

Expertise and Scottish Abortion Practice: Understanding Healthcare Professionals' Accounts

Siân M. Beynon-Jones

PhD, Science and Technology Studies

The University of Edinburgh

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Abstract

Current UK abortion law has been subjected to extensive feminist critique because of the relationships that it constructs between healthcare professionals (HCPs) and women with unwanted pregnancies. The law allows HCPs to opt out of abortion provision on the grounds of conscience, implying that it is not something which they have an automatic duty to provide to their patients. It also gives doctors the authority to decide whether an abortion can legally take place, thus suggesting that women's reproductive decisions should be regulated by medical 'experts'. However, little is known about how HCPs who are involved in twenty-first century UK abortion provision define their relationships with their patients *in practice*. My thesis makes an important empirical contribution by responding to this gap in the literature and exploring the subjectivities which these HCPs construct for themselves and their pregnant patients.

I address this issue by analysing Scottish HCPs' interview accounts of their involvement in (or conscientious objection to) abortion provision, using conceptual tools provided by Science and Technology Studies (STS) and feminist theory. I begin by utilising HCPs' discussions of the practice of 'conscientious objection' as a means of exploring how they define the boundaries of their professional responsibilities for abortion provision. I then move on to address HCPs' accounts of their interactions with women requesting abortion, and analyse how they define legitimate or 'expert' knowledge in this context.

A key conclusion of the thesis is that HCPs do concede some authority to women with unwanted pregnancies; this is revealed by their reluctance to suggest that they have the right to prevent individual women from accessing abortion. At the same time, I argue that the legitimacy granted to pregnant women by HCPs is limited. My analysis reveals that, in constructing knowledge claims about the use of abortion, HCPs co-produce troubling definitions of femininity, socio-economic class, age and ethnicity. I develop a strong critique of this process, and highlight its potential implications for women's experiences in the abortion clinic. However, I conclude that this situation cannot be addressed by simply attacking the practices of HCPs as individuals. Rather, it is necessary to understand and critique the limitations of the discursive context in which HCPs are working, because this context shapes the subjectivities available to pregnant women *and* HCPs.

Declaration of Originality of Submitted Work

In accordance with University regulations, I hereby declare that:

1. This thesis has been composed solely by myself;
2. It is entirely my own work; and
3. It has not been submitted in part or whole for any other degree or personal qualification

Signed: _____

Date: _____

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Table of Contents

Chapter One: Why healthcare professionals and abortion, now?.....	4
1.1 Introduction	4
1.2 A recent history of UK abortion law	5
1.2.1 The protection of medical discretion over abortion decision-making	6
1.2.2 The definition of the fetus	11
1.3 Why focus on healthcare professionals?	18
1.4 Thesis outline	23
1.5 Negotiating a terminological minefield	25
Chapter Two: Theoretical positionings.....	28
2.1 Introduction	28
2.2 STS and the deconstruction of scientific authority	28
2.2.1 The politics of expertise	28
2.2.2 A new approach to expertise?	32
2.2.3 Expert-lay asymmetries?	33
2.3 Medical practice as the (re)production of gender? Insights from feminist STS	35
2.3.1 Shared understandings	36
2.3.2 Productive tensions	42
2.4 Making space for materiality	50
2.5 Conclusion	55
Chapter Three: Methodology	57
3.1 Introduction	57
3.2 Choosing interviews as a research method	57
3.3 Defining and recruiting a sample of HCPs	60
3.3.1 Why Scotland?	62
3.3.2 Which HCPs?	64
Figure 1: Key abortion pathways in central Scotland	66
3.4 Data analysis	72
3.4.1 Discourse analysis, in theory	72
3.4.2 DA in practice 1: Generating and analysing interview transcripts	80
3.4.3 DA in practice 2: Beyond transcripts	84
3.5 Obtaining ethical ‘clearance’	86
3.6 Engaging in reflexivity?	88
<i>Intermission: Methods of abortion</i>	<i>94</i>
<i>Medical abortion</i>	<i>94</i>
<i>Surgical abortion</i>	<i>97</i>
Chapter Four: “It’s like being a chest physician and saying you don’t do asthma”- Conscientious objection and the boundaries of professional responsibility for abortion.....	99
4.1 Introduction	99
4.2 Legitimizing conscientious objection	102

4.2.1 The Othering of ‘genuine’ objections	103
4.2.2 Opting out: Enacting morality.....	105
4.3 An ‘impossible’ option.....	112
4.4 The boundaries of ‘conscience’	115
4.5 Conclusion	123
Chapter Five: Knowing women? Accounting for the decision to terminate a pregnancy.....	127
5.1 Introduction	127
5.2 Demarcating legitimacy: Denying responsibility.....	131
5.2.1 “Discourses of ignorance”	131
5.2.2 A discourse of women’s suffering	133
5.2.3 A discourse of ‘woman’s choice’?.....	137
5.3 Becoming insignificant: Dispersing responsibility	139
5.4 Assessing women’s decisions: Embodying responsibility.....	142
5.5 Avoiding “decisional control”	150
5.5.1 Demarcating legitimacy	151
5.5.2 Becoming insignificant	152
5.5.3 A discourse of (HCPs’) suffering.....	154
5.6 Conclusion	157
Chapter 6: Fertility, control and the delineation of acceptable reproductive futures	160
6.1 Introduction	160
6.2 A discourse of prevention	163
6.2.1 The ‘choice’ to use contraception?	166
6.2.2 The gendering of responsibility for contraception.....	169
6.2.3 Correcting misperceptions of contraceptive ‘risk’	171
6.3 The Othering of ‘contraceptive exceptions’	175
6.4 Defining desirable reproductive futures.....	181
6.5 Conclusion	186
Chapter Seven: Timing is everything - The reappearance of the fetus.....	189
7.1 Introduction	189
7.2 Expertise concerning the meaning of gestational time	191
7.2.1 Accounting for a twenty week time limit.....	192
7.2.2 And, by extension... ..	197
7.3 Expertise concerning the method of later abortion	201
7.3.1 The time-limited availability of surgical abortion	202
7.3.2 Demarcating ‘later’ medical abortion	203
7.3.3 Some alternative accounts of the medical abortion ‘experience’	208
7.4 Expertise concerning the experience of providing later abortion	211
7.4.1 Hearing nurses’ accounts of later abortion.....	214
7.4.2 Opening up nurses’ accounts of later abortion work	218
7.5 Conclusion	225
Chapter Eight: Concluding discussion.....	229
8.1 Introduction.....	229

8.2 HCP- patient relationships: Women's (limited) legitimacy as reproductive decision-makers.....	231
8.2.1 Constructing obligations	232
8.2.2 Constructing inequalities.....	234
8.2.3 Avenues for 'real-world' reform?	238
8.3 Relationships between HCPs	243
8.3.1 Destabilising dichotomies	243
8.3.2 Situating HCPs within the workplace	246
8.4 Unwanted interventions? Speaking to 'the time limit debate'	252
References.....	257
Appendix A.....	270
Laws relating to abortion, c.1800-1990	270
Appendix B.....	272
Schedule 1 of the Abortion (Scotland) Regulations 1991.....	272
Appendix C.....	274
Schedule 2 of the Abortion (Scotland) Regulations 1991.....	274
Appendix D.....	277
Letter of invitation/information pack.	277
Appendix E	282
Topic Guides	282
<i>Guide 1 - GPs.....</i>	282
<i>Guide 2 – Gynaecologists</i>	288
<i>Guide 3 – Gynaecology Nurses.....</i>	293
<i>Guide 4 – Conscientious objectors (GPs).....</i>	298
<i>Guide 5 – Conscientious objectors (Gynaecologists)</i>	302
<i>Guide 6 – Conscientious objectors (Nurses).....</i>	306

Chapter One: Why healthcare professionals and abortion, now?

1.1 Introduction

Recent years have seen considerable media and parliamentary debate about the terms of UK abortion law. Currently, abortion is regulated by the 1967 Abortion Act, as amended by the 1990 Human Fertilisation and Embryology Act. This legislation states that abortion is only legal if two doctors agree that it is necessary on one of four grounds, all of which refer to the health of the pregnant woman or that of her fetus. It thus defines the decision to terminate a pregnancy as one which depends upon the knowledge of medical experts, rather than pregnant women. As well as giving doctors the right to decide whether an abortion should take place, the law gives them the right to refuse to become involved in abortion provision on the grounds of personal conscience, thus distinguishing abortion from most other medical treatments (Sheldon, 1997).

Feminist scholars (e.g. Brookes, 1988; Fyfe, 1991; Boyle, 1997; Sheldon, 1997; Lee, 2003b) have criticised UK abortion law on two related grounds. In the first place, rather than granting women a positive right to abortion, it allows doctors to control the terms on which the procedure is provided. Secondly, by defining abortion as a deviant reproductive act that must be regulated by medical experts, the law co-produces problematic constructions of femininity (Boyle, 1997; Sheldon, 1997). It positions motherhood as the *normal* outcome of pregnancy and simultaneously suggests that women are not reliable judges of the circumstances in which they should become mothers (Boyle, 1997; Sheldon, 1997).

While feminist critiques have highlighted important problems with the framework of UK abortion law, little is known about how healthcare professionals (HCPs)¹ define their role(s) in twenty-first century abortion practice. What

¹ While the law grants decision-making rights only to doctors, nurses also play an important role in the provision of abortion. They are involved in interviewing and counselling patients, as well as in providing the procedure and, like doctors, can also exercise their legal right to opt out of abortion

subjectivities do they delineate for themselves, and for their pregnant patients? What are the implications of this process for women who are, or could become, pregnant? My thesis sets out to address these questions, by analysing Scottish HCPs' interview accounts of their involvement in (or conscientious objection to) abortion provision, using conceptual tools provided by Science and Technology Studies (STS) and feminist theory.

The following chapter explains my rationale for this research in further detail. It begins by outlining some of the critical events in the recent history of UK abortion law, in part because this provides important background information for the chapters which follow. However, through this discussion I also aim to illustrate that the history of the regulation of abortion in the UK can be written as an account of increasing parliamentary deference to medical experts. Drawing on this discussion, as well as an examination of the existing empirical literature, I offer further justification for my decision to study contemporary HCPs' accounts of their role in abortion provision. I also explain why it is particularly important to conduct this research using the theoretical lens supplied by STS. I then move on to outline the structure of my thesis, and list the specific research questions which I aim to address. I conclude the chapter by highlighting some of the difficulties that I have faced in attempting to find a 'feminist' language through which to write about this research topic.

1.2 A recent history of UK abortion law

Numerous historians and sociologists have analysed the processes which led to the construction of current UK abortion law (Macintyre, 1973; Brookes, 1988; Keown, 1988; Fyfe, 1991; Newburn, 1992; Boyle, 1997; Sheldon, 1997; Halfmann, 2003; Davis & Davidson, 2006). While the precise details of their accounts vary, one overarching theme which unites them is an agreement that the UK medical profession has played a significant role in shaping the terms of abortion legislation. Rather than simply repeating other authors' chronological descriptions of the law's

work on the grounds of conscience. My use of the term 'HCPs' is thus intended to acknowledge the role of both doctors *and* nurses in abortion provision.

history,² the following discussion focuses on two ways in which the medical profession is held to have influenced the parameters of UK abortion law.

1.2.1 The protection of medical discretion over abortion decision-making

The 1967 Abortion Act is often portrayed as a permissive law which ‘legalised’ abortion in the UK³ (Newburn, 1992). However, rather than completely decriminalising abortion, the Abortion Act in fact clarified the grounds on which doctors could legally carry out the procedure (Fyfe, 1991).

In pre-1967 Scotland, abortion was an offence under common law, “subject to an ill-defined exception for abortions necessary to preserve the mother’s life or health” (Gordon, 1978: 812). Because of this ambiguous definition, in Scotland doctors could (at least in theory) provide the procedure legally before 1967, if they were acting in good faith in the interests of their patients (Davis & Davidson, 2006).⁴ In contrast, in England abortion had been criminalised by statute law from 1803 onwards (Brookes, 1988). The 1861 Offences Against the Person Act made it illegal for any person to attempt to procure or provide an abortion at any stage of gestation (Brookes, 1988; Keown, 1988; Fyfe, 1991). However, Keown (1988) suggests that, even in the more restrictive context of pre-1967 English abortion law, informal deference to medical discretion characterised the regulation of abortion. He provides evidence to suggest that doctors believed abortion to be a legal practice if their clinical judgment deemed it to be necessary. He also points out that several judges supported this view by stating that doctors acting in the best interests of their patients need not fear prosecution.⁵

² A time line summarising major events in the history of UK abortion law is provided in Appendix A.

³ In using the term, ‘UK’ I am (perhaps problematically) excluding Northern Ireland, where the 1967 Abortion Act does not apply. Abortion in Northern Ireland is regulated by the pre-1967 legislation and, as a result, abortion is almost unavailable to women in this part of the UK. A similar situation exists in the Republic of Ireland.

⁴ As Davis and Davidson (2006) point out, this did not translate into the widespread provision of the procedure by doctors. In most areas of Scotland, gynaecologists were reluctant to perform abortions in the absence of “medical emergency” e.g. risk to the life of the pregnant woman.

⁵ Brookes (1988) highlights the contrast between the way in which doctors and non-professional abortionists (who were often women acting to help other women for minimal fees) were treated by the court; the latter were prosecuted more often and received harsher sentences.

Concern about loss of control over the criteria for legal abortion was central to the medical profession's response to parliamentary attempts to clarify and liberalise abortion law during the 1950s and 1960s (Macintyre, 1973; Brookes, 1988; Keown, 1988; Newburn, 1992; Halfmann, 2003). Although the profession was divided concerning the circumstances in which abortion was justifiable, it was united in its insistence that *only* doctors possessed the expertise necessary to decide when abortion was the correct course of action (Macintyre, 1973). The medical profession's desire to protect its own autonomy can be illustrated by its response to two grounds for the procedure that were originally included in the Private Members' Bill which David Steel introduced in his attempt to liberalise abortion law in 1966:

- c) that the pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be; or
- d) that the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape. (Quoted in Newburn, 1992: 143)

Many members of the medical profession viewed these clauses with hostility because, as well as making no specific reference to 'medical' knowledge, they outlined very precise grounds upon which an abortion would be legal. It was feared that as a result of this, women would be able to 'diagnose' themselves as entitled to legal abortion, and that doctors would be confronted with massive patient demand for the procedure (Macintyre, 1973; Keown, 1988; Newburn, 1992; Halfmann, 2003). Even doctors who supported the liberalisation of abortion law and provision objected to the inclusion of explicitly 'non-medical' indications for abortion in the proposed legislation (Keown, 1988; Newburn, 1992; Davis & Davidson, 2006). From their perspective, abortion was always a question of medical judgments concerning a woman's 'health', and they interpreted this term broadly to include the assessment of the social circumstances in which she was living (Keown, 1988; Newburn, 1992; Davis & Davidson, 2006).

Subjected to extensive lobbying by medical organisations, David Steel seems to have been convinced by this second viewpoint (Keown, 1988; Newburn, 1992; Davis & Davidson, 2006). He removed clauses c and d from the Bill, replacing them

with a general reference to the ‘environment’ of the pregnant woman. With some modifications (which are described in section 1.2.2), the resulting legislation continues to regulate the provision of abortion in the UK:

(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 and 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 foreseeable environment. (The Abortion Act 1967)

Sheldon (1997) suggests that, in addition to the pressures placed on Parliament by the medical profession, the legalisation of abortion as a ‘medical’ issue can also be viewed as an active attempt to gain control over women’s reproductive behaviour. From the 1930s onwards, the Abortion Law Reform Association had campaigned vociferously for women’s right to control their own bodies through legal, safe abortion. Their campaigns heightened public awareness of the numbers of women dying annually through illegal abortions performed by individuals without medical training (Brookes, 1988). However, Sheldon argues that, rather than reflecting support for women’s reproductive autonomy, parliamentary support for abortion law reform in 1967 represented an attempt to deal with the *unregulated* basis of the pre-1967 situation. She suggests that the deaths of wives and mothers through unsafe abortion represented a threat to the institution of the family, and that the prevalence of illegal abortion was perceived as a threat to the authority of the State. Given these concerns, the solution was not to give women the power to make their own decisions about abortion, but to attempt to regulate their behaviour more effectively *through* the medical profession:

A dark mass of unknowable female criminality which had been perceived as profoundly threatening to the existing social order (and, in particular,

to the family) is thus brought into the open, and isolated in the bodies of individual women, where it can be contained, monitored and controlled. The problem of abortion is changed from one of widespread and unquantifiable *deviance*, to one of isolated, identifiable and treatable individual *deviants*. (Sheldon, 1997: 29 – emphasis in original)

Similar accounts are also provided elsewhere in literature addressing this topic. For example Keown describes “the statutory transfer of abortion from the court to the consulting room” (Keown, 1988: 165) and Fyfe suggests that the Abortion Act can be construed as “a shift of the patriarchal power relationship between the legal and medical professions; an exchange of women (or control over reproduction) from the former to the latter” (Fyfe, 1991: 166).

While the framework of the 1967 Abortion Act may have enshrined medical expertise as the basis for determining whether an abortion should take place, it also defined abortion as an unusual medical intervention, which requires legal oversight (Sheldon, 1997). In other words, while it granted doctors power in relation to women with unwanted pregnancies, it also meant that medical discretion became regulated to an unusual degree. No doctor can act alone with regards to abortion; two medical practitioners must agree that the procedure is necessary, and they must indicate this agreement by signing a legal document called Schedule 1 (see Appendix B)⁶. Schedule 1 is then kept in the patient’s notes and is used as the basis for completing Schedule 2 (commonly referred to in practice as the ‘notification form’ – see Appendix C). Schedule 2 is completed by the operating physician and must be sent to the Chief Medical Officer within seven days of the abortion. It details the names of the operating physician, the two doctors who signed Schedule 1, and the place where the abortion was carried out,⁷ as well as several pieces of information about the woman undergoing the abortion, e.g. marital status and obstetric history. In addition to indicating the ground under which the abortion was carried out, the doctor who

⁶ Appendix B provides a copy of Schedule 1 of the Abortion (Scotland) Regulations 1991. These regulations are the Statutory Instrument currently used to enact the 1967 Abortion Act (as amended by the 1990 Human Fertilisation and Embryology Act) in Scotland. A separate Statutory Instrument applies to England and Wales. Schedule 1 of these regulations is in fact a sheet composed of two sides, Certificate A and B. Certificate A is the one that is normally completed, whereas Certificate B applies in the case of emergency operations and only requires one doctor’s signature. Because it involves an emergency situation, Certificate B does not have to be completed prior to the abortion.

⁷ The procedure is only legal if carried out on government-approved premises.

completes this form must give a brief statement of “the main indication” for the procedure.

Although these documents appear to render doctors unusually accountable for their work, in his analysis of the working of the Abortion Act from 1967 to 1982, Keown (1988) suggests that its apparent legal restrictions on medical discretion do not interfere in any way with clinical freedom. He points out that, while Schedule 1 may ensure that a second doctor’s opinion is obtained before any abortion, it does not in fact require that the doctor in question *sees* the patient; s/he simply has to agree with the first doctor’s assessment. Additionally, although Schedule 2 is sent to the Chief Medical Officer, Keown argues that, because “notification is made to the CMO on a doctor-to-doctor basis rather than to, say, the police, any suspicion of criminality which might arise from the form is less likely to be followed up” (Keown, 1988: 132). Sheldon (1997) reaches a similar conclusion in her analysis of legal cases relating to the Abortion Act, and suggests that doctors seem to be almost immune from prosecution in this area of medical practice. She points out that the only requirement which doctors must fulfil in order to comply with the terms of the legislation is to act “in good faith”, and that it is extremely difficult to prove non-compliance with this requirement in court.

Sheldon also concedes that the Abortion Act’s deference to medical discretion, along with the court’s refusal to interfere with this discretion, has had broadly *beneficial* implications for British 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 opposition and political controversy. Since 1967, doctors have grown increasingly liberal in the provision of abortion and the courts have refused to check this development. (Sheldon, 1997: 152)

At the same time, she draws attention to two problems with the framework of abortion law which were highlighted in the introduction to this chapter, namely, its problematic constructions of femininity and the potentially powerful position that it allows doctors to occupy in relation to women requesting abortion. In addition to these problems, Sheldon (1997) highlights the phenomenon of *entrenchment*, whereby a tradition of legal deference to medical expertise concerning abortion pre-

frames public debate on the issue, making it difficult to discuss abortion as anything other than a matter for medical judgment. In the following section, I will address feminist critiques of this phenomenon, as well as illustrating their relevance to contemporary discussion of the subject in the UK. Through this discussion I will reveal that public discourse concerning the regulation of abortion continues to construct the medical profession as a source of enormous epistemological authority. This highlights the importance of exploring whether HCPs involved in contemporary abortion practice are constructing similarly authoritative positions for themselves in relation to their pregnant patients.

1.2.2 The definition of the fetus

Historical accounts of the development of UK abortion law suggest that a second critical way in which Parliament has deferred to the judgment of the medical profession is in its attempts to define the legal status of the fetus. In this section I will provide an historical overview of this phenomenon, and will also draw attention to feminist critiques of the ways in which medical definitions of the fetus have come to dominate public debate about abortion in the UK. In order to illustrate the continuing relevance of these critiques, I end this section by considering extracts from a recent parliamentary debate about abortion, which took place during the passage of the 2008 Human Fertilisation and Embryology Bill.

Before the nineteenth century, abortion in England was regulated under common law and was an offence only after ‘quickening’, i.e. the point at which pregnant women become aware of fetal movement (Keown, 1988). This distinction was associated with the belief that only after a fetus became ‘animated’ was it morally significant (Keown, 1988). However, Keown argues that, by the beginning of the nineteenth century, doctors had begun to challenge the idea that quickening marked a significant point in fetal development, which, they argued, should instead be viewed as a continuous process following conception (see also Brookes, 1988). He suggests that medical opinion may have been reflected in the Act that first made abortion a statutory offence in England (The Malicious Shooting or Stabbing Act, 1803) which stated explicitly that abortion was an offence both before and after

quickening (albeit a lesser offence before this point). As the nineteenth century progressed, Parliament continued to support the medical professions' view of fetal development. The 1837 Offences Against the Person Act made no use of the quickening terminology, and removed any distinction between pre- and post-quickening abortion from the law (Keown, 1988).

Fyfe (1991) suggests that the removal of quickening terminology from abortion legislation is symbolic of a broader shift which took place during the nineteenth century. Along with other feminist scholars (see Chapter Two) she suggests that, as biomedical accounts of reproduction gained greater authority, women's embodied accounts of this process became de-valued and their control over their own reproductive bodies was diminished. She cites the 1929 Infant Life (Preservation) Act⁸ as further evidence of this trend (see also Brookes, 1988). This piece of legislation was primarily intended to close a loophole in existing abortion law, which had allowed a fetus to be legally destroyed *during* birth (Brookes, 1988). It achieved this by creating the new (and more serious) offence of 'child destruction', to be applied to the abortion of fetuses capable of being born alive.⁹ On the basis of medical consensus, this capacity was stated to be presumed from twenty-eight weeks' gestation onwards (Brookes, 1988). Fyfe suggests that this Act was significant because it singled the fetus out "as a potential victim in need of state protection" (Fyfe, 1991: 164), and introduced the notion that a fetus which doctors deemed capable of being born alive was a distinctive legal entity.

Fyfe suggests that the 1967 Abortion Act reiterated the view that medical expertise should determine the status accorded to the fetus. In the first place, it stated that:

Nothing in this Act shall affect the provisions of the Infant Life (Preservation) Act (protecting the life of the viable fetus). (The Abortion Act 1967, section 5, paragraph 1)

⁸ Like other statutory abortion laws prior to 1967, this Act did not apply to Scotland.

⁹ It also contained a defence against the crime of child destruction, in cases where this act was performed in "good faith for the purpose only of preserving the life of the mother" (The 1929 Infant Life (Preservation) Act, paragraph 1 [1]).

In doing so, it made abortion beyond twenty-eight weeks' gestation illegal, and entrenched the notion that medically defined fetal viability was a legally significant point in time (Fyfe, 1991). Additionally, as Fyfe points out, the Abortion Act *extended* the medical profession's right to define the meaning of the fetus by making medical assessments of fetal health an explicit criterion for legal abortion (Abortion Act 1967, clause 1b – see p.8).

Almost as soon as the Abortion Act had been passed it was subjected to extensive critique, and the anti-abortion movement mobilised around attempts to restrict it via a series of Private Members' Bills throughout the 1970s and 80s (Keown, 1988; Newburn, 1992). Several of these aimed to reduce the upper time limit on legal abortion from twenty-eight weeks' gestation,¹⁰ and in recent decades, the question of appropriate 'time limits' on abortion has become the most pervasive feature of public debate about its regulation.

As the Science and Technology Subgroup (1991) point out, the most striking aspect of 'time limit' debates is the way that they are dominated by discussion of the status of the fetus. They illustrate this argument through their analysis of David Alton's Abortion Amendment Bill, which was introduced to Parliament in 1987 and sought to dramatically lower the legal time limit on abortion from twenty-eight to eighteen weeks' gestation. Alton's principle argument was that medical advances in the care of premature babies had reduced the point of fetal viability far below the twenty-eight week limit set in the 1929 Infant Life (Preservation) Act, and that the point of viability was more accurately placed at eighteen weeks. However, although the Alton campaign introduced the notion that 'late' abortions after eighteen weeks' gestation were particularly problematic, Steinberg (1991) suggests that the campaign's rhetoric revealed an "intent to erode the social legitimacy of abortion at any stage" (Steinberg, 1991: 179). In addition to the specific argument about fetal

¹⁰ The question of the upper time limit on abortion was also considered as part of a three year Government Committee enquiry (1971-4) chaired by Justice Elizabeth Lane, which was set up in response to critiques of the 1967 Abortion Act (Davis & Davidson, 2006). Desire for regulatory restriction and clarification of the upper time limit was a key feature of the Scottish medical profession's evidence to the Lane Committee (Davis & Davidson, 2006). As Davis and Davidson point out, because the 1929 Infant Life (Preservation) Act did not apply in Scotland, at this time there was *no* upper time limit in Scottish abortion practice.

viability, Alton and his supporters also drew more broadly upon medical discourses about fetal development, in order to construct the fetus *in utero* as a human baby deserving of protection by law (Franklin, 1991).

A critical point revealed by the Science and Technology Subgroup's analysis is that MPs who opposed Alton let the "fetal-centred" (Steinberg, 1991: 179) nature of his arguments about abortion go unchallenged. Rather than introducing alternative discourses concerning the rights or needs of women, Alton's opponents suggested that eighteen weeks was an unrealistic estimate of fetal viability, which the medical profession in the late 1980s placed at twenty-four weeks. While they may have questioned Alton's proposed time limit, they thus accepted his premise, i.e. that there is a category of 'late' abortion which should be discussed on a different basis from 'early' abortion (Steinberg, 1991).

Alton's opponents also argued that a lower legal time limit would prevent doctors from offering abortion in cases where prenatal diagnostic testing revealed the presence of fetal abnormality (Franklin, 1991; Steinberg, 1991). Such testing can generally only be conducted towards the end of the second trimester of pregnancy. By relying on this argument, Alton's opponents again accepted Alton's framing of the debate because they conceded that 'late' abortions require special circumstances to be justifiable (Steinberg, 1991). Additionally, in defining these circumstances entirely as a matter of medical experts' assessments of the status of the fetus, they concurred with Alton that abortion law should be determined by "medical judgments and technical possibilities or limitations, not women's needs or lives" (Science and Technology Subgroup, 1991: 214).

Although the Alton Bill was ultimately unsuccessful, Sheldon (1997) argues that the Science and Technology Subgroup were right to be concerned about the future legacy of the narrow framework in which it was debated. Amendments to the 1967 Abortion Act were subsequently attached to the 1990 Human Fertilisation and Embryology Act. Echoing the debate about the Alton Bill, parliamentary discussion of these amendments was framed almost exclusively in terms of medical knowledge,

and was focussed upon the status of the fetus (Sheldon, 1997). The legislation that was ultimately passed decoupled the 1967 Abortion Act from the 1929 Infant Life (Preservation) Act in order to reflect medical consensus that fetal viability was most accurately placed at twenty-four weeks' gestation (Sheldon, 1997). As a result of this legislation, abortion is currently legal in the UK under the following conditions:

(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, of injury to the physical or mental health of the pregnant woman or any existing children of her family; 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 foreseeable environment. (The Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990).

The 1990 Human Fertilisation and Embryology Act thus entrenches two key assumptions about abortion that were visible in previous laws and parliamentary debates on the subject. Firstly, it assumes that, after a point in gestational time which the medical profession demarcates as significant, the fetus gains a distinctive status in relation to the woman who is pregnant. Secondly, it assumes that the abortion of this legally distinctive fetus requires more 'extenuating' circumstances, the existence of which is to be determined by doctors (grounds b, c and d).

The vast majority of abortions which take place in the UK each year are conducted under clause 'a', which is the only clause to which the twenty-four week time limit applies. In recent years, there have been calls for further legislative restriction of these 'clause a' (often informally termed 'social') abortions on the basis

of advances in medical knowledge about fetuses and premature babies. The move for restriction seems to have gained momentum in part because of fetal ultrasound footage that was released to the media by Professor Stuart Campbell in June 2004. Using 4-dimensional imaging technology (which generates 3-dimensional images that move in 'real' time), Campbell claimed to have uncovered the "complexity" of fetal behaviour *in utero*. As evidenced by the following quotation from the *Guardian*, he argued that this provided sufficient justification for the upper time limit on abortion to be lowered:

For normal babies being terminated for social reasons it's probably unacceptable nowadays to be terminating them much after 14 weeks. They can suck their thumbs, they can open their eyes, they can perform complex movements. I think it's time we got our act together. (Stuart Campbell, quoted in Adam, 29th June 2004)

However, although these images attracted considerable media attention, full-blown parliamentary debate about the upper time limit did not occur until 20th May 2008, during the Committee stage of the Government's Human Fertilisation and Embryology Bill. The debate which took place addressed a number of proposed restrictions on abortion legislation,¹¹ but was dominated by discussion of the upper time limit. Six amendments were tabled in order to give MPs the opportunity to vote on six alternatives (ranging from twelve weeks to twenty-two weeks) to the current twenty-four week limit. Although all of these amendments were rejected, the terms in which they were debated reveal the continuing relevance of feminist critiques of the narrow discursive space within which abortion is discussed in the UK.

As in previous attempts to lower the time limit, proponents of restriction drew primarily upon medical discourses in order to blur distinctions between fetuses *in*

¹¹ Other restrictions discussed during this debate included an attempt to clarify (and restrict) the grounds on which abortions could be provided, and the introduction of formal 'consent' procedures, detailing information that HCPs would have to provide to all women requesting abortion (including developmental information about fetuses). MPs in favour of liberalisation later tabled amendments to abortion law (such as extending abortion law to Northern Ireland, reducing the number of doctors' signatures required, and allowing nurses to perform abortions) at the Report stage of the Human Fertilisation and Embryology Bill, which took place on October 22nd 2008. However, as a result of a procedural motion tabled by the Health Minister, the order of the debate at the Report stage ensured that there was insufficient time to address any amendments relating to abortion law – a move which attracted considerable criticism from the pro-choice lobby.

utero and babies/children. This allowed them to argue that the former deserved legal protection:

On the question of viability, we have heard a great deal about studies of the viability of the foetus—or the baby, in some hon. Members' terminology; I think that I agree with that terminology. If there were any doubt in my mind that a baby might be viable, I find it difficult to see how the Committee would not vote to lower the limit. Viability is everything. If even a single baby could live, with the help of modern medical science, that baby deserves the chance to live. [Mike Penning, Hansard Column 244, May 20th 2008]

Why 16 weeks? Scientific evidence increasingly suggests that unborn children feel pain at 16 weeks. That is not simply a stress response; it is a physiological response, perhaps not the same as in a fully grown adult, but a physical and even emotional response beyond the norms of passive reflex. Pain is felt, which is why specialist, gifted surgeons who perform surgery on babies in the womb use anaesthetic. Now, 4D imaging reveals that 16-week-old unborn babies are very much alive and kicking, although their limbs are too small to be felt by the mothers. [Mark Pritchard, Hansard Column 235, May 20th 2008]

This second quotation exemplifies feminist arguments concerning the way in which women's embodied knowledge of their pregnancies has become devalued in relation to medical discourses of fetal development (Oakley, 1987; Fyfe, 1991; Duden, 1993). Mark Pritchard positions a medical imaging technology as a source of objective knowledge concerning the status of the fetus, and dismisses women's embodied knowledge of their pregnancies as inaccurate.

Interestingly, in responding to these arguments, many of those defending the current time limit *did* make a concerted attempt to challenge their opponents' "fetal-centred" framing of the debate:

The first gross misconception is the assumption that restricting abortion or making it illegal would in some way be pro-life. The error in that argument is that the exclusive focus is on the foetus. The woman is totally ignored, as if she does not count. [Chris McCafferty, Hansard Column 236, May 20th 2008]

It is all about women's autonomy and control over their own bodies rather than being forced to continue with an unwanted pregnancy or to seek an unsafe abortion, which could be the consequence. The point was well made by my hon. Friend the Member for Calder Valley (Chris McCafferty): "If you don't believe in abortion, don't have one." I think

that that sums up very well what the debate is about. It is about respecting another person's right to choose, even if it is not a choice that one would make oneself. [Julie Morgan, Hansard Column 269, May 20th 2008]

However, it seemed difficult for speakers to rely entirely on these woman-centred arguments about abortion, and they turned repeatedly to the authority of medical science in order to reinforce their defences of the current time limit on abortion. Citing the support of major medical organisations, they argued that there was no evidence to suggest that fetuses/premature babies could be 'viable' before the current twenty-four week time limit:

Of course, I agree that legislation should always adapt to take account of scientific and technical progress, but all the recent independent peer-reviewed research has shown very clearly that survival at below 24 weeks' gestation has not improved, despite advances in other aspects of antenatal care and the care of premature babies. When the 24-week limit was approved by Parliament in 1990, a key argument was that that was the stage at which the foetus was considered viable. It is the considered view of the British Medical Association, the Royal College of Obstetricians and Gynaecologists, the Royal College of Nursing and the British Association of Perinatal Medicine that there is no evidence of a significant improvement in the survival of extremely premature babies below 24 weeks' gestation in the UK within the last 18 years. The recent EPICure and Trent studies that were referred to earlier also say the same thing. There is no significant statistical improvement in survival under 24 weeks. [Chris McCafferty, Hansard Column 239-240, May 20th 2008]

As has been suggested previously (Science and Technology Subgroup, 1991; Sheldon, 1997), such 'pro-choice' arguments are disturbing for two reasons. Firstly, because they concede ground to those who want to place fetuses at the centre of the legislative agenda, and secondly, because they frame abortion law as something which should automatically reflect "scientific and technical progress". In doing so, they suggest that, if such progress *did* occur in the future, then it would become acceptable to impose restrictions on women's access to abortion.

1.3 Why focus on healthcare professionals?

Given Parliament's continuing deference to the voices of medical experts, why have I decided to conduct research which focuses on the perspectives of the 'powerful'? Surely it is more important to engage with those who are marginalised by the framing of abortion law and public debate in the UK, namely, women with unwanted

pregnancies? Although I recognise the importance of making women's needs and lives central to any discussion of abortion, in the following section I will justify my decision to analyse the accounts of those who are involved in its provision.

In the first place, several contemporary qualitative studies have focussed on women's experiences of accessing and having abortion in the UK (Lattimer, 1998; Harden & Ogden, 1999; Kumar *et al.*, 2004; Lee, 2004; Lee *et al.*, 2004). Echoing the findings of earlier studies (Macintyre, 1977; Allen, 1985), this work illustrates that, in contrast to the law's construction of abortion decision-making as a matter for the judgment of doctors, women decide to end their pregnancies *outside* of the clinic (Lee, 2004) on the basis of their very particular, and complex, social circumstances.

In contrast to the regularity with which qualitative researchers have asked women to explain their reproductive decisions and experiences, in recent decades HCPs have rarely been asked to account for their practice in UK abortion clinics. This research thus sets out to address an important gap in the empirical literature. However, in doing so, it does not set out to 'amplify' the voices of HCPs, but rather to critically explore the implications of their accounts for women's access to, and experience of, abortion. It is precisely *because* these actors are granted such authority over the regulation of abortion in contemporary public discourse that it is vital to understand the roles which they construct for themselves in practice.

Studies of women's experiences in the abortion clinic highlight the positive behaviour of some HCPs, but also draw attention to the negative impact that the behaviours of doctors and nurses can have upon patient experiences. One problem that emerges repeatedly is that women requesting abortions feel "over-counselled" and questioned by HCPs about decisions which they have reached for themselves in non-clinical settings (Macintyre, 1977; Allen, 1985; Harden & Ogden, 1999; Kumar *et al.*, 2004; Lee, 2004). In light of this, a key motivation for this research was to explore whether insights into this problem could be generated by approaching it from an alternative angle, i.e. by analysing the ways that *HCPs* are positioning themselves in relation to their pregnant patients.

A crucial feature of my analysis of HCPs' accounts is that I am drawing on the theoretical resources provided by Science and Technology Studies (STS). While there is considerable debate about the origins, methods and aims of STS, this interdiscipline converges around an important principle, namely that technoscientific¹²/medical 'facts' or 'truths' are not determined by the material world, but are produced through human¹³ activity. Based on this central insight, STS has revealed the processes by which technoscientific/medical facts are constructed in a wide variety of locations, including laboratories (e.g. Latour & Woolgar, 1986 (1979); Knorr-Cetina, 1999), the clinic (e.g. Berg & Mol, 1998; Mol, 2002), in scientific literature (e.g. Gilbert & Mulkay, 1984; Latour, 1987), or during controversies that develop within the scientific community (e.g. Collins, 1981; Pinch, 1985) and which also extend far outside of it through public debates about various technoscientific/medical innovations (e.g. Kerr *et al.*, 1997; Wynne, 2001). Although it has long been impossible to provide a comprehensive overview of this extensive body of research (Pickering, 1992), collectively, STS's case studies demonstrate that, while technoscientific/medical knowledge may appear 'factual' in retrospect, its treatment as such is the product of earlier processes of negotiation. In highlighting the role of human practice (or 'the social') in the production of technoscientific/medical knowledge, STS has also illustrated how the definition of what is to count as 'factual' (i.e. expert/authoritative) knowledge is interwoven with particular definitions of the society that we inhabit.

This argument is outlined in further detail in Chapter Two, which provides a more precise account of the theoretical resources that have shaped my analysis. However, for the purposes of this discussion, the critical point is that, rather than

¹² The term 'technoscience' was first employed by Latour (1987), who rejects the idea that 'science' and 'technology' are easily distinguishable categories; indeed, he suggests that their treatment as such is the outcome of the ways in which technoscience is practiced. Likewise, I employ this term in order to signal the messiness of the boundaries of what is to count as 'science' or 'technology'. However, pragmatically speaking, this expression is also useful as shorthand in order to avoid the cumbersome listing of 'science, technology and medicine' (Latour, 1987).

¹³ Several schools of thought would insist that nonhuman actors should also be included in STS analyses of the production of technoscientific/medical knowledge (e.g. Callon, 1986; Latour, 1987; Latour, 1988; Haraway, 1991; Haraway, 1997). This issue will be considered in detail in Chapter Two.

reinforcing the epistemological authority granted to practitioners of technoscience/medicine in public fora, STS makes it possible to question and destabilise this authority. This is because it has revealed that knowledge claims made by practitioners of technoscience/medicine are as amenable to sociological analysis as any other kind of knowledge claim. By addressing my empirical research questions through this theoretical framework, I aim to conduct a critical analysis of HCPs' accounts of abortion provision, which asks questions about the implications of their knowledge claims for women who are, or could become, pregnant. Through this approach, as well as by drawing on existing literature which has explored women's experiences in the abortion clinic, I will ensure that questions about women's needs and lives remain central to my analysis.

Although I am approaching HCPs' accounts of UK abortion practice using a novel theoretical perspective, it would be wrong to suggest that this is a 'new' empirical area of qualitative research. It is perhaps more accurately described as one which has become rather unfashionable and, hence, neglected. During the 1970s and 80s there seems to have been considerable interest in understanding how the 1967 Abortion Act was working in practice, and several qualitative studies addressed HCPs' perspectives on this issue (e.g. Horobin, 1973; Aitken-Swann, 1977; Macintyre, 1977; Ashton *et al.*, 1980; Allen, 1985). The very different theoretical perspectives, design and aims of these studies, as well as the socio-historical context in which they were written, often makes direct comparison with my own findings very difficult. However, these earlier studies formed an important source of background information during the design of my project, and where relevant, in the empirical chapters that follow I draw attention to the relationship between these studies and my own findings. I also consider links between my findings and those of qualitative studies which have researched the perspectives of HCPs involved in abortion provision in other countries, in particular, the US (e.g. Joffe, 1986; Roe, 1989; Simonds, 1996; Lazarus, 1997).

