foetus).

(2) For the purposes of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless authorised by section 1 of this Act.

Interpretation

6. In this Act, the following expressions have meanings hereby assigned to them:-

"the law relating to abortion" means sections 58 and 59 of the Offences Against the Person Act 1861, and any rule of law relating to the procurement of abortion;

"the National Health Service Acts" means the National Health Service Acts 1946 to 1966 or the National Health Service (Scotland) Acts 1947 to 1966.

Short title, commencement and extent

7.-(1) This Act may be cited as the Abortion Act 1967.

(2) This Act shall come into force on the expiration of the period of six months beginning with the date on which it is passed.

(3) This Act does not extend to Northern Ireland.

APPENDIX 2

THE ABORTION ACT, AS AMENDED IN 1990[1]

Medical Termination of Pregnancy

1. (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 two registered medical practitioners are of the opinion, formed in good faith -

(a) **that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, or of injury to the physical or mental health of the pregnant woman or any existing children of her family; or**
[that the continuance of the pregnancy would involve risk to the life of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or]

(b) **that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or**

(c) **that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or**

(d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

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

(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or Secretary of State.

(3A) The power under subsection (3) of this section to approve a place includes power, in relation to treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places.

(4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

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[1] The Amendments introduced to s.1 by s.37 of the Human Fertilisation and Embryology Act, are recorded in **bold**. Sections which were repealed in 1990 are included in the text in square brackets []. S.37 also 'uncoupled' the *Abortion Act* from the *Infant Life Preservation Act*.

REFERENCES

Aitken Swan, I. (1977); *Fertility Control and the Medical Profession*; London; Croom Helm.

Aktionsforum MoZ (1992); *RU 486 - un choix qui n'en est pas un*; leaflet.

Alberman, E. and Dennis, K. (Eds.) (1987); *Late Abortions in England and Wales*; London; Royal College of Obstetricians and Gynaecologists.

Albury, R. (1993); *Women and the Duty of the State: Deployment of Expert Knowledges*; unpublished working paper.

Allison, M. (1994); The right to choose: abortion in France; 47 *Parliamentary Affairs*; no. 2, April; 222-37.

Alton, D. (1988); *What Kind of Country?*; Basingstoke; Marshall Pickering.

Andrews, L.B. (1986); Remaking conception and pregnancy: how the laws influence reproductive technology; in IX *Frontiers* no. 1; 36-40.

Armstrong, T. (1992); *Michel Foucault Philosopher*; New York; Harvester Wheatsheaf.

Arney, W. (1982); *Power and the Profession of Obstetrics*; Chicago; University of Chicago Press.

Aubeny, E. (1991); Introduction à la table ronde sur l'avortement précoce par Ru 486 + prostaglandines; in *Neuvièmes journées nationales d'études sur l'avortement et la contraception*; Creil; Association Nationale des Centres d'Interruption de Grossesse et de Contraception; 33-5.

Aubeny, E. (1993); Clinical experience in France - new developments in medical abortion; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 9-12.

Bachelot, A., Cludy, L. and Spira, A. (1991); IVG par RU 486 et IVG par aspiration; in *Neuvièmes journées nationales d'études sur l'avortement et la contraception*; Creil; Association Nationale des Centres d'Interruption de Grossesse et de Contraception; 37-40.

Bainham, A. (1987); Protecting the unborn - new rights in gestation; 50 *Modern Law Review*; 361-8.

Baird, D. (1990); What it is, how it works and its development; in *The Abortion Pill (Mifepristone/RU 486): Widening the Choice for Women*; London; Birth Control Trust; 12-15.

Baird, D. (1993); Clinical trials - the UK experience; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood

Federation; 5-7.

Barrett, M. (1988); *Women's Oppression Today*, London/New York; Verso.

Barrett, M. and Roberts, H. (1978); Doctors and their patients: the social control of women in general practice; in *Women, Sexuality and Social Control*; Smart, C. and Smart, B. (Eds.) 41-64; London, Henley and Boston; Routledge and Kegan Paul.

Baulieu, E.-E. (with Rosenblum, M.) (1991); *The Abortion Pill*; London, Sydney, Auckland and Johannesberg; Century.

Baulieu, E.-E. (1993); Putting anti-progestins in context: how RU 486 works; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 2-4.

Beech, B. (1985); The politics of maternity: childbirth freedom versus obstetric control; in *Gender, Sex and the Law*; Edwards, S. (Ed.); London; Croom Helm; 50-78.

Berer, M. (1988); Whatever happened to 'a woman's right to choose?'; *Feminist Review*; no. 29, Spring; 24-37.

Berer, M. (1993a); Abortion in Europe from a woman's perspective; in *Progress Postponed: Abortion in Europe in the 1990s*; London; International Planned Parenthood Federation (Europe Region); 31-46.

Berer, M. (1993b); Women's views on anti-progestin abortion; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 16-19.

Birman, C. (1989); The experiences of women having an abortion with RU 486; *Women's Global Network for Reproductive Rights*, October-December; 7-9.

Birth Control Trust (1990); *The Abortion Pill (Mifepristone/RU 486): Widening the Choice for Women*; London; Birth Control Trust.

Boston Women's Health Book Collective (1971); *Our Bodies; Ourselves*; New York; Simon and Schuster.

Bourne, A. (1962); *A Doctor's Creed: The Memoirs of a Gynaecologist*; London; Gollancz.

Brazier, M. (1988); Embryo's "rights": abortion and research; in *Medicine, Ethics and the Law*; Freeman, M.D.A. (Ed.); London; Stevens & Sons; 9-22.

Brazier, M. (1992); *Medicine, Patients and the Law*; Harmondsworth; Penguin.

Brewin, C.R. and Bradley, C. (1989); Patient preferences and randomised clinical trials; 299 *British Medical Journal*; 313-5.

Bridgeman, J. (1993a); Old enough to know best?; 13 *Legal Studies*; 69-80.