Another important empirical resource is provided by Davis and Davidson's (2005) analysis of the Scottish medical community's reaction to the immediate

aftermath of the 1967 Abortion Act. This work reveals the importance of studying HCPs' reactions to the subject positions that appear to be created for them by UK abortion law. Davis and Davidson point out that, while Parliament may have granted considerable 'power' to the healthcare profession, it also gave it explicit *responsibility* for abortion provision. Following the passage of the Abortion Act, HCPs were confronted with unprecedented numbers of requests for the procedure, which suggests that, in spite of the Act's deference to medical authority, patients believed the procedure to be legal, and available on request (Davis & Davidson, 2005). This massive increase in patient demand not only placed a structural-level strain upon gynaecological services, but also forced HCPs to manage responsibility for abortion provision on an individual level (Davis & Davidson, 2005). Many doctors argued that they were being forced to negotiate a situation where patient requests for abortion bore no resemblance to the grounds on which their clinical judgment deemed the procedure to be 'necessary', and therefore legal (Davis & Davidson, 2005). Davis and Davidson reveal the creative ways in which individual HCPs sought to avoid dealing with this situation by devolving responsibility for (and thus, authority over) abortion decision-making (see Chapter Five). Their analysis illustrates that, even in the early years of its operation, HCPs did not simply accept the roles which the Abortion Act constructed for them.

A final, more contemporary, body of qualitative research which relates closely to the empirical topic of my thesis concerns HCPs' encounters with so-called 'new' reproductive technologies (NRTs). Of particular relevance is work that has addressed HCPs' involvement in the provision of prenatal screening and diagnostic services, which intersect implicitly and explicitly with the provision of abortion. This intersection arises because most of the fetal abnormalities diagnosed *in utero* cannot be treated, and the abortion of affected fetuses is the only 'option' which HCPs can offer to their patients. The dilemmas which HCPs face during the provision of prenatal testing are addressed by Williams *et al.* (2002d; 2002c; 2002b; 2002a) and Farsides *et al.* (2004), and the issue of HCPs' involvement in abortion in cases of fetal abnormality is considered by Statham *et al.* (2006) and Graham (2006). However, while these studies form a useful point of reference in the chapters that

follow, their focus is very different from my own. Abortion on the grounds of fetal abnormality is, comparatively speaking, an unusual procedure,¹⁴ which is carried out following diagnostic testing provided as part of antenatal services. In other words (and somewhat paradoxically), it only takes place when a woman has first decided that her pregnancy is ‘wanted’, by entering into a programme of antenatal care. In contrast, although my analysis touches on the issue, my concern is primarily with abortion in the *absence* of diagnosed fetal abnormality, which tends to be accessed through a different system of healthcare provision (see Chapter Three).

1.4 Thesis outline

As stated in the introduction to this chapter, this thesis sets out to explore Scottish HCPs’ accounts of their involvement in (or conscientious objection to) abortion provision. In response to feminist concerns about the way in which UK law frames the relationship between HCPs and women with unwanted pregnancies, it asks the following key research question:

- What subjectivities do HCPs delineate for themselves and for their pregnant patients?

This, in turn, is broken down into three more specific sub-questions, which are addressed in the empirical chapters:

- Do HCPs place limits upon their own/their colleagues’ ‘rights’ to make use of the conscience clause? If so, how, and what are the implications? (Chapter Four)
- How do HCPs’ accounts of their interactions with their pregnant patients relate to the expert-lay relationships constructed by UK abortion law? (Chapter Five)
- What, if any, claims to expert knowledge are articulated by HCPs? (Chapters Five, Six, and Seven)

¹⁴ Only 1.2% of all the abortions which took place in Scotland in 2008 were carried out for this reason (Information and Statistics Division Scotland, 2008).

As indicated earlier, the thesis begins by providing a more precise account of the theoretical resources from STS which have shaped my analysis (Chapter Two). Chapter Three extends this discussion by explaining how these theoretical perspectives relate to the methodology of the thesis, in particular, my use of discourse analysis as a method of data analysis. This chapter also justifies other key methodological choices that I have made, such as the decision to use semi-structured interviews to generate data, and to situate the research in Scotland. Additionally, it provides important background information about the context in which my participants work.

The main body of the thesis is comprised of four empirical chapters. In Chapter Four, I consider how HCPs relate to the law's suggestion that they have the legal right to opt out of abortion provision on the grounds of conscience. I argue that HCPs' discussions of the practice of 'conscientious objection' represent an interesting site at which to explore how they define the boundaries of their professional responsibilities for abortion provision. During this analysis, I draw attention to differences in the ways that 'conscientious objection' is constructed by those who are involved in, and those who opt out of, abortion provision.

Chapter Four also illustrates that, when HCPs who are involved in abortion provision position themselves in relation to those who conscientiously object to the practice, they construct abortion as a normal and legitimate part of their work as HCPs. This analysis forms a useful point of contrast to the subsequent empirical chapters, which explore how HCPs position themselves in relation to their pregnant patients. I reveal that, in this second context, HCPs do not always construct abortion as a legitimate course of action.

Chapters Five to Seven centre on HCPs' definitions of the knowledge relevant to decisions about the use of abortion and explore the subjectivities that these definitions construct for women who are, or could become, pregnant. Chapter Five considers how HCPs relate to the law's apparent definition of abortion decision-

making as a process that entails their expert judgment. I reveal that HCPs articulate three key subject positions for themselves, through which they claim varying degrees of expert (i.e. authoritative) knowledge in relation to their patients. Although individual HCPs favour particular subject positions, they also switch between them in different discursive contexts, and I suggest that there are particular contexts in which HCPs are more likely to position themselves as ‘experts’, who should assess (and potentially, alter) women’s reproductive decisions.

The two remaining empirical chapters go on to explore these contexts in greater detail. Chapter Six focuses on the relationship which HCPs construct between different methods of fertility control, and argues that HCPs’ definitions of acceptable reproductive behaviour co-produce definitions of the kinds of people who should, and should not, be reproducing. Chapter Seven addresses the issue of gestational timing and explores the claims to expertise which HCPs mobilise when they question the acceptability of providing abortion to patients at later stages of gestation. Finally, Chapter Eight moves on to draw together the central conclusions of the thesis and outlines its key contributions. In this chapter I will also reflect critically on the limitations of my analysis and outline potential avenues for future research.

1.5 Negotiating a terminological minefield

Numerous STS scholars have revealed the important role played by practices of textual representation in the generation and negotiation of knowledge claims (e.g. Gilbert & Mulkay, 1984; Latour & Woolgar, 1986 (1979); Latour, 1987; Ashmore *et al.*, 1995). Clearly, this applies to social scientific texts as much as scientific ones, and when writing about a topic that is as politically important as abortion it becomes necessary to choose one’s words particularly carefully. In the following discussion I address this issue and explain the reasoning behind some of the terminology which I have used in this thesis.

Essentially, all of these choices stem from an attempt to write about abortion in a way that makes “women’s needs and lives” (Science and Technology Subgroup, 1991: 214) central to the analysis, without suggesting that abortion has a simple,

universal meaning for all women. Nevertheless, although I have tried to be very careful about the words that I use, perhaps the most important point to take away from this discussion is that there is no straightforwardly ‘feminist’ language through which to write about this topic. In part this is because, as Simonds (1996) notes, so many of the words associated with abortion seem to belong to those who want to restrict or otherwise regulate women’s reproductive behaviour. However, it is also because of my awareness of the way in which feminist discourse can become subverted by those with oppositional political goals. As the Science and Technology Subgroup (1991) point out, discourse used to support women’s access to abortion (such as the argument that it is “a woman’s right to choose”) can and has been re-appropriated by those who oppose the practice (e.g., through the argument that “fetuses have rights too”). Clearly, this raises broader questions about the potential ramifications of engaging in and publishing ‘feminist’ research on the subject of abortion, which I return to in the final chapter of this thesis.

One of my key decisions regarding language is that, for the most part, I use the word ‘abortion’ rather than ‘termination’. Although my participants did use both of these words, they clearly preferred the latter, or else used its abbreviated form “T.O.P.” (termination of pregnancy). This preference is also visible in the medical literature on this subject and, arguably, represents an attempt to frame the practice as a technical procedure rather than a political or ethical issue. As I have indicated through the preceding discussion, one of my key aims in this thesis is to problematise narrowly technicist framings of abortion, which is why I favour the word ‘abortion’.

The dangers of homogenising ‘women’ as a category of persons, and of suggesting that abortion has universal implications for all women are highlighted in Chapters Two and Six. Nevertheless, there are times in the analysis that follows where it becomes necessary to find practical, shorthand ways of referring to the group of patients that HCPs interact with in the abortion clinic. One expression which I use is ‘women requesting abortion’, on the basis that the literature suggests most women decide upon this course of action before they enter the clinic, and that they only approach HCPs to ask for access to the procedure (Allen, 1985; Kumar *et*

al., 2004; Lee, 2004). However, in order to acknowledge that some women may be less certain of their decisions than others when they enter the clinic, I also use the expression ‘women with unwanted pregnancies’. Through this expression I mean to indicate that, at this particular point in her life a woman does not want to be pregnant, and it as a result of this situation that she is in the clinic.

At the same time, it is important to acknowledge that the phrase ‘unwanted pregnancy’ is an analyst’s category which does not necessarily capture the complexity of women’s reproductive decision-making. This problem is highlighted by studies which have explored the terms that women use to define their own pregnancies. Fischer *et al.* (1999) suggest that some of their pregnant participants could not relate to this term because the idea that a pregnancy could be “unwanted” was incompatible with their identity as mothers, or as potential mothers. Likewise, Barrett *et al.* (2002) found that women who had decided to have abortions were often reluctant to apply the term “unwanted” to their own pregnancies because, they argued, their pregnancies *were* wanted, but were also impossible at this particular point in time.

The non-neutrality of the language which surrounds abortion becomes most obvious when it comes to attempts to find words for the entities that are aborted. Several of the conscientious objectors that I interviewed argued that any word other than ‘baby’ was merely euphemism, and represented a refusal to acknowledge that abortion involves the destruction of a human person. Other HCPs talked about ‘fetuses’, ‘babies’, ‘products of conception’, ‘the contents of the uterus’ and ‘the pregnancy tissue’, sometimes with clear preferences but often using these terms interchangeably. Throughout this thesis I use the term ‘fetus’ to refer to the entity which exists *in utero*, or which has been aborted whilst *in utero*. I use the term ‘baby’ to refer to an entity which has been born and exists independently of a woman’s body. These separate terms are not chosen arbitrarily, but are intended to emphasise the critical difference in the physical and social location of these entities.

Chapter Two: Theoretical positionings

2.1 Introduction

The discussion in the previous chapter revealed that one form of specialist knowledge, medical expertise, has become central to the way in which abortion is debated and regulated in the UK. I suggested that this continuing deference to medical expertise makes it important to understand how contemporary British HCPs construct their role in decisions about abortion provision. I argued that, by utilising STS theory, it would be possible for me to conduct an analysis of HCPs' accounts without reinforcing the epistemological authority which is granted to these professionals in public fora.

The first section of this chapter takes this issue as its point of departure and addresses the tools which STS has used to theorise the construction of expert knowledge, explaining why some of these are particularly useful in the context of this thesis. The second section of the chapter then goes on to highlight the importance of combining this approach to the study of expertise with the analytical focus provided by feminist STS.

The discussion in the first two sections of the chapter addresses the production of knowledge as the outcome of human action. However, in the final section of the chapter I go on to explain why, in the context of this thesis, it is necessary to create space to conceptualise the non-human, or material, world as an active participant in this process. I argue that Haraway's (1991; 1992; 1997) work makes it possible to create this conceptual space, whilst remaining focussed upon the political outcomes of human interactions with the material world.

2.2 STS and the deconstruction of scientific authority

2.2.1 The politics of expertise

As Barnes and Edge (1982) point out, speakers of established scientific facts are granted extraordinary authority in contemporary western society. Recognising this, STS has often drawn attention to the political dimensions of scientific knowledge

production, and the ways that this process marginalises the perspectives of those who cannot claim to speak as scientific ‘experts’ (e.g. Nelkin, 1992 ; Jasanoff, 1995; Irwin & Wynne, 1996b). Such political dimensions are obvious when science enters the courtroom; the establishment of a witness’s status as an ‘expert’ determines who is a speaker of scientific truth, with immediate repercussions for both plaintiffs and defendants (Jasanoff, 1995).

The politics involved in defining what is to count as expert (i.e. authoritative/legitimate) knowledge also become particularly visible during public controversies that intersect with technoscience and medicine. STS analyses of such controversies have challenged the widespread assumption that negative public reactions to scientific institutions result from publics’ lack of scientific knowledge – the so-called “deficit model” of public understanding (Irwin, 1995). Employing the insights of STS, critical Public Understanding of Science (cPUS) problematises the deficit model and its reliance upon a simplistic, de-contextualised understanding of both science and its’ publics (Irwin & Wynne, 1996a). Although cPUS takes science-public relationships as its empirical focus, it has generated broader theoretical insights concerning the ways that the definition of relevant knowledge or ‘expertise’ can reinforce existing power relations by delineating the epistemological resources that can be used to interpret particular issues.

One of the central arguments of cPUS is that, while the value commitments of various publics are used by policy-makers and scientists as evidence of their irrationality and thus inability to engage with scientific facts, the framing of public issues in terms of scientific ‘facts’ itself embodies commitments to specific values, or ways of living. Wynne (2001) illustrates this argument in the context of policy responses to the widespread public rejection of genetically modified organisms (GMOs). He reveals how attempts to engage in dialogue with publics about this issue proceed from the assumption that the only important risks of GMOs are those which science can predict. As Wynne points out, this assumption represents a commitment to a particular model of society, in which human manipulation and control of the environment is seen to be an achievable and desirable goal. However, this

commitment is rendered invisible by the representation of the scientifically-defined risks of GMOs as objective, and as separable from publics' concerns about this innovation (Wynne, 2001). When this dual move (framing in terms of scientific knowledge, and the denial of the contextual nature of this knowledge) is instead made visible, opposition to GMOs can be explained in terms of publics' *understandings* of the way in which "prescriptive ontologies of human relations, human subjects and society" (Wynne, 2001: 479) are being imposed upon them, in a manner that they are relatively powerless to contest.

In the chapters that follow, I will draw on the insights of cPUS (and particularly the work of Brian Wynne), in order to explore how HCPs' definitions of relevant knowledge (or 'expertise') about abortion co-produce particular understandings of society. The idiom of co-production is now widely employed within many strands of STS as:

...shorthand for the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it. Knowledge and its material embodiments are at once products of social work and constitutive of forms of social life; society cannot function without knowledge any more than knowledge can exist without appropriate social supports. (Jasanoff, 2004: 3)

As I suggested above, the particular value of cPUS is its relational focus (Irwin & Wynne, 1996a). Unlike a great deal of work within STS, it decentres scientific framings by positioning them in relation to alternative forms of understanding. Simultaneously, by retaining an awareness of the wider policy context in which scientific voices are granted legitimacy as experts, cPUS remains sensitive to the power relations which render other perspectives illegitimate.

Both of these points are clearly illustrated by Wynne's (1996b) now classic study of Cumbrian sheep farming in the aftermath of the Chernobyl disaster. Because of the high-level of radioactive rainfall in this area of the UK, restrictions on the movement and sale of lambs were introduced on the advice of government scientists, in order to prevent radioactivity ingested by lambs spreading to humans. These restrictions were initially introduced as a temporary measure; scientists

insisted that radioactive isotopes in the grass would eventually become locked up in the soil, and would thus no longer be available for ingestion by the lambs. However, when this failed to occur, the ban was extended indefinitely (albeit over a smaller area) and it was eventually discovered that scientists had been working with the wrong type of soil in modelling the movement of isotopes. Wynne reveals how, from the perspective of the farmers, this was simply one of a series of incidents where scientists made exaggerated and ultimately false claims to be able to predict and control the hill farming environment, with serious implications for farmers' livelihoods. Wynne also demonstrates that, in their determination to conduct laboratory-style experiments, government scientists persistently ignored farmers' advice concerning crucial aspects of this environment, e.g. about the behaviour of sheep. Scientists thus failed to acknowledge the assumptions about prediction and control that were embedded in their own approach to the production of knowledge. Simultaneously, they imposed these assumptions on farmers, who were relatively powerless to challenge them. In doing so, Wynne argues, they alienated those who they were supposed to be helping:

...the typical scientific idiom of certainty and control was culturally discordant with the farmers, whose cultural ethos routinely accepted uncertainty and the need for flexible adaptation rather than prediction and control. (Wynne, 1996b: 26)

Crucially, in developing his critique of the imposition of scientific frameworks of understanding, Wynne does not deny that scientific knowledge is a useful and important resource. To illustrate the ontologies performed by scientific knowledge claims is not to suggest that such knowledge is somehow false (Wynne, 2002). Rather, it is to draw attention to the fact that, like any form of knowledge, it is developed within a particular context, and co-produces commitments to a particular kind of society (Wynne, 2002). Highlighting this means that, instead of taking scientific knowledge and its commitments as an automatically superior framework of meaning, it becomes possible to acknowledge and discuss a diversity of understandings of issues such as environmental 'risk' (Wynne, 2002), or, in the case of this thesis, abortion.

2.2.2 A new approach to expertise?

While they acknowledge the value of the approaches considered in the previous subsection, Collins and Evans (2002) have recently argued that STS needs to move beyond deconstructing scientific claims to expertise. They suggest that this move is necessary because, while STS has revealed that the designation of ‘expert’ status is a social process with political ramifications, it has so far failed to offer any means of identifying those who have legitimate claims to this status. They advocate the development of a theoretical approach which would allow STS to make normative claims as to who possesses the expertise necessary to contribute to “technical decision-making”. They use this term to describe:

Decision-making at those points where science and technology intersect with the public domain because the issues are of visible relevance to the public: should you eat British beef, prefer nuclear power to coal-fired power stations, want a quarry in your village, accept the safety of anti-misting kerosene as an airplane fuel, vote for politicians who believe in human cloning, support the Kyoto agreement and so forth. (Collins & Evans, 2002: 236)

However, in responding to Collins and Evans, Wynne (2003) points out that their normative theory of expertise automatically co-produces normative definitions of the policy decision-making process. By focussing on the expertise required for “technical decision-making”, Collins and Evans reinforce assumptions central to UK policy culture, namely, that when it comes to issues involving science and technology, the most crucial questions are ‘technical’ ones. Moreover, Collins and Evans argue explicitly that such questions can be addressed separately from ‘political’ or ‘ethical’ questions. As outlined above, Wynne has shown that it is precisely this prescriptive process of issue definition which closes down space for discussion and generates public resentment.

Wynne’s (2003) critique of Collins and Evans’s approach to expertise also resonates with the arguments that I set out in Chapter One. Drawing on feminist critiques I suggested that a central problem with UK abortion law and debate is that it takes technical questions about the current status of medical science as the only relevant starting point from which to discuss issues such as the upper time limit on abortion (Science and Technology Subgroup, 1991; Sheldon, 1997). This technicist

framing has led to a focus on medical questions concerning the survival rates of premature babies, and has made it very difficult to discuss abortion as a question of gender politics. In this context, adopting Collins and Evans's (2002) attempt to define new boundaries around what is to count as technical expertise would simply perpetuate the assumption that such "technical decisions" are what is at stake.

Given that the definition of expert knowledge inevitably co-produces "prescriptive ontologies of human relations, human subjects and society" (Wynne, 2001: 479), my thesis deliberately eschews any attempt to classify or measure claims to expert knowledge. Instead, I will explore the *construction* of expertise, i.e. the knowledges which HCPs' designate as authoritative/legitimate, and the realities that are performed through this process.

2.2.3 Expert-lay asymmetries?

However, a recent critique of cPUS, and in particular, the work of Brian Wynne, raises questions about my use of this work to explore the accounts of those working within the institutions of technoscience/medicine, e.g. HCPs. Durant (2008) suggests that, in contrasting the behaviour and understanding of members of scientific institutions with their publics, Wynne posits an essential difference between two types of actor. Members of scientific institutions are critiqued for their inability to recognise the social commitments which are co-produced by their knowledge claims, and which they impose on the public (Durant, 2008). In contrast, publics are constructed as actors who are intrinsically more reflexive about the basis and commitments of their own, and other actors', knowledge (Durant, 2008).

In his response to Durant, Wynne (2008) contests the suggestion that he claims any essential difference between the reflexive capacities of scientists and other publics. In the first place, he suggests that Durant has misinterpreted the primary focus of his critique. He draws a distinction "between "science" as research scientific knowledge-culture, and "science" as aspirant public authority knowledge" (Wynne, 2008: 24). He notes that, while he has always recognised that his work addresses the latter cultural form of science, critics such as Durant conflate the two,

thus ignoring a vast body of STS literature which has illustrated the complexities, tensions and enforced reflexivity generated by involvement in day-to-day scientific *practice*. Focussing on this distinction, Wynne implies that his critiques of the unreflexive imposition of scientific framings upon publics do not centre on the individuals working within scientific institutions. Rather, they aim to draw attention to the way in which, without any debate, science is simply treated as a *de facto* resource for policy decision-making (Wynne, 2008).

However, Wynne also argues that, in comparison to members of scientific institutions, lay actors *are* far more likely to reflect upon the socially contingent basis of their own and other actors' claims to knowledge:

In the situations where I have analyzed public-science interactions, in all of which cases science was being enacted as attempted but contested public authority, over far more than scientific propositions alone, the relative extent of self-reflexivity was, as I described it – much greater for the powerless publics on the receiving end, than it was for the scientists embedded as they were as agents in the institutional nexus of policy, science advice, political economy, and power. But this does not mean this difference was a reflection of essential qualities of their subjects. Just to clarify, I would continue to assert this difference, but not remotely as the claim which Durant takes it to be, a claim of *intrinsic ontological* difference of reflexivity between scientists and publics. Instead I cleave to just what I stated it to be in the “buried” footnote: actors' reflexivity as a function of their situational power and related social-institutional conditions. (Wynne, 2008: 24)

Like feminist standpoint theorists,¹⁵ claims that those who are most oppressed by structuring systems of inequality can visualise these structures most clearly, Wynne's assertion that actors' reflexivity is a function of power relations is very tempting. However, Haraway (1991) has revealed the dangers involved in pursuing this line of argument. As she points out, claims concerning the clearer vision of the 'oppressed' perpetuate the problematic belief that there is one form of vision that enables its possessor to see the world as it 'really' is. Aware that *any* claim to absolute objectivity can ultimately become a tool of oppression, Haraway (1991) introduces the term “situated knowledges” in order to emphasise the partial basis of all

¹⁵ A critical overview of feminist standpoint theory is provided by Harding (1986).

knowledge claims; these are inevitably produced by *somebody*, situated *somewhere*.¹⁶

Haraway's (1991) work forms a useful corrective to Wynne's tendency to suggest that lay actors' social positioning provides them with privileged epistemological insights. However, her analysis is also attractive because it insists that emphasising the situated basis of all knowledge claims is not synonymous with political relativism. Rather, situating knowledge claims *ensures* that we engage in "power-sensitive [...] 'conversation(s)'" (Haraway, 1991: 195), by recognizing the location of particular speakers, and thus their potential to impose their definitions of reality upon others. In the following discussion I will go on to explain why, in addition to this aspect of Haraway's work, I have used other key insights from feminist STS in developing a theoretical framework through which to analyse HCPs' accounts.

2.3 Medical practice as the (re)production of gender? Insights from feminist STS

As outlined above, many STS researchers have addressed science and technology and their role within society as political issues, with cPUS providing particularly useful analytical tools in this respect. However, from the late 1970s onwards, feminists have argued that technoscience/medicine is implicated in understandings of sex and gender,¹⁷ in ways that impact disproportionately on the lives of women. While some examples of this type of research were highlighted in Chapter One (e.g. the ways in which medical knowledge has been mobilised in attempts to limit women's access to abortion), in the following discussion I clarify what I mean by claiming to adopt 'feminist STS' as a theoretical lens through which to analyse HCPs' accounts of abortion practice.

¹⁶ The partiality of my own perspective will be discussed as a topic in its own right in Chapter Three.

¹⁷ In employing the terms 'sex and gender', I do not mean to essentialise either of them, and recognise that *both* sexed bodies and gender identities are now treated by gender theorists as performative accomplishments (Butler, 1990), rather than as fixed attributes of human beings.

Before beginning this discussion, it is important to explain and qualify my decision to adopt the term ‘feminist STS’. I am using this term as a broad label to encompass a diverse literature that shares a particular orientation to the study of technoscience/medicine, i.e. as socially and historically specific practices which are amenable to gender-sensitive analysis. However, I recognise that this is my own categorisation, and that the literature discussed here is the product of a number of fields of academic research. As such, it is important not to overemphasise its homogeneity (McNeil, 2007). Additionally, I acknowledge that some of the authors cited would not describe themselves as practitioners of feminist ‘STS’. In part this is a reflection of the ambiguous boundaries of STS, as well as the various names this type of research goes by (e.g. science studies, history of science/medicine, social/cultural studies of science, technology studies etc.).¹⁸

Although this field of scholarship has explored many forms of technoscience and medicine, it has often addressed medical practices that are centred upon women’s reproductive bodies. In the first sub-section below, I outline some of the central narrative threads which run through feminist research on this topic, in order to exemplify the theoretical argument that medical practice is produced by, and productive of, understandings of sex and gender, in ways that have particularly significant consequences for women. The second half of the discussion then goes on to explore some tensions in this body of feminist literature, and reflects on the significance of these tensions in the context of this thesis.

2.3.1 Shared understandings

One central and recurring theme within feminist STS is the way in which scientific authority rests on claims to be able to represent nature, in terms that are saturated with cultural understandings of gender. For example, in *The Death of Nature*, Merchant (1982) reveals the significance of the way that the seventeenth century Scientific Revolution redefined the symbolic meaning of nature in western culture. From being viewed as an active, nurturing (female) force, nature became

¹⁸ As Law (2008) notes, it is important not to dismiss the significance of these alternative designations, which are often used to signal nuances in theoretical and/or methodological approach.

reconstituted as a passive (female) object, to be explored and improved upon by (male) scientific enquiry (Merchant, 1982). Likewise, Jordanova describes the rise of the Enlightenment view of progress during the eighteenth and nineteenth centuries, in which “human history, the growth of culture through the domination of nature, was represented as the increasing assertion of masculine ways over irrational, backward-looking women” (Jordanova, 1989: 37). She reveals how gendered symbolism permeated the pursuit of scientific and medical knowledge, which was repeatedly characterised as the scrutiny and control of female nature by a male gaze.¹⁹

Merchant (1982) also argues that changing conceptualisations of nature were central to the way in which the male medical profession managed to expand its practice into an area previously designated as ‘women’s work’ – midwifery – during the eighteenth and nineteenth centuries. She describes how nature/culture, female/male dualisms were employed by male medical practitioners in their attempts to discredit and displace female midwives: “the midwife symbolised female incompetence in her own natural sphere, reproduction, correctable through a technology invented and controlled by men – the forceps” (Merchant, 1982: 155).

As McNeil (2007) points out, the invention and use of forceps in childbirth has itself become routinised as a starting point in feminist narratives about how, alongside the professionalisation of medicine, women’s reproductive bodies became subject to increasing technological intervention over the nineteenth and twentieth centuries. Such narratives often highlight the discrepancy between the treatment of men’s and women’s bodies, and suggest that the association of nature with women’s bodies has positioned them as natural objects of scientific enquiry and medical intervention (e.g. Jordanova, 1989; Jacobus *et al.*, 1990; Oudshoorn, 1994; Oudshoorn, 2003). This discrepancy is rendered particularly clear by Moscucci (1993), in her history of the way that gynaecology (*The Science of Woman*) emerged as a medical specialism in the UK. Strikingly, she begins this history by

¹⁹ However, Jordanova also recognises the instability of this kind of dualistic thinking, which is full of tensions, not least because ‘nature’ is a symbolic resource that can be drawn upon in multiple, often contradictory ways (Jordanova, 1989: 41-2).

pointing out that, even today, there is no corresponding medical specialism concerning the 'science of man'.

In studying the practices of gynaecology as an emerging medical specialism, many feminist historians have argued that such practices were themselves significant in re-defining the meaning of women's bodies. By the close of the nineteenth century, these were treated as intrinsically pathological entities dominated by the activities of their reproductive organs (Douglas Wood, 1974; Smith-Rosenberg, 1974; Ehrenreich & English, 1979; Showalter, 1981; Digby, 1989). Moscucci (1993) suggests that these developments in medical practice reflected and reproduced prevailing anxieties about the structure of society. Concerns were emerging about the large workforce required to support Industrialisation, leading to greater scrutiny of women's health and the process of reproduction (Moscucci, 1993). Additionally, inequalities between men and women had become increasingly hard to reconcile with the liberal values of the Enlightenment (Moscucci, 1993), as evidenced by the emergence of the 'first wave' of feminism in the second half of the nineteenth century. This movement questioned the inevitability of women's confinement to the domestic sphere. In contrast, the 'discoveries' of medical science represented a means of understanding the different roles of men and women in terms of natural, dichotomous differences between two types of sexed bodies, with women's reproductive organs preventing them from entering the workplace or higher education (see also Smith-Rosenberg, 1974; Ehrenreich & English, 1979; Digby, 1989).²⁰

Interestingly, Boyle (1997) suggests that a long history of scientific attempts to define women's 'difference' from men is reflected in the framework through which abortion was legalised in the UK in 1967. At this time, doctors were predominantly male, and it was they, rather than women, who were depicted as responsible and rational concerning decisions about abortion:

²⁰ Several authors have noted the class biases intrinsic to this definition of women's health. It clearly applied only to women of the middle and upper classes because "a continuing need for the hard physical labour of working class women made their exclusion from the 'female equals frailty' equation socially desirable" (Digby, 1989: 214).

Women's lack of moral judgment, their emotionality and their psychic and physical delicacy were therefore part of a unified system of thought in which woman's 'body' was – and is – a signifier of the negative (right-hand) poles of culture-nature, reason-emotion, strength-weakness, active-passive. It was this theoretical unity which enabled many participants in the abortion debates to bypass the sensitive issue of women's status as moral agents, but nevertheless to remain within a construction of woman as weak and as not to be trusted with the abortion decision. (Boyle, 1997: 43)

However, while the prominence of women's reproductive bodies in medical discourse is a feature of much feminist historiography of the nineteenth and early twentieth centuries, research addressing contemporary medical practice is often concerned with the erasure of women's bodies and needs from dominant discourses about conception, pregnancy and childbirth. A major focus of such research is the so-called new reproductive technologies (NRTs), a term which has "emerged as a collective designator of the range of reproductive technologies that became available from the 1960s onwards" (McNeil, 2007: 73) in western countries. Although this literature has explored a range of technologies, including hormonal contraceptives and abortifacients, 'assisted' conception,²¹ prenatal screening and diagnosis (PNS/D),²² fetal surgery, and hospitalised childbirth, it seems to centre upon three related themes, as follows.

Firstly, in many cases, concerns have been raised about the interests served by the design, control and implementation of NRTs, and the marginalisation of women's needs and voices throughout this process (e.g. Clarke, 2000). While these technologies are often introduced as a means of improving reproductive 'choice', feminist critiques emphasise that, in a context where women continue to have primary responsibility for childcare, these technologies may simply introduce new

²¹ This term has been used to refer to a variety of procedures used to treat male and female infertility, ranging from simple techniques like donor insemination to more invasive ones such as *in vitro* fertilisation (IVF).

²² I use the term prenatal screening to refer to the less invasive processes (e.g. blood tests and fetal ultrasound) which are used initially to assess a pregnancy's 'risk' of producing a baby with particular health problems. Prenatal diagnosis refers to techniques then used to provide a more definitive diagnosis, which are often more invasive and associated with a risk of miscarriage (e.g. amniocentesis or chorionic villus sampling). As Rapp (2000) points out, even diagnostic technologies can only provide limited information; in many cases they tell prospective parents nothing about the quality of life associated with particular conditions (e.g. Down's syndrome).

forms of gendered responsibility. This critique has been particularly marked in the case of PNS/D (e.g. Rothman, 1988; Lippman, 1991; Ettorre, 2000). Few of the fetal ‘abnormalities’ detected *in utero* through PNS/D can be treated, which means that the only options are to terminate the pregnancy, or continue with the knowledge of the diagnosis, and the lack of social support available to those living with disabilities (e.g. Rothman, 1988; Lippman, 1991; Shakespeare, 1998; Ettorre, 2000). In spite of this, these technologies have become routinised as part of antenatal care – a setting which focuses on women’s obligations to *ensure* fetal ‘health’ (Press & Browner, 1997). Lippman argues that:

...to the extent that she is expected generally to do everything possible for the fetus/child, a woman may come to “need” prenatal diagnosis [...] With prenatal diagnosis presented as a “way to avoid birth defects,” [*sic*] to refuse testing, or perceive no need for it, becomes more difficult than to proceed with it. This technology perversely creates a burden of not doing enough, a burden incurred when the technology is *not* used.
(Lippman, 1991: 28)

Within this context, critics of PNS/D argue that the routinisation of these technologies has restricted, rather than increased, women’s reproductive choices. In her analysis of this process, Ettorre (2000) points to the wider interests that are served by restricting women’s ability to ‘choose’ to give birth to disabled babies, who will require extra social, economic and medical support.

A second manner in which NRTs are said to reinforce existing gendered divisions of labour around reproduction is the ways in which they, almost universally, place a greater burden on women’s, as opposed to men’s, reproductive bodies. This issue is often highlighted by feminist literature which has addressed IVF, a physically demanding and invasive technique which is applied to the bodies of women, but which is often used to address problems with men’s fertility (Franklin, 1997; van der Ploeg, 2001; Thompson, 2005). It is also a central theme in literature which has addressed the development of new contraceptive technologies, particularly hormonal contraceptives. The female pill is popularly celebrated as a technology which has given women ‘control’ over their own fertility. However, the routinisation of the female pill and the subsequent development of hormonal contraceptives targeted towards women’s bodies, has led to a strong association between femininity

and responsibility for contraception, along with its associated health risks (Oudshoorn, 1994; Oudshoorn, 2003). As Oudshoorn (2003) demonstrates convincingly, the rigidity of this gendered association has created barriers to the development of contraceptive technologies for men.

A third theme which emerges from feminist engagement with NRTs is the way in which technologies applied to women's reproductive bodies have focussed attention away from these bodies and their material labour, and towards the 'products' of this labour (Martin, 1989), i.e. embryos, fetuses and babies. The discussion in Chapter One suggested that one way in which the development and use of NRTs has led to the erasure of women from discussions of pregnancy is through the dismissal of women's embodied accounts of this process. For example, Duden reveals that, in eighteenth century Europe, women's experiential knowledge was central to medical understanding and treatment of pregnancy. Particular importance was attached to 'quickening' (i.e. the point at which a pregnant woman becomes aware of the fetus moving inside her) as the only reliable means of determining whether conception had taken place (Duden, 1993; Duden, 1999). In contrast, modern obstetrics no longer relies on women's accounts of their embodied experiences because ultrasound has given physicians direct access to the fetus (Duden, 1993; Duden, 1999). In Chapter Seven of this thesis, I will describe how the HCPs that I interviewed also used ultrasound imaging as a means of asserting their authoritative status as 'experts', who are better placed than pregnant women to assess the significance of the fetus.

Feminist concerns about the erasure of women's bodies from discussions of pregnancy and childbirth have been directed towards a range of NRTs which address the fetus as an object of medical attention in its own right. However, of all the technologies directed towards the fetus *in utero*, fetal ultrasound has undoubtedly attracted more feminist attention and critique than any other.²³ In her seminal essay

²³ Other examples include PNS/D and fetal surgery. Feminist critiques of the latter practice centre upon its experimental status, as well as the way in which it positions pregnant women as obstacles/containers which must be breached to facilitate treatment of the fetus *in utero* (Casper, 1998; van der Ploeg, 2001; Williams, 2005).

on this topic, Petchesky argues that “fetal imagery epitomizes the distortion inherent in all photographic images; their tendency to slice up reality into tiny bits wrenched out of space and time” (Petchesky, 1987: 62). She critiques the dominant visual representation of the fetus²⁴ as “solitary, dangling in the air (or in its sac) with nothing to connect it to any life support system but ‘a clearly defined umbilical cord’” (Petchesky, 1987: 61). In other words, fetal images erase the pregnant woman, thus allowing us to forget that the fetus exists only because of her body. This process of erasure has been pivotal in the anti-abortion movement’s attempts to represent the fetus as an individual deserving of protection, and thus to impose restrictions on the behaviour of women who are, or who could become, pregnant (Petchesky, 1984; Petchesky, 1987; Science and Technology Subgroup, 1991; Daniels, 1993; Hartouni, 1997; Sheldon, 1997; Stabile, 1998; Zechmeister, 2001; Hopkins *et al.*, 2005).

2.3.2 Productive tensions

Although the previous discussion presented a uniform ‘picture’ of feminist STS approaches to reproductive medicine, there are many important tensions within this body of literature. To a certain extent, these tensions can be situated historically, as the product of transitions between second-wave feminist theory, and the poststructuralist/postmodernist feminist approaches that emerged from the 1990s onwards (Thompson, 2005), as well as in relation to developments in the ways that STS has approached its subject matter. However, as McNeil (2007) points out, attempts to provide overarching accounts of the history of a field often obscure the diverse voices which have contributed to it, as well as concealing ongoing debate and dissent. Mindful of this insight, in the following discussion I do not claim to provide a definitive account of ‘the history’ of feminist approaches to the subject of reproductive medicine. Instead, by engaging with some of the tensions which characterise this body of literature, I clarify how *I* intend to draw on ‘feminist STS’ as a theoretical approach to the analysis of HCPs’ accounts of abortion practice.

²⁴ It should be noted that Petchesky’s critique refers both to the images produced through fetal ultrasound, as well as to other forms of fetal imagery, for example, pictures of aborted fetuses.

The complexities of 'critique'

A common feature of earlier feminist historiographies of reproductive medicine (e.g. Douglas Wood, 1974; Barker-Benfield, 1977; Ehrenreich & English, 1979), as well as research addressing NRTs (e.g. Arditti *et al.*, 1984; Corea, 1988) is that they tend to produce top-down accounts, wherein medical knowledges and practices are seen to result from the medical profession's or the State's patriarchal, misogynist interests in controlling women's reproductive behaviour. An obvious problem with this mode of critique is its representation of the relationship between HCPs and their patients. HCPs are depicted as agents acting on behalf of a monolithic and deliberately oppressive institution, in relation to which women have only one identity: as its victims.

In contrast, more contemporary feminist work has argued that it is necessary to consider the creative, as well as oppressive, implications of reproductive medical practices. Such practices do not impose straightforward limits or constraints on the forms of existence open to women, but also generate new forms of existence with which individual women engage actively, and reflexively (Sawicki, 1991; Riessman, 1998; Rapp, 2000; Thompson, 2005). In highlighting the agency and voices of women who engage with reproductive medicine (e.g. through the use of NRTs), feminists have also had to take seriously the ways in which it is "about *dreams* as well as *oppression*, and about *women's aspirations* as well as those of *male doctors and scientists*" (McNeil, 2007: 71 - emphasis in original).

In line with this more nuanced approach to women's encounters with reproductive medicine, contemporary literature has also tended to move away from critiquing the medical profession as a monolithic institution united by patriarchal interests (Thompson, 2005). Thus, for example, feminist scholars have drawn attention to the varieties and complexities of reproductive medical practices, and have highlighted controversies within medical communities both past and present (e.g. Moscucci, 1993; Theriot, 1996; Casper, 1998; Clarke, 1998).

McNeil's (2007) reflections on contemporary feminist approaches to technoscience and medicine illustrate that this shift towards engagement with the complexities of technoscientific/medical practice is not simply confined to studies of reproductive medicine. In highlighting this trend, one of the examples that she cites is Mol's (2002) ethnography of the diagnosis and treatment of lower-limb atherosclerosis. Mol argues that major insights and possibilities are lost when social researchers position doctors as objects to be studied and critically judged from afar, rather than as academic colleagues with whom it is possible to engage in positive and productive dialogue.

Related arguments concerning the insights generated by a move away from critique in favour of closer 'understanding' are also articulated by Graham (2006), who makes this point in her analysis of sociological approaches to the medical profession. Graham is concerned that overly critical sociological analyses make it impossible to capture and theorise the emotional complexities of certain areas of medical practice. She advocates the adoption of a more "compassionate" approach in order to understand how doctors manage to "participate in unpleasant, distressing or even abhorrent tasks" (Graham, 2006: 44), such as the performance of feticide²⁵ in cases of fetal abnormality.

This kind of compassion and understanding is often expressed by researchers who have explored HCPs' and scientists' views about working in controversial areas of reproductive medicine, such as prenatal diagnosis (Williams *et al.*, 2002a; Williams *et al.*, 2002b; Williams *et al.*, 2002d; Williams *et al.*, 2002c; Farsides *et al.*, 2004) and embryo diagnostics and research (Wainwright *et al.*, 2006; Ehrich *et al.*, 2007; Ehrich *et al.*, 2008). Rather than developing a critical analysis of the accounts of these practitioners, this body of literature draws attention to the complexity of their day-to-day work, arguing that such work generates ethical and emotional dilemmas that are rendered invisible by the simplistic terms of public debate. Related arguments have been made by researchers in the US, who argue that HCPs' concrete

²⁵ Feticide is a procedure often performed before abortion at later gestations of pregnancy. It refers to the ultrasound-guided injection of potassium chloride through the pregnant woman's abdomen into the fetal heart, to stop it beating before the abortion.

experiences of abortion provision are not captured by the polarised terminology of the US abortion debate (Roe, 1989; Simonds, 1996).

However, as McNeil (2007) cautions, there is a serious danger that, in attempting to empathise with and understand existing cultures of technoscience/medicine, feminist researchers will simply *align* with them. In other words, they may lose the critical ‘outsider’ perspective that is required in order to argue for political change (McNeil, 2007).

Throughout the chapters that follow, I will highlight and attempt to negotiate the risks posed by the alternative temptations of “critique and enmeshment” (McNeil, 2007: 146). I aim to find a position from which to remain sensitive to the contexts from which HCPs are speaking, without becoming so “enmeshed” in this context that the possibility of productive political critique disappears from view.

Destabilising essentialisms

The discussion in section 2.2.1 revealed how the treatment of ‘nature’ and ‘culture’ as essential, dichotomous categories forms part of a system of dualisms which have long been used to naturalise hierarchical differences between men and women (Harding, 1986; Haraway, 1991). However, some of the earlier feminist literature on ‘gender’ and ‘science’ makes use of these dichotomous categories as explanatory analytical resources, thus perpetuating the situation which it sets out to critique. For example, when Merchant (1982) highlights the historical exclusion of women from science, she does so by depicting science as an intrinsically ‘masculine’ project whose goal is the domination of nature and women. In doing so, she reifies numerous problematic dichotomies such as feminine/masculine, and nature/culture (Faulkner, 2001).

Recognising this difficulty, and responding to insights from gender theorists such as Judith Butler (1990), contemporary feminist studies of technoscience/medicine tend to avoid reifying or essentialising categories of meaning such as ‘nature’ or ‘gender’ in favour of exploring how these categories, and their

political effects, are constructed, or ‘performed’ in practice (e.g. Haraway, 1991; Faulkner, 2001; van der Ploeg, 2001; Roberts, 2007). Crucially, this approach undermines the power of appeals to ‘nature’ or ‘biology’ as explanations for the differential treatment of men and women, by revealing the constructed character of such essentialist categorisations. In doing so, it also highlights the possibility that we could construct the world very differently.

The problems generated by reifying particular categories of meaning are evident in some of the existing feminist literature which has addressed abortion law and provision in the UK. For example, although Boyle provides an important critique of the way that the Abortion Act frames abortion as a matter for the expertise of medical professionals, she does so by arguing that “...the abortion decision clearly involves factors beyond the medical” (Boyle, 1997: 63). Similarly, Sheldon suggests that “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” (Sheldon, 1997: 25). Although these authors are attempting to undermine the legitimacy of medical expertise by highlighting the ‘other’ factors relevant to abortion decisions, such reification of what is to count as ‘medical’ or ‘technical’ expertise is ultimately counterproductive. By failing to interrogate the classification of what is to count as ‘medical/technical’ knowledge as a social process with political effects, they imply that practitioners of science and medicine *do* possess a sphere of authoritative knowledge which is not amenable to feminist critique. In light of this problem, and the insights of feminist STS, my thesis will instead explore how what is to count as ‘medical’ or ‘technical’ about abortion is *constructed* by those involved in its provision.

Feminist attempts to destabilise essentialisms and binaries often seem to resonate with the approach advocated by Actor-Network Theorists. While an enormous body of literature could now be considered as part of ‘Actor-Network-Theory’ (ANT), this tradition began with the work of Latour and Woolgar (1986 (1979)), Latour (1987), Callon (e.g. 1986), and Law (e.g. 1986). An important move made by ANT is that, rather than asking ‘why’ certain knowledge claims are treated

as scientific facts, it asks 'how' this is achieved (Law, 2008). This represents an alternative focus to the Strong Programme of the Sociology of Scientific Knowledge (e.g. Bloor, 1976), which defines the status of 'society' and then uses this to explain the content of scientific knowledge/practice. As Callon and Latour (1992) point out in their debate with Collins and Yearley (1992), the latter type of causal explanation artificially separates 'society' and 'nature,' and unreflexively privileges sociologists' knowledge of society as a basis for explaining scientists' knowledge of nature. They suggest that studies of scientific knowledge production should instead address how this process reconfigures the world, so that what is held to be 'natural' or 'social' is altered (Callon, 1986; Latour, 1987; Callon & Latour, 1992).

By eschewing the reification of 'nature' and 'society' as binary analytical resources, in favour of understanding the processes through which certain versions of reality become performed as 'natural' (i.e. scientific) fact, ANT seems highly compatible with feminist concerns. However, as Haraway points out, ANT theorists (as well as other STS scholars)²⁶ sometimes seem to operate with troublingly narrow concerns about the realities performed through technoscientific/medical practice:

Correctly working to resist a "social" explanation of "technical", [sic] practice by exploding the binary, these scholars have a tendency covertly to reintroduce the binary by worshipping only one term – the technical. Especially, any consideration of matters like masculine supremacy or racism or imperialism or class structures are inadmissible because they are the old "social" ghosts that blocked real explanation of science in action. (Haraway, 1992: 332, n14).

Through its technicist focus, this type of analysis ignores an issue which has long been central to feminist STS scholarship, namely, the ways in which "systems of exploitation might be crucial parts of the "technical content" of science" (Haraway, 1992: 332, n14).

Theorising fetal/pregnant bodies

In highlighting the contingencies of categories of meaning which are normally taken for granted as 'natural', contemporary feminist studies of reproductive medicine have

²⁶ It should be noted that Haraway does not actually refer to the term 'ANT' in her critique but rather to the work of STS authors who are associated with this approach, such as Latour.

engaged fruitfully with feminist theories of the body (e.g. Butler, 1990) in order to destabilise its treatment as a fixed material entity determined by 'biology' (Wajcman, 2000). This perspective has been employed by feminists who have challenged biomedicine's claim to 'know' the fetal body by revealing the different fetal bodies which have materialized across different cultures (Conklin & Morgan, 1996; Casper, 1998) and time periods (Duden, 1993; Duden, 1999; Morgan, 1999). For example, Duden (1993; 1999) demonstrates that the fetal patient/person of biomedical discourse was simply not part of the experience of an eighteenth-century pregnancy in the west:

What we today perceive as an abortion, a 'miscarriage', or the premature birth of a fetus, then in the eighteenth century, could be perceived as emitting bad blood, the birth of a mole, a moon-calf, as 'cleansing' of the womb, or as healthy flux against unhealthy stoppage. (Duden, 1999: 16)

As described above, Duden (along with other feminist theorists) also positions the emergence of the modern fetal body as part of a process which has led to the denigration of women's embodied knowledge of their pregnancies.

However, Michaels (1999) suggests that Duden's account contains an unacknowledged asymmetry in its treatment of fetal vs. women's bodies, and that this asymmetry is characteristic more generally of feminist approaches to pregnant embodiment. She suggests that, in deconstructing the modern fetus, feminists often have an unacknowledged goal, which is to reveal contemporary fetal bodies as somehow "less real" or "more contingent" than pregnant women's bodies. She argues that this position is epistemologically unsustainable because, once it is accepted that embodiment is culturally and historically specific, both fetal bodies and women's bodies must be understood in terms of this context-specificity; the latter cannot be treated as any less 'constructed' than the former (Michaels, 1999). A similar point is made by Petchesky (1987), when she suggests that women's embodied experiences of contemporary western pregnancy (or abortion) are partly produced *through* the experience of living in a society which also contains the individualised, free-floating fetus of ultrasound imagery (see also Morgan, 1996).

Recognising this point, in the chapters that follow I will try to avoid the temptation to apply the constructivist tools of STS in a selective or asymmetric manner. As Haraway (1997) points out, accepting the contingency of all forms of embodiment (and likewise, claims about what is ‘real’ or ‘natural’), need not detract from the possibilities of engaging politically with the ways in which bodies are produced, and the forms of existence which become possible (or impossible) through their production:

These ontologically confusing *bodies*, and the practices that produce specific embodiment, are what we have to address, not the false problem of *disembodiment*. Whose and which bodies - human and non-human, silicon based and carbon based - are at stake, and how, in our technoscientific dramas of origin? (Haraway, 1997: 186 – emphasis in original)

Universal ‘woman’?

A central move that is made by postmodernist feminist theory is to highlight the difficulties involved in treating ‘women’ as a homogeneous category of persons who have a shared experience of oppression. As Haraway (1991) points out, feminist projects which start by assuming women’s sameness are often attempts to obscure highly salient differences produced by the intersection of multiple structuring systems of inequality (see also Harding, 1986; Butler, 1990). The significance of this point has not been lost on feminists studying NRTs, and other reproductive issues, and is reflected in their attempts to engage with the nuances and complexities of reproductive politics.

For example, in an edited collection of essays, Ginsburg and Rapp highlight the processes through which “some reproductive futures are valued while others are despised” (Ginsburg & Rapp, 1995: 3). Similarly, Hill Collins (1998) reveals that contemporary family planning policies in the US are geared towards the reproduction of some forms of life, and not others.²⁷ She argues that, while wealthy white women are encouraged to bear and raise more children, white working class women are frequently persuaded to give up their babies for adoption by white middle

²⁷ For an earlier analysis of this phenomenon see Petchesky (1984).

class families (Hill Collins, 1998). Simultaneously, working class African-American women are generally offered no reproductive ‘choices’ other than sterilisation and long acting contraceptives such as Depo-Provera (Hill Collins, 1998). Roberts (1998) illustrates that similarly discriminatory reproductive policies are part of the US judicial system. Focussing on pregnant crack cocaine addicts who are prosecuted for endangering their fetuses, she questions the law’s claim to be concerned with fetal well-being. She points out that the pregnant addicts who are prosecuted are disproportionately black and poor, and suggests that their prosecution is a form of punishment for their decisions *not* to have abortions. In other words, these women are being punished because they have persisted in their attempts to become mothers (Roberts, 1998).

In view of such insights, in the analysis that follows, I aim to avoid suggesting that “women” are somehow a universal, homogeneous, category of person, or that the practice and control of abortion has any one, straightforward meaning. Instead, I will focus on the *various* forms of subjectivity for “pregnant women” that HCPs’ claims to expertise make possible. This includes paying attention to the distinctions which are made between the desirability of different kinds of “reproductive future” (Ginsburg & Rapp, 1995) – a topic which is the primary focus of Chapter Six.

2.4 Making space for materiality

Constructivist approaches are clearly indispensable tools for feminist theory in its attempts to destabilise essentialisms, and to underline the potential for political change. However, to suggest that the production of reality is entirely dependent on human action, “is to place humans above all other entities, including the living and non-living, and to position the non-human world as passive” (Roberts, 2007: 23). It is precisely this positioning which has allowed science and medicine to claim the authority to represent the ‘truth’ about the world, in ways that have been problematic both for women and many other entities (Haraway, 1989; 1991).

In addition to the problems posed by positioning the world as a passive resource for scientific representation, there are two further reasons why, in terms of the aims of this thesis, it is necessary to create space to conceptualise reality as something more than the outcome of human negotiation. Firstly, it is unlikely to have gone unnoticed that, throughout the preceding discussion, I have simultaneously referred to the socio-historical contingency of bodies, whilst taking it for granted that there are only certain kinds of bodies which can become pregnant. In making the second, apparently contradictory, move, I am arguing that there *are* limits to the possibilities of bodies, and that these can have major consequences for the lives of particular people. However, in order to avoid suggesting that these limits are straightforwardly fixed or knowable, I require a theoretical basis from which to hold the constructedness/materiality of bodies together simultaneously.

Such a perspective is also necessary for a second reason. In order to develop an account which is sensitive to the lived contexts in which HCPs work, I cannot treat the targets of this work (e.g. pregnant women, cervixes, legal documents, fetuses) as infinitely malleable human constructs. To do so would make it impossible to gain any analytical purchase on the ways in which HCPs' encounters with material entities are implicated in their depictions of their involvement in abortion practice.

Fortunately, because "science and technology are contexts in which human agents conspicuously do not call all the shots" (Pickering, 1993: 562), STS has often confronted and created space for the nonhuman world in its theory. While many scholars have addressed this issue, it is perhaps best known as a central component of Actor-Network Theory (ANT). However, in the remainder of this discussion, I will argue that, while ANT's inclusion of nonhuman actors is undoubtedly useful, I prefer Haraway's (1991; 1992; 1997) explicitly feminist approach to engagement with the nonhuman world.

Once more, it is necessary to proceed with caution. Any attempt to summarise and critique the enormous and diverse body of writing that has become contemporary ANT cannot hope to do justice (and is likely to do violence) to the

nuances of this theoretical approach. As a result, it is necessary to qualify my misgivings concerning ANT by noting that these are directed primarily towards the tradition as it originally emerged in the work of Latour and Woolgar (1986 (1979)), Latour (1987), Callon (e.g. 1986), and Law (e.g. 1986).

In studying the practices by which particular realities are produced, ANT (as indicated by its name) relies on the concept of networks of interaction between actors which, when done in particular ways, produce particular effects. In exploring these networks of association, ANT deliberately avoids making analytical distinctions between humans and nonhumans (e.g. machines, instruments, animals etc.); all are viewed as potential agents in the webs of interaction through which realities are performed (Callon, 1986; Latour, 1987; Latour, 1988).

ANT undoubtedly makes a radical and theoretically interesting move by bringing nonhuman activities into its analyses. However, as Casper (1994) points out, in making this move, ANT theorists often seem unconcerned about the responsibilities of humans, who are in a position to *define* the status of nonhumans, and the roles that they play in the production of technoscientific/medical knowledge. In other words, by treating all actors equally, ANT neglects critical political and methodological questions concerning human involvement in the representation of nonhuman actors (a similar point is made by Collins & Yearley, 1992).²⁸ Whether nonhumans are being described as agents, whose ‘interests’ scientists must ‘translate’ into their own (e.g. Callon, 1986) or are being ‘discovered’ as the cause of a particular problem by a scientist, a remarkably similar account emerges (Collins & Yearley, 1992). In both cases the actions of the nonhuman world are depicted as something that can be accessed and described by humans. There is no

²⁸ It should be noted that, although they critique the same issue (ANT theorists’ claims to access and describe the actions of nonhumans), Collins and Yearley’s (1992) concerns are very different from those of Casper (1994), and thus, my own. Collins and Yearley are keen to ensure that particular disciplinary boundaries are maintained, on the basis that this is the only way to protect the cognitive authority of STS practitioners. They argue that, by bringing nonhuman actors into its analyses, ANT de-centres the role of humans in the production of technoscientific/medical knowledge and thus undermines STS practitioners’ unique claims to expertise, i.e. to be able to reveal that scientific knowledge is socially determined. At the same time, they suggest that *only* scientists are qualified to investigate the action of nonhuman entities/nature. As Callon and Latour (1992) point out, this line of argument reifies a binary split between the ‘social’ and ‘natural’ worlds, and reinforces scientists’ authority to speak about the latter.

acknowledgement of the fact that these descriptions are acts which impose specific, human, definitions upon the world (Casper, 1994).

In contrast, the work of Donna Haraway provides a very different conceptualisation of humanity's relationship with the nonhuman world.²⁹ Haraway argues that, to avoid treating this world as an object ripe for scientific representation (and thus, human exploitation), we must acknowledge "the agency of the world" (1991: 199), and its frequent *refusal* to comply with human desires and aims:

Richly evocative figures exist for feminist visualizations of the world as witty agent. We need not lapse into an appeal to a primal mother resisting becoming resource. The Coyote or Trickster, embodied in American Southwest Indian accounts, suggests our situation where we give up mastery but keep searching for fidelity, knowing all the while we will be hoodwinked [...] we are not in charge of the world. (Haraway, 1991: 199)

Haraway's approach thus de-centres human agency by arguing that we should develop a humbler, more respectful attitude towards the capacities of the "trickster" world that we inhabit. By treating "the world as witty agent" Haraway (1991; 1992) insists simultaneously that nonhumans are active beings who must be respected as such, *and* that there is no way for humans to encounter or represent their activities in any final, 'objective' form, because "the world" will always elude them. In other words, she acknowledges that human meanings concerning the nonhuman world that they live in are *inevitably* contingent.

Her position on this issue is also clear from her use of the term "material-semiotic actors" as a means of signalling:

the object of knowledge as an active, meaning-generating axis of the apparatus of bodily production, without *ever* implying immediate presence of such objects or, what is the same thing, their final or unique determination of what can count as objective knowledge at a particular historical juncture. (Haraway, 1991: 200)

Like ANT's integration of nonhuman actors into its analyses, Haraway's term "material-semiotic" creates space for the interaction of the material and discursive

²⁹ My use of Haraway's work is indebted to insights gained from reading Roberts (2007), which enabled me to understand Haraway's theorisation of materiality in relation to a concrete empirical context.

(or, nonhuman and human) in the production of what is to count as reality. However, unlike many ANT theorists, Haraway insists that the study of this process should be oriented towards a concern with the *kinds* of realities that are produced, as well as an acknowledgement of human responsibility for this process. Her work consistently addresses questions of power, and the possibility of interacting with the world in ways that result in less human/non human suffering: “lives are built; so we had best become good craftspeople with the other worldly actors in the story. There is a great deal of rebuilding to do” (Haraway, 1992: 300).

By creating space for the actions of the material world, Haraway’s work circumvents the problems that I outlined in the introduction to this section. It allows me to claim that bodies are socio-historically contingent productions that cannot be encountered ‘outside’ of human discourse, whilst acknowledging that these entities are simultaneously produced by material activities outwith human control. It also enables me to consider the material world as an active presence in the abortion clinic, without suggesting that HCPs’ interactions with this world provide them with objective insight into its meaning. This argument becomes particularly important in Chapter Seven, where I consider HCPs’ accounts of their interactions with aborted fetuses. In this context, creating space for materiality allows me to treat the significance which some HCPs seem to invest in their physical encounters with these entities with respect. Nevertheless, Haraway’s emphasis on the *situated* and *elusive* basis of human interactions with the material world prevents me from suggesting that HCPs (or indeed, I) possess privileged knowledge concerning the meaning of these entities. Additionally, her focus on the political outcomes of human interactions with material-semiotic entities enables me to ask questions about the subjectivities made possible for pregnant women through HCPs’ accounts of their interactions with fetal bodies.

However, I deliberately use the term “material-semiotic” *entities*, rather than *actors* throughout this thesis in order to respect the active existence of “the world”, without imbuing it with qualities such as subjectivity or agency which are associated

with the term ‘actor’.³⁰ In doing so, I take note of Casper’s arguments concerning the dangers posed by attributing liberal theories of human agency or subjectivity to contested entities such as fetal bodies:

As a pro-choice feminist from a nation where abortion is one of the most contentious and divisive issues in the public arena, where the fetus has emerged as a major cultural icon (Petchesky, 1987) at the hands of antiabortion forces granting it personhood, and where abortion doctors are now being murdered by “pro-life” terrorists, I am quite resistant to engaging in any practice that grants agency to the fetus. Yet as an analyst of social life, I remain committed to understanding the meaning that my informants attach to this contested material and symbolic entity. (Casper, 1994: 851-2)

2.5 Conclusion

Although this chapter has explored a range of STS literatures, the theoretical approaches that have informed this thesis have one important theme in common. This is the analysis of technoscience/medicine as key sites in the negotiation of what is to count as authoritative (i.e. ‘expert’) knowledge about the world, and a concern with the way in which this process defines the forms of existence open to humans and/or non-humans.

The preceding discussion has revealed the specific theoretical resources that will be used to approach the empirical analysis in the following chapters. These chapters will focus primarily upon the ways that HCPs define the knowledge which is relevant to decision-making about abortion, thus illustrating what HCPs depict as ‘expertise’ in this context. Drawing on the insights provided by cPUS, and particularly the work of Brian Wynne, I will explore the “prescriptive ontologies of human relations, human subjects and society” (Wynne, 2001: 479) co-produced through this process.

Crucially, I am combining Wynne’s work with the theoretical focus provided by feminist STS. In the first place, Haraway’s (1991) theorisation of situated

³⁰ As Roberts (2007) points out, Haraway also recognises these problematic associations. She suggests that she prefers the term ‘actant’ to ‘actor’, because the former is simply associated with ‘activity’, whilst the latter carries the difficult connotations of human agency associated with liberal thought (Haraway, 1992: 331 n.11).

knowledges provides a useful corrective to Wynne's tendency to portray lay actors (i.e. those who are not recognized as legitimate 'experts') as more capable of generating 'reflexive' knowledge by virtue of their social positioning. More broadly, feminist STS analyses serve as an important reminder that the construction of expertise is often a process with *gendered* implications. This perspective enables me to focus upon the construction of expertise about abortion as a process that has particularly significant consequences for the forms of existence open to women who are, or could become, pregnant.

At the same time, feminist analyses of the multiplicity of women's encounters with reproductive medicine also point to the dangers involved in making statements which imply that the implications of HCPs' definitions of abortion are in any way straightforward or universal. These dangers will be born in mind throughout the analysis that follows, and the complexities of reproductive politics are addressed explicitly in Chapter Six.

Finally, as described in the last section of this chapter, I will draw upon Haraway's (1991; 1992; 1997) theorisation of materiality in order to make space for the material world in my analysis of HCPs' accounts. For the majority of the thesis this argument remains implicit, because the practices which HCPs describe centre primarily upon their verbal and/or emotional interactions with their patients or their colleagues. However, it becomes very important in the final empirical chapter, which as indicated above, attempts to conduct a sensitive analysis of HCPs' accounts of their physical encounters with aborted fetuses. Crucially, Haraway's work ensures that, in keeping with the rest of the thesis, my analysis of these accounts remains focussed upon the ontologies that HCPs prescribe as they describe their interactions with material entities.

Chapter Three: Methodology

Methods are not a way of opening a window on the world, but a way of interfering with it. (Mol, 2002: 155)

3.1 Introduction

Having outlined my rationale for this study, and explained the theoretical resources that I am drawing upon, this third chapter moves on to describe the methods through which I generated my empirical data. I begin by providing an account of my decision to use semi-structured interviews as a method of data collection. Following this discussion I go on to explain how I defined and recruited a sample of HCPs to the study, and also provide key background information about the system of abortion provision in central Scotland. In the third section of the chapter I describe the process through which interview transcripts were produced and analysed. To conclude the discussion, I move on to address questions of research ethics, and consider my own position in relation to the HCPs who participated in my study.

3.2 Choosing interviews as a research method

In many ways, semi-structured interviews represented the most obvious data collection method through which to address the research questions outlined in the preceding chapters. This type of interview provides the opportunity to engage in detailed conversations (Kvale, 1996) with individual HCPs, and to explore their accounts of their involvement in abortion provision in considerable depth. However, there are several alternative data collection methods which I could have employed in this research project. In the following section I discuss these alternative methods, and explain why interviews were chosen in preference to them.

One alternative to an interview-based study of HCPs' discourse would have been to use participant observation to write an ethnography of HCPs' involvement in abortion decision-making. Through participant observation, I could have watched and listened to the discursive practices which HCPs *actually* engage in as they interact with their patients. In contrast, by drawing on interview data, I am limited to

exploring the ways that HCPs retrospectively represent their interactions with their patients to me, a professional ‘outsider’.

Nevertheless, it could also be argued that, as a method of data collection, participant observation generates many of the same limitations as semi-structured interviewing. Like interviews, participant observation produces data concerning participants’ discursive practices. The ability to observe these practices in a less artificial setting does not grant the analyst superior insight into what these practices mean or why individuals engage in them (Gilbert & Mulkay, 1984). Additionally, the participant observer, like the interviewer, is still implicated in the practices which research participants engage in. In other words, if I had sat in the room during abortion consultations, or ‘hung out’ on a hospital ward, my presence would still have impacted on the data produced.

However, a critical difference between participant observation and semi-structured interviewing is that, in the context of this study, the former method posed ethical and logistical difficulties which made it untenable. The most fundamental of these problems was that it would not have been possible to observe HCPs’ abortion consultations *without also observing their patients*. When I embarked on this project, I was not convinced that the insights into HCPs’ practice which might be gained from this method of data collection would have justified my intrusion at what is potentially a very stressful time in these women’s lives. In particular, I was very aware of my own inexperience as a researcher and felt that I lacked the skills necessary to negotiate the more sensitive situations that would undoubtedly arise through participant observation. Added to this was the knowledge that gaining ethical approval for a project which impacted upon patients as well as HCPs would be extremely difficult.

Even if I had managed to gain ethical approval for participant observation, logistical problems with this research method would still have posed major difficulties. As described below (section 3.3), GPs are the main gatekeepers to abortion services in Scotland and, for this reason, they represent an important group

of participants. However, unless they are conducting a specialised clinic (e.g. diabetes, baby clinics etc.) GPs do not have any advance notice of the nature of their consultations. As a result, attempting to conduct observations of GP abortion consultations would have meant waiting at a GP surgery until the participating doctor came across a woman requesting the procedure (some GPs informed me this occurs less than once a month). This GP would have then have had to obtain their patient's consent for me to be able to sit in during the consultation and observe/record it. This second problem, of obtaining a sufficient number of consenting patients, would have remained even if I had attempted to observe consultations at a hospital outpatient clinic dedicated to abortion provision.

At the same time, my decision to make use of interviews should not be viewed simply as a negative choice based on the difficulties involved in participant observation. As suggested in the introduction to this section, this was also a positive choice based on the interventions that interviews make possible. The dialogical aspect of interviewing proved vital in allowing me to probe the limits of the discursive possibilities open to participants as they described particular topics. It also allowed me to introduce a broader kind of dialogue, for example by asking HCPs to respond and to engage with recent public debates about abortion. The importance of this approach is highlighted in several of the empirical chapters that follow, and arguably, would not have been available to me if I had conducted this study as a more passive 'observer' of HCPs' practice in the clinic.

Nevertheless, there is an alternative research method which would have allowed me to engage in this kind of dialogue and which might have made a useful contribution to the analysis. Initially, I had envisaged that my research would take place through two phases of fieldwork. The main phase, of approximately forty semi-structured interviews, was conducted as planned. However, I had intended to go on to use the data from this phase of fieldwork as the basis from which to run follow-up focus groups with HCPs. As well as giving HCPs the opportunity to respond to my analysis of the interviews, these focus groups would have provided an alternative context in which to explore HCPs' discursive practices. Although interviews and

focus groups both rely upon conversation as a method of generating data, in focus groups HCPs would have been engaging in discussion with their colleagues as well as with me. Williams *et al.* (2002c) suggest that HCPs may become less reticent about discussing controversial practices (such as deviation from the goal of non-directive counselling) in a focus group setting. They argue that, in this context, HCPs feel reassured and supported by the fact that the difficulties and dilemmas they encounter in their work are echoed by their peers.

In spite of the potential insights that would have been generated through focus group research, I decided not to proceed with this additional phase of data collection for two reasons. Firstly, because the data generated through the forty-two interviews that I conducted was so rich and complex that it represented a considerable analytical challenge in its own right. Secondly, I was aware of the major practical difficulties that would have to be overcome in order to organise focus groups with busy HCPs. As will be described in section 3.3, it often proved difficult to persuade HCPs to find the time for one-to-one interviews. When I discussed the possibility of participating in focus groups, most argued that it would be almost impossible for me to schedule an event that required *multiple* HCPs to be in the same place at the same time. However, in the conclusion to this thesis (Chapter Eight), I return to the issue of focus group research as a potential means of taking the findings of this project forward in future work.

3.3 Defining and recruiting a sample of HCPs

Like decisions about data collection methods, decisions about the construction of research samples cannot be separated from the goals of a particular social research project. In quantitative studies, the aim is to be able to make statistical generalisations from the sample selected for study to its parent population. Such generalisations concern the statistical probability that a phenomenon measured in the sample will be present in its parent population. In order to facilitate this type of analysis, members of the parent population must be selected for study through probability sampling, which means they are “chosen at random and have a known probability of selection” (Ritchie *et al.*, 2003: 78). In contrast, qualitative research

samples are chosen to facilitate an in-depth understanding of a particular phenomenon, within a specific context (Ritchie *et al.*, 2003). As a consequence, questions about the extent to which this sample is statistically ‘representative’ of a broader population are both irrelevant and inappropriate (Lewis & Ritchie, 2003; Ritchie *et al.*, 2003).

This thesis aims to develop a detailed analysis of the discourses employed by a sample of Scottish HCPs during 2007-8, as they described their involvement in (or conscientious objection to) abortion provision. Each of the forty-two HCPs who participated in the study interacts regularly with women requesting abortion (or at least, with colleagues who provide the procedure) outside of the interview setting. On this basis I would argue that individual HCPs’ discursive practices are interesting and significant regardless of how ‘prevalent’ particular practices are within the wider community of HCPs.

However, although it would be inappropriate to talk about the ‘generalisability’ of my findings in the conventional, quantitative sense of this term, I would like to be able to suggest that my analysis of HCPs’ discursive practices is relevant beyond the immediate context of the forty-two interviews that I conducted. In order to make this suggestion, it becomes necessary to address the relationship between my sample of interviewees and its ‘parent’ population, i.e. HCPs in the UK involved in abortion provision. In the context of this analysis, key questions about this relationship concern the way in which the sampling process may have shaped the range of discursive practices that I was able to explore. Did this process lead to the recruitment of an unusually ‘homogeneous’ group of HCPs, thus restricting my ability to address the diversity of subjectivities which HCPs construct for themselves and their pregnant patients in the UK in the early twenty-first century? This issue is considered in the remainder of this section, which provides further information about the selection of my sample of research participants. Ultimately, however, as with any measurement, the answer to what is to count as a ‘diverse enough’ qualitative sample of HCPs remains a matter of social convention.

3.3.1 Why Scotland?

Although abortion laws are uniform across Scotland, England and Wales, there are extreme regional differences in provision. Following the passage of the 1967 Abortion Act, fears that NHS provision would prove inadequate led to the establishment of an independent sector of abortion clinics in England and Wales (Abortion Law Reform Association, 1997). For the most part, this independent sector consists of abortion charities, whose low prices have made it hard for a profit-making sector to become established (Abortion Law Reform Association, 1997). Although these charities play a vital role for women with unwanted pregnancies, their very existence means that local health authorities in England and Wales have choices about the extent to which they provide abortions through NHS services. Although the majority of abortions provided annually in England and Wales are NHS-funded (89% in 2007), more than half of these are provided by the independent sector under NHS contracts (Department of Health, 2008). There is also extreme geographical variation in the relationship between the NHS and the independent sector. For example, 87% of all abortions in Sheffield in 2007 were provided on NHS premises, whereas in Doncaster this figure was 4%, with 93% being carried out by independent agencies under NHS contracts, and 3% being paid for privately (Department of Health, 2008).

Conducting my research in a setting with such a variable NHS/independent system of abortion provision would have introduced layers of complexity that would have been difficult to accommodate within an exploratory, qualitative project. In the first place, it would have been necessary to address the basis of local decisions concerning the level of NHS vs. independent agency/private abortion provision. Research by the Abortion Law Reform Association in 1997 (which is, admittedly, now outdated) points to the potential complexity of such decisions. They uncovered major regional variation in the local ‘cultures’ of gynaecology units and their associated health authorities; these differed in the extent to which they viewed abortion provision as a core part of NHS gynaecology services (Abortion Law Reform Association, 1997). Such local contexts would have to be taken into account in exploring the discursive practices of HCPs, a process which would have become still more complicated if I had wanted to interview HCPs working within more than

one health authority. Additionally, I would probably have had to widen the scope of my research in order to address and compare the accounts of HCPs working for the NHS and independently/privately.

In comparison to England and Wales, on the surface, Scotland offered a less complex and more geographically uniform ‘culture’ of NHS abortion provision within which to base a qualitative study. The majority of abortions in Scotland have always been carried out on NHS premises (Abortion Law Reform Association, 1997), and 99.3% were provided in this manner in 2007 (Information and Statistics Division Scotland, 2008). This different system of abortion provision is reflected in the absence of the two major UK abortion charities (bpas and Marie Stopes International) from Scotland. The bpas (British Pregnancy Advisory Service) is the UK’s primary charitable abortion provider but its only presence in Scotland is one referral clinic in Glasgow, through which women can be referred down to bpas clinics in England for the procedure.³¹ There are no Marie Stopes clinics in Scotland.

Arguably, the absence of an independent abortion sector in Scotland makes this an ideal setting within which to address my research questions. Unless they are willing and able to travel long distances, Scottish women are acutely dependent on the practices of NHS gatekeepers for their access to abortion. In this context, it seems particularly important to understand how HCPs’ construct the meaning of UK law, which appears to grant complete discretion over abortion decision-making to doctors. At the same time, I acknowledge that the decision to restrict my study to the Scottish context of abortion provision ultimately contains a trade-off, in terms of the potential relevance of the study beyond this context. I will return to this issue in the concluding chapter of this thesis.

Within Scotland, I further confined my research to the area known informally as the ‘central region’, which is the most densely populated and includes the major Scottish cities, as well as rural areas. This region was selected on the basis that it would provide access to a large and diverse potential pool of participants, whilst

³¹ For Scottish women, the nearest bpas clinics that actually provide abortions are those based in Liverpool, Leeds or Doncaster.

being easily accessible by public transport. In the following discussion, I will go on to describe how I defined and recruited a sample of HCPs from within this geographical region.

3.3.2 Which HCPs?

My decision to interview GPs, gynaecologists and gynaecology nurses was based upon my research questions, which primarily concern HCPs' relationships with women requesting abortion. In Scotland, these are the three key groups of HCPs who are involved in the pathways through which women access the procedure (see Figure 1, below). By the end of my fieldwork I had constructed a research sample from these three groups; its final composition included twenty GPs, twelve gynaecologists and ten gynaecology nurses.³² Inevitably, the generation of this sample occurred in a slightly messier fashion than is implied by the prescriptive summaries which appear in research design textbooks. In spite of this, the discussion that follows attempts to provide an overview of the sampling process, as well as reflecting upon some of its limitations.

Abortion provision in central Scotland

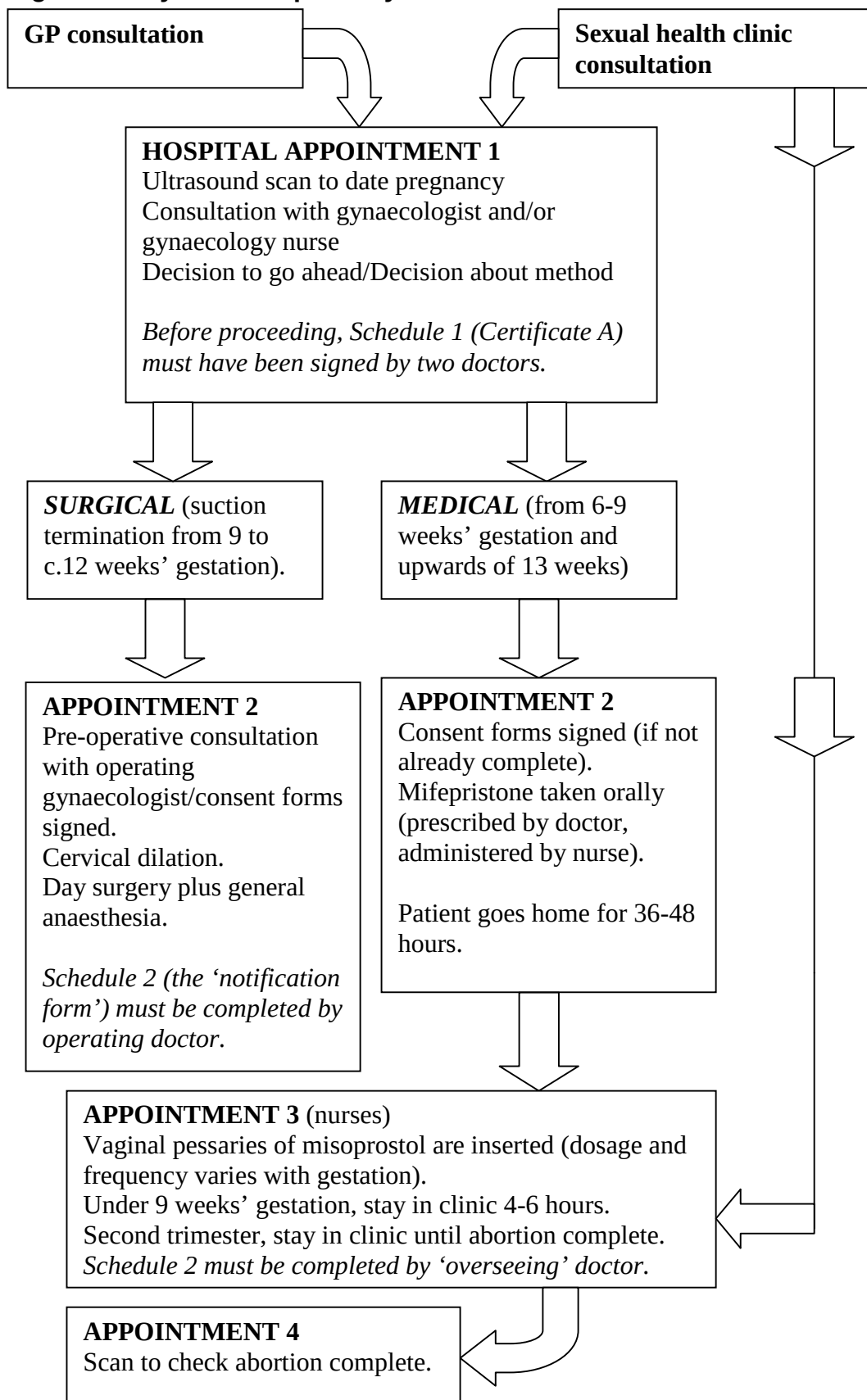
Before outlining the characteristics of my sample, it is necessary to provide some further information about the organisation of abortion provision in central Scotland (see Figure 1, below). In addition to being referred by their GP, women can access NHS abortion through community sexual health clinics, which are sometimes also termed 'family planning' or 'well woman' clinics. These clinics are staffed by a range of HCPs including GPs (who often run such clinics in addition to their general practice work), as well as by gynaecologists and gynaecology nurses who have chosen to specialise in community gynaecology. The availability and organisation of these clinics varies with geographical region, as does the service which they provide.

³² Throughout the thesis I use the terms 'gynaecologist' and 'gynaecology nurse' to highlight the specialist status of these HCPs. However, while my participants did describe their specialism in this way, they also used the word 'gynaecology' interchangeably with many other terms such as 'sexual health', 'reproductive health', 'obstetrics and gynaecology', 'women's health' and so on. My decision to utilise one term to describe this specialism of medicine is largely a pragmatic one, based on the fact that gynaecology was the term that was employed most consistently.

In terms of their involvement in abortion provision, sexual health clinics seem to operate on much the same basis as the GP referral system. In other words, following a consultation with a member of clinic staff, women are given an outpatient appointment at the nearest hospital. Here they will receive an ultrasound scan to date their pregnancy, and will have a second consultation with a gynaecologist and/or a gynaecology nurse. It is during this consultation that the decision whether to make use of medical or surgical abortion methods is made. Women are then given a date for the procedure. This basic process was repeated across all of the hospital sites I visited. The only exception occurred in one city, where the community sexual health clinic enabled women to be referred directly for the procedure, cutting the hospital outpatient consultation from the referral pathway. In this case, women decided on their method of abortion at the sexual health clinic. If they chose to undergo a medical abortion, clinic staff administered the first drug necessary for this process, and the second stage was then completed in hospital (see Figure 1, below).

A detailed description of the methods which can be used to terminate a pregnancy follows this chapter. However, for the purposes of this discussion, it is sufficient to note that abortions can be conducted using either surgical or medical (i.e. pharmacological) methods. In Scotland, surgical abortions are usually carried out on day surgery units under general anaesthetic. They are provided by gynaecologists, with assistance from nurses. Medical abortions are induced using the drugs mifepristone and misoprostol, and the patient is conscious throughout the process. Apart from prescribing the drugs, every aspect of a medical abortion can be supervised by nursing staff, i.e. doctors are not involved unless there is an emergency. Although the procedure is always supervised by nurses, the precise organisational location of medical abortion provision seems to vary considerably from hospital to hospital. At some sites, these procedures take place in specialist clinics staffed by nurses for whom it is the sole part of their job, whereas in other cases they take place on general gynaecology or obstetric wards.

Figure 1: Key abortion pathways in central Scotland



The GPs

As the key gatekeepers to NHS services, GPs occupy a particularly important and potentially powerful position in relation to women with unwanted pregnancies. For this reason, I was very interested in their accounts of their practice, and conducted around half of the total number of interviews with this group of HCPs. All of the GPs were recruited using letters of invitation/information packs (see Appendix D), but the basis on which I contacted individual GPs varied. Three of the GP participants were recruited through personal contacts, which allowed me to conduct my earliest interviews in a slightly more relaxed and informal setting. Two were recruited deliberately on the basis of information obtained from other participants (i.e. snowball sampling). In one case this was to ensure that the sample contained a GP who had been active for many years in pro-choice campaigns, and in the other it was to recruit a GP who opted out of abortion provision on the grounds of personal conscience.