Bridgeman, J. (1993b); Medical treatment: the mother's rights; *Family Law*; 534-5.

Bridgeman, J. (1993c); Demanding reproductive control?; in *Body Politics: Control v Freedom: the Role of Feminism in Women's Personal Autonomy*; Feminist Legal Research Unit (University of Liverpool) (Ed.); 31-49.

Bromham, D. (1994); Setting up services; in *Running an Early Medical Abortion Service*; Furedi, A. (Ed.); London; Birth Control Trust; 13-15.

Brookes, B. (1988); *Abortion in England, 1900-1967*; London, New York and Sydney; Croom Helm.

Buckley, M. and Anderson, M. (Eds.); *Women, Equality and Europe*; London; Macmillan.

Cahill, L.S. (1987); 'Abortion pill' RU486: ethics, rhetoric and social practice; *Hastings Center Report*; October-November; 5-8.

Callum, J. (unpublished); RU-486 and Early Termination Abortion; Federation of Feminist Women's Health Centers, Atlanta.

Cameron, I.T. and Baird, D. T. (1988); Early pregnancy termination: a comparison between vacuum aspiration and medical abortion using prostaglandin or the antiprogestogen RU 486; 95 *British Journal of Obstetrics and Gynaecology*; March; 271-6.

Cavadino, P. (1976); Illegal abortions and the Abortion Act 1967; 16 *British Journal of Criminology*; no. 1, January; 63-70.

Chalker, R. and Downer, C. (1992); *A Woman's Book of Choices: Abortion, Menstrual Extraction, RU 486*; New York and London; Four Walls, Eight Windows.

Chicoine, D. (1993); RU486 in the United States and Great Britain: a Case Study in Gender Bias; XVI *Boston College International and Comparative Law Review* no. 1; 81-113.

Clarke, L. (1990); Abortion: a rights issue?; in *Birthrights: Law and Ethics at the Beginnings of Life*; Lee, R. and Morgan, D. (Eds.); London and New York; Routledge; 155-70.

Colvin, M. (1990); The legal situation; in *The Abortion Pill (Mifepristone/RU 486): Widening the Choice for Women*; London; Birth Control Trust; 18-21.

Cooke, M. and Ronalds, C. (1987); The Manchester Experience III, Rusholme Well Women Clinic; in *Women's Health in the Community*; J. Orr (Ed.); Chichester; John Wiley & Sons.

Cook, R. (1990); 'The moral property of women?'; 17 *People*; no. 3; 12.

Cossey, D. (1982); *Abortion and Conscientious Objection*; London; Birth Control Trust.

Cossey, D. (1990); The politics of the 'abortion pill': breaking down barriers; in *The Abortion Pill (Mifepristone/RU 486): Widening the Choice for Women*; London; Birth Control Trust; 52-58.

Coulet, M.-F. (1993); Anti-progestins in France: questions women ask; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 20-22.

Dahlerup, D. (1986); *The New Women's Movement: Feminism and Political Power in Europe and the USA*; London; Sage.

Dall'Ava Santucci, J. (1988); Punition; *Le Monde*; 29 October.

Daud, S. (1993); Abortion, contraception and ethnic minorities; in *Progress Postponed: Abortion in Europe in the 1990s*; London; International Planned Parenthood Federation; 148-56.

Davies, C. (1975); *Permissive Britain: Social Change in the Sixties and Seventies*; London; Pitman.

Davies, V. (1991); *Abortion and Afterwards*; Bath; Ashgrove Press.

Davis, K. (1988a); *Power Under the Microscope: towards a Grounded Theory of Gender Relations in Medical Encounters*; Amsterdam; Foris Publications.

Davis, K. (1988b); Paternalism under the microscope; in *Gender and Discourse: The Power of Talk*; Todd, A.D. and Fisher, S. (Eds.); Norwood and New Jersey; Ablex Publishing Company; 19-54.

Diamond, I. and Quinby, L. (Eds.) (1988); *Feminism and Foucault: Reflections on Resistance;* Boston; Northeastern University Press.

Dickens, B.M. (1966); *Abortion and the Law*; Bristol; MacGibbon and Kee Ltd.

Diggory, P. (1991); *Abortion - an Introduction: Guidance on Technique, Complications and the Provision of Services*; London; Birth Control Trust.

Donnison, J. (1988); *Midwives and Medical Men: a History of the Struggle for the Control of Childbirth*; London; Historical Publications Ltd.

Donzelot, J. (1979); *The Policing of Families: Welfare versus the State*; London; Hutchinson and Co Ltd.

Douglas, G. (1991); *Law, Fertility and Reproduction*; London; Sweet and Maxwell.

Douzinas, C. and McVeigh, S. (1992); The tragic body: the inscription of autonomy in medical ethics and law; in *Law, Health and Medical Regulation*; Wheeler, S. and McVeigh,

S. (Eds.) Altershot and Brookfield, Vermont; Dartmouth Publishing Co.; 1-34.

Drakopoulou, M. (1993); Feminism and the siren call of law; *Feminist Approaches to Law and Cultural Diversity*; Conference: European University Institute, Florence; 26-27 November.

Draper, H. (1993); Women, forced caesarians and antenatal responsibilities; in *Body Politics: Control v Freedom: the Role of Feminism in Women's Personal Autonomy*; Feminist Legal Research Unit (University of Liverpool) (Ed.); Liverpool; University of Liverpool; 1-16.

Dreyfus, H. and Rabinow, P. (1982); *Michel Foucault: Beyond Structuralism and Hermeneutics*; Brighton; Harvester.

Duncan, S. (1994); Disrupting the surface of order and innocence: towards a theory of sexuality and the law; 2 *Feminist Legal Studies*; 3-28.

Dworkin, A. (1983); *Right Wing Women: The Politics of Domesticated Females*; London; The Women's Press.