The remaining fifteen GPs were recruited simply on the basis of information available in the public domain (e.g. on NHS Scotland websites). Letters and information packs were sent out to a sample of 148 GPs that was constructed purposefully (Ritchie *et al.*, 2003) to ensure that an equal number of men and women were contacted, in a range of geographical locations.³³ These locations were selected in order to ensure diversity in the likely socio-economic characteristics of GPs' practice populations, to ensure that some rural areas were included in the study, and to include GPs who interacted with different hospitals. GPs were asked to complete and return an expression of interest form to me, indicating whether or not they wanted to take part in a digitally recorded face-to-face interview, at a time and location of their choosing.

During the process of recruiting GPs, I realised that I would have to be content with a great deal less than the hour-and-a-half of their time which I had initially asked them for in the information pack. Several forms were returned stating "Yes – but I can only give you X number of minutes". On this basis, I changed the

³³ These letters were sent out in four separate batches, rather than simultaneously.

wording of the information pack, to indicate that I was entirely flexible, and would adapt to the amount of time that GPs had available. In most cases, the resulting interviews lasted around forty minutes.³⁴

The final sample of GPs contained nine men and eleven women, ranging in age from thirty-one to sixty years old. Two stated that they held conscientious objections to abortion, and three claimed varying degrees of activity as part of UK-based pro-choice campaigns. Many others suggested that the issue of abortion was not one which they expended a great deal of thought or time upon, beyond their encounters with patients. For example, several ended the interview by saying that they had found it interesting to talk to me because “this is an issue I rarely think about”. Others stated that they were interested in contributing to my findings because abortion is not a topic that is discussed in the workplace, and they wanted to find out “how other people practice”. In a couple of cases, GPs stated that they had agreed to take part simply because my information pack happened to arrive on the same day that they had seen a patient requesting an abortion.

Overall, the GP participants came from sixteen different practices located within two health boards and, collectively, interacted with three different hospitals. The majority (fifteen) sent their patients to the key hospital where I conducted several of my subsequent interviews with gynaecologists and gynaecology nurses. However, GPs’ precise organisational locations seemed to have very little impact on their interview accounts of their work. I feel relatively confident in making this claim because in several cases I interviewed more than one GP from the same practice. Even when they worked within the same *building*, individual GPs constructed their involvement in abortion provision entirely differently from one another.

In spite of the diversity of the accounts of abortion provision provided by GPs, by the time I reached the twentieth interview, it was clear that no new issues or

³⁴ During the earliest phase of my fieldwork I conducted one telephone interview, to see whether this might work as an alternative data collection method. However, this interview only lasted ten minutes and I decided not to pursue this approach. I realised that, once I was physically inside their consulting rooms, GPs were prepared to give me much more of their time. The shortest face-to-face interview was twenty-five minutes, and the longest lasted for an hour and a half.

questions were arising from the data, and that it was time to move on to another group of HCPs. In many qualitative research textbooks, this would be deemed “theoretical saturation” i.e. a point beyond which further empirical research is no longer fruitful. However, I remain sceptical about this term because it seems to me that it is always possible that another interview *might* generate new analytical themes. In the case of my own research, this seems particularly likely, because of an obvious limitation in the process through which I generated my sample. The fifteen GPs successfully recruited through unsolicited letters of invitation were the end result of 148 such letters being sent out. In other words, I was only able to interview roughly 10 % of those whom I contacted using this method. It is possible that those who did agree to participate were in some crucial way qualitatively different from those who did not, and that I reached “theoretical saturation” with a sub-group of highly ‘atypical’ GPs.

Nevertheless, there are two aspects of the interview data which make this limitation less troubling than it first appears. Firstly, even if they do share some unknown characteristic which distinguishes them from GPs who did not take part, major variations emerged between the accounts of participating GPs. This produced a rich and diverse body of data for analysis. Secondly, in terms of their accounts of abortion decision-making, the range of discursive practices which GPs engaged in mapped closely onto the range which emerged from my sample of gynaecologists and gynaecology nurses. The fact that a shared range of discursive resources seem to be available to these different groups increases my confidence that my findings might resonate with the wider community of HCPs involved in abortion provision in central Scotland.

The Gynaecologists

The names and workplaces of GPs are readily available in the public domain, which makes them relatively easy to contact (if difficult to recruit). In contrast, the names and contact details of gynaecologists are much more difficult to access. For this reason, my sample of gynaecologists was constructed entirely by snowball sampling. When I first began this phase of recruitment I drew on one personal contact, as well

as recommendations from GPs. Following initial interviews with gynaecologists I was able to continue ‘snowballing’ by asking gynaecologists to recommend the names of other potential participants. When I had obtained the name and contact details of a potential participant I sent them an information pack, as well as a personalised letter of invitation explaining (having first obtained permission to do so) that I was writing at the recommendation of their colleague, Dr X. This method of recruitment produced a much higher response rate; almost all of the gynaecologists that I contacted in this manner agreed to participate. It is difficult to know whether this is because they were particularly interested in the subject, or had more time than GPs, or simply because I was approaching them with better credentials.

The final sample of twelve gynaecologists contained six men and six women. They were aged between thirty-five and fifty-seven years old, and were at various stages of their career (most were Consultants, but some were Specialist Registrars). Three of these participants worked in community sexual health clinics. However, while this work involved them in counselling and referring patients for abortions, they had previously worked in hospitals where they had regularly performed surgical abortions. Perhaps as a result, their accounts of their experiences and practice were not markedly different from those of the other nine gynaecologists I interviewed, who worked in hospitals. Collectively, these gynaecologists were recruited from five different hospitals, across two health boards. Unless they held conscientious objections to abortion (which two of them did), their work involved them in outpatient consultations with women requesting the procedure (see Figure 1), and/or carrying out surgical abortions.

As described above, there was considerable overlap in the discursive practices of gynaecologists and GPs, and as a result of this, a point of “theoretical saturation” was reached much more quickly with this group of doctors. The only major new analytical issues which emerged during these interviews were the ways in which gynaecologists described performing surgical abortions, and the time limits on the procedure that were in place at individual hospitals (see Chapters Five and Seven). Like the GP interviews, my interviews with gynaecologists tended to last

around forty minutes (the shortest being twenty-five minutes and the longest lasting for one hour).

The Gynaecology Nurses

Gynaecology nurses play two major roles in abortion provision. Firstly, as described above, they are almost entirely responsible for medical abortion provision.³⁵

Secondly, in both sexual health clinics and hospital outpatient clinics, nurses are often trained to counsel/interview women with unwanted pregnancies. At several of the hospitals that I visited, a system had been set up whereby nurses used a pro-forma to interview patients, thus obtaining sufficient information from them for an 'overseeing' doctor to be able to sign Schedule 1/Certificate A.

However, recruiting nurses to my study proved to be the most challenging aspect of my research. My initial attempts to 'snowball' these participants using the methods that I had employed with the gynaecologists were met either with no response, or with replies that stated nurses' refusal to participate. As a result, many of the interviews that I conducted with nurses were the outcome of a rather more direct system of 'snowballing', which raises ethical questions and is considered further in section 3.5, below. On several occasions, when I had finished interviewing hospital gynaecologists, they took me to outpatient clinics or to the wards where medical abortions were provided in order to introduce me to their nursing colleagues. Through these introductions, I managed to conduct five short (c. twenty minute) interviews with gynaecology nurses. On the basis of information obtained during interviews with gynaecologists and nurses, I was later able to recruit an additional five nurses via letters of invitation. This second set of interviews lasted between forty minutes and an hour-and-a-half.

³⁵ Although the Abortion Act indicates that a pregnancy can only be terminated by "a registered medical practitioner", a House of Lords ruling in 1981 clarified that "provided a doctor prescribed the treatment for abortion, remained in charge and accepted responsibility throughout, and provided that the treatment was carried out in accordance with his directions, the pregnancy was 'terminated by' a registered medical practitioner within s.1 of the Act, even though the treatment was carried out by a nurse" (Keown, 1988: 130).

Unsurprisingly, given that the nursing profession is overwhelmingly female, all of my ten nurse participants were women. They were aged between thirty-seven and sixty-one years old, and worked in a variety of aspects of abortion provision. One nurse worked in a community sexual health clinic, where she was involved in counselling patients and referring them to the hospital. One worked in a hospital outpatient clinic, where she chaperoned the patients for ultrasound scans, as well as during any medical examinations. Six were, or had previously been, involved in providing medical abortions (although in several cases their current work focussed primarily on interviewing, counselling, or chaperoning patients). One nurse worked on a gynaecology ward where medical abortions were provided but described herself as someone who made use of her legal right to opt out of this practice on the grounds of conscience. The final nurse participant worked in a day surgery unit where surgical abortions were provided.

3.4 Data analysis

3.4.1 Discourse analysis, in theory

In keeping with the theoretical framework and research questions developed in the previous chapters, my analysis of the interview data asks questions about the realities that are constructed through HCPs' accounts of their involvement in (or conscientious objection to) abortion provision. In addressing HCPs' interview talk as a practice which actively *constitutes* reality, my analysis of this data is best characterised as a form of 'discourse analysis' (hereafter DA). DA represents a particular theoretical orientation towards data; it focuses on the constitution of reality through discourse. However, as Wetherell (2001) argues, although discourse analysts share this core theoretical focus, it is important to acknowledge that a number of distinctive approaches to DA exist, which are informed by very different research traditions.

Within STS, a particular form of DA was developed in the 1980s by Gilbert and Mulkay (1984), as a means of dealing with scientific discourse. The following discussion begins by summarising the key features of this approach to data analysis, as well as acknowledging its shortcomings. I then go on to argue that some of the

problems with Gilbert and Mulkay's approach are circumvented by the work of Potter and Wetherell (e.g. Potter & Wetherell, 1987; Wetherell & Potter, 1992), and explain the elements of their approach that I am drawing upon. However, I conclude this section by highlighting continuing points of divergence between DA as it is formulated by these authors, and my own work. Having explained how I am conceptualising the meaning of my interview data, I then move on to describe the process through which this data was generated and analysed in practice.

Gilbert and Mulkay

In developing their approach to DA, Gilbert and Mulkay (1984) criticise the tendency of earlier STS literature to use scientists' accounts of their work as a means to a particular end, i.e. to produce a definitive version of "what really takes place" in the laboratory and then to develop sociological explanations for 'why' these things happen. They argue that, rather than being used as an analytical "resource" in this manner,³⁶ scientific discourse should be treated as the "topic" for analysis. This shift in focus means that their analysis addresses the ways in which discourse is organised to produce particular *versions* of 'reality'.

Gilbert and Mulkay illustrate this approach with reference to several forms of scientific discourse, including formal biochemistry research literature, pictorial representations of biochemical processes, and transcripts based upon their interviews with a particular research network of biochemists. Their analysis attempts to uncover uniformities (for example, particular ways of describing experiments) within these different forms of scientific discourse, and to relate these "interpretative regularities" to the contexts of their production (e.g. formal research literature vs. informal conversation).

Throughout their analysis, Gilbert and Mulkay argue that variability within and between scientists' accounts of the same phenomena is a valuable means of understanding how discursive resources are used and organised in practice. For

³⁶ It should be noted that this characterisation (or perhaps, caricature-rization) of the existing literature is disputed (e.g. Shapin, 1984).

example, they reveal that, when drawing on the “empiricist repertoire”, scientists describe experiments in terms which imply that they are simply accessing facts about the world. At other times, scientists draw on the “contingent repertoire” and describe their work in terms which emphasise how it is influenced by human agency. Gilbert and Mulkay argue that these repertoires are drawn upon and combined selectively in order to reinforce individual scientists’ own ‘expert’ status, and to discredit the status of their scientific opponents.

Given that their approach is grounded in arguments concerning the context-specificity of discursive practices, Gilbert and Mulkay acknowledge that the context of the social research interview setting must shape the production of their participants’ accounts.³⁷ However, at the same time, it is clear that they want to use interviews to explore a social world which exists beyond this immediate context (a goal that I share in making use of this research method). They suggest that studying the discursive practices which scientists engage in as they describe their work in face-to-face interviews provides insights into the everyday discursive practices which they engage in beyond the interview setting. This argument, and an acknowledgement of the assumption that it rests upon is stated explicitly in a related piece by Potter and Mulkay:

Although we have abandoned the traditional assumption that we can infer from interview talk what actually happens in the social realm under investigation, we are nevertheless continuing to assume that we can, in a more restricted sense, generalise from interviews to naturally occurring situations. For we are assuming that the interactional and interpretative work occurring in interviews resembles to some degree that which takes place outside interviews. (Potter & Mulkay, 1985: 269)

In other words, these authors are suggesting that it is possible to use interviews to do more than study the conversational interactions which take place between interviewer and interviewee. They suggest that the study of interview discourse can form part of a more macro-level sociological project, namely, “to identify recurrent, regularly used, and in this sense collective, cultural resources which are embodied in and visible in participants’ discourse” (Gilbert & Mulkay, 1984: 140).

³⁷ The argument that interview accounts are the product of the interaction which takes place between interviewer and interviewee has been articulated by numerous qualitative researchers (e.g. Kvale, 1996).

However, while they address scientists' discursive practices as the product of "collective cultural resources", the collective that Gilbert and Mulkay are concerned with is that of the scientific community. As a result, they do not consider the broader social dynamics of scientists' discursive practices, for example the fact that, in relation to members of non-scientific communities, their voices are granted far greater authority (Kerr *et al.*, 1997). Indeed, they state explicitly that:

We will not try to explain the nature of scientific discourse by presenting it as an outcome of the actions of dominant social groups. Nor will we try to establish connections between scientific discourse and the wider structure of society. These analytical objectives resemble those characteristic of most traditional sociological research and are unacceptable to us for much the same reasons. (Gilbert & Mulkay, 1984: 16)

Clearly, this narrow focus raises a number of problems when viewed against the backdrop of the theoretical framework and research questions developed in the preceding chapters.

Potter and Wetherell

In contrast, the approach to DA developed in the work of Potter and Wetherell (e.g. Potter & Wetherell, 1987; Wetherell & Potter, 1992) provides a broader, more power-sensitive analytical focus. These authors demonstrate that the kind of DA advocated by Gilbert and Mulkay is also relevant to the field of social psychology. In common with a large body of constructivist work within social psychology (e.g. Gergen & Davis, 1985), one of their central aims is to destabilise the idea that there is an essential 'self' waiting to be uncovered through psychological analyses of 'attitudes' or 'perspectives', and to emphasise instead how identities are constructed through discourse. In the remainder of this section I will highlight several important elements of their approach which have informed my conceptualisation and analysis of the interview data, as well as noting how my methodology diverges from their work.

However, before doing so, it is important to acknowledge that, in discussing Potter and Wetherell's 'approach,' I am referring to a large body of writing, which

spans a long period of time. This work includes several different forms of DA, some of which seem more akin to conversation analysis, e.g. a fine-grained analysis of the processes through which identities are negotiated during conversational exchanges (Potter & Wetherell, 1987; Potter, 1996; Wetherell, 1998). However, in other cases, Wetherell and Potter address longer segments of text (e.g. an individual's interview account of their experiences) as a means of exploring how individuals construct identity (Wetherell & Potter, 1992; Reynolds & Wetherell, 2003). As indicated by the discussion earlier in this section, my own DA takes place at this second level of analysis.

As noted above, a distinguishing feature of Potter and Wetherell's approach to DA is that, in contrast to Gilbert and Mulkay, they acknowledge the broader dynamics of the social contexts in which individuals construct particular identities. For example, they point out that the construction of identity is often a statement about who can claim a particular social status and, as such, it may be bound up with the perpetuation of oppressive power relations (Potter & Wetherell, 1987; Wetherell & Potter, 1992). Clearly, adopting this explicitly political approach to DA would allow me to explore how HCPs construct their own status in decision-making about abortion, as well as considering the broader understandings of society that are co-produced through this process, and the implications of these understandings for women who are, or could become, pregnant. Indeed, other STS researchers have demonstrated the compatibility of this kind of DA with analyses of how individuals construct their authority to speak about technoscientific issues, in ways that marginalise particular voices (Kerr *et al.*, 2007).

In order to depict identity construction as an active and flexible process, Potter and Wetherell often employ the term 'subject positions' in their work. This term signals the way in which, rather than *possessing* identities, individuals *achieve* particular subject positions such as that of 'expert' through their discourse (Kerr *et al.*, 2007). It also points to the relational character of identity construction; in constructing a particular subject position, individuals are always positioning themselves in relation to other possible identities, and are thus making statements

about these identities (Wetherell & Potter, 1992). In the analysis that follows, I have adopted this term, as it seems to provide a useful means of conceptualising how HCPs are constructing their own and others' (e.g. mine or patients') identities as they account for their practice. However, its precise origins remain ambiguous; like the term 'discourse analysis,' the concept of 'subject positions' has been employed by researchers within a number of distinctive analytical traditions.³⁸

As indicated in Chapter Two, this thesis aims to integrate critical approaches to the construction of expert authority with a sensitivity to the contexts from which HCPs are speaking. In view of this, another important feature of Potter and Wetherell's DA is that, in addressing the social dynamics of discursive practice, they acknowledge that the actions of individual speakers are shaped by the contexts in which they speak. This view of the creative/constrained process of identity construction is particularly well articulated in their interview-based study of racism in New Zealand:

Identity is not formed from scratch every time a person speaks. Continuity comes from what we described as the sedimentation of discursive practice over time. Identity can only be constructed from those narratives which are available, and discursive practice, as we noted, intertwines with other social practices. Those enmeshed in one set of social relations will thus construct identities from rather different resources than those enmeshed very differently. (Wetherell & Potter, 1992: 78-79)

The importance of this perspective is clear when it comes to analysing problematic discursive practices such as racism (Wetherell & Potter, 1992). On the one hand, individuals can be called to account for engaging in discursive practices which have extremely troubling implications for the lives of other people (Wetherell & Potter, 1992). On the other hand, racist accounts can also be viewed as the effect of a broader set of practices which, historically, have limited the discursive resources available for constructing human identity (Wetherell & Potter, 1992). When these limits are highlighted, the primary target for critique becomes the society which

³⁸ For example, compare Harre *et al.*'s micro-level analyses of "positioning" as a regular mechanism which operates within conversation (Davies & Harre, 1990; Harre & van Langenhove, 1991), with Wetherell's (1998) discussion of how "subject positions" are employed by post-structuralists, and Edley's (2001) linkage of "subject positions" to the work of Althusser.

generates them and racism is seen as a political problem which can be tackled and changed (Wetherell & Potter, 1992).

Clearly, this approach also circumvents the pitfalls of some of the earliest feminist critiques of reproductive medicine that were highlighted in the previous chapter. While individual HCPs can be called to account for problematic discursive practices, these practices are not viewed as the product of fixed patriarchal or misogynist ‘attitudes’. Rather, they are evidence of the discursive resources available for discussing abortion provision within a social research interview setting in the UK at the beginning of the twenty-first century. When conceptualised in this way, interview conversations become a means of exploring and critiquing the limitations of these resources. Additionally, the possibility that HCPs might one day engage in different kinds of discursive practices remains central to the analysis.

The discursive ‘context’ which Wetherell and Potter address in their analysis of racist accounts is a very broad one, and incorporates the ways that Pākehā and Māori relationships have developed historically in New Zealand. However, from the quotation above, it is obvious that their approach makes it possible to consider the discursive possibilities open to individuals in a much more immediate sense than this, i.e. as shaped by the specific sets of social relations in which individuals are enmeshed in their everyday lives. Because of this, it seems appropriate to use DA to understand HCPs’ interview accounts as intertwined with the discursive resources generated through the day-to-day experience of being involved in (or opting out of) abortion practice. As highlighted in the previous chapter, the social relations under consideration here are not simply those which HCPs engage in with other human actors, but include their encounters with a range of “material-semiotic” entities such as legal forms, surgical equipment and fetuses.

In spite of the value of Wetherell and Potter’s conceptualisation of interview data, it remains important to acknowledge differences between their work and the approach which I have adopted in this thesis. These differences stem primarily from (what I would identify as) a gap between Wetherell and Potter’s *conceptualisation of*

interview data, vs. the types of analyses which they often provide in practice. For example, in theorising how reality is constituted through discourse, they argue that it is important not:

...to make the process seem necessarily deliberate or intentional. It may be that the person providing the account is not consciously constructing, but a construction emerges as they merely try to make sense of a phenomenon or engage in unselfconscious social activities like blaming or justifying. (Potter & Wetherell, 1987: 34)

However, because their analyses are primarily illustrations of the ways that individuals achieve particular rhetorical effects through their speech, Wetherell and Potter often do imply that people's accounts are the outcome of deliberative planning towards specific rhetorical goals. This aspect of Wetherell and Potters' work means that they potentially ignore the most interesting aspect of their interviewees' discourse, namely, that regardless of the rhetorical 'effects' highlighted by the discourse analyst, individuals' interview accounts may simply reflect the ways in which they routinely make sense of their lives. In the analysis that follows I will try to overcome this problem. Although I will pay attention to the rhetorical dimensions of my participants' accounts, I will also remain open to the possibility that the discursive practices which HCPs engage in during interviews are simply routine methods of sense-making, which are highly meaningful to them beyond the context of the interview.

As noted previously (p. 77), Potter and Wetherell also claim to theorise the speaking subject as simultaneously creative (agential) and constrained (structured). However, because they focus their analyses on individuals' *uses* of discourse, it is the former construction of the subject which dominates their accounts of human action. In my own work, I aim to engage more explicitly with the notion that individuals are limited by the discursive resources available to them.

This aim is linked to my decision to avoid using one of the key terminologies employed by Potter and Wetherell. These authors utilise the expression 'interpretative repertoires', rather than 'discourses', to signify "broadly discernible clusters of terms, descriptions and figures of speech often assembled around metaphors or vivid images" (Wetherell & Potter, 1992: 90). While speakers are said

to be constrained by the fact that interpretative repertoires are not infinite, the analysis is directed towards the creative ways in which these repertoires are employed in practice. Potter and Wetherell's preference for this term represents an attempt to distinguish their work from Foucauldian analyses, which they criticise for treating discourses "as potent causal agents" (Wetherell & Potter, 1992: 90) which produce human subjectivities. They argue that this top-down treatment of discourse results from the fact that Foucauldian analysts address 'discourse' in an abstract sense without ever engaging with the ways in which people use discourse in day-to-day practice. However, although this is an important point, it once more signals Wetherell and Potter's commitments to exploring discourse as something which people *use*, as opposed to something which shapes the possibilities of human subjectivity. As highlighted above, one of my concerns about their work is that it sometimes over-emphasises the freedom of the speaking subject. For this reason, I have chosen to use the term 'discourse,' rather than 'interpretative repertoire' in my own analysis.

3.4.2 DA in practice 1: Generating and analysing interview transcripts

Potter and Wetherell argue that DA provides a theoretical orientation towards data, rather than a prescriptive 'method' of analysing it (Potter & Wetherell, 1987: 175). It is in this sense that I have found it useful to draw on elements of their approach, i.e. as a means of *conceptualising* the meaning of my interview data. In contrast, the following discussion provides an account of the *method* through which this interview data was actually generated and condensed in order to facilitate my analysis of it. The analysis was informed primarily by my research questions, as well as by the theoretical framework described in Chapter Two.

As explained in the previous section, advocates of DA, like many other qualitative researchers, stress the active role of the interviewer as well as the participant in generating interview accounts. From this perspective, the questions that I asked my participants during interviews are very important. Recognising this, I spent a considerable length of time constructing a topic guide before entering the field. This guide was developed on the basis of discussions with researchers who had

conducted studies in related empirical areas, as well as on the basis of my reading of the existing literature. Although specific topic guides were constructed for each group of HCPs (see Appendix E),³⁹ they all centred on key descriptive questions about HCPs' work practices, and ended with a discussion of relevant questions that had recently been debated in the media. Beneath each of the main questions was a list of potential follow-up points. As my research progressed, and a series of clear themes began to repeat themselves across the interviews, this list was altered accordingly in order to ensure that critical themes were explored with every participant.

To some researchers, my lengthy topic guide probably appears unusually detailed, and perhaps resembles that expected of a 'structured' rather than a 'semi-structured' interview. However, the detail of the topic guide aided the interview process on several levels. In the first place, it meant that if I froze up with nerves (particularly during the early interviews) I had follow-up questions available at my fingertips. The fact that I had thought about how to word the questions in advance also meant that, while the precise details of the conversations altered, I asked the critical questions in roughly the same way in all of the interviews, thereby making it easier to compare participants' responses.

However, although interviews were loosely structured around the key (numbered) questions, it is important to note that they rarely followed the precise format of this guide. My aim in all of the interviews was to begin with an open-ended question, which provided HCPs with enough space to bring up and discuss topics that they considered relevant, and to construct their own narrative and agenda. During the interview, I then asked progressively more specific questions in order to address my own research interests. I made every effort to word these more specific questions so as to give participants the greatest possible freedom to respond to them, i.e. I endeavoured not to 'lead' HCPs into providing particular answers. However, *any* question inevitably frames the answer which is given to it in some way, even if

³⁹ For the most part, I went into interviews without knowing whether an HCP would identify him/herself as a 'conscientious objector' who opted out of abortion provision. For this reason I had to take two versions of each topic guide into every interview.

this is just to highlight a particular topic as something that is of interest to the researcher.

In the chapters that follow, I have explicitly acknowledged my own role in the generation of interview data by prefacing participants' responses with my questions,⁴⁰ where appropriate. On many occasions, HCPs gave lengthy responses, and there are cases where it seemed inappropriate to present extracts of their talk as a direct response to an easily identifiable 'question'. Nevertheless, even in these cases, HCPs' accounts must still be understood as shaped by the dynamics of the social research interview. In addition to the specific characteristics that I, personally, brought to this interaction (see section 3.6), it is widely acknowledged that the act of asking interview participants to *describe* particular actions/beliefs can be perceived as an attempt to interrogate these actions/beliefs. In other words, interviewers' questions may encourage participants to try and present themselves as 'moral' beings who act in accordance with perceived social norms. Viewed in this way, interviews become an opportunity to witness the *construction* of such norms, e.g. what is to count as 'acceptable' abortion practice.

Following the generation of interview data, the transcription of digital recordings itself forms another key stage in the analytical process. Although the interviews were transcribed verbatim, there are clearly a number of possible interpretations of this term. Potter and Wetherell suggest that, "for many sorts of research questions, the fine details of timing and intonation are not crucial" (1987: 166). As my research questions concern the ways in which subjectivities are constituted through HCPs' accounts rather than, for example, the fine-grained mechanisms through which conversational turns proceed, I have chosen not to include this level of detail. This decision was also influenced by the practical consideration that such detail would add months to what was already (given my inexperience) a very lengthy process. Finally, as Potter and Wetherell also note, the inclusion of such details "can interfere with the readability of the transcript" (1987:

⁴⁰ When I list more than one response to the same (or a similarly worded) question, I have only included the question once.

166) and detract from the meanings conveyed by the data when presented in a more simplified form.

Having transcribed the data, the next stage involved constant re-reading of the transcripts, and the condensation of the data through coding, in order to make it more manageable. The development of codes was informed by my research questions, and the coding process was aided by the use of the qualitative data management package NVivo 7. Once the data existed in a more manageable format, a more detailed categorisation and analysis of the broad codes was conducted. This primarily involved looking for patterns in the ways that HCPs talked about particular issues (e.g. decision-making about abortion or conscientious objection). It also involved paying close attention to the way in which such issues were variably constituted, either between or within participants' accounts. This aspect of the analysis was informed by the work of Gilbert and Mulkey (1984) and Potter and Wetherell (1987), who argue that exploring variability between and within participants' accounts provides fruitful insights into the ways in which discursive resources are utilised.

A final issue which is important to consider in any discussion of data analysis is the means by which this process can be critically assessed. Potter and Wetherell argue that, although DA represents a theoretical orientation to analysis rather than a prescriptive method, it remains possible to assess such analyses for their 'rigour'. In particular, it is possible to examine the extent to which analyses take account of and explain examples which do not apparently 'fit' into the theoretical framework which is being developed (Potter & Wetherell, 1987). The extent to which such deviant cases are accounted for is, more generally, considered to be an important criterion of the robustness of a piece of qualitative research (Lewis & Ritchie, 2003). Another criterion which is also widely used in assessing a qualitative analysis is the extent to which it reflects participants' own 'realities' (Lewis & Ritchie, 2003). While this term can be variably interpreted, in the case of DA this involves providing evidence that the contradictions and variability identified in participants' talk are significant

not simply for the analyst but also for those engaged in these discursive practices (Potter & Wetherell, 1987).

3.4.3 DA in practice 2: Beyond transcripts

As noted in section 3.4.1, an attractive feature of Potter and Wetherell's work is that it allows the discourse analyst to consider the role of the discursive 'context' in which interviews are conducted. This argument is made explicitly in *Mapping the Language of Racism*, where they suggest that, in some research projects, there is a need to develop an "ethnographic understanding" (Wetherell & Potter, 1992: 102-4) of the research context in which particular texts (e.g. interview transcripts) are produced. In the case of their research, this was necessary because they wanted to be able to integrate the ways that their participants talked in interviews with Wetherell's native understandings of the ways that such discourses functioned within New Zealand society.

Likewise, while my analysis draws primarily on interview transcripts, I have also found it important to move beyond the limits of these texts. In the case of my research this is because of the aim which I have described previously: to explore the implications of HCPs' accounts whilst remaining sensitive to the contexts of their production. In developing an ethnographic understanding of this context, I have relied upon several years spent following media and parliamentary discussions of abortion in the UK, and the analysis of secondary literature concerning the history of abortion law and practice in the UK (see Chapter One). A particularly important resource is provided by the Hansard transcripts of the House of Commons debates about abortion which took place during the passage of the Government's Human Fertilisation and Embryology Bill in 2008. As Sheldon points out, parliamentary debates represent useful data because:

...speakers are inevitably aware that what they say (especially on a topic of popular interest such as abortion) will be recorded, read and possibly reported in the media. As such, there is every incentive to speak to the spirit of the times, to try to tap into and to give voice to a perceived popular morality. (Sheldon, 1997: 34)

Because of the opportunity provided by this resource, I supplemented my analysis of the interview transcripts with an analysis of the Hansard transcript of May 20th, 2008,

which was the date that MPs debated amendments to abortion law. Extracts from this debate were addressed in Chapter One, and are also considered (where relevant) in several of the empirical chapters that follow.

My understanding of the ‘context’ in which my participants are working has also been transformed through my own experience of conducting interviews with HCPs, as well as reflecting upon and writing about this process. In particular, the visibly emotional ways in which some HCPs spoke about their practice shaped my understanding of their experiences of this practice, and thus the immediate ‘contexts’ from which they were speaking.

Reference to an understanding of the emotions of participants is a well-known rhetorical device used to imply that an interviewer or analyst has some kind of privileged access to the inner ‘realities’ of those whom they study (Silverman, 2001). However, by bringing my interpretation of the emotions displayed by my participants into the analysis that follows, I am not attempting to make any such claim. As Wittgenstein (1972) demonstrates, what we take to be a display of a particular emotion (e.g. ‘joy’ or ‘pain’) occurs on the basis of our interpretations of *public* signs (e.g. words or other bodily signals). For example, we may respond to a person who cries as though they were suffering in some way, but this is because particular public signs (e.g. certain words, tears, a trembling lip) are socially designated as evidence of pain. Witnessing and interpreting the emotional signs displayed by others gives a researcher no more direct insight into participants’ intangible private feelings or thoughts than any other medium of communication.

At the same time, in revealing the conventional character of emotional display, Wittgenstein (1972) also illustrates that signs other than words are a routine and important means through which we *do* communicate (Hallowell, 2006). For example, when somebody cries, I will try to comfort them; when a person’s voice rises in a certain way in response to something that I have said, I understand that I have made them angry. In other words, while emotional display should not be privileged as an unmediated gateway into people’s inner worlds, it is undoubtedly an

important and meaningful dimension of social life. Moreover, it is one which has been too often neglected in STS, which, by focussing on the generation and contestation of technoscientific knowledge, has often ignored the different, e.g. non-cognitive ways in which people relate to technoscience and medicine (McNeil, 2007). Accordingly, in the analysis that follows I will draw upon my ethnographic understanding of the conventional aspects of emotional display, and explore emotion as *one* of several forms of data generated in these interviews.

3.5 Obtaining ethical ‘clearance’

My project was subjected to a process of ethical review before I began to contact any HCPs. According to the Governance Arrangements for Research Ethics Committees (RECs), my study should, in theory, have required approval from an NHS REC because I wanted to recruit participants on the basis of their professional role as NHS practitioners. However, advice was sought from my local NHS REC, who read an outline of my study and stated that it did not require this level of ethical approval.

On this basis, the project was instead reviewed under the terms of the University of Edinburgh’s School of Social and Political Studies research ethics audit process. Completion of an ethical self-audit confirmed that the project did not raise any unusual ethical issues, beyond those which can be addressed by good social research practice. Such practice typically involves procedures to ensure (as far as possible) participant anonymity and confidentiality (Lewis, 2003). In view of this, I produced codes for participant identities⁴¹ and used these to ensure that interview transcripts and digital recordings could not be linked directly to participants. Information required to decode participant identity was stored in a separate location from the interview data (both were kept in locked storage cabinets).

However, the possibility that interview data might be attributed indirectly to participants is a more complex problem (Lewis, 2003). Several HCPs were acutely

⁴¹ These codes indicate the ‘type’ of HCP (i.e. GP, Nurse, Consultant, Specialist Registrar) being interviewed, plus a number. My decision to use a numerical system to distinguish participants was based on the idea that numbers *feel* more anonymous than pseudonyms. As described below, several of my participants were very concerned about the possibility that they might be identified, and they seemed to be reassured when I said that they would be distinguished on the basis of numbers.

anxious about being identified, on the basis that their work as abortion providers might result in their being targeted by anti-abortion activists. Because of their concerns, in transcribing the interviews I have erred on the side of caution in making decisions about whether to omit particular details. For the same reason, I have also decided not to specify the precise geographic areas in which my research took place.

Another central tenet of ‘good’ social research practice is that participants are given the opportunity to make an ‘informed’ decision about whether or not they wish to take part (Lewis, 2003). In my study this process was facilitated by giving each participant the opportunity to read a written summary of my research (see Appendix D). This included information about the empirical questions that I wanted to address, as well as an outline of what participation would involve, and the measures in place to ensure confidentiality and anonymity. Additionally, at the beginning and end of each interview, I gave participants the opportunity to ask questions about my research. They were also asked at the outset whether or not they objected to my use of a digital voice recorder (only two participants refused – see below).

All participants were asked if they would be happy to sign a written consent form stating that they agreed voluntarily to take part in my research, that they understood what was involved and that they were happy for me to use the data obtained. When I first began my fieldwork, I asked HCPs to sign this form at the beginning of the interview. However, this request often got the interview off to a bad start because, I subsequently realised, HCPs resented being asked to ‘consent’ to a completely unknown intervention. In view of this problem, I started to begin all interviews by telling HCPs that I had a consent form with me and that, if following the interview they were comfortable with the discussion, I would ask them to sign it. This alternative approach appeared to work much more smoothly but led me to wonder who was benefiting from the process of obtaining written consent. I now have a drawer full of signed forms symbolising HCPs’ ‘informed’ and ‘voluntary’ participation, but I remain unconvinced that asking them to give me their signatures helped to make this process any more informed, or voluntary. More generally, the suggestion that ethical difficulties in social research can be resolved through

techniques such as written consent seems acutely problematic in light of sociological critiques of the way that scientists and HCPs rely upon this procedural approach to ethics (e.g. Corrigan, 2003; Tutton & Corrigan, 2004).

In spite of my scepticism about the purpose of obtaining written consent, the process of interviewing doctors generated few ethical dilemmas for me, personally. This is because, in most cases, the dynamics of these interviews were such that I often felt doctors had a great deal more control over the situation than I did. In contrast, recruiting and interviewing nurses was an entirely different experience. As described in section 3.3, several nurses were invited to participate directly by doctors, who took me to meet their nursing colleagues following their own interviews. When these nurses said “Yes of course, she can talk to me now”, my eagerness to obtain nurse participants probably meant that I did not reflect enough on whether or not I should conduct these interviews. Subsequently, I have become concerned about whether these nurses ‘really’ wanted to take part in my research, or whether they were doing so because they perceived the invitation as a directive from doctors.

However, in all cases, once the doctors in question had left the room, I gave nurses the opportunity to change their mind, and made it clear that I had no problem in leaving the hospital without the interview. As in all of the other interviews, I gave them a verbal and written summary of my research, and allowed them to ask me any questions that they wanted. Finally, it was clear that nurses did feel able to ‘say no’ to research interventions with which they were uncomfortable, because on two occasions they agreed to participate but refused to be recorded.

3.6 Engaging in reflexivity?

Social scientists are often instructed (and spend a great deal of time encouraging others) to ‘be reflexive’ about their claims to knowledge. However, as Lynch (2000) points out, there are multiple definitions of reflexivity; like any form of other social action, its designation as ‘successful’ will depend on the context in which it is performed (e.g. the expectations of a particular disciplinary audience). Lynch

outlines a typology of ‘reflexivities’ and identifies six different uses of the term, which are further divided into sub-types. One of these, “methodological self-consciousness”, is the form of reflexivity often advocated by qualitative research text books, which “instruct students to be conscious of their own assumptions and prejudice, and to focus upon uncertainties, possible sources of bias,” etc. (Lynch, 2000: 29), which impinge upon the knowledge claims that can be made.

To a certain extent this is the approach to reflexivity that I have implemented throughout this chapter, by describing how my methodological choices have shaped the meaning of my data. From here I could move on to add a long list of the personal characteristics that may have impacted on the dynamics of the interviews, as well as upon my analysis of them. I could cite my (relative) youth and inexperience as an interviewer, the fact that I am female, white and from a middle-class background. However, while these things are undoubtedly important, there are no ‘rules’ to indicate where this process of self-examination should begin and end (Lynch, 2000). Should I go on to draw attention to the anxiety that I feel (and probably display) when I enter any medical consulting room, and describe how this relates to my own history with the healthcare profession?

While there are undoubtedly problems involved in drawing boundaries around the scope of such ‘reflexivity’, a more troubling ambiguity concerns the underlying purpose of this process. Like Haraway (1997), I worry that, behind the injunction for the researcher to consider how their person impacts upon the research process lurks the assumption that, once identified, this impact might be measured and somehow removed. This returns us to the search, familiar from scientific discourse, for an undistorted account of the ‘object’ of study. This assumption is fundamentally incompatible with the stance central to STS research, i.e. that all knowledge claims are inseparable from the social context in which they are produced. It is also antithetical to the goals of feminist research which, by emphasising the situatedness (Haraway, 1991), and thus partiality of all knowledge claims, aims to avoid silencing those whose alternative situation produces very different kinds of ‘truth’. An insistence on the embodied, and thus always partial, basis of ‘knowing’ is also vital if

researchers are to be held accountable for their research interventions, and the kinds of world which these support (Haraway, 1991).

An alternative approach to the issue of ‘reflexivity’ is advocated by scholars such as Woolgar (e.g. 1988) who have illustrated how STS’s mode of analysis can be applied to STS texts. Following this approach, I could turn this concluding discussion into an analysis of the ways in which, through the construction of this methodology text, I have positioned my thesis as a ‘robust enough’ piece of research that accords with the conventions typically used to assess qualitative studies. Moreover, I could repeat this process in each of the empirical chapters that follow, using DA to reflect upon the ways in which I try to ensure that the reader is convinced by my own DA of HCPs’ accounts, and so on *ad infinitum*. However, while I acknowledge that the analysis which follows is certainly amenable to this kind of deconstruction, like Haraway (1997), I would argue that this version of reflexivity is unnecessarily paralyzing. Recognizing that all claims to knowledge are partial should not mean losing sight of the possibility of constructing different and better kinds of world through research interventions.

In taking responsibility for this particular research intervention, I want to situate the partial truth that follows as a feminist project, that sets out to use the tools of STS to critically explore the forms of existence that HCPs’ discourse make possible for pregnant women. This aim was initially based upon the (probably naive) hope that, through this kind of analysis, it might be possible to engage in further dialogue with HCPs involved in abortion provision in the UK, and improve the experiences of pregnant women in the clinic.

However, this wider ethical purpose raises questions about the information that I provided to my participants. Although I outlined the empirical questions that I was interested in (see Appendix D), I did not state that I was relating to my participants’ answers from a critical ‘feminist perspective’, or suggest that I was interested in (at least potentially) generating changes in their practice.

Arguably, however, it would have been impossible for me to explain my ‘position’ as a feminist researching the healthcare profession when I constructed my information pack. This is because my approach towards HCPs has not remained static, but has been affected by my experience of conducting and writing about this project. As I indicated in Chapter Two, the analysis which follows this chapter represents my attempt to *construct* a critical, yet sensitive and hopefully productive relationship with the HCPs whom I interviewed. In the concluding chapter of this thesis, I will return to this issue and will reflect upon the further interventions that the approach adopted in this thesis might make possible (or impossible) in the future.

As outlined in Chapter One, my analysis of the empirical data begins in Chapter Four, which addresses HCPs’ discussions of the practice of ‘conscientious objection’. I argue that these discussions represent an interesting site at which to explore how HCPs define the limits of their rights to act as individuals, vs. their responsibilities to their patients and their colleagues as members of the healthcare profession. In the three remaining empirical chapters I then move on to address the central topic of the interviews, namely, HCPs’ accounts of their interactions with their pregnant patients. In Chapter Five I explore HCPs’ accounts of their involvement in abortion decision-making, and compare these accounts to the expert-lay relationships which are constructed by the terms of the Abortion Act. In Chapters Six and Seven I focus in detail upon some of the key claims to expert knowledge that are articulated by HCPs, and explore the “prescriptive ontologies” (Wynne, 2001: 479) which are co-produced by these claims.

Rather than moving straight into an analysis of my empirical data, this methodology chapter will be followed by a brief intermission, in which I provide some important background information concerning the abortion procedures which my participants are discussing in the chapters that follow. I would argue that an awareness of these procedures is essential both in order to comprehend the terminology employed by HCPs, and to understand the material practices to which they are referring. At the same time, the act of producing and including such a description in this thesis is extremely problematic, for several reasons.

Firstly, in order to produce this description, I have had to rely upon the accounts of my participants (along with guidance from Royal College of Obstetricians and Gynaecologists, 2004), treating these accounts as a *resource* in order to define the work practices which are involved in abortion procedures. Necessarily, this involves the temporary suspension of the analytical approach outlined in this chapter, in which the ways that HCPs account for particular practices are treated as a *topic* for analysis. Treating HCPs' accounts as a resource in order to generate a coherent description of abortion methods also leads to a second problem; it suppresses variation between accounts, falsely implying that all HCPs narrate these events in the same way.

In Chapter Seven I will attempt to rectify this problem, by turning HCPs' accounts of abortion methods *back* into a topic for analysis. In doing so, I will analyse the realities which HCPs construct as they define particular abortion methods, and will also emphasise that HCPs do not produce a single narrative concerning these methods. However, arguably, this analysis cannot compensate for an additional problem with my decision to include a 'description' of abortion methods in this thesis. The act of outlining the work practices involved in abortion procedures involves talking about women's bodies, as well as those of their fetuses. To attempt to construct a single definition of this process seems to me to be an incredibly violent act, which silences women's situated definitions of their experiences of abortion. This silencing is, arguably, made worse by the fact that the 'experiences' of women and their fetuses during abortion procedures are regularly appropriated by anti-abortionists (Steinberg, 1991). In Chapter Seven, I make an attempt to compensate for this troubling aspect of the following description by drawing attention to literature that has addressed women's own accounts of medical abortion procedures.

In light of the problems generated by my description of abortion methods, I have found it difficult to accommodate it as part of the main text of this thesis. Instead, this description occupies an uneasy position outside of this text as necessary

‘information’, which simultaneously produces a particular version of reality and frames the reader’s perspective on the empirical data which follows. As such, it also serves to highlight an important tension that emerges from my participants’ accounts. As I will acknowledge in the chapters that follow, HCPs must fulfil their legal obligations to gain informed consent from their patients before performing any procedure. However, in doing so, they inevitably impose particular definitions of abortion upon women with unwanted pregnancies.

Intermission: Methods of abortion

As indicated in Chapter Three, an abortion can be conducted using either medical (i.e. pharmacological) or surgical methods. The Royal College of Obstetricians and Gynaecologists (2004) outlines the potential for both medical and surgical abortion techniques to be used across all (legal) gestations of pregnancy. However, my data suggest that, in Scotland, local practice is to use particular methods at particular stages of gestation.

Medical abortion

Medical abortions are conducted between approximately six to nine weeks' gestation, and this method is also used for abortions at upwards of thirteen weeks' gestation. The HCPs that I interviewed suggested that, in the interim period (nine to thirteen weeks), surgical abortion is preferred because it has a higher success rate than medical abortion.

The medical method of abortion involves several stages, and visits to hospital (see Chapter Three, Figure 1). Patients are conscious throughout the procedure. On the first visit, they are given orally-administered mifepristone, a drug that blocks the actions of the hormone progesterone. By blocking the action of progesterone, mifepristone causes the

lining of the uterus to start disintegrating and also softens the cervix. In rare cases, mifepristone will induce abortion, and women are warned of this possibility before being sent home. However, in most cases, women have to return to the hospital forty-eight hours after taking mifepristone, and then they are given a vaginal suppository of misoprostol. This drug is a prostaglandin which induces cervical dilation and uterine contraction, thus helping the pregnancy tissue and fetus to be expelled through the vagina.

In most hospitals, women undergoing first trimester medical abortion remain at the clinic for observation and nursing assistance for four to six hours, within which time they will, in most cases, expel the fetus. Women are provided with cardboard bedpans and use these when going to the toilet so that nurses can check whether or not the fetus has been passed before patients leave the clinic.

Second trimester medical abortions are lengthier than first trimester ones, and often involve an overnight stay. The total number of misoprostol suppositories, and the frequency with which they are administered, increases with the gestation of a pregnancy. Additionally, whereas the uterine contractions involved in first trimester medical abortions were described to me as being like "bad period cramps", second trimester medical abortions

can involve much stronger, and thus more painful, contractions (particularly later in the second trimester). In other words, as the length of gestation increases, and the fetus becomes progressively larger, women's bodies become more actively involved in its expulsion. They are offered pain relief up to and including morphine.

Patients often require a great deal of support from staff during second trimester medical abortion, particularly at the point when the fetus is being delivered. Staff informed me that they encourage women "not to look" at this point, and that they remove the fetus quickly in order to prevent women being distressed by an entity which, although very small and incompletely developed, could be considered "baby-like". For this reason, as well as the higher risk of complications developing, women are kept in the clinic until the abortion is complete.

As described in Chapter Three, although doctors prescribe the drugs, it is nurses who supervise medical abortions. This involves administering the drugs, providing assistance to women undergoing abortion and disposing of the fetus, plus other pregnancy tissue (e.g. the amniotic sac/placenta) following the procedure. As noted above, later medical abortions necessitate a greater amount of staff involvement, particularly at the point of

delivery where, as well as assisting the patient, the nurse must cut the umbilical cord and ensure that the placenta is delivered.

Procedures for fetal disposal vary from hospital to hospital. However, in general, pregnancy tissue produced through first trimester medical abortion is packaged for incineration (although my nurse participants were keen to reassure me that it is always kept separate from other forms of hospital 'waste'). At later gestations, fetuses are packaged individually in small boxes (referred to as "white baby coffins" by some nurse participants). Most hospitals dispose of these fetuses through cremation via arrangements with local funeral directors/crematoriums (patient consent is obtained for this).

I was also told that, with the prior consent of patients, fetuses produced through medical abortion are sometimes used for research purposes rather than being incinerated/cremated. The collection and use of aborted fetuses in stem cell research has been studied by Pfeffer and Kent (Pfeffer & Kent, 2007; Pfeffer, 2008; Pfeffer, 2009).

Surgical abortion

As noted above, surgical abortion is the main method used to terminate a pregnancy in Scotland from nine to approximately twelve weeks' gestation. It is

rarely performed above gestations of about thirteen weeks. The reasons for this time-limit on the provision of surgical abortion are considered in Chapter Seven.

Before a surgical abortion, suppositories of misoprostol are used to soften and open women's cervixes. The primary technique involved is the use of a suction curette to remove the fetus/other pregnancy tissue from the uterus under vacuum aspiration (the use of forceps is also sometimes required). Theatre nurses dispose of this tissue (ultimately, for incineration) following the procedure.

At all of the hospitals I visited, surgical abortions were performed on a day case basis (i.e. as part of the day-surgery workload), under general anaesthesia. I was told that the only exceptions to this would be if a woman had health problems which made her unsuitable for day surgery; in this case she would be admitted to a gynaecology ward.

Chapter Four: “It’s like being a chest physician and saying you don’t do asthma”- Conscientious objection and the boundaries of professional responsibility for abortion.

4.1 Introduction

As described in Chapter One, the 1967 Abortion Act marked abortion out from most other medical procedures (Sheldon, 1997) by giving HCPs the right to refuse to become involved in its provision on the grounds of conscience:

(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... (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. (The Abortion Act 1967)

However, in their analysis of the aftermath of the 1967 Abortion Act in Scotland, Davis and Davidson (2005) highlight the tensions and complexities generated by the operation of this clause in practice. While the right of individual HCPs to opt out of abortion provision was seen as something which should be protected, it was not always easy to accommodate alongside the provision of an NHS abortion service (Davis & Davidson, 2005). In this chapter I will build on this work by exploring how the meaning of “conscientious objection” is constructed in the context of contemporary Scottish abortion practice.

The analysis that follows is informed by the theoretical framework outlined in Chapters Two and Three, but draws particularly on Gieryn’s insights concerning the ways in which scientists delineate the boundaries of their professional practice. As Gieryn describes it, such “boundary-work” involves:

the attribution of the selected characteristics to the institution of science for the purposes of constructing a social boundary that distinguishes “non-scientific” intellectual or professional activities. (Gieryn, 1983: 791)

Using a number of case studies Gieryn reveals that the definition of the boundaries of ‘science’ has major political repercussions. For example, groups of scientists often

try to define the boundaries of their work in such a way that potential competitors are prevented from defining their work as ‘scientific’ (Gieryn, 1983). Being unable to lay claim to the authoritative status of ‘science’ can put such competitors at a major disadvantage, for example, by making it impossible for them to gain financial support for their work.

As Gieryn (1983) notes, the concept of boundary-work is relevant in contexts other than the delineation of what is to count as ‘science’, because it is a ubiquitous rhetorical strategy through which specialist groups try to demarcate and thus legitimate the basis of their ‘professional’ status. In the discussion that follows I argue that, as HCPs articulate the meanings of conscientious objection, they engage in important boundary-work. Through this process they define the parameters of the activities which members of the healthcare profession can legitimately engage in with respect to the provision of abortion.

However, before beginning my analysis, it is important to explain how my use of the term “boundary-work” differs from the recent development and use of this concept by Wainwright *et al.* (2006) in their analysis of embryonic stem cell researchers’ accounts of their practice. Like abortion, embryonic stem cell research is frequently discussed as a controversial practice which intersects with questions concerning the beginning of life, and the legitimacy of human intervention in this process. In their analysis, Wainwright *et al.* concentrate on the research practices which are demarcated as ‘good’ or ‘ethical’ by their participants. They argue that this process of demarcation represents a distinctive form of “boundary-work,” which they term “ethical boundary-work”.

Wainwright *et al.* suggest that the introduction of this new terminology is necessary because, when stem cell researchers draw boundaries around more and less acceptable practices (e.g. by distinguishing different sources of embryos), this:

is not about differentiating science from non-science, but rather, about drawing boundaries between what is ethically preferable. (Wainwright *et al.*, 2006: 739)

However, an alternative approach to their findings would be to suggest that their participants are demarcating the types of work that can legitimately be conducted as part of “embryonic stem cell research”. As such, it is possible to understand their participants’ accounts of good research practice simply as “boundary-work” in the original sense outlined by Gieryn, i.e. as the demarcation of limits around activities which can/should be conducted by members of a profession.

In order to argue that their participants are engaging in a different kind of demarcation activity called “ethical boundary-work”, Wainwright *et al.* first assume what it normally means to differentiate ‘science’ from ‘non-science’. In other words, they define the meanings of both ‘science’ and ‘non-science’ in advance of their analysis. That they are working with these kinds of analytical assumptions is suggested very strongly in the introduction to their paper, where they argue that they will show how “non-science, in the form of ‘ethics’, is becoming an integral part of maintaining the image of science” (2006: 735). Such an approach is incompatible with that advocated by Gieryn who, like many STS researchers, focuses upon the way in which the meaning of “science” is accomplished in practice. As he points out:

Because of considerable material opportunities and professional advantages available only to ‘scientists’, it is no mere academic matter to decide who is doing science and who is not. (Gieryn, 1983: 781)

Likewise, in this chapter I argue that the demarcation of limits around the activities which HCPs can legitimately engage in as members of the ‘healthcare profession’ has major implications both for their own and their patients’ experiences of abortion provision.

The discussion that follows is divided into three parts. In the first section I explore two discourses through which conscientious objection is constructed as a legitimate practice, and reveal that HCPs who are involved in abortion provision characterise this legitimacy very differently from those who opt out. In the second section, I illustrate an alternative discourse, through which HCPs reject conscientious objection as a practice which is incompatible with their work as HCPs. In the final section, I go on to illustrate how these seemingly incompatible discourses are brought together by individual HCPs. I suggest that, by exploring this process, it is

possible to see where HCPs demarcate limits around the right to conscientiously object to abortion, and thus the fundamental responsibilities which HCPs have for abortion provision as members of the healthcare profession.

4.2 Legitimizing conscientious objection

One of the few analyses which has addressed the issue of conscientious objection in UK abortion practice within the last two decades is provided by Roe *et al.* (1999). Their paper begins by framing the issue of conscientious objection as a particular kind of problem:

Concerns that a dwindling number of younger doctors are both fully trained and willing to provide abortions when they qualify prompted the London-based Abortion Law Reform Association (ALRA) to carry out a two-part national survey to determine the extent of this problem. (1999: 98)

Based on this concern, they survey the views of consultants and trainee doctors in obstetrics and gynaecology, and try to establish the extent to which abortion provision is viewed as an integral part of training in this specialty.

Throughout Roe *et al.*'s analysis it is assumed that only certain individuals can legitimately make use of the conscience clause and opt out of abortion provision:

Most consultants (86 per cent) thought that trainees who opted out of abortion training conscientiously objected to abortion on religious or moral grounds. Even so, many consultants thought there were other reasons why junior doctors opted out of abortion training, which gave considerable cause for concern. (1999: 100)

In response to these concerns, the authors recommend that junior doctors who make use of the conscience clause should be obliged to declare "their reasons" (1999: 104) for their objection. In doing so, they imply that it is possible to distinguish reasons for opting out of abortion provision which are legitimate from those which are not. However, rather than adopting this assumption, in the following sections, I address this issue as a topic for analysis. How are 'legitimate objections' to abortion constructed by HCPs?

4.2.1 The Othering of 'genuine' objections

Echoing Roe *et al.* (1999), several of the HCPs I interviewed expressed their suspicions that not everybody who opts out through the conscience clause holds a 'genuine' conscientious objection to abortion:

But there are, there are one or two there at [*hospital*]. And, and some of them are truly conscientious objectors. Some of them used to do abortions and then, on the road to Damascus they decided that they didn't want to do abortions any more and I'm slightly suspicious that it's nothing to do really with conscientious objection, it's just that, you know there is this view among gynaecologists that women having, women coming for abortion are undeserving and that everybody else that they see is far more deserving of their time um than women coming for abortion and they resent the fact that the operating lists are fill up, filled up with people having an abortion when they, that means that people with post menopausal bleeding or infertility or something have to wait longer for their operation. [Consultant 4, female]

Interviewer: And you said that it's registrars and um SHOs, does that mean that it's increasingly people coming from uh sort of, the next sort of generation of doctors that are opting out?

Participant: Ah... I get that impression, it's based on no hard evidence.

I: Yeah, sure.

P: But I get that impression that there's more. Now whether that's because actually it's just out of laziness and they don't want to be involved cos 'oh it's a hassle', don't know. Certainly in [*city A*] I remember a story that [*a doctor*] who [*omitted for anonymity*] said to me one time that, you know exactly this situation in [*city A*] there were a couple of registrars who refused to be involved with terminations in the gynaecology wards at [*hospital*]. Uh and they said, 'that's fine, when you're on you can be on call for the labour ward and whoever's on labour will be on call for gynaecology'. They soon changed their minds about their social [*laughs*] um, their position on that! Because, in fact it's much harder work to be on call for labour than it is for gynaecology.

I: Right, ok.

P: So people's minds can be changed. So that's, see that's naughty. If it's just out of laziness then that's naughty that's uh, um so you know it's, but you can't prove anything.

I: No.

P: But there are people who, you know, for religious views or moral views – that's fine, that's cool. What I don't like is inconsistency. [Consultant 7, male]

In this and the previous quotation, as well as in the analysis performed by Roe *et al.* (1999), boundary-work is used to distinguish cases of 'genuine' conscientious

objection from situations in which HCPs are making an illegitimate use of the conscience clause. Through this process, a definition of ‘genuine’ conscientious objection, and thus legitimate use of the conscience clause, emerges. Both Consultant 4 and Consultant 7 highlight the importance of consistency; a ‘genuine’ objection is a perspective that you either possess or you do not. As a result, suspicions are automatically generated by those who appear to ‘switch sides’. Additionally, each of these HCPs refers to religious belief as a circumstance in which conscientious objection to abortion is ‘genuine’. Consultant 7 concedes that those who possess “religious views or moral views” can legitimately opt out of abortion provision. Likewise, through her Biblical reference to St Paul’s revelation “on the road to Damascus”, Consultant 4 seems to imply that the development of a *real* ‘conscientious objection’ to abortion requires conversion to religious belief. However, her sarcastic tone signals her scepticism concerning those HCPs who suddenly decide to stop being involved in abortion provision. She suggests that, rather than undergoing revelations of religion, these doctors hold inappropriate beliefs about the deservingness of abortion patients.

The distinctive “personal” views of ‘conscientious objectors’ were also emphasised by HCPs who were unusually tolerant of those who opted out:

I: And so how do you feel about people who decide to um opt out the, you know, through the conscience clause?

P: I think that’s, that’s for them, yep. If uh, if they make it clear to uh, uh their patients that uh they have a, that’s their, their personal feeling and view and I, I wouldn’t want them to uh uh do something that would conflict heavily with their own conscience. [GP16, male]

I can see that people have, you know, to wrestle with their conscience about lots of different things and um ah, and if that’s part of their religion, or a part of the way they think about things or view things then, I don’t think there’s a lot you can do to change it. I don’t think people do, I don’t think people hold that opinion to make life diffi-specifically to make life difficult for someone, I think that is just the way they, the way they feel yeah. [GP6, female]

Although HCPs often suggested that conscientious objection to abortion is an automatic corollary of “having religion”, my data suggest that the relationship between religion and the practice of conscientious objection is very complex. Several

of the HCPs I interviewed did not identify as conscientious objectors but *did* identify as members of faith groups (including the Catholic, Methodist and Anglican faiths). Additionally, one of the ‘conscientious objectors’ stated that she did not belong to any religious faith.

Whether or not they make explicit reference to the importance of religious belief, these extracts all construct genuine conscientious objection to abortion as an intrinsic and inalterable part of certain HCPs’ identities. Through this discourse, conscientious objection to abortion becomes characterised almost as an affliction, or a condition which certain individuals have ‘got’, and which must therefore be tolerated by other HCPs. In other words, this stance is constructed as Other than the norm. Simultaneously, participation in abortion provision becomes normalized and HCPs do not have to reflect upon or justify their own involvement in this practice.

4.2.2 Opting out: Enacting morality

Those HCPs who objected to abortion also depicted these objections as distinctive personal viewpoints that make it impossible for them to be involved in its provision. However, while the extracts above construct genuine objection to abortion as a passive part of HCPs’ identities that forces them to opt out, those who *identified* as conscientious objectors depicted their use of the conscience clause as a deliberate moral act:

P: Um, I’m totally against abortion.

I: Ok

P: Um I, I suppose it’s all to do with when one accepts when life begins. And if the concept of life begins at the point of conception then whatever you do after that has to be wrong. In my view. Um while recognising that uh there are certain circumstances where one can be sympathetic to the plight of certain patients um you know, that, that is how, that’s the view that I hold and will not waver from that.

[GP20, male, conscientious objector]

In this extract GP20 portrays himself as someone who works hard to enact his personal moral beliefs; he will not “waver” in spite of the temptation to be sympathetic towards his patients. However, while he depicts the belief that life begins at conception as one that he must honour through his practice, he does not try

to assert this as an absolute truth. His acknowledgement of the situated basis of perspectives concerning when life begins is interesting when contrasted with the way in which anti-abortion groups portray the immorality of abortion as objective ‘fact’, and seek to convince others of this perspective (e.g. Petchesky, 1987; Franklin, 1991; Hopkins *et al.*, 2005).

A similar account is produced by GP7, who locates his beliefs about abortion within his Christian faith, and goes on to argue that, in spite of his sympathy for his patients, he cannot personally sanction the practice:

Um I, you know I think it’s recognising this is a, a life um ok a, you know, a, a fetus at six, six weeks it certainly has the potential to be a human, it may not at that stage display all human traits but it certainly will, will develop into one and to, to, I don’t believe then it’s necessarily our choice to, to, to, to give and take away life in a sort of God-like fashion um and that um, you know, so that relates to sort of euthanasia, that relates to, to um sort of termination and, you know, the care of the vulnerable, and the unborn I would say would be the most vulnerable um is, is, is um something that that, you know, I can’t in due conscience sanction and that is partly rooted in my, I suppose my Christian faith that I believe that there’s a sanctity of life. Um, I can understand why a lot of the reasons and be sympathetic towards a lot of the reasons where women come and say I really just think I couldn’t cope with another child, but um I don’t think morally I can sort of say that that can then justify what’s basically terminating a, a, a life. [GP7, male, conscientious objector]

As in the previous extract, the impression is created of a personal belief which, rather than being passively possessed, is lived out through conscious moral reasoning and action.

In addition to constructing abortion as a practice which is incompatible with their own beliefs about when life begins, GPs 7 and 20 also developed critiques of the *grounds* on which the procedure is carried out in the UK. In other words, they positioned their use of the conscience clause as a moral act which does not simply dissociate them from the practice of abortion *per se*, but from a situation in which patients try to access the procedure for ‘objectionable’ reasons:

I have to say with all, with my experience of general practice etc., that most patients’ need for abortion is convenience rather than any sort of, you know, great medical problem related to them. You know it’s a, it’s a,

it's an inconvenience to be pregnant for whatever uh reason that may be. Um so there's no major issues to do with mother's health.

[...] I'm Catholic um and I suppose I was born Catholic, I suppose, I suppose that's been one of the stones, the, the foundation stones of my life. Um, so I've always had that view if you like, I suppose. Um but, and maybe that colours my mind as to some of the, the apparent trivial reasons that people seek abortions for. You know, one can, you know, when the, when the Abortion Act was coming through there was all this about 'oh, mothers being ill' and all this kind of business. I've, I've still to find a mother whose life has depended on an abortion.

[GP20, male]

... I don't think morally I can sort of say that that can then justify what's basically terminating a, a, a life. Um, it's always a grey area, you know, so there are, you know, and the, the law was set up with these sort of, these more in mind, you know, where the woman was at a high risk of death or um because of a continuing pregnancy. Um the basis of the law, that you've, you've highlighted⁴² in a sense is the statistical anomaly that basically is used to justify abortion on request is that, yeah, I mean statistically you are more likely to die in a childbirth, however low that is in this country, than you are in having a termination. So, that is statistically true, but not in a sense in the spirit of the law in which it was written, in my understanding of it. Um, you know, my understanding is that was written in a sense for people who were really going to have a very severe problem with bleeding or high blood pressure or something like that, by going through a childbirth. Whereas, it's sort of written that, well statistically, there is a very small chance you might die in pregnancy, there's always a small, small, small, small amount of women who do. So, and that's how it's justified um. [GP7, male]

Both of these GPs engage in boundary-work to distinguish situations of 'medical need', from the grounds upon which abortions are generally carried out. GP7 contrasts his own interpretation of the "spirit" of the Abortion Act (i.e., that a pregnancy should pose a "severe" risk to a woman's physical health before an abortion is justifiable) with an alternative argument that, because a woman is statistically more likely to die through childbirth than abortion, the latter is *always* justifiable. He discounts the legitimacy of this second argument by dismissing it as a technicality which is used to get around the "spirit" of the Act. In doing so he also manages to discount the women who *do* die annually through childbirth.

⁴² During this part of the interview, GP7 was pointing to the information sheet which I had given him prior to the interview (see Appendix D).

However, a more troubling feature of GP7's account is that, like GP20, he reduces the question of the justifiability of abortion to an issue of doctors' assessments of immediate physical danger. In arguing that abortions are not justifiable in the absence of such medically defined 'need', both of these GPs suggest that women should be able to accommodate their "inconvenient" pregnancies rather than ending them. This argument makes the work of pregnancy, childbirth and motherhood invisible, and implies that any other "aspirations which women might have are of no value beside the opportunity to become a mother" (Boyle, 1997: 39).

Although these two GPs implied that HCPs who 'opt in' are not necessarily regulating the provision of abortion satisfactorily, they did not explicitly condemn the actions of their colleagues. In contrast, Consultant 8, who opted out of abortion provision through the conscience clause, criticised the "liberal" attitude of those who are involved in abortion provision:

I would argue that there's a lot of evidence that doctors are in that way eh less if you like ethically bound than their community because by and large, philosophically they tend to be a liberal group of people and therefore perhaps to an extent tend to be more liberal in the application of the Abortion Act than numbers of members of society might wish. And in fact, that's born out by a number of recent studies showing that, that the general population, many of the general population feel that, in quotes "abortion is too easy" [...] So they're not particularly ethical, if that's the right phrase – it's not actually – but for want of a better one at the moment. The best example of that is that I have a, an interest in, in, and I don't want to go into emotive language but the medical profession in the Nazi era was particularly interesting. And the highest per capita professional membership of the Nazi party in 1934 were doctors. Isn't that interesting? [Consultant 8, male, conscientious objector].

Comparison between the liberal provision of abortion and the Holocaust in Nazi Germany is a well known feature of anti-abortion rhetoric. Indeed, before the passage of the Abortion Act, doctors opposed to the legislation argued that, by forcing the healthcare profession to 'take life' at the direction of the State, it would equate with Hitler's programme of eugenics (Macintyre, 1973; Davis & Davidson, 2006). However, what is interesting about Consultant 8's critique is that it is not directed towards the State, or to the law, but rather towards the healthcare profession itself.

Freidson (1970) argues that medicine's legitimacy as a self-regulating profession is dependent on its claim to 'ethical' practice. In contrast, Consultant 8 suggests that moral integrity or 'ethics' is not something which is integral to the profession of medicine. Rather, he implies, the majority of those who practice medicine are "liberal" (or morally lazy) in character. By implication, the capacity for moral thought is limited to a minority of individuals, such as Consultant 8.

While Consultant 8 suggested that the liberal views of the medical profession were the sole cause of an objectionable system of abortion provision, Nurse 10 was keen to emphasise the contribution made by women requesting the procedure, who, she argued, "abuse" the NHS:

The system is abused. The system is grossly abused. They should only be allowed one – it's not a means of contraception.

[...]

Abortion is too easy. There is a place for abortion but I think it's abused. The service is grossly abused. What it was designed for [*the law*] and what it's doing is two different things. [Nurse 10, female, conscientious objector]⁴³

Throughout the interview, she returned repeatedly to the issue of this "gross abuse" of the service by a particular group of patients, the same ones "who keep coming back" for abortions. In doing so, she constructed her use of the conscience clause as an act that prevents her from becoming complicit with women's immoral uses of abortion.

However, Nurse 10's critique of the current status of abortion provision in the UK also concerned the ways in which those who opt out of the system are treated by their colleagues. She argued that she had to suffer endless, indirect "stick" for her refusal to administer "the miso or the miffy"⁴⁴ to medical abortion patients, as evidenced by her colleague's constant questioning of her position on abortion – "why don't you agree with it?" etc. She suggested that one of the reasons that she was subjected to this questioning was because her colleagues believed that she was trying

⁴³ All comments from Nurse 10 are approximately verbatim. She did not mind me taking notes, but did not want to be tape-recorded.

⁴⁴ "The miffy" is mifepristone, the oral tablet given to women to cause the tissue in the uterine wall to disintegrate. "The miso" is misoprostol, a prostaglandin which is given to women as a vaginal suppository forty-eight hours after they have taken mifepristone.

to avoid work. However, she also argued that her colleagues' resentment stemmed from the fact that many more HCPs possess the belief that abortion is wrong than *practice* their objections:

Every nurse has got a right and can exercise that right, but it's extremely difficult. Young girls [*nurses*] are coerced into doing it. They're annoyed with themselves and take it out on me because they didn't have enough backbone to exercise their rights. [Nurse 10, female, conscientious objector]

Throughout her account, Nurse 10 implied that disagreement with abortion was a widespread, rather than a minority perspective. Simultaneously, she distinguished herself from her morally lazy colleagues, claiming that the latter group lacked the strength (or "backbone") to put this disagreement into practice.

Nurse 10's portrayal of herself as someone who overcomes difficulties to enact her objection to abortion clearly echoes the accounts of GPs 7 and 20, who stressed that they have to struggle against their natural sympathies for their patients in order to live up to their moral convictions. However, although it is important to acknowledge the rhetorical power of this kind of accounting, it is also vital to pay attention to a key point raised by these HCPs; individuals' relationships with one another and with patients may impact upon their ability to opt out of abortion provision.

The importance of workplace relationships is emphasised by Davis and Davidson (2005) in their analysis of the operation of the Abortion Act in the Scottish medical community in the years following its introduction. They contrast the inclusion of a legal clause to protect the rights of individual HCPs with the reality of gynaecological work, which (particularly for nurses),⁴⁵ tends to be conducted as part of a team rather than as an individual activity. Within this context, individual HCPs were reluctant to opt out, because of the fear that they would become extremely

⁴⁵ Bolton (2005) suggests that the emotionally difficult and stigmatised nature of gynaecological nursing (which can involve dealing with miscarriage and gynaecological cancers as well as abortion) means that gynaecology wards tend to be characterised by an unusually close-knit, mutually supportive workplace culture. While she does not address the issue, it seems likely that, if gynaecology nurses deal with the difficulties of their work by operating as a 'collective', then major tensions could be created if individuals are seen to be placing an additional burden on the rest of the team. Additionally, such 'individual' action would, presumably, transgress the 'collective' culture of gynaecology nursing.

“unpopular” with their colleagues (Davis & Davidson, 2005). As I will reveal in the following section, this argument was also mobilised by some of the HCPs whom I interviewed, who constructed ‘conscientious objection’ as a desired but impossible course of action.

However, an additional issue which emerges from Nurse 10’s account is the potential for workplace *hierarchies* to become interwoven with individuals’ ability to enact their objections to abortion. Whilst complaining that the more junior nurses lack “backbone”, she simultaneously described these trainees as people who are “coerced” into participating in abortion provision. Later in the interview, she suggested that senior staff deliberately kept trainee nurses uninformed about their right to opt out because of the pressure that conscientious objection could place on the provision of abortion services. In other words, the ‘right’ to opt out may only exist if you are, firstly, aware of its existence, and secondly, if you also feel empowered to exercise it. While a consultant gynaecologist can make it known that he will not see patients requesting abortions, the situation of a trainee nurse or a junior doctor is likely to be very different.

In comparison to the four other conscientious objectors I interviewed, Consultant 9 appeared to be unusually tolerant of the ways in which others acted in relation to abortion. I end this section with a quotation from his interview in order to highlight the contrast between his account and those described previously. Although he described abortion as a practice which he felt unable to take part in, he did not suggest that he was in a position to define what it should mean for other HCPs, or for pregnant women:

But I, I think there, lots of people would say there is a need for the service. And, just as I want my uh uh ideas and thoughts respected I have to respect what other people feel about this so. So, so I have no, no particular problem if that’s what the majority want. So long as I am not forced to take part in it. [Consultant 9, male]

4.3 An ‘impossible’ option

In describing the practice of conscientious objection, several HCPs who were involved in abortion provision suggested that it is an option which is, or should be, impossible. For example, Consultant 5 talked at length about how “difficult” it must be “not to do abortion”, if you are a gynaecologist:

Um, it’s a, I, as I said it is possible for people now to opt out, they can do um. But um it is the, it is an important part of um reproductive health um I think that it must be difficult to, to be, I think it must be difficult not to do it. Um, but um I think gynaecology and gynaecology people are quite accommodating and it is possible for others not to, to do it. But it is very important and um, you know, it affects so many women. And in other parts of gynaecology, you know, women coming with miscarriage, many of them will have had a, it may be an unintentional pregnancy that’s ended in miscarriage or they may have had unwanted pregnancies in the past. And similarly in infertility so um I think it must, it would be difficult to hold those views and to, and to work in gynaecology but it, but you can! [*laughs*] [Consultant 5, female]

Throughout her account, Consultant 5 engages in boundary-work which locates abortion firmly within the parameters of routine gynaecological practice. She argues that abortion is “an important part of reproductive health”, which is the primary concern of gynaecologists. She also emphasises the overlap between patients who have unwanted pregnancies and those who are treated by conscientious objectors in other areas of gynaecological practice, for example, infertility patients. In doing so, she implies that HCPs who opt out of abortion and work in this specialty fail to understand the nature of gynaecological practice, and the responsibilities of gynaecologists towards their patients.

The construction of conscientious objection as an ‘impossible’ option was most often employed by HCPs who worked within gynaecology. Interestingly, gynaecologists sometimes argued that HCPs who did not work in their own specialty *could* hold conscientious objections to the practice:

Some people will discuss it, refer, sign, but wouldn’t actually do the abortion. And, and that’s ok – for GPs. My personal view is that, if you’re going to be a gynaecologist, abortion is such a big part of the gynae workload, you shouldn’t do gynaecology if you don’t do abortion. *It’s a bit like being a chest physician and saying ‘sorry I don’t do asthma’*. Um I don’t think that actually you should have the right to opt out as a gynaecologist. I think if you don’t approve of abortion, do something else. [Consultant 4, female – emphasis added]

In this extract Consultant 4, who earlier questioned whether HCPs who opt out always hold genuine objections (see p.103), suggests that, even when an objection to abortion *is* genuine, the *practice* of conscientious objection is not legitimate within the specialty of gynaecology. She argues that to be a gynaecologist and to practice conscientious objection to abortion is as ludicrous as being a chest physician who refuses to treat asthma patients. As in the previous extract, abortion provision is located firmly within the boundaries of ‘gynaecology’.

The workload produced through abortion provision was a major feature of accounts in which the practice of conscientious objection was portrayed as incompatible with gynaecological work. For some HCPs, this workload was constructed as a burden which they wished that they did not have to deal with (an issue which is discussed further in Chapters Seven and Eight). Nevertheless, when I suggested that it might be possible for them to opt out through the conscience clause they argued that this is not a “real” option because abortion is part of the specialty they have chosen to work in:

P: I mean if I didn't um if someone said I didn't need to do them then I'd be very happy. But it's part of obstetrics and gynaecology unfortunately so.

I: Um I suppose, in theory, you um some people do opt, opt out of, of providing um um terminations through the um conscience clause.

P: Mmm

I: Um, is that something, I mean how do you feel about the conscience clause?

P: Um, it's diff – it's difficult. I mean I totally understand why people don't want to do it. But when you go into obstetrics and gynaecology it is actually – not a major part of it – but it is a part of um the specialty. And the trouble is, when people opt out it means that other people have to do more. Um so I think, I don't know, you'd probably find that um some people feel slightly aggrieved that because other doctors just decide they don't want to do them they end up getting, getting landed with, you know, double the amount on their lists. [Specialist Registrar 1, male]

I: Sure. Um and you said that you um if you had the, the choice you would not maybe be involved in it?

P: Yeah

I: Um cos in theory, people um do have the choice – I, I mean in theory.

P: Yeah

I: But what do you think about that?

P: Yeah, the the, the theory, the theory of that is then it then falls to your colleagues.

I: Mmm, yeah.

P: And, and I would never put anybody in a, in the the situation. [Nurse 1, female]

In describing the ‘impossibility’ of opting out, these two HCPs make a similar argument to those conscientious objectors who suggest that the ‘right’ to opt out is one which is difficult to exercise in practice (see section 4.2.2). However, rather than simply focussing on these accounts as evidence of the potential difficulties which HCPs may face in attempting to enact their legal rights, it is also possible to consider their more positive implications. Specifically, when HCPs portray conscientious objection as an impossible option, it could be argued that they are situating themselves as relational actors, who have important obligations to their colleagues and/or to their patients. As Lazarus (1997) points out, when opting out of abortion is discussed merely as an issue of individual rights, we cease to pay attention to the relevance of these obligations. In a study of doctors who were training in an obstetrics/gynaecology programme in the US, she criticises the narrow focus of these HCPs:

When residents think of ethical considerations they generally think of their own beliefs and values, in terms of their own autonomy. “Will I do abortions? Under what circumstances? How much will I participate in the process?” Rarely do they think in terms of “what do I [much less ‘we’] owe this patient?” (Lazarus, 1997: 1422)

In contrast, HCPs working in central Scotland seem much more prepared to position abortion within this second framework, wherein it becomes an obligation that falls to those who choose to work within this specialty.

While this is an encouraging aspect of the interview data, it is clearly vital to reflect upon the fact that, by depicting abortion work as a normal part of the work of gynaecology, HCPs who are involved in abortion provision are able to *criticise* the actions of conscientious objectors. In doing so, they can legitimate their own involvement in abortion provision as the only morally acceptable course of action available to someone working in the specialty of gynaecology. Moreover, when HCPs construct conscientious objection as a *desired* but impossible course of action

(e.g. Specialist Registrar 1 and Nurse 1), they are able to portray themselves as individuals who endure hardship in order to fulfil their obligations to others.

The accounts described in this section construct conscientious objection as a practice which is incompatible with the specialty of gynaecology. However, several participants suggested that opting out of abortion should not be an option for *any* HCP, with GP15 stating this particularly strongly:

I: Um and the um, you said that it really pisses you off that some people [*doctors*] have a hang up about it?

P: Oh, absolutely, yeah! Absolutely! You know, get on their soapbox and lecture young kids about, you know, all the religious nonsense and so on. So I do not believe it's their place to do so. So, on you go.

I: Ok. Um and uh I suppose related to that, you know, there's the conscience clause that exists – this is one of the few areas of medical practice where you can opt out.

P: Yeah, absolutely.

I: So what do you think about that?

P: Well it's there to pacify those that like to get on their soapbox really isn't it? But uh I do not believe it's their place to do, get on their soapbox really so, there we are.

I: Ok, um-

P: See we wouldn't have all these problems if we didn't have religion! [*laughs*] Load of nonsense. [GP15, male]

As in the accounts outlined in section 4.2.1, conscientious objection is depicted as synonymous with religious belief. However, in this case, the GP does not tolerate the rights of individual HCPs to exercise such beliefs by opting out of abortion provision. Rather, he suggests that the practice of religion cannot be accommodated as part of the practice of medicine.

4.4 The boundaries of 'conscience'

The preceding discussion implies that there was a clear distinction between those HCPs who accepted that conscientious objection to abortion could be a legitimate practice (section 4.2) and those who did not (section 4.3). However, in the vast majority of the interviews, HCPs drew on a combination of the two discourses outlined in section 4.2 and 4.3 respectively. In other words, they depicted the

practice of genuine conscientious objection as legitimate, whilst simultaneously suggesting that it is problematic.

These accounts of conscientious objection were routinely constructed through what Wetherell and Potter term “the concession/criticism disclaimer format” (1992: 153). They identify this as one strategy that New Zealanders use to criticize the behaviour of public protesters, whilst depicting their critique of protesters as moderate, and thus reasonable. This process typically involves “a limited concession of the legitimacy of protest, followed by the postulation of the limits of legitimacy around the rights of others” (Wetherell & Potter, 1992: 153). Likewise, in many HCPs’ accounts, the practice of conscientious objection was first accepted, and then qualified by statements which delineated the acceptable boundaries of this practice:

I: Sorry the, you know, the conscience clause, you can in theory opt out of provision. So how do you feel about that being a possibility, that people can say-

P: Well, if that’s what they have to do, that’s what they have to do. I wouldn’t particularly want to work with people like that. Um we have from time to time had registrars who didn’t want to see women requesting terminations and um they, they just have to be sure that they can pass somebody on to somebody who will discuss it with them. And that there isn’t any time wasted. Cos that, that’s really the problem, that um a lot of time can pass while doctors, you know, make up their minds.
[GP14, female]

In this extract, GP14 makes it clear that she understands some people may “*have*” to opt out. However, having made this concession, she goes on to demarcate clear boundaries around the kinds of opting out which are possible. She does this by highlighting the responsibilities which GPs who object to abortion have towards their patients; they cannot block or delay women’s access to the procedure.

It is possible to argue that the “concession/criticism” format is simply a rhetorical strategy which HCPs use in order to legitimate their own positions as individuals involved in abortion provision. Through this strategy they can appear respectful of other people’s “moral views”, whilst simultaneously criticising the position of those HCPs who choose to opt out. However, this explanation does not capture the way in which some HCPs seemed to literally *experience* the idea of conscientious objection as ‘acceptable’ and ‘impossible’ at the same time:

Well I think, I think you can't make practitioners do something that they fundamentally believe is against their culture, their religion or whatever. So as long as that opt out conscience clause doesn't actually make it difficult for a woman to access a termination and, and also making sure that that practitioner doesn't enhance or increase a woman's distress by telling them that they're not prepared to do it um so I think that again it's about how you do things. So actually, 'I'm really sorry but you know my I,' I mean I don't know how you would say it actually but you know 'I - because of my religious faith you know this is just one of the things that I find difficult and um that's just my own personal view so I want to help you and what I'm going to do is get my colleague to see you and we'll sort that out now or however.' So I think, I think um, I think it's a difficult one. Um I don't know that you could be that dogmatic about saying practitioners just have to toe the absolute line here. But I don't know where you draw the line because, you know, say you've got a gynae nurse who says, 'I'll do every other procedure but I'm not gonna, or I'll assist at every other procedure but I'm not going to assist at a termination'. And it's almost like, if you feel like that maybe you shouldn't be working in this area um and certainly we wouldn't have anybody here who would be able to opt out with their conscience, you know, because of their conscience um so I don't know. Maybe I'm kind of sitting a bit on the fence a bit. [Nurse 7, female – emphasis added]

In the italicised sections of this account, Nurse 7 accepts the practice of conscientious objection, constructing it as something necessitated by the “fundamental beliefs” of individual HCPs. However, she also positions this practice as a potential threat to patients, and suggests that it is irreconcilable with the work of gynaecology. At the end of her account the tension between these two discourses has become so obvious that she acknowledges and apologises for her failure to reconcile them.