Dworkin, R. (1993); *Life's Dominion: an Argument about Abortion and Euthanasia*; London; Harper Collins.

Easlea, B. (1981); *Science and Sexual Oppression*; London; Wiedenfeld and Nicolson.

Ehrenreich, B. and English, D. (1976); *Witches, Midwives and Nurses: A History of Women Healers*, London; Writers and Readers Publishing Cooperative.

Ehrenreich, B. and English, D. (1979); *For Her Own Good: 150 Years of the Experts' Advice to Women;* London; Pluto.

Eisenstein, Z. (1988); *The Female Body and the Law*; Berkley, Los Angeles and London; University of California Press.

Farrant, W. (1985); Who's for Anmiocentesis? The Politics of Prenatal Screening; in *The Sexual Politics of Reproduction*; Homans, H. (Ed.); Hampshire; Gower; 96-122.

Feminist Legal Research Unit (University of Liverpool) (Ed.) (1993); *Body Politics: Control v Freedom: the Role of Feminism in Women's Personal Autonomy*; Liverpool; University of Liverpool.

Feminist Review (1980); No right to choose; 4 *Feminist Review*; 57-79.

Feminist Review (Ed.) (1987); *Sexuality: A Reader*; London; Virago.

Ferris, P. (1966); *The Nameless: Abortion in Britain Today*; London; Hutchinson;

Finley, L.M. (1989); Breaking silence in law: the dilemma of the gendered nature of legal reasoning; in 64 *Notre Dame Law Review*, 886-910.

Fitzpatrick, P. (1987); Racism and the Innocence of Law; in *Critical Legal Studies*; Fitzpatrick, P. and Hunt, A. (Eds.); Oxford; Basil Blackwell.

Fitzpatrick, P. (forthcoming); Foucault's case: subject and subjection in law; in Smart, B. (Ed.); London; Routledge.

Fitzpatrick, P. and Hunt, A. (Eds.) (1987); *Critical Legal Studies*; Oxford; Basil Blackwell.

Flax, J. (1990); *Thinking Fragments: Psychoanalysis, Feminism and Postmodernism in the Contemporary West*; Berkeley, Los Angeles and Oxford; University of California Press.

Fortin, J. (1988a); Legal protection for the unborn child; 51 *Modern Law Review*; 54-83.

Fortin, J. (1988b); Can you ward a foetus?; 51 *Modern Law Review*; 768-775.

Foucault, M. (1979a); Governmentality; *m/f*; no. 3, July, 5-21.

Foucault, M. (1979b); *The History of Sexuality: Volume 1: An Introduction;* Harmondsworth; Penguin.

Foucault, M. (1980a); Body/power; in *Michel Foucault: Power/Knowledge. Selected Interviews and Other Writings, 1972-1977*; Gordon, C. (Ed.); Hemel Hempstead; Harvester Press; 55-62.

Foucault, M. (1980b); Two lectures; in *Michel Foucault: Power/Knowledge. Selected Interviews and Other Writings, 1972-1977*; Gordon, C. (Ed.); Hemel Hempstead; Harvester Press; 78-108.

Foucault, M. (1980c); Truth and power; in *Michel Foucault: Power/Knowledge. Selected Interviews and Other Writings, 1972-1977*; Gordon, C. (Ed.); Hemel Hempstead; Harvester Press; 109-33.

Foucault, M. (1980d); The politics of health in the eighteenth century; in *Michel Foucault: Power/Knowledge. Selected Interviews and Other Writings, 1972-1977*; Gordon, C. (Ed.); Hemel Hempstead; Harvester Press; 166-83.

Foucault, M. (1980e) Confessions of the flesh; in *Michel Foucault: Power/Knowledge. Selected Interviews and Other Writings, 1972-1977*; Gordon, C. (Ed.); Hemel Hempstead; Harvester Press; 194-228.

Foucault, M. (1981a); Questions of method: an interview with Michel Foucault; *I&C;* Spring; 3-14.

Foucault, M. (1981b); Is it useless to revolt?; in *Philosophy and Social Criticism*; Spring; 5-9.

Foucault, M. (1982); The subject and power; in *Beyond Structuralism and Hermeneutics*; Dreyfus, H. and Rabinow, R. (Eds.); Brighton; Harvester; 1982.

Foucault, M. (1989a); *Madness and Civilization: A History of Insanity in the Age of Reason;* London and New York; Tavistock and Routledge.

Foucault, M. (1989b); *The Birth of the Clinic*; London and New York; Routledge.

Foucault, M. (1991); *Discipline and Punish: The Birth of the Prison*; London; Penguin.

Francke, L. (1980); *The Ambivalence of Abortion;* Harmondsworth; Penguin.

Francome, C. (1984); *Abortion Freedom: A Worldwide Movement*; London; Allen and Unwin.

Francome, C. (1986); *Abortion Practice in Britain and the United States;* London; Allen and Unwin.

Francome, C. (1991); *Abortion and Public Opinion*; London; Abortion Law Reform Association and National Abortion Campaign.

Franklin, S. (1991); Fetal fascinations: new dimensions to the medical-scientific constructions of fetal personhood; in *Off-Centre: Feminism and Cultural Studies,* Franklin, S., Lury, C. and Stacey, J. (Eds.); London; Harper Collins Academic; 190-205.

Franklin, S., Lury, C. and Stacey, J. (Eds.) (1991); *Off-Centre: Feminism and Cultural Studies*; London; Harper Collins Academic.

Freeman, M.D.A. (Ed.) (1988); *Medicine, Ethics and the Law*; London; Stevens & Sons.

Friedson, E. (1970); *Profession of Medicine: A Study of the Sociology of Applied Knowledge*; Chicago, London; University of Chicago Press.

Furedi, A. (Ed.) (1994); *Running an Early Medical Abortion Service*; London; Birth Control Trust.