The attempts that HCPs made to accommodate tensions between these two discourses represent an interesting starting point for further analysis. This is because, as they negotiated these tensions, they placed limits upon the forms of opting out which individual HCPs can legitimately engage in. Simultaneously, they were defining the aspects of abortion provision which lie fundamentally inside the boundaries of ‘healthcare’, i.e. the activities which HCPs are obliged to engage in because they are members of the healthcare profession. Unsurprisingly, every HCP delineated these boundaries slightly differently. However, across the interview

transcripts it is also possible to discern a bottom line beyond which the rights of HCPs to opt out of abortion were rejected by *all* of my participants.

Within gynaecology, the ‘limit of conscience’ was placed at saving the life of a pregnant woman. This is illustrated in the following quotation from Consultant 7, who begins by saying that opting out is “absolutely fine”, but goes on to amend this by demarcating a point where HCPs’ obligations towards patients override their right to opt out:

I: Ok. Um and the other thing was there’s been a bit of discussion about the conscience clause that allows people to opt out of being involved in termination provision, and how you feel about the fact that people can choose to not get involved with the service?

P: Oh, that’s absolutely fine by me. Oh, we have lots and increasingly unfortunately which is a pain from a service provision point of view, registrars and SHOs who are saying ‘we do not want to be involved with this, we’re not going to sign anything’. We, if a patient is bleeding heavily and the registrar or an SHO refuses to be involved because she’s had a social termination then I’ll bloody have him against the wall for that because that’s contravention of the GMC kind of guidelines. They’re there to provide healthcare for patients, no matter what their views are. And if the patient is bleeding heavily they have to, you know, resuscitate that patient no matter that she’s having a procedure they don’t agree with socially or um morally. [Consultant 7, male]

As illustrated in the quotation at the beginning of this chapter, the Abortion Act also demarcates emergency situations as a context in which HCPs’ rights to conscientiously object no longer apply. Interestingly, however, Consultant 7 does not cite this legislation. Instead, he refers to the healthcare profession’s own guidelines as evidence that HCPs would be breaking a formalised professional rule if they failed to provide care for a patient in an emergency situation. In doing so he reiterates that this is a matter of *professional* obligation; HCPs are there to provide care to patients in an emergency situation.

Both of the conscientious objectors in my sample who worked within gynaecology appeared to agree that they had an obligation to provide assistance to their colleagues if something went wrong during the process of an abortion, and a woman’s life became endangered as a result. For example, Consultant 8 states that:

My only involvement for example, would be if a woman was undergoing and the process was underway, and she developed a complication which might seriously impair her wellbeing or life. In which case there's no hesitation in undertaking whatever has to be done. *But I wouldn't have started it.* [Consultant 8, male, conscientious objector – emphasis added]

However, it should be noted that, while they concurred about this overall bottom line, my sample only contained two gynaecologists who made use of the conscience clause. Disturbingly, Nurse 6 suggests that other HCPs working in the specialty of gynaecology do not always recognise this limit on the exercise of personal conscience:

From the nursing side as well um I think for working [indirectly] in services fine, but I do think that it gets taken a bit far sometimes. And the same with hospital doctors as well that they've gotta realise that if somebody's in an emergency situation they cannot conscientiously object and that actually taking somebody's blood pressure, is not performing an abortion, you know. And so why, why would you, you know, say 'I don't want to'. [...] And again if I do get an emergency situation where somebody's haemorrhaging and I need people to come and help quickly, you don't want people standing outside the door going 'oh, well...'
[Nurse 6, female]

Legally, the scenario which Nurse 6 describes should never arise, because HCPs do not have the right to conscientiously object to any aspect of medical treatment “which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman” (The Abortion Act 1967). In spite of this, an interesting point that emerges from her account is the ambiguity of what is to count as “performing an abortion”. Nurse 6 describes the difference between measuring a patient's blood pressure and actually performing an abortion as self-evident. However, just as the Abortion Act does not define what it means to hold a “conscientious objection” to abortion, it also fails to specify what it means to *practice* this objection and, correspondingly, what it means to perform an abortion. It simply says that, in the absence of emergency, HCPs are under no obligation “to participate in any treatment authorised by this Act”. Farsides *et al.* (2004) point to this ambiguous situation in their analysis of HCPs' perspectives about working within the field of prenatal screening. They argue that HCPs who work in this area, and who personally disagree with the practice of abortion, “must define for themselves what counts as an action contributing to the performance of a termination” (Farsides *et al.*, 2004: 507), and opt out accordingly.

While GPs are unlikely to encounter a pregnant woman in an emergency situation, the interviews reveal another important consensus about the limit beyond which their rights as individuals cease, and their obligations as HCPs become paramount. As indicated by the quotations earlier in this section, HCPs concurred that GPs had an obligation to facilitate, even if indirectly, their patients' access to this procedure:

I mean I don't think you can expect a doctor if they've got a, if it's against their moral judgment, you couldn't expect a doctor to sign the form. But what I would expect a doctor to do is to make sure the patient then saw somebody that could offer that service. [GP9, female]

This obligation was also echoed by the two GPs in my sample who described themselves as holding conscientious objections to abortion:

Uh that does not mean to say that I don't uh shall we say enable patients who want to have an abortion to take advantage of other doctors' position which would be radically different from mine. [GP20, male, conscientious objector]

Um so in a sense I, I recognise I have a duty under sort of GMC guidelines that if someone requests a termination they should be able to see someone about that. [GP7, male, conscientious objector]

HCPs' consensus concerning the professional responsibilities of GPs is interesting, particularly in light of the fact that there is legal confusion about whether or not GPs have an obligation to facilitate women's access to abortion (see Sheldon, 1997).

However, while they may have agreed about this fundamental limit on their rights as individuals, the extent to which these two 'conscientiously objecting' GPs were willing to become involved in facilitating their patients' access to the procedure was very different. GP20 said that he provides his patients with the phone number of a family planning clinic:

I mean I give them a phone number uh and I say, you know, phone them up and um, as far as I know, other than perhaps those who've changed their mind, they've all gone through that, that process. [GP20, male, conscientious objector]

In contrast, GP7 said that he refers his patients on to the hospital, but does so without signing Schedule 1 of the Abortion Act.⁴⁶ He was adamant that this still constituted conscientious objection, and said that he told his patients and his colleagues what he was doing:

P: It's standard practice well a GP would sign what would be one signature and the hospital would do the other signature, [I usually then put a kind of note to say um] 'I have not completed this form da da da for reasons of personal conscience' um and there's always two doctors in the clinic in the hospital and they would just co-sign it.

I: Has that ever caused you any problems?

P: Well no-one's ever got back to me and saying that's, that's, 'what are you doing, you're causing hassle'. I usually say to, to the ladies at the time 'I'm very happy to refer you, but for reasons of personal conscience I, there's a form that needs signed and I won't be signing it, but there are doctors in the hospital who will sign it for you. [GP7, male, conscientious objector]

He acknowledged that other GPs who share his views might not be able to enact their objections in the same way, and that they would send their patients away to see another HCP. However, he argued:

I feel at least by doing what I do I have the option to discuss the issue and, and maintain some sort of relationship with the patient. [GP7, male, conscientious objector]

Thus, like many other HCPs, GP7 also places limits on the possibilities of "opting out", and rejects some forms of this practice because they are too disruptive to his relationship with his patients. His ability to enact his conscientious objection through his refusal to sign the Certificate A undoubtedly has material implications for his patients, who will not experience any delay in obtaining a hospital appointment. In contrast, after going to see GP20, patients will have to phone up and make a further appointment at the family planning clinic and then attend this appointment before gaining access to hospital services.

During my interviews with GPs 7 and 20, another critical distinction concerning the boundaries of conscience/healthcare emerged. GP20 argued that,

⁴⁶ As described in Chapter One, the grounds under which an abortion is carried out are recorded via two documents. The first is Schedule 1 (see Appendix B), which interviewees referred to as 'Certificate A', or 'the green form'.

because he believes that life begins at fertilisation, it is impossible for him to participate in the prescription of emergency contraception:

Well, it all gets back to the point of, point of life and whether she's pregnant or not – 'but I'm just doing it cos I'm not pregnant!' Well why are you wanting emergency contraception? So I would offer them uh alternative choices, you know, and you can buy it over the counter, you go to A and E, go to family planning. So, there are at least three alternatives uh for anybody to actually, to actually do if they wanted it.
[GP20, male, conscientious objector]

While GP20 is keen to emphasise the other choices that are available to women seeking emergency contraception, it is important to locate these choices within their social context. Without a GP prescription, emergency contraception can cost upwards of £20 from a pharmacist (and, in any case, cannot be bought over the counter by those who are under sixteen years old). When it is considered that patients may be living out of easy reach of either family planning or an Accident and Emergency department, and that emergency contraception is a time-limited drug,⁴⁷ the choices open to them appear rather more restricted.

In contrast, the lack of alternatives which are open to his patients are emphasised in GP7's account of his decision to provide emergency contraception to his patients:

I: Um uh, do you prescribe emergency contraception?

P: I do at the moment. Again, that was a bit of a sort of a dilemma I've, I've kind of faced uh as to, to, to what to do. Initially I made a choice of I'm not happy with that, when I was in the hospital. Cos again there was the choice of not having to do it, someone else can do it then. As a GP I've sort of taken the choice I will do that, partly because it's not always easily available to sort of say go and see somebody else, you know, if you're the only doctor there and it's now six o'clock. [GP7, male, conscientious objector]

However, as well as arguing that his obligations to his patients restricted his ability to exercise his objection to abortion/emergency contraception, GP7 also drew broader boundaries around the point at which 'life' begins than GP20:

Um um and I suppose my view of it, it sort of, you know when somebody is pregnant, at six or seven weeks pregnant it's, it's um, there's no ambiguity as to you know, that this is a fetus with viability vs. a sort of a

⁴⁷ It can be taken within seventy-two hours of sexual intercourse, but its efficacy in preventing pregnancy starts to decrease after the first twenty-four hours.

kind of a, a pre-implanted uh zygote [*laughs*] basically. Um so, the potential for life is, is overwhelmingly different between the sort of something that's kind of at the two cell stage versus a six week sort of pregnancy with a, with a heart-beat. So, it's possibly the lesser of two evils, um, I think. [GP7, male, conscientious objector]

The use of biological discourse to differentiate acceptable from unacceptable interventions into embryonic/fetal development is well known from public debates about abortion (Franklin, 1991; Sheldon, 1997) as well as embryo research (Mulkay, 1997; Franklin, 1999; Parry, 2003). In Chapter Seven, I will go on to illustrate that, while they do not share GP7's stated "conscientious objection" to abortion, many of the other HCPs that I interviewed made very similar uses of biological discourse in order to demarcate a point in time beyond which abortion becomes unacceptable. Arguably, the only difference between their accounts and GP7's is that they are referring to later thresholds in gestational time.

The major differences between the accounts of GP7 and GP20 raise questions about my labelling of "conscientious objectors" as a distinctive, homogeneous group of HCPs, easily separable from the rest of my sample by virtue of their 'objection' to abortion. In many ways, this is a perfectly legitimate characterisation because, unlike the other HCPs I interviewed, the five HCPs whom I have termed "conscientious objectors" responded to my opening question (see Appendix E) by making some statement about the fact that they used the conscience clause, or opted out. However, the contrast between GP7's and GP20's accounts reveals variation both in terms of what it means to *practice* a "conscientious objection" to abortion (i.e., not signing a legal form vs. not referring a patient), as well as the precise act which is being objected *to* (i.e., the destruction of a six/seven week fetus vs. any interference in the development of a fertilised egg).

4.5 Conclusion

In this chapter, I have illustrated that HCPs draw on one of two discourses to construct conscientious objection as a legitimate practice. I have also argued that the discourse which individual HCPs employ in legitimating the practice of conscientious objection is linked to whether or not they are involved in abortion provision. HCPs who participate suggest that there are certain individuals who

possess ‘genuine’ objections to abortion as an intrinsic part of their identity, often attributing this to religious belief. In doing so, they position conscientious objectors as individuals who are different from the norm, but who must be tolerated and allowed to opt out. In contrast, HCPs who *identified* as conscientious objectors legitimated the practice of opting out very differently. They represented their use of the conscience clause as the enactment of an important moral belief, and emphasised that this process is sometimes made difficult by relationships with patients or colleagues. Additionally, they often developed critiques of the behaviour of those who did not abstain from involvement in abortion, including other HCPs and/or women who request the procedure.

In section 4.3 I revealed that, just as some conscientious objectors criticised others for their involvement in abortion, several of those who were involved in abortion provision (particularly those working in gynaecology) developed critiques of HCPs who made use of the conscience clause. This second group of HCPs engaged in boundary-work, through which conscientious objection became defined as a theoretical right which cannot legitimately be enacted in practice because of HCPs’ obligations to one another and to patients.

Collectively, the data considered in sections 4.2 and 4.3 points to the contemporary relevance of Davis and Davidson’s (2005) insights concerning the tension between the existence of a legal ‘opt out’ clause for individual HCPs vs. the social context in which this clause is being enacted. Both HCPs who opt in and those who opt out often depict the possibility of utilising this clause as something which is shaped by workplace relationships (whether with patients or colleagues). Nurse 10’s account also draws attention to the possibility that HCPs’ ability to opt out may be *differently* influenced by these relationships, for example, senior staff may have a greater potential to determine their own involvement in abortion provision than trainees.

However, while HCPs’ accounts of the social shaping of ‘conscientious objection’ are undoubtedly interesting, I have also emphasised the rhetorical

dimensions of accounts in which HCPs are contrasting their own behaviour with that of colleagues who behave differently. Whether they are describing the practice of 'opting in' or 'opting out', HCPs could be said to be engaged in attempts to represent their own behaviour as morally superior, e.g. by emphasising the hardships which they face in order to 'do the right thing' (however this is defined).

In the final section of the chapter I went on to illustrate that, in most cases, HCPs who are involved in abortion provision draw on a combination of the discourses described in sections 4.2 and 4.3 in order to represent conscientious objection as a practice which is simultaneously 'legitimate' and 'impossible'. I argued that HCPs' attempts to reconcile these discourses represent a useful site at which to explore the elements of abortion provision which are located as an intrinsic part of 'healthcare', from which HCPs cannot opt out because of their obligations to their patients. Although the boundaries of 'healthcare' vary across the transcripts, a clear consensus does emerge concerning the absolute limit of conscience. HCPs involved in gynaecology cannot refuse to participate in treatment which is necessary to save a pregnant woman's life, and GPs must help to facilitate, even if indirectly, women's access to abortion.

At the same, my data also suggest that, in spite of this broad consensus, individual HCPs retain the freedom to delineate the boundaries of 'healthcare' in ways that have troubling implications for their patients. The comparison of the practices of two GPs who conscientiously object to abortion illustrated the potential variability in the 'healthcare' which may result from this process. In one practice, patients will receive emergency contraception and, if they request an abortion, they will receive an immediate referral to hospital. In another, they will not receive emergency contraception and, if they request an abortion, they will have to see another doctor at a family planning clinic before being given a referral to hospital.

A final issue which emerges from this chapter is that, when HCPs who are involved in abortion provision position themselves in relation to conscientious objectors, they tend to define abortion as a practice which is a normal and legitimate

part of their work. However, in the following chapters I will reveal that a very different picture emerges when these same HCPs describe their interactions with pregnant women. In this alternative context, ‘abortion’ often becomes differentiated as several kinds of practice, not all of which are constructed as acceptable.

Chapter Five: Knowing women? Accounting for the decision to terminate a pregnancy

5.1 Introduction

As outlined in Chapter One, feminist critiques of UK abortion law often centre on the requirement for two doctors to agree that a woman has grounds for an abortion (Brookes, 1988; Fyfe, 1991; Boyle, 1997; Sheldon, 1997; Jackson, 2000; Lee, 2003b). Both Boyle (1997) and Sheldon (1997) argue that this requirement rests upon and perpetuates the problematic constructions of femininity which dominated the parliamentary debates leading up to the partial decriminalisation of abortion in 1967. In separate analyses of these debates, they criticise the way in which pro-liberalisation discourse depicted abortion as the last resort available to women whose unwanted pregnancies placed them in ‘desperate’ circumstances. Although the portrayal of women’s desperation evokes sympathy, it simultaneously frames the experience of being a woman with an unwanted pregnancy as one of overwhelming distress. Both authors point out that this framing overlaps dangerously with the anti-liberalisation position, which depicted women seeking abortion as impulsive, and incapable of making moral judgments. The law which resulted is suggestive of the resonance between these two positions. Women are neither burdened with or allowed responsibility for abortion because this decision is located with the medical profession, who are portrayed as having access to the knowledge and reason that women requesting the procedure lack (Boyle, 1997; Sheldon, 1997).

In addition to critiquing the way in which UK law and debate constructs abortion and femininity, Sheldon (1997) suggests that the Abortion Act’s deference to medical expertise facilitates the deployment of power over women in the clinic. Based on an analysis of existing literature (concerning women’s experiences of requesting abortion, empirical studies of abortion decision-making, medical reports etc.), she identifies several levels of “control” made possible by the terms of the Abortion Act. Three of these are created by the fact that two doctors’ signatures are required to make an abortion legal. “Decisional control” (Sheldon, 1997: 58) refers

to the power which doctors are given to grant or refuse a woman's request for abortion. Sheldon argues that this level of control then makes women with unwanted pregnancies particularly vulnerable to two other types of control which are routinely exercised during medical consultations.⁴⁸

In order to illustrate the first of these, which she terms "normalising control" (1997: 67), Sheldon draws on Foucault's (1991) concept of "normalizing judgment". In contrast to the simplicity of judgments such as guilty/not-guilty, the plurality of 'norms' open up infinite avenues for the operation of power. As there is not simply one 'norm' but rather "degrees of normality" (Foucault, 1991: 184), the possibilities for classifying 'deviations' and punishing/treating them are endless. Sheldon's concern with the operation of this mechanism of power relates to the *process* of medical interviewing which women must undergo in order to access an abortion:

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 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. (Sheldon, 1997: 68)

Sheldon also identifies a second type of control that is intensified by "decisional control", namely "paternalistic control" in which "the sympathetic doctor imposes his own views" (1997: 149) about what is in a woman's best interests. However, it is difficult to understand why she identifies this as a separate analytical category from that of "normalising control"; both refer to a process in which HCPs measure abortion requests against particular standards, and respond accordingly.

Writing in 1997, Sheldon acknowledges the limitations of the empirical material available to her (drawn primarily from the 1970s and 80s), and the

⁴⁸ The dynamics of medical consultations have been studied extensively by medical sociologists, who have illustrated how asymmetric power relations are maintained between doctors and their patients. Although this body of literature is too large to summarise adequately, some examples include Fisher (1984), West (1984) and Silverman (1987). As a field of theory, medical sociology is characterised by many of the same tensions as those considered in section 2.3 of Chapter Two, for example, concerning the extent to which patients co-operate with, rather than being oppressed by, doctors' attempts to exercise power over them (for an overview see Lupton, 2003).

difficulties of drawing conclusions about the operation of power in contemporary abortion practice, because “it is inconceivable that medical practice and opinions will not have been subject to some change over the past years” (1997: 53). Indeed, more recently, Lee (2003b) has reviewed changes in abortion counselling policy and argues that they reflect a significant shift away from the assumptions about femininity and abortion that are embedded in the law. In the 1970s, Department of Health guidelines advocated the provision of counselling to all women requesting abortion, who “remained constructed in a way similar to that in legal debate, as vulnerable when pregnant and in need of guidance” (Lee, 2003b: 540) from HCPs. In contrast, contemporary guidelines provided by the Department of Health and the Royal College of Obstetricians and Gynaecologists emphasise that only a minority of women will experience difficulties making the decision to terminate a pregnancy, and most will not “need to undergo significant interventions or engage in a particular kind of discussion in order to decide whether to have an abortion” (Lee, 2003b: 542).

Lee also draws on ten semi-structured interviews with abortion counsellors working for non-NHS abortion providers in England, in order to argue that this shift in policy is reflected in abortion practice. Echoing contemporary counselling policy, the abortion counsellors that she interviewed were clear that pregnant women were capable of reaching their own decisions about abortion, and that, for most women, this decision is made by the time they approach abortion services (Lee, 2003b). This finding mirrors research that has explored women’s experiences of abortion, which, as outlined in Chapter One, reveals that the vast majority of women make their decision long before they approach the clinic (Allen, 1985; Kumar *et al.*, 2004; Lee, 2004). Likewise, when explaining how the subject tends to come up in a consultation, the HCPs in my sample painted a very similar picture, arguing that women simply ask directly for an abortion, or for ‘help’ with a pregnancy that they have defined as problematic before they reach the consulting room.

On the basis of her findings, Lee (2003b) argues that abortion policy and practice is now in conflict with the law which regulates abortion. She concludes that,

“Britain needs to have a law that provides for abortion on request” and that “this case is made not only by feminist academics, but more and more by the reality of abortion provision” (Lee, 2003b: 553). However, rather than talking to HCPs, Lee interviewed counsellors, who are trained to prioritise client autonomy and self-determination. She herself seems to acknowledge the contingency of her conclusions about abortion provision when she notes that the extent of the shift in practice that she describes “may vary depending on the geographical location of the provider, whether it is an NHS or specialist unit, and also on the gestation of the pregnancy” (Lee, 2003b: 549). In this chapter, I examine the way that HCPs working for the NHS in Scotland account for abortion decision-making and argue that, in this context, they do not uniformly reject the law’s assumption that they are ‘experts’ in relation to women requesting the procedure.

The discussion that follows draws on the analytical approach to expertise and discourse outlined in Chapters Two and Three, and explores expertise as a subject position which is accomplished through talk, and which can be considered in terms of its immediate and wider discursive implications (Kerr *et al.*, 2007). Using this approach, I attempt to convey the key types of discursive work which HCPs engage in as they account for their involvement in the decision to terminate a pregnancy. The discussion highlights three broad subject positions which emerge from the data, and reveals how each constructs a different relationship between HCPs and women with unwanted pregnancies.

To some extent, each of the three subject positions described can be considered as the preferred strategy of accounting adopted by a subset of HCPs. However, the reason that it is impossible to simply associate individual HCPs with individual strategies of accounting is that, in most of the interviews, they distinguished different *kinds* of decision about abortion, and, in doing so, switched subject positions in relation to their pregnant patients. I draw attention to this phenomenon in the final section of the chapter, where I also reflect upon Sheldon’s (1997) concerns about the operation of power in the abortion consultation. I reveal that, although they often position themselves as experts who can assess women’s decisions about abortion,

HCPs try to avoid claiming absolute “decisional control” over whether or not an abortion can take place. Nevertheless, the ways in which they claim to manage the outcome of decisions that their assessment has rendered problematic resonate strongly with Sheldon’s suggestion that the abortion consultation is a site at which pregnant women are subjected to “normalising control”.

5.2 Demarcating legitimacy: Denying responsibility

One striking feature of HCPs’ accounts was the regularity with which they refuted the suggestion that they could legitimately play a role in decision-making about abortion. The following discussion examines three key discourses that HCPs used to position themselves as illegitimate decision-makers in comparison to women requesting abortion. These discourses are considered individually for the sake of simplicity, but in reality, they were often combined in HCPs’ accounts.

5.2.1 “Discourses of ignorance”

In a small number of cases, HCPs’ denials of legitimacy were couched in terms of a comparison between the status of the knowledge which they possess as HCPs, and the knowledge which women requesting abortion have access to:

But yeah I think, I mean and part of my sort of thing about saying I would find it very difficult to um turn down a, a request for a termination is, is partly based on that. Why would I know better than the woman whether or not she should have a pregnancy? I, I don’t see that I would have any specialist knowledge or experience that would equip me better than her to know if she should have a baby or not. [Consultant 3, female]

P: And I think possibly years, when I, when I worked a few years back, um I mean that was how the clinic was run, I was just a sort of junior member of staff, d’you know what I mean? Um and so maybe I was just a bit more naive about it all and, and maybe felt I had more, had more you know, that was more - I had to sort of find out what was going on in the, women’s lives. Whereas I kind of more feel like you can’t possibly, you know, in, in a twenty minute, half-an-hour consultation, know the huge number of reasons and the complexities of women’s lives as to what’s brought them, do you know what I mean?

I: Yeah

P: To this point. And it’s pretty insulting to assume that you can, you know, so yeah. [Nurse 6, female]

Michael (1996) argues that these kinds of denials of knowledge cannot be treated simply as evidence of a knowledge deficit. Rather, “discourses of ignorance” are actively constructed, defining both the status of the speaker and their relationship to other sources of knowledge (Michael, 1996). Based on an analysis of the way that individuals describe their ignorance about ionising radiation, he identifies three key “discourses of ignorance” through which his interviewees constructed their relationship with scientific knowledge, two of which are particularly relevant to this discussion. Firstly, when drawing on a discourse of ignorance as a “deliberate choice” (Michael, 1996: 119), some individuals argued that they choose not to learn the scientific ‘facts’ about radiation because these just obscured the crucial issue, i.e. that radiation poses a danger to the public. In defining their ignorance, these speakers thus re-define what is relevant to the discussion of ionising radiation and make a political challenge to the legitimacy of scientific framings. In contrast, when drawing on a discourse of ignorance as a “division of labour” (Michael, 1996: 118) some individuals argue that it is not their job (or their responsibility) to know the scientific facts about radiation.

In the extracts above, Consultant 3 and Nurse 6 draw on a discourse of ignorance as a “deliberate choice” by suggesting that, when it comes to abortion decisions, they cannot occupy a more knowledgeable position than that of a woman with an unwanted pregnancy. In doing so they reframe the decision to terminate a pregnancy as something which is not amenable to their assessment; this decision rests upon a woman’s understanding of what an unwanted pregnancy means in the context of her own life.

However, the identification of those who possess legitimate knowledge also automatically defines the labour involved in decision-making. If women are the only people who can know whether an abortion should take place, then HCPs cannot and do not have to be concerned with this knowledge:

I: Sure. Um, and some of the people that I’ve spoken with have said um sort of what you’re saying - that you could see it as the, the woman’s decision as termination is effectively on demand. Um but that, they would see it as the woman’s decision because she’s the person who kind

of has the expertise to assess her own situation. And I'm just interested what you think about that argument?

P: Yeah that's, you know, what - the decision for that woman is right for her at that time. If it happens, if she got pregnant unwittingly two years later, the decision might be quite different because her circumstances will have changed in that time, or could have changed in that time anyway. And, so what's right in one situation isn't necessarily right in another. Now, you know, none of us have crystal balls so we have to um go with what the patient says, you know. [Consultant 7, male]

Crucially, by producing this "division of labour", HCPs' discourses of ignorance as a "deliberate choice" also allow them to deny responsibility for the decision to terminate a pregnancy.

5.2.2 A discourse of women's suffering

The literature reviewed in the introduction suggested that, during the passage of the 1967 Abortion Act, pro-liberalisation arguments about the suffering of women with unwanted pregnancies led to a focus on their emotionality, lack of rationality, and thus ultimately their 'protection' through a law which grants "decisional control" to doctors (Boyle, 1997; Sheldon, 1997). In this section, I will reveal that, when they positioned themselves as illegitimate decision-makers in comparison to women with unwanted pregnancies, several HCPs also drew upon a discourse of women's suffering. However I will point to an important distinction between HCPs' use of this discourse, and the way that it was employed in the parliamentary debates that preceded the Abortion Act. In HCPs' accounts, women's (alleged) emotional involvement in abortion decision-making was not portrayed as something which renders them in need of 'protection' by HCPs. Rather, it was used to position women as legitimate and authoritative abortion decision-makers:

I worked at [*family planning clinic*] for [*number of*] years so I was seeing women requesting an abortion throughout that time and if there's one thing that drives me completely scatty about the anti-abortion argument is when they, the anti-abortionists use comments like uh well women take it lightly, or they don't care or um they use it as contraception or whatever. And I've, I've I think I hardly ever met a woman who didn't think about it very deeply, and I mean it was, you know, your average woman would come having given it considerable thought. Um I'm not saying I never met a woman who was very casual about it but, even then, in my experience, women who are very casual about it had to deal with stuff at some point even if it was later. But it just, it is a very very

profound and deep um decision and, if a woman's reached that decision, it may have only taken her a day, but it still involves profound uh feelings and thoughts. And who the hell are we to say 'I know better, you're wrong'. [GP18, female]

In an analysis of the way that emotion is mobilised as a persuasive device by the anti-abortion movement, Hopkins *et al.* (2005) argue that, while 'emotionality' is often contrasted pejoratively with 'rationality', discourses of emotion can sometimes be used to persuade audiences of the objectivity of a particular position. Precisely because emotion is seen to exist in a separate realm from rational debate, it is harder to contest and "can be construed as 'unmediated' and 'authentic'" (Hopkins *et al.*, 2005: 395). Likewise, in this extract, the "profound feelings and thoughts" which GP18 suggests are part of a woman's decision to have an abortion are depicted as something which makes it impossible for GP18 to contest this decision.

Although GP18 remained vague about the nature of the "profound feelings" which are generated by the decision to end a pregnancy, her argument that even "women who are very casual about it had to deal with stuff at some point", implies that the experience of making this decision is a not a pleasant one. The suggestion that the decision to terminate a pregnancy is intrinsically difficult was made more explicitly by other HCPs:

I wasn't always aware but eventually did become aware that um you can say anything you like in a, in a discussion or an argument but until you've actually been in that situation yourself. Until you've actually thought 'gosh I might be pregnant' and realise, you know, then you realise what that's like and, and you start thinking about 'well what shall I say to my mum and dad? What shall I say to my granny!' You know, um the reality does cast a different light on it. And that, that's something that I've often heard from young women. You know, 'oh! I've always thought this was wrong!' you know or 'I've always said I would never have a termination but I just can't see any way out now'. So I, I you know, I do think that people who haven't been in that situation, and particularly men, have limitations really when it comes to talking about it. [GP14, female]

Brown and Michael (2002) suggest that, while emotions in general represent a powerful rhetorical resource, the display of pain and suffering is particularly effective in conveying the 'authenticity' of a point of view. They develop this argument by illustrating the way in which scientific institutions have responded to the public's increasingly vocal expressions of mistrust about their activities.

Although one obvious solution to this lack of trust is for institutions to render their decisions transparent, Brown and Michael point out that the contextual nature of what is to count as ‘transparency’ means that its extent can always be called into question. Because of this, institutional representatives must convey their trustworthiness by relying on the establishment of their emotional ‘authenticity’ as a substitute for the limitations of factual transparency. This authenticity is “signalled by the agonistic difficulties of ‘making tough decisions’, of being seen painfully to ponder over antagonistic positions, agonising over one course or another” (Brown & Michael, 2002: 261), i.e. the use of conventions which signal suffering or pain. In the extract above, GP14 draws upon similar conventions in suggesting that women are torn between and forced to reconcile competing perspectives concerning abortion when they decide to end their pregnancies. She suggests that, by virtue of the fact that they occupy such a difficult position, these women’s voices are imbued with a greater authority when it comes to deciding (or even simply talking) about abortion.

However, while such accounts may legitimate the perspectives of women with unwanted pregnancies, they simultaneously reinforce the association between abortion and women’s suffering which, as outlined above, is a framing which has long dominated public discussion of abortion in the UK. The persistence of this framing was visible during the Committee Stage of the Government’s Human Fertilisation and Embryology Bill in 2008. Those defending women’s access to abortion relied heavily on the argument that it is an agonising decision, made by desperate women who should be treated with compassion:

Far from reducing the frequency of unwanted pregnancies and abortions, restricting abortion forces women to resort to illegal and mostly unsafe abortions, which endangers their health and their lives. That is why virtually all developed countries legalised abortions in the previous century—because they could no longer accept the tragic suffering and loss of their female population. If women have no access to legal abortion, they resort to illegal means. Women will go to any lengths and will take any risk to end an unwanted pregnancy—and “any” means exactly that [...] What I am saying is that putting restrictions in the way of women who have already made a difficult and, as my hon. Friend the Member for Crosby (Mrs. Curtis-Thomas) said, traumatic decision—she used that word about three times—is just prolonging the agony. Doing so is cruel and unnecessary. [Chris McCafferty, Hansard Column 236-239, May 20th 2008]

As well as critiquing this kind of discourse for its equation of emotionality and femininity, Boyle (1997) points out that it individualises, rather than politicises, the ‘need’ for abortion. The suggestion that abortion is necessary to relieve individual women’s suffering makes it very difficult to discuss it as a social justice issue, “a positive and enabling condition for full human participation in social and communal life” (Petchesky, 1984: 378). However, Boyle also acknowledges that the mobilisation of this negative legitimacy discourse by pro-choice groups may be a strategically important response to the anti-abortion movement’s insistence that women have abortions for unnecessary, frivolous reasons (see Chapter Four). Additionally, she notes that it may have been the only response “available in a context which lacked – and still lacks – positive discourses for women’s rejection of motherhood” (Boyle, 1997: 45).

The absence of such positive discourses often seemed to visibly constrain HCPs as they accounted for their practice. On several occasions HCPs literally stopped themselves mid-sentence in order to re-describe women’s experiences in more ‘appropriate’ language. For example:

Um so the most common presentation I would have to say is um somebody coming in, realising they’re pregnant. Um most people seem to have an idea where they want to go with the pregnancy even to begin with, in the, there are a few people that actually sway back and forth I have to say. But most people will want a termination or – I shouldn’t say want because nobody really wants a termination – um but no most people who know that this is where they’re going to go are upset in some form or another. You know, they may not be crying upset but, you know, it’s it’s upsetting in some way, either because of the partner situation or because [*inaudible word*] at the thought of the loss of a child or um. So, so you know, you very seldom get somebody bouncing in saying ‘oh! I want to be referred’ you know. [GP10, female]

In trying to describe the certainty which some women experience concerning the decision to terminate a pregnancy, GP10 suggests that abortion is something that they know they ‘want’. However she quickly corrects this suggestion, and goes on to testify to the various ways in which the fact that it is impossible to ‘want’ an abortion causes women to suffer. As in the accounts described above, the impression which is created is that the decision to terminate a pregnancy is intrinsically distressing. However, the difference is that, whereas the accounts above seem to make *use* of a

discourse of suffering, GP10 seems to find it impossible to talk about abortion decision-making in any other way. As the discussion in section 5.5 will demonstrate, the difficulties involved in discursively separating the legitimacy of abortion from women's suffering also has important implications for those who request the procedure.

5.2.3 A discourse of 'woman's choice'?

When drawing on discourses of ignorance or suffering, HCPs constructed their position of illegitimacy in abortion decision-making with reference to the fact that they are not the person who is *experiencing* an unwanted pregnancy. This experience is said to provide women with privileged insights or 'expertise'. However, in other cases, HCPs rejected "decisional control" over abortion on the basis that women should automatically have ownership over decisions about their own bodies:

I: Ok. Um, you said you saw your role as a sort of facilitator. Um I'm not trying to put words in your mouth I just want to know if this is what I've understood – does that mean that you see the decision as being, as women's, women making the decision?

P: Absolutely. Yeah, women. It's, the decision is the woman's decision, it's not my decision. And if she comes in here and says 'this is what I want to do, I've had a discussion with', whoever she wants to discuss it with, or me if she wants to discuss it further then I'll pass on what she wants to do. But it's not my role to make her decision for her.

I: Could you say a bit about why you see it as being the woman's decision to make?

P: Well she's the one that's pregnant! [laughs]

I: Ok.

P: Absolutely, and it's her decision to make. It's not her husband's, partner's, boyfriend's, whatever else decision to make, it's her own decision to make. And I firmly hold that view, so. [GP15, male]

I: Could you say a bit about why you see it as being the woman's decision, you know if she wants a termination and she just feels...?

P: Well I don't believe that life begins at conception, you see, I think that life is life when it can exist as autonomous or uh from you know another human being um so, in my view it is a woman's body and it's a woman's choice and just through the, you know, that's all very high brow. But I, I think at the end of the day, if you look at it from a pure practical point of view, it's the woman that's going to get stuck with the, with the situation so um until the system works better and until the, the men take more responsibility I think that's entirely a woman's choice um. [GP10, female]

Interestingly, GP10 combines an ‘individual/biological’ argument concerning women’s rights to bodily self-determination with the alternative, ‘social’ argument which feminists have used to advocate women’s reproductive freedom (Petchesky, 1984), namely, that in comparison to men, women bear a disproportionate share of the burden of childcare.

However, more often, HCPs’ representations of abortion as ‘woman’s choice’ seemed to be articulated as part of a discourse of ‘*patient’s choice*’. In other words, rather than depicting abortion as a political issue, HCPs constructed a model of medical practice which, regardless of context, prioritises patient autonomy. In doing so, they suggested that it is never part of their job to make decisions for their patients:

I: And how does the role that patients - ok so in the case of termination it’s, you say it’s the woman’s decision. And how does that compare with the role that patients play in making decisions about other kinds of medical procedures?

P: Well, I really feel that patients have to take a greater responsibility for what they do and don’t do. And I give them the information and they choose to ignore it, accept it or whatever um so. So, basically it’s a bit like [what] I would practice anyway. [GP15, male]

I: Um, could you say a bit about why you see it as the woman’s decision?

P: Because I suppose that’s the way I practice medicine. I always feel very much I’m, I’m an informer and I give people information in order to help them make choices about their health and illnesses and things um. But also um because I don’t want the woman to come back a few months down the line and say ‘you made me have a termination’ or ‘you made me not have a termination, it’s your fault I made the wrong decision’ um and that’s that’s not, not what I’m there for mmm. [GP11, female]

The emphasis which HCPs placed on patient choice is unsurprising given that, “the primacy of patient autonomy has emerged as a central theme within medical law” (Jackson, 2000: 468) in recent years.⁴⁹ Moreover, as noted by numerous medical sociologists, western medicine is increasingly characterised by the expectation that individuals should be more concerned with, and take greater responsibility for, their own health (e.g. Lupton, 1995; Petersen & Lupton, 1996).

⁴⁹ The priority granted to this principle is central to the closely related practice of prenatal screening and abortion for fetal abnormality (e.g. Williams *et al.*, 2002c), in spite of the fact that the pregnant woman is entirely absent from the legal clause which regulates this particular practice (Scott, 2005).

When considered in this broader context, it is clear that a discourse of ‘woman’s choice’ does not necessarily pose any challenge to HCPs’ status as professionals; the centrality accorded to this principle is simply represented as a feature of normal medical practice. Crucially, this discourse allows HCPs to locate all responsibility for abortion decisions with individual pregnant women, without suggesting that their patients have privileged insights when it comes to making such decisions.

5.3 Becoming insignificant: Dispersing responsibility

In their analysis of the impact of the 1967 Abortion Act on the Scottish medical community, Davis and Davidson (2005) highlight the possibilities which existed for HCPs to minimise their personal responsibility for decisions about abortion. This sometimes involved the active manipulation of the system of abortion provision to ensure certain outcomes, whilst ensuring that they were personally distanced from these outcomes. For example, GPs could engage in strategic referral practices which ultimately prevented women from accessing the procedure, gynaecologists could claim their waiting lists were too long to see individual patients, and Consultants could impose blanket policies about the acceptance/rejection of abortion requests on the rest of their staff (Davis & Davidson, 2005). Forty years on, it is hardly surprising that such practices do not feature in HCPs’ accounts. However, Davis and Davidson also illustrate how GPs in particular were able to make a more passive use of the system of abortion provision:

...he could obligingly refer patients to a local hospital but, rather than make his own recommendation for or against the procedure, write a neutral letter committing himself to no decision and thus evading responsibility for whatever would follow. (Davis & Davidson, 2005: 301)

Likewise, the discussion in the remainder of this section will reveal that HCPs in contemporary Scotland continue to draw discursively on structural aspects of abortion provision, in order to position themselves as subjects whose responsibility for decisions about abortion forms a small part of a wider system.