Fyfe, W. (1991); Abortion Acts: 1803 - 1967; in *Off-Centre: Feminism and Cultural Studies*; Franklin, S., Lury, C. and Stacey, J. (Eds.);London; Harper Collins Academic; 160-174.

Gallagher, J. (1987); Prenatal invasions and interventions: what's wrong with fetal rights; in 10 *Harvard Women's Law Journal* 1987, 9-58;

Gardner, K. (1981); Well women clinics: a positive approach to women's health; in *Women, Health and Reproduction*; Roberts, H. (Ed.); London; Routledge and Kegan Paul; 129-143.

Gautier, A. and Heinen, J. (Eds.) (1993); *Le sexe des politiques sociales*; Paris; Côté-femmes.

Gelsthorpe, L. and Morris, A. (Eds.) (1990); *Feminist Perspectives in Criminology*; Milton Keynes; Open University Press.

Gillespie, R.M. and Hubbard, R. (1986); Contraception in Context; IX *Frontiers*; no. 1; 3-8.

Glasier, A. (1993); Provision of medical abortion in the UK - organisation and uptake; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 13-15.

Gordon, C. (Ed.); *Michel Foucault: Power/Knowledge. Selected Interviews and Other Writings, 1972-1977*; Hemel Hemstead; Harvester Press.

Gordon, L. (1980); Review of James Mohr's Abortion in America: the Origins and Evolutions of National Policy; in 13 *Journal of Social History*; Spring; 514-7.

Gordon, R. (1984); Critical legal histories; 36 *Stanford Law Review*; 57-125.

Graycar, R. (Ed.) (1990); *Dissenting Opinions: Feminist Explorations in Law and Society*; Sydney; Allen and Unwin.

Graycar, R. and Morgan, J. (1990); *The Hidden Gender of Law*; Annandale; Federation Press.

Greenwood, V. and Young, J. (1976); *Abortion in Demand;* London; Pluto.

Grice, E. (1988); A matter of conscience; *The Sunday Times*; 31 January.

Grubb, A. (1990); Abortion law in England: the medicalization of a crime; 18 *Law, Medicine and Health Care*; nos. 1-2, Spring - Summer; 146-61.

Hall, M.H. (1990); Changes in the law on abortion; 301 *British Medical Journal*; 17 November; 1109-10.

Halpern, S. (undated); RU-486: the unpregnancy pill; in *RU486: a Collection of Articles and Press Cuttings on the 'Abortion Pill';* London; National Aboriton Campaign; 8-10.

Hartnell, V.H. (1993); Medical termination of pregnancy and the future provision of termination services; 19 *British Journal of Family Planning* 143-4.

Hartouni, V. (1991); Containing women: reproductive discourse in the 1980s; in *Technoculture*; Penley, C. and Ross, A. (Eds.); Minneapolis and Oxford; University of Minnesota Press; 27-56.

Harvard, J.D.J. (1958); Therapeutic abortion; *Criminal Law Review*; 600-13.

Henshaw, R. (1993); Comparison of medical abortion with surgical vacuum aspiration: women's preferences and acceptability of treatment; 307 *British Medical Journal*; 714-7.

Henshaw, R. (1994); The acceptability of medical abortion; in *Running an early medical abortion service*; Furedi, A. (Ed.); London; Birth Control Trust; 38-42.

Himmelweit, S. (1987); Abortion: individual choice and social control; in *Sexuality: A Reader*; Feminist Review (Ed.) 98-104; London; Virago;

Himmelweit, S. (1988); More than 'a Woman's Right to Choose'?; *Feminist Review*; no. 29, Spring; 38-55.

Hindell, K. and Simms, M. (1971); *Abortion Law Reformed*; London; Peter Owen.

Hoggett, A.J.C. (1968); The Abortion Act 1967; *Criminal Law Review*; 247-58.

Holdsworth, A. (1990); *Out of the Doll's House*; London; BBC Books.

Homans, H. (1985) (Ed.); *The Sexual Politics of Reproduction*; Hants; Gower.

Homans, H. (1985); 'Discomforts in pregnancy: traditional remedies and medical prescriptions' in *The Sexual Politics of Reproduction;* Homans, H. (Ed.); Hants; Gower; 139-162.

Hordern, A. (1971); *Illegal Abortion: the English Experience*; Oxford, New York; Pergamon Press.

Hühn, C. (1992); Under pressure you can't talk freely. Compulsary counselling for women with unwanted pregnancy; Conference: *European Network for Women's Right to Abortion and Contraception*; Geneva; September 1992.

Hudson, D. (1987); You can't commit violence against an object: women, psychiatry and psychosurgery; in *Women, Violence and Social Control*; Hanmer, J. and Maynard, M. (Eds.); Hampshire, Macmillan; 110-121.

Hunt, L. (1993); Stigma and secrecy that marked a different world; *The Independent*; 27 April.

Illich, I. (1977); *Disabling Professions*; London; Marion Boyars Publishers Ltd.

Jacobus, M., Fox Keller, E. and Shuttleworth, S. (1990); *Body Politics: Women and the Discourses of Science*; New York; Routledge.

Jenkins, A. (1960); *Law for the Rich*; London; Victor Gollancz.

Joffe, C. (1984); Comments on Mackinnon; *Radical America*; March-June; 68-9.

Jones, I. (1994); Setting up the services; in *Running an Early Medical Abortion Service*; Furedi, A. (Ed.); London; Birth Control Trust; 19-23.

Kane, A. (1990); Anti-abortionists defeated; 7 *Socialist Action*; May-July, 18-20.

Kaye, T. (1986); Are you for RU486?; *The New Republic*; 27 January.

Kennedy, I. (1988); *Treat Me Right: Essays in Medical Law and Ethics*; Oxford; Clarendon Press.

Keown, J. (1988); *Abortion, Doctors and the Law: Some Aspects of the Legal Regulation of Abortion in England from 1803 to 1982*; Cambridge; Cambridge University Press.

Ketting, E. and van Praag, P. (1986); The marginal relevance of legislation relating to induced abortion; in *The New Politics of Abortion*; London; Sage Publications; 154-69.

Kingdom, E. (1985); Legal recognition of a woman's right to choose; in *Women-in-Law: Explorations in Law, Family and Sexuality*; Brophy, J. and Smart, C. (Eds.); London; Routledge and Kegan Paul; 143-161.

Kingdom, E. (1991); *What's Wrong with Rights? Problems for Feminist Politics of Law*; Edinburgh; Edinburgh University Press.

Kingdom, E. (1992); Problems with rights; Conference: *The Rights of Women*, European University Institute, Florence; 17 October 1992.

Kitzinger, S. (1978) *Women as Mothers*; Oxford; Martin Robertson.

Klein, R.D. (Ed.) (1989); *Infertility: Women Speak Out About Their Experiences of Reproductive Medicine*; London; Pandora.

Klein, R., Raymond, J. G. and Dumble, L. J. (1991); *RU 486: Misconceptions, Myths and Morals*; Melbourne; Spinifex.

Kravaritou, Y. and Sheldon, S. (Eds.) (1994); *Abortion: Challenges to the Status Quo*; European University Institute; Working Paper Law 94/1.

Lacey, N., Wells, C. and Meure, D. (1990); *Reconstructing Criminal Law: Critical Perspectives on Crime and the Criminal Process;* London; Weidenfeld and Nicolson.

Lader, L. (1990); *RU 486: The Pill That Could End the Abortion Wars and Why American Women Don't Have It*; Reading, Massachussetts; Addison-Wesley Publishing Co. Ltd.

Laing, B. (1970); *The Labour Government 1964-70*; Harmondsworth; Penguin.

Laqueur, T. (1990); *Making Sex: Body and Gender From the Greeks to Freud*; Cambridge, Massachusetts and London; Harvard University Press.

Lee, R. and Morgan, D. (Eds.) (1990); *Birthrights: Law and Ethics at the Beginnings of Life*; London and New York; Routledge.

Lees, C. (1991); Abortion pill available in the autumn; *The Sunday Times*; 30 May.

Lewis, J. (1984); *Women in England, 1840-1950*; London; Wheatsheaf Books;

Lloyd, L. (1993); What is happening about RU486?; in 1 *Women's Choice: a Magazine of Reproductive Rights*; no. 3, Spring; 2-6.

Lobel, J. (Ed.) (1988); *A Less than Perfect Union*; New York; Monthly Review Press.

Lockwood, M. (1985); Where Does a Life Begin in *Moral Dilemmas in Modern Medicine*; Lockwood, M. (Ed.); Oxford; Oxford University Press.

Lockwood, M. (Ed.) (1985) *Moral Dilemmas in Modern Medicine*; Oxford; Oxford University Press.

Logan, A. (1994); Provision and practice; in *Running an Early Medical Abortion Service*; Furedi, A. (Ed.); London; Birth Control Trust; 33-5.

Longley, D. (1993); *Public Law and Health Service Accountability*; Buckingham and Philadelphia; Open University Press.

Lovenduski, J. (1986); Parliament, pressure groups, networks and the women's movement; the politics of abortion law reform in Britain (1967-83); in *The New Politics of Abortion*; London; Sage Publications; 49-65.

Lovenduski, J. and Outshoorn, J. (1986a); *The New Politics of Abortion*; London; Sage Publications.

Lovenduski, J. and Outshoorn, J. (1986b); Introduction: the new politics of abortion; in *The New Politics of Abortion*; London; Sage Publications; 1-4.

Luker, K. (1984); *Abortion and the Politics of Motherhood*, Berkeley and Los Angeles; California University Press.

Lukes, S. (Ed.) (1992); *Power*; Oxford; Blackwell.

McDonnell, K. (1984); *Not an Easy Choice: A Feminist Re-examines Abortion*; Toronto; The Woman's Press.

MacIntyre, S.J. (1973); The Medical Profession and the 1967 Abortion Act in Britain; 7 *Social Science and Medicine*; 121-34.

MacIntyre, S.J. (1977); *Single and Pregnant*; London; Croom Helm.

MacKinnon, C. (1982) Feminism, marxism, method and the state: an agenda for theory, 7 *Signs: Journal of Women in Culture and Society*; no. 3; 515-44.

MacKinnon, C. (1983a); The Male Ideology of Privacy: A Feminist Perspective on the Right to Abortion; 17 *Radical America*; July-August; 23-35.

MacKinnon, C. (1983b); Feminism, Marxism, Method and the State: Toward Feminist Jurisprudence; in 8, *Signs: Journal of Women in Culture and Society*, 1983, 635-58;

MacKinnon, C. (1984a); Reply by Mackinnon; *Radical America*; March-June; 69-70.

MacKinnon, C. (1987); *Feminism Unmodified: Discourses on Life and Law*; Cambridge, Massachussets and London; Harvard University Press.

MacKinnon, C. (1991); Reflections on Sex Equality Under Law; 100 *Yale Law Journal*; March, no 5; 1281-328.

Macnaughton, M. (1990); Preface; in *The Abortion Pill (Mifepristone/RU 486): Widening the Choice for Women*; London; Birth Control Trust; 5.

McNeil, M. (1991); Putting the Alton Bill in context; in *Off-Centre: Feminism and Cultural Studies*; Franklin, S., Lury, C. and Stacey, J. (Eds); London; Harper Collins Academic; 149-159.

McKnorrie, K. (1985); Abortion in Great Britain: one Act, two laws; *Criminal Law Review*; 475-88.

McNally, R. (undated); *A Foucauldian Analysis of Abortion for Foetal Handicap*; unpublished MA thesis, Brunel University.

Mancina, C. (1993); La scelta americana sull'aborto è quella giusta; *L'Unita*; 25 January.