In England, the existence of private and charitable abortion providers means that, if they can afford to do so, women can self-refer to these services, by-passing the primary care system. However, as described in Chapter Three, the absence of such clinics in Scotland means that women are dependent on NHS abortion services, which can only be accessed following referral by a GP or community sexual health clinic. In general, this means that they will have to have two consultations (one in primary care and one at the hospital) before being given an appointment for the procedure.⁵⁰ During interviews, GPs often utilised this situation to characterise the decision to terminate a pregnancy as something that extends into a future which exists beyond their consulting rooms:

And if they, if I'm going to refer them on to the hospital I often point out that they can still change their mind about that decision right up to the last minute. And me referring them, or them agreeing with the doctor that they're going to go ahead and arrange a date for termination does not tie them into anything, right up to the last minute. Um cos people often do change their minds. They change their minds between me referring them to the hospital and them being seen, and they change their minds in between them being seen and actually having the procedure. Um and I think they need to know that they've got that possibility as well. [GP17, female]

Unlike the accounts considered in the previous section GP17 raises, and has to deal with, the possibility that women may change their minds about the best outcome of their unwanted pregnancies. She manages this problem by constructing the decision to terminate a pregnancy as a process that encompasses a series of consulting rooms, and thus an extended period of time. In doing so, she reveals the opportunities for women to change their minds, and simultaneously highlights the fact that her action in referring somebody is not synonymous with an abortion.

Interestingly, those working in the hospital outpatient clinics where women have their second consultation also drew on structural aspects of abortion provision to distance themselves from the decision to terminate a pregnancy. Unsurprisingly, rather than describing the decision as something which will occur at some point in

⁵⁰ In recent years, community sexual health clinics in some NHS Boards have developed arrangements with local hospitals, enabling women to be given direct access to the procedure from the community without a separate outpatient consultation at the hospital.

the future, they emphasise the time and events which have transpired before women reach their own consulting rooms:

P: I think I spent a lot more time initially um asking them more about their decision, checking the decision was ok. But I think now I almost feel that that's, you know, *there's so much opportunity to talk about it* that, you know, as long as I'm sure in the few minutes that I talk to them about it I don't pry too much about why they're doing it or what brought them to make that decision.

I: Yeah. Yeah, that's something I'm quite interested in cos um some of the GPs I've spoken to have said that they see decision-making taking place more in secondary care – and some of them have said it takes place in primary care. So I'm just interested how you see the relationship between the first consultation and the second consultation that women will have?

P: Um, I think it's very variable. I think, I suspect you're right, I think some GPs maybe, you know, feel that we'll then go and spend a lot of time talking to them about how, how they came to their decision. *And, but I think the good thing about having – a lot of people talked about not having two doctors – I think the good thing about it is that you know that they've gone and discussed it, even if it's just for a few seconds they've discussed it with someone, and then there's been a time period usually for a few days or a week so they, before they have to then discuss it again* and I think that time period's probably quite important to allow them to think about things. Cos, you know, you can talk to a patient for an hour and that's not necessarily going to get you any further forward with them, I think that they've got to go away and think about it themselves.

[Specialist Registrar 1, male – emphasis added]

In this extract, not only is the structure of abortion practice used to introduce the dimension of time to decision-making, but, additionally, the law is invoked as another layer of structure, which ensures that this temporal dimension is kept in place.

By emphasising the multiple safeguards and exit routes which are built into abortion practice, HCPs do not simply minimise their own role in abortion decision-making. At the same time, they construct women requesting the procedure as individuals who (at least potentially) require protection from themselves.

Nevertheless, in the accounts presented so far in this section, it is the time and space created by medical practice which enables women to reach the right decision, rather than any expertise on the part of HCPs. In contrast, some HCPs who engaged in the dispersal of responsibility attached great significance to the fact that their patients

will encounter other members of the healthcare profession before accessing the procedure:

I: Um I was going to ask if you always refer a woman on if she's requesting a termination, or if there's any cases where you say no or?

P: Never said no, I think, I'd, I, I'd always refer them on because they, I think they go through the same process again, I don't know what they do in the gynae clinic but I think they go, do the same process again, you know, that they usually see them in the gynae clinic and then give them a date then. So I know it's a kind of a second, a second line so I'd always refer them on. I don't think I'd say, I'd say, I'd say no to someone.
[GP13, male]

Who is it that makes the decision in practice? Yeah. Um I, in a, in a sense although I am a gatekeeper um I am also a kind of signposter in that, in a sense um many people that, who are wanting a termination have to go through some facilitator. And I will facilitate getting them from where they are uh to the person that can do it. Um, so I suppose in a sense the decision is between them and the person that actually does, you know, particularly with a, a surgical procedure, but in a sense the same kind of ethical decisions lie with a medical procedure. If you are um terminating a potential life, that's a fairly big issue and therefore um, if you are directly responsible for doing it I think it's appropriate that that person um agrees that they feel that this is the right thing to do. [GP1, male]

In these extracts, GPs position HCPs who work in hospitals as *obstacles* which women have to overcome before being given access to an abortion. While GP13 is vague about the nature of this "second line", GP1 states explicitly that the doctor who carries out the abortion must judge and agree with a woman's request for the procedure. In doing so, he simultaneously distinguishes his own identity from that of a doctor who is "directly responsible" for abortion, and suggests that women do not automatically make the "right" decisions by themselves.

5.4 Assessing women's decisions: Embodying responsibility

During the interviews HCPs often pointed out that, as with any other medical intervention, they have a legal obligation to ensure that their patients are making "informed" decisions about abortion. However, as argued in Chapters Two and Three, the definition of relevant 'information' or 'knowledge' is never neutral because this process inevitably asserts a particular version of reality. This is particularly obvious in public discussions of abortion, where those opposed to the

practice insist that women who undergo the procedure are doing so in ignorance of ‘the facts’. This argument was mobilised during the passage of the 2008 Human Fertilisation and Embryology Bill, when anti-abortion MPs tabled an amendment in an attempt to make it mandatory for HCPs to provide certain information to women requesting abortion. In doing so, they engaged in the well-known anti-abortion tactic (Petchesky, 1984) of subverting feminist arguments about women’s “right to choose”, by emphasising women’s “right to know the facts” about abortion:

Having an abortion is a very serious undertaking, and women who have had one rarely ever mention it again. I suppose that for many it is something that they would prefer to forget, but even for them, echoes of that day will live with them for ever. Some will come to bitterly regret their decision. Some women will invariably develop depressive anxiety or other mental health disorders as a direct result of a five-minute decision. The new clause seeks to ensure that women presenting themselves for an abortion are given the sort of information that women should have had since the introduction of the law. I am arguing that at least five days before a woman finally makes any decision to have an abortion, a doctor should be required to offer her counselling and the details of the embryonic and foetal development of her baby at two-weekly intervals. She should also have information about the physical, psychological and psychiatric risks associated with the termination of pregnancy, including a description of the methods of termination of different types of pregnancies and any risks associated with those methods. Finally, the woman should have a right to know about adoption services and other sources of help and advice, including information on any disability or abnormality from which the pregnant woman’s embryo or foetus is at risk of suffering if born. [Claire Curtis-Thomas, Hansard Column 228, May 20th 2008]

In this extract, the information that is portrayed as relevant to the decision to terminate a pregnancy encompasses medical definitions of embryonic/fetal status, as well as the risks of undergoing abortion.⁵¹ A pregnant woman’s situated understanding of what a pregnancy means to her is not acknowledged as important ‘information’. Indeed, Claire Curtis-Thomas suggests that the perspective of a pregnant woman who requests an abortion is not simply irrelevant but is also *dangerous*; such women should be prevented from acting until they have been subjected to a particular kind of medical enlightenment.

⁵¹ Lee (2003a) provides an in-depth analysis of the anti-abortion movement’s use of arguments concerning the damage that abortion poses to women’s mental health.

Rather than contesting this construction of pregnant women, or pointing out that definitions of the ‘facts’ of abortion are inevitably situated, those MPs who opposed Curtis-Thomas’s amendment depicted it as a cruel piece of legislation which would unfairly “burden” women:

Does the hon. Lady accept, first, that the existing consent forms and information sheets approved by the Royal College of Obstetricians and Gynaecologists provide information about the risks associated with abortion and as much information as the woman needs? Secondly, does she accept that it cannot be right to force doctors to give information that a woman says she does not want because she would find it distressing? Does the hon. Lady accept that the role of the doctor is not to hector or impose on women burdensome information, which they do not want to know, about the methods of abortion? That does not happen in any other form of medicine, and it should not happen in the one that we are discussing. [Evan Harris, Hansard Column 228, May 20th 2008]

Through this discourse, MPs essentially accepted the premise of their opponents’ criticisms of the current system of abortion provision, i.e. it is only doctors who possess relevant knowledge about the meaning of abortion, and they choose to shield pregnant women from certain aspects of this knowledge.

In contrast to this public depiction of informed decision-making about abortion, several of the HCPs I interviewed problematised what was to count as relevant ‘information’. For example, in the following extract, Nurse 7 tries to reconcile an obligation to ensure that women have been allowed to consider certain options with her acknowledgement that, for somebody who is requesting an abortion, certain options may simply not exist:

I would say, obviously ‘it sounds like you’re really very certain but for the purposes of um referring you I do need to just check out with you that you’ve kind of considered all your options and that another option would be – well you’ve got three options. Either to continue with the pregnancy um to terminate the pregnancy, and the other one would be that you could continue with the pregnancy and consider adoption.’ And usually what happens at that point is a woman will react in terms of saying ‘I just couldn’t go through with continuing with the pregnancy to then have the baby adopted’. And and I might then say well ‘yeah I think that’s what a lot of women in this situation uh tend to say but for the purposes of making sure that you’re well aware of all of your options that’s just why I wanted to mention it.’ Cos sometimes I think women find that a bit insensitive. They might perceive it as being a bit insensitive. [Nurse 7, female]

However, although some HCPs reflected upon the contingent basis of what counts as informed decision-making, in many cases they took particular definitions of this process for granted. In the remainder of this section, I will provide examples which illustrate this point. I will suggest that, through these accounts, HCPs were positioning themselves as experts who can and should assess women's decisions about their pregnancies.

Like Nurse 7, GP14 stressed the importance of ensuring that women are given the opportunity to consider the different options available to them. However, unlike Nurse 7, she did not suggest that the treatment of these options as objective 'facts' might be perceived as insensitive by her pregnant patients:

I kind of talk through the, the – there's basically there's, there's three options. If you're already pregnant you've got three options. One to have a termination, two to have the baby and three um and this doesn't commonly happen nowadays um to give the baby up for adoption. Obviously it still happens sometimes but it's not a common thing. And um what, what you need to talk through is um *even although the woman may feel it's perfectly obvious what she wants to do*, you need to spend a bit of time talking through each one um because *I want to be sure that she was making a decision that she had actually thought through* and was reasonably confident about. Because you can't change your mind afterwards. [GP14, female – emphasis added]

Interestingly, although this account is structured around the provision of certain information to pregnant women, its central point is that GP14 is able to make an informed decision about her patients' choices ("I want to be sure"). Rather than simply informing women that they have three 'options', she suggests that talking through each of these is necessary because this process allows her to become certain that they have "thought through" their decisions. She went on to construct her desire for this certainty in relation to the problematic futures which become possible when women do not think things through:

Because you can't change your mind afterwards. Um and, and I think it's quite helpful to think about, you know, the next twenty years because if you have the baby and bring that baby up, it's actually going to be more than twenty years that they're going to be your responsibility at least one way or another. But you know, you, you're certainly [as I say] thinking about eighteen-twenty years. And a, a lot of younger women do rather think that it's a matter of bringing them up, getting them through school and then that's it. Um which isn't, isn't really the reality of life in Britain

now. Um so thinking through the next twenty years um. After every pregnancy there is a risk that you might not get pregnant again. And that goes for full term pregnancy or miscarriage or termination, there's always a risk that you might not get pregnant again. And - so you have to kind of bear that in mind, that there is a possibility this might be your only chance. And um you know, how you would feel if, when you, you know, years later you decide you want to have children and you stop using contraception and you don't get pregnant, how you would feel then. [GP14, female]

GP14 was extremely unusual in focussing explicitly on the regrets which result from the wrong decisions being made about a pregnancy *per se*. In the majority of cases, HCPs focussed on the difficult futures which become possible because women do not "think through" their decisions to *terminate* their pregnancies:

I: Do you get some women who will come in and they're pretty sure already that's, you know, what the, what they want to do?

P: Yes, but you get people who come in all the time pretty sure that this is the condition that they've got uh at the end of the day they don't have the medical training so they mightn't be aware of the alternatives um. Um so it's, while you have to respect if it's a considered decision, part of being a considered decision is that they're aware of the options and have thought through.

I: And when you say uh aware of, of the options and the alternatives, what kind of alternatives are we talking about?

P: Well they, they may or may not be aware that there are adoption agencies and things who could make this a very smooth and straightforward process for them. Um or that their own personal circumstances which may appear disastrous from their subjective point of view, perhaps a more objective reading of it is, well actually the situation mightn't be as bad as you think. [...] Sometimes they can be spot on, you know, maybe it isn't the right time for them to be proceeding with a pregnancy. But again, rather than just sign a bit of paper it's important for, for both of us, the doctor and the patient that we've explored these things, a consensus has been reached. [GP12, male]

In both this and the previous extract, women with unwanted pregnancies are represented as decision-makers who are potentially unreliable if left to their own, subjective, devices. Because of this, the certainty which women *claim* about their decisions cannot be taken for granted, necessitating HCPs' assessments of whether a decision has been "thought through". Although these HCPs do not go as far as suggesting that they decide whether an abortion should take place, their accounts thus recreate the kinds of anxieties about women's decision-making abilities which

resulted in the terms of the current law, and which continue to dominate public discussion of the subject in the UK.

Parallels can also be drawn between these accounts and the ways in which scientists have been found to emphasise the irrationality and illegitimacy of non-scientific perspectives as they attempt to shore up their own positions of authority over contested technoscientific issues (Wynne, 1996a; Kerr *et al.*, 1997; Wynne, 2001). A particularly useful point of comparison is provided by literature which has analysed the way in which genetics professionals account for their work. Kerr *et al.* (1997) argue that, given the public controversies (e.g. fears concerning genetic discrimination) which surround their practice, geneticists must carefully negotiate their responsibilities towards their publics in order to maintain their status as legitimate experts. In this context, the demarcation of a specific and limited sphere of responsibility becomes strategically advantageous (Kerr *et al.*, 1997). For example, by highlighting their duty to educate the public concerning the ‘facts’ about genetics, scientists can define the relevant facts in terms of their own knowledge and enhance their professional status, whilst presenting themselves as individuals who act responsibly (Kerr *et al.*, 1997).

To a certain extent, HCPs’ attempts to define abortion decisions which have been “thought through” can be interpreted in light of these findings. By constructing the decision-making process as something which they are in a privileged position to assess, HCPs are able to present themselves as ‘experts’ in relation to their pregnant patients. Simultaneously, they gain control over the extent to which they can be held accountable for their patients’ decisions, and thus abortion. Their responsibilities are fulfilled by their attempts to make sure that abortion decisions are “thought through” on the basis of (what they define as) the correct information.

However, it is important to be cautious in drawing comparisons between scientists’ rhetorical negotiation of their responsibilities towards distant publics, and the explicit responsibilities which HCPs have for their patients’ future well-being. In

many of the interviews, the immediacy and significance of these responsibilities dominated HCPs' accounts:

Um because I think, if the patient herself is certain of their decision then as far as I'm concerned, job done. I think the important thing is, is she certain? Am I certain that she's certain? And if she's not what do we need to do to make sure that I can be certain that she's certain. Cos it's, it's a one-way ticket. Once you've terminated a pregnancy you can't un-terminate it. So you need to be as sure as you can be that the woman has made a decision with which she's completely comfortable by the time you commit her to whatever route of treatment you commit her to.
[Consultant 2, male]

Although Consultant 2 insists that he is able to assess women's 'certainty', the repetition of this word throughout this extract (and indeed, throughout the interview) is suggestive of a situation in which he confronts considerable *uncertainty*, whilst shouldering responsibility for the aftermath of an abortion.

As Sheldon (1997) points out, the Abortion Act could be interpreted as not only allowing but *requiring* HCPs to shoulder this responsibility. As described in Chapter One, two doctors must sign a legal document (Schedule 1) to certify that an abortion is less risky than the continuation of a pregnancy. In some cases, HCPs constructed their signature of this document as a significant act that makes it essential to achieve a particular level of individual, embodied certainty that abortion is the correct course of action:

I: Um yeah, you were talking about women's awareness of the law I think.

P: Right ok, yeah. So part of information giving, yeah so I mean you have to tell them, but I usually say, you know, if, if you feel this is the right decision for you and I agree, you know I feel that you've explored all the options and you understand that, that'd be my criteria for signing the form. And that, you know, from my point of view that they, I have to be certain in my own mind that the woman is as certain as she can be that this is the right way forward for her. [GP9, female]

P: Well clearly the law that surrounds it is, is important and when patients get a bit [*sniffs*] 'why are you asking me all these questions I'm entitled to a termination' I point out to them that no, they have the right to ask for a termination and I have the right to make a, an informed decision on whether I can legitimately um agree with them and sign the form. [Specialist Registrar 3, female]

From these HCPs' accounts, Schedule 1 emerges as a rigid entity which forces HCPs towards a position of 'expert' in relation to women with unwanted pregnancies (as well as providing them with justification for the adoption of this position). However, when the interview data is considered as a whole, the "interpretative flexibility" (Pinch & Bijker, 1984) of Schedule 1 becomes clear. In the majority of the interviews it was dismissed as a mere "legal formality" [Consultant 2], or "a bit of paper" [GP12], which has to be signed but which does not otherwise impinge on the actions of HCPs.

Although most HCPs attached little significance to Schedule 1, it remains important to acknowledge that the requirement to certify an abortion *might* encourage HCPs to position themselves as experts who must assess women's reproductive decision-making. As noted at the beginning of this section, it is also vital to consider the role of the more general legal context in which HCPs are working, e.g. the requirement to ensure that patients make 'informed' decisions about any medical intervention. Linked to this, HCPs' focus on the potentially negative outcomes of abortion should be contextualised in relation to the fact that, if women do experience difficulties following the procedure, they may require follow-up care. This was a recurring theme during interviews with GPs, many of whom articulated concerns about the possibility that patients would return with problems following an abortion, and suggested that they could be blamed if they allowed a pregnant woman to make the 'wrong' decision.

Nevertheless, as argued above, by claiming that they possess the expertise necessary to assess the 'best' outcome of a pregnancy, HCPs are co-producing "prescriptive ontologies of human relations, human subjects and society" (Wynne, 2001: 479). In the accounts considered in this section, this process of co-production positions pregnant women as intrinsically unreliable reproductive decision-makers who require guidance from HCPs. In the remainder of this discussion, and in subsequent chapters, I will explore additional "prescriptive ontologies" that emerge through HCPs' claims to expertise about abortion.

5.5 Avoiding “decisional control”

Wetherell (1998) argues that the construction and negotiation of identities should be viewed as a continuous activity which occurs in relation to particular discursive contexts. From this perspective, it is unsurprising that, although individual HCPs had a tendency to draw more heavily on particular subject positions, this process was shaped by the specific topics under discussion, including issues raised by the interviewer, as well as those introduced spontaneously by interviewees. For example, the discussion in section 5.2 used extracts from my interview with GP15 to argue that he constructed abortion as ‘woman’s choice’. However, this GP also suggested that his patients’ ownership of decisions about abortion is contingent upon the length of gestation of their pregnancies:

I: Ok. Um and if a woman comes in requesting a termination what kind of things would you talk about with her?

P: I have, up to twelve weeks I have basically a free open access, I’ve no restriction at all up to twelve weeks. Um thereafter we’ll have a bit more debate about, you know, um what she feels about it, any alternatives. Um after sixteen weeks I have a definite embargo, unless there are medical grounds for termination. I mean serious medical grounds as opposed to the usual section Cs and all, you know, on the form. [GP15, male]

Distinctions based upon gestational timing were made during nearly all of the interviews. When they discussed requests for later abortion, HCPs were far more likely to position themselves as experts who could assess whether or not the procedure should take place.⁵²

However, GP15 was unusual in suggesting that he placed an outright “embargo” on women’s access to abortion beyond a certain point in gestational time. More often, GPs made more ambiguous claims concerning their “reluctance” to refer women requesting later abortions. Indeed, when I later went on to probe GP15’s description of this situation, he back-tracked, possibly because my question implied that he gave me the ‘wrong’ answer the first time:

⁵² The significance which HCPs attach to gestational timing has been highlighted by several researchers. For example, in her interview-based study of Scottish doctors’ abortion practice in the 1970s, Aitken-Swann found that many GPs would not refer women for an abortion beyond thirteen weeks gestation, and that there was considerable variation in the gestational limits beyond which individual gynaecologists were prepared to terminate a pregnancy. Likewise, quantitative surveys consistently suggest that, as gestational time passes, the range of situations in which gynaecologists are prepared to conduct abortions narrows considerably (Farrant, 1985; Savage & Francome, 1989; Green, 1995).

I: So would you still refer women on if they requested later?

P: If they were absolutely certain that's what they wanted to do, yeah, I don't have a problem referring them on. [GP15, male]

Such back-tracking was a regular feature of the interviews, where HCPs seemed very keen to avoid stating directly that they would refuse a woman's request for abortion. Thus, although they often positioned themselves as experts who can *assess* women's reproductive decisions, it seemed that HCPs did not want to suggest that they have absolute "decisional control" (Sheldon, 1997) over whether an abortion takes place.

The following discussion explores how, in a situation where HCPs do not want to suggest that they decide 'for' their patients, they account for the outcome of abortion decisions that they have defined as problematic. Through this discussion, I aim to do more than illustrate the micro-level discursive practices via which HCPs negotiate responsibility for these situations during interviews. By revealing these practices I will also demonstrate that, although they may avoid claiming absolute "decisional control" over abortion, HCPs nonetheless suggest that attempts to regulate women's behaviour form a legitimate part of their work.

5.5.1 Demarcating legitimacy

In several cases, HCPs drew on a discourse of 'woman's choice' in order to avoid responsibility for decisions which they defined as problematic:

I mean there's always the, the odd person that comes along that you either wish wasn't doing it, or that does change, that do change their mind. And there are often people who come along and um I mean you can't pretend that your own kind of moral um sort of ethical standards and so on don't play a part because they inev- of course they do. Um and it's the sort of people who kind of, you know, their lives are ok and they may be in a situation where they are planning a family, but just not at the moment because it's just not quite convenient. And they get pregnant and they're thinking 'oh no I'll just terminate it just now because next year is when we'd planned to have our first child,' this sort of thing. And um I you know, you just maybe just um, you know *I would never try and say to anybody 'no I think that's the wrong thing to do'. I would still say, 'well you know this is your decision to make'* um but I would maybe just kind of question them about um you know, talk to them about how they're going to feel about that, about another pregnancy, about maybe the risks involved in any kind of procedure. Um you know, I wouldn't kind of - what would I say to somebody like that? I'd maybe just

question them. That, that's all I would do, I would, I would just kind of, you know, put, put the seeds of questions in their mind about this, and about how they were going to feel and about whether next year it actually was going to happen because sometimes things didn't all turn, always turn out as they planned um and *uh you know, but then leave it up to them because people have their own choices in life to make.* [GP17, female – emphasis added]

Here, albeit apologetically, GP17 argues that she is able to assess women's accounts of their reasons for abortion, and identify cases where it is not the best course of action. Although she appears to recognise that her knowledge of whether an abortion should proceed is situated in relation to her own "moral and ethical standards", she simultaneously disclaims personal responsibility for this - "you can't pretend they don't play a part because *of course they do*". In fact, the absence of personal responsibility is carefully negotiated throughout the remainder of her account. While she makes an effort to prevent what she defines as 'bad' decisions, it is her patients who ultimately choose whether or not to have an abortion. The distance she achieves through the discourse of 'woman's choice' also allows her to avoid reflecting on her own potential to shape her patients' decisions, or their experience of abortion, through her practice of questioning them.

5.5.2 Becoming insignificant

As described above, one important context in which HCPs suggested that they had to assess abortion decisions is when they described requests made during the second trimester of pregnancy. In this situation, HCPs often emphasised the insignificance of the part that they play in comparison to other HCPs, in determining whether an abortion takes place. Given that this is a position which is particularly easy for GPs to construct, it is perhaps unsurprising that they often used it to deal with the case of second trimester abortion. For example:

If somebody came to me twenty-two weeks pregnant and said um 'I want a termination' uh I suspect I would probably say 'I'm afraid you're too far gone'. If somebody came at... eighteen weeks um, still a pretty grey area because they're not very far short of possibly viable um and you're also into an area where it must be awful doing it. Um I suspect hmm, what would I do in that situation? I mean thankfully again it's not one which has arisen. But if somebody came along at that stage um... I, I think if somebody felt very strongly I probably would still refer them um although as I say because I feel the ultimate responsibility lies with the

person undertaking the procedure um, that's where the real decision takes place. If I say 'yes I think you should go ahead' and they go to see somebody who says 'I really don't think it's a good idea' then, what I say doesn't really, doesn't really count. [GP1, male]

However, during the course of my research, I became aware of another important aspect of Scottish abortion practice which means that gynaecologists can also 'become insignificant' in the decision to terminate a second trimester pregnancy:

I: Sure. Um yeah, the, the issue of um women requesting terminations later on, um if a woman is to, was to request termination sort of towards the end of the second trimester, what might happen then? I mean-

P: Well, we have a limit here at the [hospital] of sixteen weeks' gestation.

I: Ok

P: And that's because, well for several reasons. Um certainly by then a patient should be able to make up her mind, one way or the other. If she hasn't, and she's ambivalent beyond that then we, then would say look well hang on a minute there's something not quite right here. But the exceptions would be say a fourteen year-old or something who presents at eighteen weeks or something - too frightened to speak to anybody, and everything else. So everything is taken kind of on an individual basis but by and large it's a sixteen week limit. Beyond that, what we tend to do is refer them to the British Pregnancy Advisory Service in [city B] and then, if they say that's fine they then, the patient then kind of has a mechanism to go usually to kind of somewhere down south and have a second trimester termination. [Consultant 7, male]

Each of the hospitals where I conducted interviews appeared to have a different policy regarding the upper gestational limit (ranging from fifteen to twenty weeks' gestation) at which abortions were provided. However, in all cases this limit was placed below the twenty-four week cut-off stated in the Human Fertilisation and Embryology Act (see Chapter One). The issue of local hospital time limits upon abortion and the possible reasons for such limits will be discussed further in Chapter Seven. However, for the purposes of this discussion, what is remarkable is that Consultant 7 is able to define abortions after sixteen weeks as unacceptable, whilst simultaneously stating that "if they [bpas] say that's fine" then there is a mechanism for such abortions to take place in England.

The construction of later abortion as a more dubious practice associated with the work of abortion charities rather than the NHS echoes the findings of Lee *et al.* (2004). These authors conducted a large-scale study to explore national variation in rates of teenage abortion and motherhood. Focussing on abortions in the absence of

fetal abnormality, they surveyed the upper gestational limits of abortion provision at twenty-one (randomly selected) NHS sites across the UK and found that:

There was a commonly perceived problem of poor access to abortion after the first trimester, reflected in the almost uniformly low scores achieved by all sites [...] the highest cut-off point was 20 weeks. In most sites, it was reported that abortions are not provided in NHS hospitals from an earlier stage (between 13 and 16 weeks in most cases). Comments made by respondents indicated that, commonly, a 'division of labour' existed between NHS providers and bpas in this regard, with bpas providing these later terminations. (Lee *et al.*, 2004: 30)

Interestingly, my findings reveal that Scottish HCPs seem keen to stress that this 'division of labour' is also interwoven with national boundaries:

But uh for anything other than the fetal abnormality uh we don't do beyond eighteen weeks. If the patient expresses the wish to continue down the line of termination of pregnancy we put them in touch with the British Pregnancy Advisory Service [*omitted for anonymity*] and we can usually get an appointment that week for them, we send their scans all with them to see that they've done that and [*the health board*] has an agreement that in most circumstances it will pay the cost for the patient. It has to be approved theoretically but in practice I've never actually known it to be turned down. Um that means of course patients have to go outwith [Scotland], there's no bpas set up in, in Scotland they go south of the Border for that. [Specialist Registrar 3, female]

In other words, it is not simply abortion charities but *English* abortion charities that are positioned as responsible for an aspect of abortion provision that is constructed as problematic.

5.5.3 A discourse of (HCPs') suffering

In section 5.2, I argued that one of the ways in which HCPs depicted women as legitimate reproductive decision-makers was by emphasising the emotional difficulties which women experience when they decide to end their pregnancies. However, I also suggested that this argument is problematic because it seems to render the legitimacy of women's decisions *contingent* upon their suffering. This contingency was made explicit by many HCPs, who highlighted the absence of visible suffering as a criterion which leads them to question women's decisions about abortion.⁵³

⁵³ A related point is made by Joffe (1986), in her ethnography of family planning workers in the US. She argues that counsellors' positive experiences of their work were linked directly to their ability to

Occasionally it, sometimes feels like it's inconvenient and that's what, I, I find those quite difficult. There's a few people who come in and it's just not the right time and that's, that's, that's something I do struggle a wee bit. Again, I'll try and not make it affect the way I go about it but that's, that's not so easy, mmm. [GP11, female]

Interestingly, when GP11 draws attention to women's lack of suffering, she simultaneously emphasises her own. She stresses the awkward position that she is placed in by virtue of some women's requests for abortion, which she struggles to reconcile with her obligation to treat all of her patients equally. Like the suffering of women in the accounts outlined in section 5.2, the difficulties which GP11 describes imply that she is a morally responsible person who does the best job possible in difficult circumstances.

Although accounts that draw upon discourses of suffering are rhetorically powerful, it is problematic to suggest that HCPs' descriptions of the emotional difficulties generated by abortion work are merely calculated rhetorical performances. Throughout the interview, GP11 seemed to struggle with my questions. In answering them, she was not simply talking about emotion but was talking emotionally (Crossley, 1998), as she constructed and tried to reconcile conflicting obligations; to treat her patients 'non-judgmentally,' whilst simultaneously assessing their requests for abortion.

Nevertheless, in acknowledging the possibility that HCPs are trying to convey sincere emotional experiences through their interview accounts, it is important not to obscure the political dimensions of this process. When they emphasise the emotional difficulties that are created by their interactions with their patients, HCPs are also defining limits around what is to count as 'acceptable' reproductive behaviour. Furthermore, in some cases HCPs suggested that they made no effort to conceal their emotional reactions from their patients:

Um, but I, so, you know, I find –it's difficult, you know, occasionally you do get pissed off with individual women that come asking for abortion because you kind of think 'well, you want the pregnancy

feel that they were helping their clients, and reveals that counsellors disliked women who appeared to be completely emotionally unaffected by their situation. She concludes that, "what the abortion counselling situation suggests – with implications, perhaps, for other services involving morally problematic issues – is the power of clients to grant absolution to professionals" (Joffe, 1986: 122).

terminated this year but not next year. Um or, you're an intelligent woman, you had an IUD, you had it taken out cos you didn't really like it. And here you are back again, pregnant again, it needn't have happened!' [Consultant 4, female]

While she did not suggest that she would prevent her patients from accessing an abortion, Consultant 4's account indicates that she leaves them in no doubt as to the unacceptability of their behaviour.

In other cases, HCPs spoke even more directly about their attempts to change their patients' behaviour on occasions when it angered or distressed them. For example, Specialist Registrar 3 described how she attempts to get patients who fail to display sufficient emotional suffering to change their body language, and engage with (what she defines as) the emotionally distressing nature of abortion:

There are very few people – there are some people who do a very good um impression of being blasé, they'll come back a second time maybe six months apart you know 'what are you doing to yourself?' And I'm really very blunt with patients about it um to the point of saying, you know 'this is, this is not on, you can't do this to yourself. And please don't do it to me. Because hopefully you'll never be back to see me again. But I have to do this week in, week out and you have to recognise that it has an impact on me as well.' Um and you'll then get this sort of alteration in body language – they've been putting on a, a nice brave face, there's a lot of bravado goes on in a, a social gyn clinic [Specialist Registrar 3, female]

Similarly, Specialist Registrar 2 described how he is angered by patients "who show absolutely no remorse whatsoever and treat the whole process as a joke". Initially, he suggested that he would deal with this situation by asking these patients to leave the clinic, and that he is prepared to occupy a position of "decisional control" in this situation. However, when I went on to probe him further about this, he back-tracked and suggested that it is always possible for him to ensure that women approach abortion "seriously" enough:

P: There's no decision-making – there's no decision-making process aside from which route they're going to go down, medical or surgical. They come to us, they're having an abortion.

I: Unless they're um treating it as a, a joke.

P: That doesn't happen really.

I: Ok.

P: And the minute you, they, there are ways and means of telling, or bringing patients to understand what they're actually doing, which is

terminating a life. And the minute you do that they tend to become slightly more serious. [Specialist Registrar 2, male]

5.6 Conclusion

Many HCPs actively position women with unwanted pregnancies as legitimate abortion decision-makers, and the general (if grudging) acceptance of this legitimacy is suggested by their reluctance to state directly that they would refuse requests for abortion. Simultaneously, it appears difficult for HCPs to suggest that they could abdicate entirely from assessing the decisions which women make about abortion. On the one hand, this difficulty must be contextualised in terms of the explicit responsibilities which HCPs have for their patients' future well-being. On the other, when they suggest that the possible outcomes of their assessments include the questioning of a decision, the expression of anger, or the 'reminder' that abortion involves the death of a fetus, their accounts clearly lend support to Sheldon's (1997) argument that the abortion consultation operates as a site of "normalising control".

At the same time, it is important not to concede too much authority to HCPs by accepting their description of their ability to assess and moderate women's behaviour at face value. Doing so risks perpetuating HCPs' own construction of women requesting abortion as objects of their expert knowledge, and ignores the creative ways in which women may fail to co-operate with HCPs' attempts to assess their decisions. As Lupton points out, "the patient cannot be forced to speak; he or she has the ability to remain silent, or to lie" (2003: 127). Although the medical interview may be an intensified site of "normalising control", outwith this context women live in a society which produces and polices limits on the meaning of abortion. As outlined in Chapter One, abortion is debated extensively in public fora, albeit within a narrow framework which does not reflect women's reality (Lattimer, 1998). Research exploring women's experiences of requesting abortion suggests that their awareness of these public framings leads them to present themselves accordingly:

Women often use these ideas to construct themselves as a particular kind of woman who has an abortion; the good kind, the 'responsible', 'fair' kind, the justified kind with good reasons that correspond with mainstream ideals. Abortion is constructed in British culture in such an

overwhelmingly negative way, that many women seeking abortion try to construct themselves as exceptional. (Lattimer, 1998: 71)

In fact, a number of HCPs acknowledged this possibility; it was a topic that was often central to accounts in which they stressed the limits of their knowledge and their dependency upon what pregnant women choose to tell them.

Another way in which women's agency becomes relevant to any discussion of "normalising control" is that (in cases other than the direct refusal of their requests) women can ignore and even challenge HCPs' attempts to impose a particular definition of their situation upon them:

She (Family Planning clinic doctor) kept saying, "are you sure (of your request to have an abortion)? Are you sure?" She said she thought I should have another week to decide, and I said I didn't want another week, I'd already done that! She kept trying to push me... I quizzed her, asked her "why do you keep doing that?" (quoted in Lee, 2004: 298)

The importance of acknowledging women's ability to challenge HCPs' definitions is underlined by literature that has examined decision-making in the context of prenatal screening programmes, which by definition normalise certain outcomes (Lippman, 1991), i.e. the detection and abortion of 'abnormal' fetuses. Even when bombarded with biomedical definitions of the 'impact' that a certain condition will have on their fetus's life, women remain quite capable of countering such definitions and making decisions based on their own, contextualised understandings of disability (Rapp, 2000).

Nevertheless, in the interests of engaging in fully "power-sensitive [...]" 'conversation(s)' (Haraway, 1991: 195), HCPs' accounts must be situated in relation to the fact that they are gatekeepers to the abortion procedure, and that, as such, they have a greater *potential* than pregnant women to shape the discursive limits of abortion decision-making. As GP12, who works in a socio-economically deprived area, notes, there are circumstances in which this capacity can become particularly accentuated:

I mean uh, I can bully my patients into respecting my opinion in a way they [*HCPs in wealthier areas*] couldn't dream of, you know 'you're going to go away and think about this'. I wouldn't like to tell somebody who's a rich business woman to go away and think about it, you know, and say actually 'you're going to do what I tell you'. [GP12, male]

The importance of considering the vulnerability of individual women to certain practices is underscored by the fact that HCPs' accounts of their attempts to assess women's decisions converge around criteria which do not simply depend on the ways in which women present themselves. Computer records tell HCPs how old a woman is, as well as how many abortions she has had previously, and even those who lack scanning equipment can identify the later gestation cases where it is "fairly obvious there's a bump coming along" [GP2, male]. Furthermore, women have little control over the assumptions which HCPs choose to make about them, for example, concerning their socio-economic background. In the following chapters I will explore these points of convergence between HCPs' accounts in further detail.

Chapter 6: Fertility, control and the delineation of acceptable reproductive futures

By using reproduction as an entry point to the study of social life, we can see how cultures are produced (or contested) as people imagine and enable the creation of the next generation. (Ginsburg & Rapp, 1995: 1-2)

6.1 Introduction

The discussion in Chapter Two introduced key STS approaches to the issue of expertise. In particular, it highlighted the insights provided by Wynne (e.g. 1996b; 2001), who shows that the definition of what is to count as expert knowledge does not simply empower those who can lay claim to this knowledge. Simultaneously, this process of definition co-produces and imposes “prescriptive ontologies of human relations, human subjects and society” (Wynne, 2001: 479). In this and the subsequent chapter I provide a more detailed analysis of the “prescriptive ontologies” that are imposed when HCPs position themselves as experts who can assess women’s reproductive decisions. In both cases, my focus is on the forms of existence which HCPs’ accounts make possible for women who are, or could become, pregnant.

This chapter begins by arguing that, in contemporary UK public discourse, abortion is demarcated from contraception as a less acceptable method of fertility control. I go on to illustrate how this distinction is perpetuated by HCPs, who portray abortion as a course of action that their patients can and should avoid through the use of contraception. I argue that, in describing their attempts to educate their patients about this distinction, HCPs position the abortion consultation as an opportunity to shape women’s future reproductive behaviour.

However, in the second half of the chapter, I argue that HCPs’ claims to expertise concerning women’s “reproductive futures” also co-produce normative definitions of the types of people who should become mothers, and thus, the types of people that should inhabit the world. In addressing this issue, I build on an extensive body of feminist scholarship concerned with the ways in which the definition of the reproductive ‘choices’ available to women intersects with structural systems of

inequality such as ethnicity and socioeconomic class (see Chapter Two). I illustrate that HCPs depict women who are young, working class, or from outwith the UK as incapable of contraceptive use and point out that, in these circumstances, they appear to support the unrestricted availability of abortion. In contrast, I end the chapter by outlining an alternative argument that emerges from HCPs' accounts, namely, that middle class women (of a particular age) are controlling their fertility too carefully, and should be having babies rather than abortions.

These findings, whilst troubling, are perhaps unsurprising when it is remembered that technologies of fertility control have long been framed as methods for controlling the size and characteristics of populations. For example, although they pioneered the idea that women should be empowered to control their fertility, influential twentieth-century birth control activists such as Margaret Sanger and Marie Stopes were also involved in the eugenics movement. As a result, they often emphasised the potential for contraceptives to be mobilised as a tool for the improvement of the 'quality' of the human race (Petchesky, 1984; McLaren, 1990; Hill Collins, 1998; Ruhl, 2002). The late nineteenth/early twentieth century eugenics movement in the US and UK portrayed the control of poor and/or black women's 'excessive' fertility as essential to the health of the population, thus positioning white, middle-class lives as the desirable future of humanity (Petchesky, 1984; McLaren, 1990; Hill Collins, 1998; Ruhl, 2002). In doing so, it simultaneously framed social inequalities as a matter of biological heredity best addressed through the technological control of reproduction (Petchesky, 1984; Hill Collins, 1998).

While the eugenics movement is often portrayed as reaching its logical and horrific conclusion through the State-sanctioned sterilization and killing of certain categories of people in Nazi Germany, Hill Collins (1998) argues that eugenic beliefs remain visible in contemporary family planning policies in the US (see also Roberts, 1998). As described in Chapter Two, she has revealed how such policies are geared towards the production of white babies, who are to be raised within white middle class families.

Nevertheless, while my participants' accounts undoubtedly reveal elements of eugenicist discourse, I am not convinced that it is possible to develop a productive critique of their practice using this terminology. Firstly, although there may be different forms of eugenic practice, involving varying degrees of coercion, I am concerned that the term has become symbolically inseparable from the horrors of Nazi Germany. In other words, its deployment represents an accusation of absolute moral reprehensibility. As Shakespeare (1999) points out, the levelling of such accusations at the medical profession is both offensive to individual HCPs, and ultimately counter-productive, because it allows them to refuse to engage in dialogue with those who appear to be making such extreme allegations about their practice.⁵⁴

A related problem with the term eugenics is that it "is a word with nasty connotations but indeterminate meaning" (Paul, 1992: 665). Existing research has revealed how this indeterminacy creates space for HCPs to evade sociological critique. For example, by defining eugenics as the State-enforced regulation of reproduction, genetics professionals are able to insist that when they offer pregnant women the 'choice' to abort fetuses with abnormalities they are not engaged in a eugenic practice (Kerr *et al.*, 1998). In doing so, they are able to avoid confronting concrete problems with the practice of prenatal screening, for example, the social constraints which operate on individual women's choices (Kerr *et al.*, 1998).