Marques-Periera, B. (1993); La multiplicité des rapports sociaux dans le cheminement d'une décision: le cas de l'avortement en Belgique; in *Le sexe des politiques sociales*; Gautier, A. and Heinen, J. (Eds.); Paris; Côté-femmes; 125-44.

Martin, E. (1987); *The Woman in the Body: A Cultural Analysis of Reproduction*; Milton Keynes; Open University Press.

Mason, K. (1990); *Medico-Legal Aspects of Reproduction and Parenthood*; Altershot; Dartmouth; 1990.

Merchant, C. (1980); *The Death of Nature: Women, Ecology and the Scientific Revolution*; San Francisco; Harper and Row.

Minow, M. (1989); Beyond universality; *University of Chicago Legal Forum*; 115-38.

Mitchell, J. and Oakley, A. (Eds.) (1986a); *The Rights and Wrongs of Women*; Harmondsworth; Penguin.

Mitchell, J. and Oakley, A. (Eds) (1986b); *What is Feminism?*; Oxford; Blackwell

Montgomery, J. (1992a); Rights to health and health care; in *The Welfare of Citizens*; Coote, A. (Ed.); London; Rivers Oram Press; 83-108.

Montgomery, J. (1992b); Doctors' handmaidens: the legal contribution; in *Law, Health and Medical Regulation*; Wheeler, S. and McVeigh, S. (Eds.); Aldershot; Dartmouth; 141-69.

Moorehead, J. (undated); Boycott call for abortion pill firm's products; in *RU486: a Collection of Articles and Press Cuttings on the 'Abortion Pill'*; National Abortion Campaign (Ed.); London; National Abortion Campaign; 1.

Morgan, D. (1988); Foetal sex identification, abortion and the law; 18 *Family Law*; 355-62.

Morgan, D. (1990); Abortion: the unexamined ground; *Criminal Law Review*; 687-694.

Morgan, D. (1992) *Re S*; New Law Journal, 1448.

Morgan, D. and Lee, R. (1991) *Guide to the Human Fertilisation and Embryology Act;* London; Blackstone.

Morris, J. (1991); Abortion: whose right to choose?; *Spare Rib*; October; 16-18.

Murphy, J. (1991); Cosmetics, eugenics and ambivalence: the revision of the Abortion Act 1967 in *Journal of Social Welfare and Family Law*; no. 5; 375-93.

National Abortion Campaign (1993a); New anti-abortion bill; *For Urgent Action*; 12 February.

National Abortion Campaign (1993b); Anti-abortionists' fake commission; *For Urgent Action*; 12 February.

National Abortion Campaign (undated); *RU486: a Collection of Articles and Press Cuttings on the 'Abortion Pill';* London; National Abortion Campaign.

Nau, J.-Y. and Nouchi, F. (1988); Une loi providentielle...; *Le Monde*; 31 October.

Neustatter, A. and Newson, G. (1986); *Mixed Feelings: The Experience of Abortion;* London, Sydney and New Hampshire; Pluto.

Newman, K. (Ed.) (1990); *Progress Postponed: Abortion in Europe in the 1990s*; London; International Planned Parenthood Federation (Europe Region).

Oakley, A. (1981); *Subject Woman*; Oxford; Martin Robertson.

Oakley, A. (1984); *The Captured Womb: A History of the Medical Care of Pregnant Women*; Oxford; Blackwell.

Oakley, A. (1986a); Wisewoman and medicine man: changes in the management of childbirth; in *The Rights and Wrongs of Women*; Mitchell, J. and Oakley, A. (Eds.); Harmondsworth; Penguin; 17-58.

Oakley, A. (1986b); Feminism, Motherhood and Medicine - Who Cares? in Mitchell, J. and Oakley, A. (Eds); *What is Feminism?*; Oxford; Blackwell; 127-50.

Oakley, A. (1987); From Walking Wombs to Test-Tube Babies; in Stanworth, M. (ed);

Reproductive Technologies: Gender, Motherhood and Medicine; London; Polity.

O'Neill, P. T. and Watson, O. (1975); The father and the unborn child; 38 *Modern Law Review*; 174-85.

Outshoorn, J. (1988); Abortion law reform: a woman's right to choose?; in *Women, Equality and Europe*; London; Macmillan; 204-19.

Outshoorn, J. (1990); Changing meanings of abortion and gender in the light of recent developments in reproductive technology in the Netherlands; Conference: *Social and Political Science Conference*; London.

Outshoorn, J. (1992); The body and reproductive rights; Conference: *The Rights of Women*; European University Institute, Florence; 17 October 1992.

Paintin, D. (1994a); Introduction; in *Running an Early Medical Abortion Service*; Furedi, A. (Ed.); London; Birth Control Trust; 9-12.

Paintin, D. (1994b); Conclusions; in *Running an Early Medical Abortion Service*; Furedi, A. (Ed.); London; Birth Control Trust; 47-8.

Penley, C. and Ross, A. (Eds.) (1991); *Technoculture*; Minneapolis and Oxford; University of Minnesota Press.

Petchesky, R.P. (1984a); *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom*; New York and London; Longman.

Petchesky, R.P. (1984b); Abortion as violence against women: a feminist critique; in *Radical America*; March-June; 64-8.

Petchesky, R.P. (1987); Foetal images: the power of visual culture in the politics of reproduction; in *Reproductive Technologies: Gender, Motherhood and Medicine*; Stanworth, M. (Ed.); London; Polity; 57-80.

Pfeffer, P. (1985); 'The hidden pathology of the male reproductive system'; in *The Sexual Politics of Reproduction*; Homans, H. (Ed.); Hants; Gower; 30-44.

Pollack, S. (1985); Sex and the contraceptive act; in *The Sexual Politics of Reproduction*; Homans, H. (Ed.); Hants; Gower.

Prentice, T. (1990); French hope to market abortion pill in Britain; *The Times*; 23 July.

Radcliffe Richards, J. (1980); *The Sceptical Feminist: A Philosophical Enquiry*; London; Routledge and Kegan Paul.

Randles, T. (1991); The Alton Bill and the media's consensual position; in *Off-Centre: Feminism and Cultural Studies*; Franklin, S., Lury, C. and Stacey, J. (Eds.); London; Harper

Collins Academic; 206-218.

Raulet, G. (1983); Structuralism and post-structuralism: an interview with Michel Foucault; in 55 *Telos*; 195-211.

Raymond, J. (1991); RU 486: a medical miracle?; *Spare Rib*; February; 34-7.

Reproductive Health Matters (1993); Research Round Up; *Reproductive Health Matters*; no. 2, November; 123-9.

Retzlaff, I. (1993); Anti-progestins - a feminist medical view; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 23-5.

Rey, A.-M. (1994); Abortion in Switzerland: a law more and more disregarded; in *Abortion: Challenges to the Status Quo*; Kravaritou, Y and Sheldon, S. (Eds.); European University Institute Working Paper Law No. 94/1; 53-61.

Ricks, S. (1989); The new French abortion pill: the moral property of women; 1 *Yale Journal of Law and Feminism*; no. 1 (Spring); 75-99.

Roberts, H. (1981); *Women, Health and Reproduction*; London; Routledge & Kegan Paul.

Roberts, H. (1985); *The Patient Patients: Women and Their Doctors*; London, Boston, Melbourne and Henley; Pandora Press.

Rodger, M. and Baird, D. T. (1987); Induction of therapeutic abortion in early pregnancy with meifepristone in combination with prostaglandin pessary; *The Lancet*; 19 December; 1415-8.

Rose, N. (1990); *Governing the Soul: the Shaping of the Private Self*; London and New York; Routledge.

Rothman, B. K. (1986); *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*; New York; Viking.

Royal College of Obstetricians and Gynaecologists (1985); *Report on Fetal Viability and Clinical Practice*; London; Royal College of Gynaecologists and Obstetricians.

Sapsted, A.-M. (1991); Abortion: the new pill; *The Sunday Times Magazine*; January 6.

Savage, W. (1982); Taking liberties with women: abortion, sterilization, and contraception; 12 *International Journal of Health Services*; no. 2; 293-307.

Savage, W. (1986); *A Savage Enquiry: Who Controls Childbirth?*; London; Virago.

Sawicki, J. (1991); *Disciplining Foucault: Feminism, Power and the Body*; London; Routledge.

Science and Technology Sub Group (University of Birmingham) (1991); Feminism and abortion: pasts, presents and futures; in *Off-Centre: Feminism and Cultural Studies*; Franklin, S., Lury, C. and Stacey, J. (Eds.); London; Harper Collins Academic; 214-8.

Scully, D. (1980); *Men Who Control Women's Health: the Miseducation of Obstetrician-Gynecologists*; Boston; Houghton Mifflin Company.

Scully, D. and Bart, P. (1973); A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks; 78 *American Journal of Sociology*; 1045-9.

Showalter, E. (1987); *The Female Malady: Women, Madness and English Culture, 1830-1980*; London; Virago.

Simms, M. (1980); *Abortion in Britain before the Abortion Act: a Survey of the Historical Evidence*; London; Birth Control Trust.

Simms, M. (1981); Abortion: the myth of the golden age; in *Controlling Women: the Normal and the Deviant*; Hutter, B. and Williams, G. (Eds.); London; Croom Helm; 168-84.

Simms, M. (1985); Legal Abortion in Great Britain; in *The Sexual Politics of Reproduction*; Homans, H. (Ed.); Hants; Gower; 78-95.

Simonnot, D. (1993a); Avortements: le retour a l'étranger; *Libération*; 3 March.

Simonnot, D. (1993b); Avortement: la loi Veil appliquée a reculons; *Libération*; 16 March.

Skegg, P.D.G. (1974); Justification for medical procedure performed without consent; 90 *Law Quarterly Review*; 512-30.

Smart, B. (1988); *Michel Foucault*; London and New York; Routledge.

Smart, C. (1976); *Women, Crime and Criminology: A Feminist Critique*; London and Boston; Routledge and Kegan Paul.

Smart, C. (1989); *Feminism and the Power of Law*; London; Routledge.

Smart, C. (1990a); Law's power, the sexed body, and feminist discourse; 7 *Journal of Law and Society*; no. 2, Summer; 194-209.

Smart, C. (1990b); Law's truth/women's experience; *Dissenting Opinions: Feminist Explorations in Law and Society*; Graycar, R. (Ed.); Sydney; Allen and Unwin; 1-20.

Smart, C. (1991); Analyzing law: the challenge of feminism and post-modernism; Conference: *Women's Studies in the European Community*; European Culture Centre at the European University Institute, Florence; 17-19 January.

Smart, C. (Ed.) (1992a); *Regulating Womanhood: Historical Essays on Marriage, Motherhood*

and Sexuality; London and New York; Routledge.

Smart, C. (1992b); Disruptive bodies and unruly sex: the regulation of reproduction and sexuality in the 19th century; in *Regulating Womanhood: Historical Essays on Marriage, Motherhood and Sexuality*; Smart, C. (Ed.); London and New York; Routledge.

Smart, C. (1992c); The woman of legal discourse; in 1 *Social and Legal Studies*; 29-44.

Smart, C. and Smart, B. (Eds.) (1978); *Women, Sexuality and Social Control*; London, Henley and Boston; Routledge and Kegan Paul.

Smith, R. (1981); *Trial By Medicine: Insanity and Irresponsibility in Victorian Trials*; Edinburgh; Edinburgh University Press.

Smith, W. (1993); Medical abortion - widening the choice for women in the UK; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 39-41.

Smith, J.C. and Hogan, B. (1988); *Criminal Law*; London; Butterworths.

Söderholm, G. (1993); The politics of medical abortion - a Swedish perspective; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 36-38.

Spelman, E.V. (1988); *Inessential Woman: Problems of Exclusion in Feminist Thought;* Boston; Beacon Press.

Steel, D. (1971); Foreward; in *Abortion Law Reformed*; Hindell, K. and Simms, M.; London; Peter Owen; 7-8.

Steinberg, D.L. (1991) Adversarial politics: the legal construction of abortion; in *Off-Centre: Feminism and Cultural Studies*; Franklin, S., Lury, C. and Stacey, J. (Eds.); London; Harper Collins Academic; 175-189.

Stewart, P. (1994); Setting up services; in *Running an Early Medical Abortion Service*; London; Birth Control Trust; 16-18.

Stubblefield, P.G. (1985); Some medical considerations; 17 *Family Planning Perspectives*; no. 4, July/August; 161-2.

Sumner, C. (1990); Foucault, gender and the censure of deviance; in *Feminist Perspectives in Criminology*; Gelsthorpe, L. and Morris, A. (Eds.); Milton Keynes; Open University Press; 26-40.

Teubner, G. (1983); Substantive and reflexive elements in modern law; 17 *Law and Society Review*; no. 2; 239-85.

Thomas, H. (1985); The medical construction of the contraceptive career; in *The Sexual Politics of Reproduction*; Homans, H. (Ed.); Hants; Gower; 45-63.

Thomson, M. (1994); Women as walking wombs; *Socialist Lawyer*; no. 21 Spring; 12-13.

Thomson, M. (forthcoming 1995); Women, medicine and abortion in the nineteenth century; 2 *Feminist Legal Studies*; no. 1.

Thoss, E. (1993); Obstacles to medical abortion provision in Germany; in *Medical Abortion Services: European Perspectives on Anti-progestins*; Furedi, A. (Ed.); London; International Planned Parenthood Federation; 30-35.

Todd, A.D. and Fisher, S. (Eds.) (1988); *Gender and Discourse: The Power of Talk*; Norwood and New Jersey; Ablex Publishing Company.

Treichler, P.A. (1990); Feminism, medicine and the meaning of childbirth; in *Body Politics: Women and the Discourses of Science*; Jacobus, M., Fox Keller, E. and Shuttleworth, S. (Eds.); New York; Routledge; 113-138.

Tunkel, V. (1974); Modern anti-pregnancy techniques and the criminal law; *Criminal Law Review*; 461-71.

Tunkel, V. (1979); Abortion: how early, how late and how legal?; *British Medical Journal*; 28 July; 253-6.

Tunnadine, D. and Green, R. (1978); *Unwanted Pregnancy - Accident or Illness?*; Oxford; Oxford University Press.

Turner, B.S. (1987); *Medical Power and Social Knowledge*; London; Sage.

Union Suisse Pour Décriminaliser l'Avortement (1990); *RU 486: Interruption de grossesse précoce: pour le droit de la femme de choisir le méthode*; Berne; Union Suisse Pour Décriminaliser l'Avortement.

United Kingdom Multicentre Trial (1990); The efficacy and tolerance of mifepristone and prostaglandin in first trimester termination of pregnancy; 97 *British Journal of Obstetrics and Gynaecology*; June; 480-6.

Urquhart, D. R. and Templeton, A.A. (1988); Acceptability of medical pregnancy termination; *The Lancet*; July 9; 106-7.

Urquhart, D. R. and Templeton, A.A. (1991); Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion; 98 *British Journal of Obstetrics and Gynaecology*; 396-9.

Vance, C. (Ed.) (1984); *Pleasure and Danger: Exploring Female Sexuality;* Boston, London, Melbourne and Henley; Routledge and Kegan Paul.

Villmoare, A.H. (1991); Women, differences and rights as practices: an interpretive essay and a proposal; 25 *Law and Society Review*; no. 2; 385-410.

Walsworth-Bell, J.P. (1992); Under-reporting of medical terminations of pregnancy; 99 *British Journal of Obstetrics and Gynaecology*; 931-6.

Warnock, M. (1985) *A Question of Life: The Warnock Report on Human Fertilisation and Embryology*; Oxford; Blackwell.

Wells, C. (1993); Maternal versus foetal rights; in *Body Politcs: Control v Freedom: the Role of Feminism in Women's Personal Autonomy*; Feminist Legal Research Unit (University of Liverpool) (Ed.); Liverpool; University of Liverpool; 17-30.

Wheeler, S. and McVeigh, S. (Eds.) (1992); *Law, Health and Medical Regulation*; Aldershot and Brookfield, Vermont; Dartmouth Publishing Co.

Williams, G. (1958); *The Sanctity of Life and the Criminal Law*; London; Faber and Faber.

Williams, G. (1994); The fetus and the "right to life"; 53 *Cambridge Law Journal*; no. 1, March; 71-80.

Williams, P. (1988); Alchemical notes: reconstructing ideals from deconstructed rights; in *A Less than Perfect Union*; Lobel, J. (Ed.); New York; Monthly Review Press.

Winn, D. (1988); *Experiences of Abortion*; London; Macdonald Optima.

Wintow, P. (1990); 24-week limit on abortions; *The Guardian*; 25 April.

Woodside, M. (1963); Attitudes of women abortionists; 11 *Howard Journal of Penology and Crime Prevention*; no. 2; 93-112.

Young, A. (1993); Decapitation or feticide: the fetal laws of the universal subject; *Critical Legal Conference*; Oxford.

Young, G. (1981); A woman inside medicine: reflections from the inside; in *Women, Health and Reproduction*; Roberts, H. (Ed.); London, Boston and Henley; Routledge and Kegan Paul; 144-63.

Zola, I.R. (1972); Medicine as an institution of social control; 20 *Sociological Review*; 4.

Zola, I.R. (1975); Healthism and disabling medicalization; in *Disabling Professions*; Illich, I. (Ed.); London; Marion Boyars Publishers Ltd.; 41-68.

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