Because of these concerns, in the analysis that follows, I have chosen to draw upon Ginsburg and Rapp's (1995) appropriation of Shellee Colen's term – "stratified reproduction" – as a means of signifying "the arrangements by which some reproductive futures are valued while others are despised" (1995: 3). As a concept developed and used by feminist theorists, this expression does not carry the problematic baggage associated with the term 'eugenics'.

Currently, the best-studied example of the way in which reproductive stratification is practiced in the abortion clinic is the provision of counselling

⁵⁴ It should be noted that Shakespeare does maintain that it is possible to distinguish between different kinds of eugenics; his concern is with disability activists' tendency to make explicit links between HCPs' engagement in prenatal diagnosis and the actions of doctors in Nazi Germany.

following the diagnosis of fetal abnormality. The assumption that abortion is the best course of action in these circumstances has become so normalized that patients are both explicitly and implicitly directed towards this outcome by HCPs (e.g. Farrant, 1985; Rapp, 2000; Williams *et al.*, 2002c). Disability studies scholars argue that this process both rests upon and perpetuates the assumption that disabled lives are not worth living (Shakespeare, 1998; Shakespeare, 1999).

In contrast, very few studies have considered how processes of stratification enter into consultations about abortion that do not concern the issue of fetal abnormality. A notable exception to this gap in the literature is provided by Macintyre (1976; 1977), who studied the experiences of single women who became pregnant in Scotland in the early 1970s. As part of her study she interviewed GPs and gynaecologists, and discovered that women's marital status determined doctors' opinions of the 'value' of their pregnancies. In cases where women were planning to marry their partners, doctors depicted pregnancy as unproblematic, and abortion as an illegitimate (or even non-existent) option. However, abortion was seen to be far more acceptable for someone who was unlikely to get married, i.e. where pregnancy would otherwise result in the birth of an illegitimate child. In the second half of this chapter I will argue that, although the significance of marital status may have diminished over the past thirty years, this along with other key social systems of stratification continues to enter into HCPs' accounts of abortion provision in the early twenty-first century.

6.2 A discourse of prevention

The assumption that abortion is distinctive from and less acceptable than contraception clearly dominates contemporary public discussion of the subject in the UK. This can be seen in the persistent media panics which follow the annual publication of the UK abortion statistics. For example, a report concerning the 2008 statistics in *The Daily Mail* states:

Record numbers of women are having two or more abortions, fuelling fears that they are increasingly seen as an alternative to contraception. One third of terminations are carried out on women who have had at least one before - and some have had eight or more. Some girls are on their

fourth abortion before they reach 18, figures from the Department of Health show. The statistics have emerged as MPs consider relaxing the abortion laws to make the procedure easier to obtain. (Macrae, 14th July 2008)

A consensus concerning this ‘problem’ also appeared to emerge between speakers on opposite sides of the parliamentary debate about abortion that took place during the passage of the Human Fertilisation and Embryology Bill in 2008:

Is it right that Britain carries out 200,000 abortions a year—600 abortions a day—and 6,200 of those abortions between 16 and 20 weeks? Is it right that 4,000 women in 2006 had had four repeat abortions, that nearly 1,000 women had had more than five abortions, and that some had had up to eight abortions, as my hon. Friend the Member for Gainsborough (Mr. Leigh) has already pointed out? Is that what our predecessors in 1967 set out to achieve in the original Act? There have been 6.7 million abortions in the United Kingdom since 1967. [...] The Government have an important part to play. For example, they could improve sex education and provide better access to contraceptive services. Nearly 70 per cent. of GPs do not offer a full choice of contraceptive methods. For too long, contraceptive services have been seen as the Cinderella service of public health, and I hope that all primary care trusts that are represented in this House today will do more to improve those services. [Mark Pritchard, Hansard Column 232-3, May 20th 2008, speaking in favour of legal restriction]

Of course we all want to cut the number of abortions, and we want to do so through better advice, better contraception and all the things that we can do to prevent abortions, but there will be circumstances in which women feel the need to go through that, and I appeal to the Committee not to make it difficult for them. [Judy Mallaber, Hansard Column 257, May 20th 2008, speaking against legal restriction]

While they may have disagreed about whether legal restriction would help them to achieve their goals, MPs clearly agreed about the meaning of abortion. It is something that can and should be prevented (or at least reduced) through the use of contraception.

MPs and media commentators discuss abortion and contraception as though these were two distinct practices, with intrinsically different meanings. However, the dichotomous classification of technologies that act as contraceptives (pre-conception) vs. those that act as abortifacients (post-conception) is easily problematised. For example, Etienne-Emile Baulieu, the scientist who developed the drug regime used to induce medical abortion – RU486 – argued that it, along with

other drugs that have traditionally been defined as ‘contraceptives’, should be re-classified as a third group of drugs termed ‘contragestives’ (Clarke & Montini, 1993). He pointed out that, along with RU486, drugs such as the pill and emergency contraception (as well as intra-uterine devices) often act during the early stages of a pregnancy, e.g. after conception has occurred (Clarke & Montini, 1993).

In addition to the complexities involved in classifying what is to count as a contraceptive or an abortifacient, a brief glance at the history of the birth control movement reveals that distinctions between the acceptability of pre- and post-conception methods of fertility control are relatively recent. In the early decades of the twentieth century, birth control activists such as Marie Stopes complained vociferously about women’s inability to understand the difference between contraception and abortion, and the fact that they regularly seemed to prefer to make use of the latter in order to control their fertility (McLaren, 1990).⁵⁵ However, as McLaren points out, at this time many women *did* regard abortion within the first three months of pregnancy as part of a spectrum of methods of fertility control, which allowed them to regain the ability to menstruate (see also Brookes, 1988; Fisher, 1998).⁵⁶

Another historical contingency which is rendered invisible by contemporary discussions of fertility control is the relatively recent incorporation of contraception as a legitimate part of medical practice. In spite of the campaigns of birth control activists, the medical profession in both the UK and the US remained extremely reluctant to become involved in the ‘unseemly’ business of discussing contraception (and thus, sex) with its patients until the 1960s onwards (McLaren, 1990). McLaren suggests that the availability of a more ‘scientific’ method of contraception in the form of the female pill was instrumental in the profession’s change of heart concerning its involvement in this practice. Interestingly however, Davis and

⁵⁵ Activists were keen to imbue the birth control movement with the legitimacy and authority of science, as well as to gain support from the medical profession. At this time abortion was illegal, and “conjured up the image of relying, not on the doctor, but on the neighbourhood wise woman” (McLaren, 1990: 231). Attempts to demarcate it from the practice of contraception were thus highly strategic (see also Petchesky, 1984).

⁵⁶ As McLaren (1990) notes, it is important not to romanticize the practice of abortion, which, when practiced illegally as it was at this time, killed and injured many women.

Davidson (2005) also draw attention to the fact that the provision of contraception became viewed as an urgent priority when the Scottish medical profession was suddenly faced with responsibility for the provision of abortion in the late 1960s (see also Aitken-Swann, 1977).⁵⁷

Arguably, the provision of contraception is now far more than simply a legitimate, or important, part of medical practice. In the extract from Mark Pritchard's speech above, the healthcare profession is positioned as the key gatekeeper to contraceptive technologies, and is *blamed* for the numbers of abortions which take place in the UK. As many of my participants pointed out to me, their accountability for the prevention of abortion is made explicit through the paperwork that has to be completed in order to facilitate a patient's access to the procedure. On the forms which GPs use to refer their patients, there is a section which asks whether or not future contraception has been discussed. Likewise, when I interviewed HCPs working in secondary care, I was shown numerous different outpatient clinic schedules which are used to ensure that particular information is obtained from all patients. On all of these forms, HCPs have to indicate what "future contraception" their patients will be using when they leave the clinic. Clearly, professional as well as public discourse about abortion is formulated in terms of 'prevention'. This must be borne in mind throughout the discussion that follows, where I explore how HCPs describe their attempts to get patients to treat abortion as a 'last resort' method of fertility control.

6.2.1 The 'choice' to use contraception?

In describing their consultations with women requesting abortion, HCPs argued that it is important for them to ask women about their contraceptive history, in order to establish what has "gone wrong" or "failed":

...we would always kind of then try and, and hospitals would usually do that too, sort of say well, 'obviously this was unplanned, don't want this to happen again I'm sure, need to think about contraception,' and we view that as contraceptive failure, lack of contraception and, and maybe

⁵⁷ This was seen to be a particularly pressing issue given that abortion was legalised at a time when decisions about whether to provide contraception through the NHS remained at the discretion of local health authorities; a situation which did not change until the 1970s (Davis & Davidson, 2005).

have some sort of plan about what the follow up of that, that is. [...] Cos in a sense that's, you know, the whole idea of choice is that, you know, women have control over their own bodies and control over their own sort of reproductive cycle, so again that's partly empowering and kind of um... and if it was an unplanned pregnancy something's not quite gone to, to plan really. [GP7, male]⁵⁸

This type of account, in which abortion was constructed as the result of a breakdown in contraceptive control over pregnancy, emerged regularly during the interviews. HCPs argued that, by establishing what has 'gone wrong' they can fix it through the provision of better information or alternative contraception. This depiction of the relationship between contraception and abortion has long been a feature of family planning discourse, which Luker describes as "contraceptive ignorance theory" (Luker, 1975: 18). However, in the following discussion, I argue that, as they describe their attempts to correct their patients' "ignorance" about contraception, HCPs are also describing how they correct their ideas about the future reproductive choices that are available to them.

A striking feature of the previous extract is that GP7 positions women's potentially pregnant bodies as a threat to their autonomy, and depicts contraceptive technologies as a means to circumvent this threat. Although he is keen to portray contraceptive education as a means of empowering his patients, this process involves representing abortion as an undesirable course of action. In other words, he makes it clear that his patients can only legitimately make use of certain kinds of reproductive technology in order to gain control over their own bodies.

GP7's depiction of the threat posed by 'unplanned pregnancy' resonates with Ruhl's (2002) argument that, in contemporary liberal societies, pregnancy is understood as a state that should not occur unless it is "willed", i.e. deliberately chosen. Although feminists' insistence that women should be allowed to control their fertility has undoubtedly had positive implications for women's lives, Ruhl argues that the notion of planning is now so central to our understanding of pregnancy that it

⁵⁸ As noted in Chapter Four, GP7 described himself as somebody who holds a conscientious objection to abortion, but said that he operationalised this objection through his refusal to sign Schedule 1. In other words, he still engaged in consultations with women requesting abortions, and referred them on to the hospital.

has become an imperative. In this discursive context, for a woman to fail to plan her pregnancies is to engage in irresponsible behaviour, for which she can be blamed (Ruhl, 2002).

This notion of responsibility enters implicitly into GP7's account, when he constructs contraception as something that women "need" to think about. In other cases, HCPs made this argument rather more explicitly:

I: Is um contraception something you discuss with women in the consultation about termination?

P: Yes, absolutely, um I will always ask and again, it isn't to make them, make them feel bad but I always ask, you know, what, what contraception were you using? Um, and often you get some convoluted story of 'well, you know I was going to start the pill but I didn't have time' or, 'um yeah I was on the pill but um' you very very rarely see a pure pill failure, or pure contraceptive failure for that matter. Um so I always ask it to begin with, when you ask about getting pregnant and that. Cos you have to establish when did it happen, and that [kind of thing] and that's what they used. And then at the end when, when you've done, when you've done the referral I always say 'well what are you, what are you going to use after?' And you may, you're probably not going to do the whole consultation then but you, I always want my ladies to say, 'yes I will use this after,' and I probably wouldn't let, I probably wouldn't let them get away with 'oh I don't know' I would say 'no, you need to know'. [GP10, female]

In this extract, the question of responsibility for an unplanned pregnancy is very carefully negotiated. Pregnancy is depicted as a failure on the part of the contraceptive user, rather than the contraceptive technology.⁵⁹ However, although the pregnant woman has 'failed', this is not depicted as deliberate, immoral behaviour; GP10 emphasises that she does not want to make her patients "feel bad" about their situation. Instead, like many other HCPs, she depicts unplanned pregnancy as the product of a failure of *understanding*. This can be corrected through education, an important part of which involves making patients understand that future contraception is a reproductive obligation, not a reproductive choice.

⁵⁹ As Oudshoorn (1994; 1999) points out, the notion of 'user failure' was central during the development of the female pill. Rather than questioning the social assumptions embedded within the technology (e.g. that users are sufficiently 'medicalised' to be accustomed to taking medication as a routine part of their daily life), when women participating in clinical trials became pregnant, this was constructed as a matter of user failure.

However, when HCPs drew attention to women who repeatedly ‘failed’ to prevent themselves from becoming pregnant they often located responsibility for this failure rather differently:⁶⁰

Um if someone had or was on their third termination we would say to them you know, we can do terminations for you, obviously. But if you’re going to repeatedly attend for terminations some of the doctors will not sign the forms and we need to look at your contraception – why has this problem occurred for a third time? Or you may find ladies will attend and they say they’ve never attended before and you look back in the notes and there is a termination sheet in their notes. And I would just say I see you’ve attended for a termination before and, you know, has this been a failure – so I would say it in the nicest possible way you know for a second one. But if we came to a third one we – I think the worst I’ve ever seen was – [*inaudible*] how many did that lady have? [*thinks*] There was one lady who had multiple terminations I think she was maybe on her fourth and we said to her, you know, this is no longer acceptable. And we can’t refuse people to have terminations but, you know, this is not just a failure of contraception and the doctors are not duty – I’m not sure if the doctor will sign the form, so you have to make sure that your contraception is in place or we can’t say that we would see you back here or be able to offer you a termination on another occasion. So it’s said in a very pleasant way, but firm. [Nurse 9, female]

Unlike GP10, Nurse 9 is quite vague about what constitutes “contraceptive failure”; she does not specify whether this refers to a user’s failure in understanding, or a failure of the technology itself. However, she does suggest that there is a point beyond which women’s repeated requests for abortion can no longer be attributed to either kind of failure. This is evident in the contrast between the gentle and sympathetic way that she describes treating patients who attend for a second abortion, and her suggestion that when it comes to three or more requests for abortion she engages in an entirely different type of interaction with her patients. At this point abortion is defined as a deliberate, and thus unacceptable, act, and Nurse 9 makes it clear that she has to educate her patients about its unacceptability.

6.2.2 The gendering of responsibility for contraception

As numerous feminist critiques have illustrated, the decision to develop modern contraceptives focussed on female bodies (e.g. intra-uterine devices and hormonal

⁶⁰ HCPs’ concern about the problem of “repeat” abortion is as old as the legalised provision of the procedure. During interviews with GPs and gynaecologists in the early 1970s, Aitken-Swann (1977) found that they were often troubled by the fact that some patients kept coming back.

methods) has provided women with more ‘effective’ methods of fertility control, whilst generating the belief that responsibility for contraception is feminine rather than masculine (Luker, 1975; Clarke, 2000; Oudshoorn, 2003).⁶¹ Within this context, it is unsurprising that several HCPs articulated an explicitly gendered dimension to the obligation to prevent further abortions:

So if you, if there was a restriction on the abortion service then people or women, and I say women because ultimately they’re the ones that carry the can – you can say we should be targeting men as well but you can target men all you want, it’s not them that carry the can. If there was a restriction on the abortion service then women would pay more attention to their contraception. [Specialist Registrar 2, male]

In arguing that women are disproportionately burdened by pregnancy and childbirth, Specialist Registrar 2 draws upon rhetoric that has long been used to argue *for* women’s access to abortion. However, his apparent sympathy for this burden is belied by his suggestion that women can best be helped by a punitive restriction on the abortion service that would force them to “pay more attention” to their contraception. Interestingly, this desire to impose restrictions on women’s reproductive options means that Specialist Registrar 2’s account resonates strongly with those of the conscientious objectors that I interviewed, in particular Nurse 10 (see Chapter Four, p. 109).

Within my sample, Specialist Registrar 2 was very unusual in calling for restrictions on abortion provision as a means of forcing women to recognise their responsibility for contraception. More often, the gendered dimensions of responsibility for contraception were articulated more subtly through the argument that women have to be made aware of their obligation to make use of female methods in order to ensure that they do not become pregnant again:

P: ... I would say ‘no, you need to know’.

I: Um, what if someone says ‘I’ll use condoms’ or, or whatever, is that?

P: I would probably not be very happy with that because I would, I would say to them, ‘that’s fine, you won’t get any sexually transmitted diseases, but that’s for the man and you’re the woman, and you’ll get stuck with the problem, failure rate is ten per cent, you need something else um.’

⁶¹ Petchesky (1984) argues that it is important not to produce an overly technologically determinist account of this phenomenon. She points out that older contraceptive practices which centre on male bodies (e.g. the condom and ‘the withdrawal method’) also require women to take responsibility for contraception, because women often have to insist on/negotiate male compliance.

You may not push them too much further at that point but I wouldn't be happy with that after a termination because, something's gone wrong you know. [GP10, female]

The portrayal of condoms as an ineffective method of fertility control, and the importance of convincing women to use hormonal methods or intra-uterine devices was widespread throughout the interviews. As the women's health movement have long argued, these 'female' methods, while more reliable in preventing pregnancy, represent significant burdens for the women who make use of them, including "undesirable to life-threatening side effects (from headaches to acne, obesity, infertility and death), and lack of protection from STDs and HIV" (Clarke, 2000: 58).

6.2.3 Correcting misperceptions of contraceptive 'risk'

In studying the reasons why women don't make use of contraceptive technologies, Luker (1975) argues that HCPs fail to understand the immediacy of "contraceptive costs" for women. Such costs include those produced through the limitations of many of the technologies, for example, the negative side effects listed above, as well as the requirement for regular clinical check-ups. They also encompass non-technical but equally important costs to identities and relationships. For example, as Luker points out, to obtain/make use of a contraceptive technology involves the cost of acknowledging to oneself and others that one is *planning* to be sexually active. Such planning may be difficult to sustain following the break-up of a relationship, when women often cease to regard themselves as sexually active.

Through her exploration of the contextualised costs of contraception, Luker highlights the competing definitions of "contraceptive risk taking" held by women and HCPs. She suggests that HCPs are working on the assumption that the most significant risk of (hetero)sex is unwanted pregnancy and abortion. In comparison, the risks of contraception are held to be minimal, and any woman who refuses to bear these risks is either "ignorant" or "self-destructive and irrational" (Luker, 1975: 140). The central aim of Luker's study was to destabilise these assumptions by revealing that, when contraception is situated within the lived context of its use it may represent a much bigger cost than abortion. When understood from this

perspective, the decision not to use contraception can be construed as active and entirely rational.

However, as Wynne (2001) points out, emphasising the co-existence of different groups' understandings of risk does not automatically destabilise the notion that publicly recognised experts know the *objective* risks of a particular course of action. Indeed, the idea that 'lay' people are working with their own, alternative understandings of risk can quickly become the basis of new attempts to educate them about the 'correct' (e.g. expert) ones. This phenomenon was clear during the interviews. Many HCPs suggested that women were working with *mistaken* perceptions of the risks of unwanted pregnancy, which they had an obligation to identify and correct:

And ideally what I want is for them to be using an effective method of contraception to prevent this happening again. And it's an uphill struggle, people are very unrealistic about what's going to happen to them after the termination of pregnancy in terms of their future relationships, quite a lot of women say 'well I'm never going to have sex again', you know, which is completely unrealistic, cos we know they'll have sex again.
[Consultant 4, female]

They just kind of assume it won't happen to them. Um, partner doesn't like using condoms or they don't like using condoms, or they got carried away. Um, and you can understand how these things happen but there's still a, a risk of pregnancy with, even if you are carried away, unfortunately um, chance or statistics or whatever doesn't make allowances for you being carried away or your partner not liking condoms you still can get pregnant. [GP3, female]

Even contextualised definitions of the meaning of contraception (e.g. as irrelevant to current circumstances) thus become subsumed within a discourse of "contraceptive ignorance", in which the prevention of future abortion through education about contraception is constructed as possible and desirable.

In informing women about the 'objective' risks of failing to use contraception, some HCPs argued that they had to educate women about the 'real' risks of abortion. For example, Nurse 8 suggested that some women mistakenly view the loss of love from a partner who wants to have unprotected sex as a bigger threat than the risk of unwanted pregnancy and abortion. Later in the interview she made it clear that she

has an obligation to prevent her patients from continuing to view abortion as a minimal threat:

I think we're very sympathetic and non-judgmental, I sometimes have a worry when people are coming back time and time again if we're too sympathetic and not judgmental enough. And that's why if somebody's back for the third time I have no problems in saying to them 'what's going on, you know, why are you doing this? You can't keep doing this to your mind or your body. What's the problem here?' [Nurse 8, female]

In this extract, Nurse 8 suggests that, because they work hard to care for women who decide to have abortions, HCPs potentially cause it to become something which women do not try to avoid. If this does happen, her job is to ensure that women do not continue to experience abortion in this way, and that they understand it as an experience which damages them both mentally and physically.

The importance of conveying the distinctive, damaging nature of abortion was a recurring theme in interviews where HCPs highlighted the 'problem' of patients who repeatedly attended for abortions:

P: Um I again feel a bit uncomfortable that a small, tiny percentage of people seem to use it as a method of contraception. And I don't feel comfortable about that, because there must, there are better ways. [laughs] Yeah.

I: When you say better ways, are they? Can you say a bit, in terms of better, is it better in terms of women's health or?

P: I suppose there, there are more effective ways, well I suppose termination's about the most effective way to not be pregnant! But um there are more um, less damaging I suppose, physically and emotionally um and less risky um and [as I say] prevention's better than, yes, general anaesthetics or, you know, whatever. [GP11, female]

Through such accounts, HCPs again attempted to maintain a clear separation between contraception and abortion, suggesting that the latter is something which can and should be prevented through the use of the former. However, by describing their patients' failure to understand that abortions should be avoided, HCPs automatically undermined their own assertions that they possessed the facts about this practice. In particular, if patients have to be *educated* that an abortion is an emotionally damaging experience, then it is clearly possible for them to experience it in other ways.

This possibility seemed to be acknowledged by GP14, who suggested that patients who have already experienced an abortion possess important knowledge, specifically, that it is a decision and experience which is “right” for them:

P: I suppose I, I tend to ask more because, if they’ve already got experience of it then it’s useful to know about that.

I: So if they already have experience of the, the process, does that change what you um talk to them about then or?

P: Yeah, well, they just know a bit more what it’s like, how it feels, how it feels afterwards um and, you know, if it’s been, if things have worked out ok last time then you can feel fairly confident that they can make the right decision again this time. [GP14, female]

Interestingly, this unusual framing of repeat abortion, as something which provides women with important experiential knowledge, was one which dominated the accounts of the US abortion clinic workers interviewed by Wolkomir and Powers (2007). These authors reveal that clinic workers classified women who had previously had abortions within the group of patients that they found “easiest” to deal with. Such women were said to be less apprehensive about abortion and more certain of their decisions, thus requiring less emotional input from clinic staff (Wolkomir & Powers, 2007).

However, most of the Scottish HCPs that I interviewed were incredibly resistant to any suggestion that women’s repeated use of abortion was unproblematic, and insisted that it was an emotionally damaging course of action:

P: Um women simply don’t want um to have the whole pattern of their lives disrupted in a way that they hadn’t bargained for, with all the consequences. Um so most women, if it’s a second termination, they’re as appalled um as you would expect. I can only think of, one particular woman sticks in my mind when I was a registrar so it’s about, a trainee, so it’s about twenty-five years ago, twenty-six years ago. And she was definitely on her fourth or fifth termination. And I just felt deeply irritated by her.

I: Do you think that for some women, although most women see it as, you know, a very significant event, there are some women who maybe don’t see it that way?

P: I think there are some women, I think she clearly, she didn’t perhaps have the emotional depth to empathise with what she was actually doing. [GP9, female]

Through this account, GP9 defines abortion as something which should “appal” women who are confronted with the prospect, because it is a life changing,

emotionally traumatic experience. In the rare cases where women request multiple (i.e. more than two) abortions, GP9 suggests that there is something psychologically wrong with *them*, rather than with her own definition of the meaning of abortion.

In drawing on a discourse of prevention, HCPs framed abortion as a course of action that was self-evidently problematic, and which they had an obligation to prevent through the education of their patients. This education involved providing ‘better’ information about contraception whilst instilling the idea that contraception was a (gendered) obligation rather than a choice. It also involved ensuring that patients understood the ‘true’ costs of abortion. However, in concluding this section I want to draw attention to an instance in which an HCP acknowledged that her definition of the relationship between abortion and contraception was “situated” (Haraway, 1991), rather than objective:

I think though undoubtedly some people do use emergency contraception and some people do use termination as a form of contraception. I don’t know what you do about that um. You can try and persuade them that it shouldn’t be. Um I don’t know morally what you do with people who still don’t, you know, and still don’t take you on board about that and still do use it as – I mean I suppose term-termination is ultimately a method of contraception. I don’t think it should be but who am I to say that, you know, that people shouldn’t do that? [GP17, female]

While it is entirely atypical, this extract reveals that it is possible for HCPs to question the discourse of prevention, and to acknowledge the contingency of the relationship between contraception and abortion.

6.3 The Othering of ‘contraceptive exceptions’

Another way in which HCPs contested the discourse of prevention was by constructing distinctive ‘types’ of women whose repeated use of abortion was tolerated. In most cases, the deliberate use of abortion as a method of fertility control was linked to the ethnicity of particular women:

I: Um if the, I suppose one of the things I was wondering cos I’m kind of interested in the relationship between contraception and termination is, is um whether for some women maybe they see termination is that’s how they go about controlling their fertility?

P: I think so, I think some women do. And I think that you see that particularly in people from other cultures. I mean in China it is a form of

contraception. So the Chinese women think nothing of it and I think it's, it's quite difficult because how do you say to somebody 'well in actual fact this isn't a form of contraception' when it is in their own country? So that, that can be a difficult one. [Nurse 8, female]

Not so much in the UK. Um in other countries it is. In China, and in the former USSR countries that, that is. Um I don't think that that's how, I think most women – perhaps in a minority of cases – but most women it genuinely is unintended and um it's, they're not using it as a method of contraception but for, for a minority yes. And they'll be quite a mixed bag of maybe women who are originally from other countries or have got chaotic lifestyles or, or um extremely keen to avoid hormones. [Consultant 5, female]

In these accounts, HCPs' acknowledgement of the cultural relativity of the use of abortion does not undermine their insistence that it is a less acceptable method of fertility control than contraception. Instead, alternative uses of abortion are constructed as a problem associated with ethnic minorities, who must be tolerated by British HCPs.

While the deliberate use of abortion as a means of fertility control was generally attributed to women from other countries, HCPs often drew attention to the case of a significant minority of women who, as Consultant 5 terms it, "have got chaotic lifestyles". From the regular way that this terminology was employed by HCPs, it seemed to have acquired a specific, consensual meaning:

[...] you know, there's people who haven't really engaged with using very good contraception and who probably also have quite chaotic lives um and um therefore um it's there as a backup. [GP7, male]

If, you know if they're very, if they're young and or chao - and have chaotic lifestyles then you, I feel you can't really blame them. Some women you do feel that they should have more sense, but I think it's very unusual for women to purposely use that as a form of contraception. I think most people it just sort of hap -happens to them. [Consultant 6, female]

The construction of certain types of contraceptive users as less capable than others is well-known within the literature on this subject (Oudshoorn, 1994; Hawkes, 1995; Oudshoorn, 1999). For example, in a study of family planning clinic staff, Hawkes (1995) reveals that age and socioeconomic class are viewed as markers of contraceptive 'responsibility'. She points out that, even when they made requests for

contraceptive advice, young women from working class backgrounds were constructed as a group who are incapable of planned, 'responsible' sexual behaviour. However, while the HCPs who I interviewed often represented young and/or "chaotic" women as intrinsically incapable of utilising contraception, in the quotations above it is clear these women are not being held to account for their actions. Rather, they are exempt from blame because they are depicted as incapable of preventing pregnancy.

One way of interpreting HCPs' constructions of 'blameless' users of abortion is that, through this process, they are trying to justify its provision and thus render *themselves* blameless for their involvement in this work. As outlined in the previous chapter (section 5.2.2), HCPs seemed to find it difficult to represent abortion as a positive course of action which allows women to assert control over their own bodies and lives. Instead, they focussed on the difficulties that women experienced in deciding to end their pregnancies, portraying abortion as a negative 'last resort' used to exit an impossible situation. I suggested that this might reflect a discursive context which encourages HCPs to justify the provision of abortion in negative, rather than positive terms. Simonds (1996) draws attention to a related phenomenon in the US, where, she argues, feminists increasingly defend abortion as a necessary evil, rather than advocating it as a political right. She suggests that this change in rhetoric may reflect a defensive response to the success of the anti-abortion movement in the US during the rise of the New Right in the 1980s and 90s (see also Petchesky, 1984).

However, while my participants may be engaged in similarly defensive tactics, this interpretation of the data is somewhat undermined by the fact that many of them constructed particular categories of people who *could* be blamed for failing to control their fertility through contraception. In other words, they explicitly drew attention to situations in which abortions were taking place on 'unjustifiable' grounds:

I've come across women, even though I wouldn't say they go in lightly in this decision, but I've come across women who've had three or more terminations. And you wonder, you know, and this is people who are older, you know, who are in their thirties, and you're thinking, 'couldn't they have a little bit more sense', you know. [GP5, female]

And I'm blunt with the patients about not wanting to see them second or third times I mean we do see the occasional patient four or five times which, by the time it gets to that stage you really just want to run away, you don't want to deal with a fourth or fifth time patient. And sometimes they're perfectly intelligent, professional people who will turn up four and five times and you think 'that is outrageous!' [Specialist Registrar 3, female]

In contrast to women who are young, or “chaotic”, those who are older, and professional were often held to be capable of “knowing better”, and through this knowledge, exerting control over their own fertility. In others words, only certain types of women were constructed as rational actors capable of determining whether or not they become pregnant through the use of contraception.

In exploring the construction of different types of contraceptive user, Oudshoorn (1999) illustrates how concerns about contraceptive failure are linked to concerns about the fertility of particular populations. She draws attention to the fact that women from developing countries are characterised as unreliable contraceptive users who are in need of longer-acting, less user-dependent methods (e.g. intra-uterine devices or contraceptive implants). Disturbingly, the delineation of these contraceptive capabilities and choices correlates with the construction of women from developing countries as the population whose fertility is most in need of regulation and limitation (Oudshoorn, 1999).

Whereas Oudshoorn highlights the limited reproductive choices offered to women who are defined as unreliable with contraception, in the quotations provided above HCPs suggest that unreliable contraceptive users should be given *more* rather than fewer reproductive choices. Those who are young, or who have “chaotic lives”, or who are from “other countries”, are exempt from the norm and are allowed to substitute abortion for contraception. I would argue that HCPs' tolerance of this option for certain kinds of people must be seen as inextricable from the values which they placed on these individuals' “reproductive futures” (Ginsburg & Rapp, 1995). While this process of reproductive stratification is only obliquely implied in the extracts outlined above, in some of the interviews it was stated explicitly:

On the other hand you see people who are having their fourth or fifth termination of pregnancy whose lives are so chaotic, so out of control,

um who can't even organize their housing arrangements let alone contraception. And, you know, you feel, well um they're never going to get it right and, and, you know, I think where some people feel that repeat abortion is, is more difficult for us to deal with, in other words it's more difficult for us to deal with people who've had one termination after another termination after another termination – everybody's different and some people are never going to get their lives into control and you think, *for the sake of the baby*, who's going to be um be brought up in this completely out of control environment um then that's fine, you go ahead and make the arrangements for the termination of pregnancy. But I've less sympathy for the woman who has had two unintended pregnancies using natural family planning, is well educated, she can understand what you're trying to say and she still goes ahead and doesn't use an effective method of contraception and comes back pregnant for the third time. [Consultant 4, female – emphasis added]

In this extract, Consultant 4 constructs two different kinds of uses of 'repeat abortion', only one of which is deemed acceptable. While she does not use the term explicitly, it is almost impossible to avoid reading 'socioeconomic class' as the key distinction between those whose repeated use of abortion is tolerated, and those whose use of abortion is rejected. "For the sake of the baby", she argues, it is best that those who live intrinsically "chaotic lives" are allowed to control their fertility by any means possible.

A connection between socioeconomic class and the importance of the availability of abortion was stated even more directly by GP8, who began the interview by saying that:

P: There are a lot of unplanned pregnancies round here but a lower than average rate of requests for termination.

I: Ok so more, more unplanned, but less terminations?

P: Yeah. And that's, I, I think that just relates to the social class five sort of population that we have. [GP8, female]

Throughout the interview GP8 was unusually supportive of women's right to control their fertility through abortion. However, this expression of support was related directly to the fact that she was dealing with a "socioeconomic class five" community of women who, she argued, were intrinsically less able to plan their pregnancies than other sections of the population, with very serious consequences:

P: I'm very, I'm very interested in promoting health and I've worked at, I've just done my baby clinic here this morning in fact. At least three-quarters of the babies I saw today were from parents who are on our

intensive health visitor extra-surveillance, nearly all for social reasons. Drug abusing parents, learning disabilities, fathers who lose their tempers, um single parents, mothers with HIV, this sort of thing, just... And I am just so aware of how unwanted fertility is a cause of such vast morbidity, mostly psychological but I mean you do get kids in poor families who aren't nourished properly round here, there is poverty round here, I mean you don't, you know you actually get to physically impaired health as well as these awful, not so easy to measure but extremely expensive to society. You know, there was something in the papers the other day about, was it ten per cent of young people not in any employment?

I: Could well be, these days.

P: They were costing Scotland six billion pounds a year or something. Now you trace them back and we're in the privileged position here of having summaries of patients. You chart their life course and you'll bet your bottom dollar that something like ninety per cent of those kids, underachieving kids will have been unplanned, unwanted pregnancies. Now that's not eugenics, that's just common sense in my book. [GP8, female]

GP8's use of the term "unwanted fertility" throughout this extract begs an important question. For whom, exactly, is this fertility unwanted? While she begins by emphasising the link between the availability of abortion and patient health, it quickly becomes clear that the health she is referring to is that of the children who are the product of (what she defines as) a failure in fertility control. More broadly, it seems that the health of these children is less significant in terms of the meaning it has for these individuals and their parents than the "burden" which these people place on society.

Another notable feature of GP8's account is that she spontaneously invokes the term 'eugenics'. In doing so, she appears to acknowledge that, in suggesting that the abortion of working class women's pregnancies is a solution to social problems such as unemployment, she could be accused of mobilising 'eugenic' arguments. However, by utilising and then dismissing the term, GP8 insists that what she advocates is *not* eugenics, thus legitimating her position as one of reasonable "common sense". Her account thus lends support to the argument that I made in the introduction, namely, that the flexibility of the term 'eugenics' allows HCPs to evade critique by contesting its definition.

Like most of the other GPs that I interviewed, GP8 stressed that requests for abortion come from the patient, i.e. consultations on the subject take place because patients have already defined their pregnancies as problematic before they reach the consulting room (see Chapter Five). In spite of this, I was left wondering how her immense support for the prevention of “unwanted fertility” might translate into practice if a pregnant patient comes to discuss the options that are available to her. Clearly, it is important to be cautious in treating HCPs’ support of the option to ‘choose’ abortion, as a measure of their support for women’s reproductive ‘freedom’.

6.4 Defining desirable reproductive futures

In the previous section I argued that, when HCPs constructed certain groups of women as unreliable contraceptive users whose use of abortion was tolerated, they were (implicitly or explicitly) defining certain types of reproductive future as undesirable. In this final section, I will strengthen my argument that HCPs were engaged in practices of reproductive stratification by revealing that HCPs criticised particular categories of patient for trying to control their fertility *too* carefully.

As Lattimer (1998) points out, women, as well as HCPs, are subjected to dominant discourses which constitute pregnancy as something that should be planned in order to ensure that children are born at precisely the right time in a woman’s life, as well as into the right circumstances. In her study of women requesting abortion, she found that they often referred to their pregnancies as wanted but impossible because the pregnancy had not been planned and it was the “wrong time” to have a child. However, many of the HCPs I interviewed were critical of women (or couples) who appeared to use abortion to re-assert control over the precise timing of their fertility. Their critiques often centred on the argument that abortion isn’t the *only* reproductive option available to these people, i.e. because it is not taking place in a situation of desperate ‘need’ it is not justified. As I argued in Chapter Five, such critiques are troubling simply by virtue of the fact that they impose and stabilise a negative definition of abortion as a ‘last resort’ course of action that should involve women’s suffering. However, when these critiques are explored further, another disturbing pattern emerges from the data; HCPs often seemed to define what is to

count as sufficient ‘desperation’ based on their assumptions about a woman’s socioeconomic background.

This argument was made particularly clearly by one GP, who began by outlining his sympathy for the situation of the majority of women in his practice population, and his support for their decisions to terminate their pregnancies:

Cos there [are] you know, a lot of unemployment, poverty, drug dependence, violence, all of you know, all these things associated with, with deprivation and, poor educational achievement and so on and uh, I certainly find it quite easy to think, yes, if a woman in those circumstances doesn’t want to bring another child into that sort of environment then yeah, I mean I don’t have any difficulty with that decision if they’re struggling already. Although, I could accuse myself of being judgmental and paternalistic and what right have I got to take, to have any view on whether a child should be born, should or shouldn’t be born just because the circumstances in which they’re going to be born are going to be a lot more challenging than the circumstances into which I was born? Um it, it’s kind of reverse view of uh sort of um right to life people who would say that a child, certainly termination shouldn’t happen under any circumstances. And I probably, this my view is probably shared by a lot of people that if the circumstances are going to be, are likely to be very tough then it makes, you know this enormous decision to have a termination very easy, certainly to sympathise with it and things and say I’m not, I don’t want to, you know, fight for this unborn child’s right to life when I know it’s going to be a tough one anyway. [GP19, male]

Just as GP8 slipped from the idea that fertility might be “unwanted” by an individual woman to the “unwanted” repercussions of this fertility for children/society, GP19’s sympathy for the contexts in which women are struggling quickly becomes sympathy for the suffering of their potential children, whose lives “are likely to be very tough”.

In contrast, he suggested that there is no suffering with which to sympathise when women request abortions in better socioeconomic circumstances. In such cases, abortion becomes a matter of mere “inconvenience”, and women should be dissuaded from it, if possible:

I suspect if I was working in [*wealthier areas of city A*] or maybe in the University Health Centre which is probably quite a, maybe a significant issue there too I um you know I might feel differently. And certainly I can feel my sort of moral views or prejudices or whatever you like to call them coming through on the rarer occasions where a um professional or

successfully employed middle-class uh well-educated patient, mother, woman comes and I've got you know, got some patients like that but not, not that many. And just wants the termination because it's sort of inconvenient, you know, not not the right time, doesn't fit in with her plans. I'm certainly aware that in those circumstances I would try... I wouldn't say 'I'm not going to sign the form' but I would probably then make a bit more, I would make a significant effort to get her to think through and make it clear, probably might make it clear to her that although I would sign the form I wasn't in myself particularly supportive of her decision. Again that's a judgment and some people might argue that I shouldn't be doing that but that's, that's the way I work I think. [GP19, male]

Throughout his account, GP19 appears to reflect upon and critique the situated basis of his belief that some types of futures should be fought for, and some should not (e.g. "I could accuse myself of being judgmental and paternalistic"). However, such reflexivity could also be understood as the rhetorical practice which Potter (1996) terms "stake confession":

Confessing stake shows that the writer is live to its relevance and is not trying to dupe the readership. It may also work as a display of honesty and objectivity: the author is someone who can stand outside his interests and is well aware of their distorting potential. (Potter, 1996: 130)

As described in Chapter Three, attempts to achieve the status of 'objectivity' through the confession and dismissal of personal 'values' are also a well-known feature of social scientific writing.

Whatever the implications of this 'reflexivity', it is interesting that GP19 seems unable to represent the circumstances in which abortion is acceptable as a simple matter of 'fact'. Such hesitancy was common when HCPs criticised women for choosing abortion when they have other options available to them, and is perhaps unsurprising when it is considered that HCPs are working in a discursive context which prioritises patient autonomy (see Chapter Five). However, HCPs' critiques were consistently directed towards the same categories of people; those who had adequate finances, were educated (and preferably) in stable relationships. Hesitant or not, through such critiques, they made potent statements about the kinds of people who should *not* have abortions, and thus the kinds of lives which *should* be reproduced:

I think, I think, you know, the people I find some of the hardest people to deal with are probably um older women, women in a stable relationship

um, you know, who seem to have financial and um emotional support, you know who, who choose. That's something I, I don't find so easy, mmm. But again, it's not my choice. [laughs] [GP11, female]

I: Um have you ever come across reasons that you find problematic at all?

P: Yeah not actually in this practice funnily enough but when I was a registrar um a very nice middle-class couple with resources and money and the intention of adding to their family but just not at this point in time. Didn't suit. I found that quite challenging.

I: How did you kind of manage that, that situation?

P: It's about five years ago now so-

I: Sorry.

P: Um but I think I just, I think you have to be honest with people and say, if you are feeling uncomfortable and you're happy that your uncomfortable feeling is not something that's so personal you know um I think other practitioners would share that sort of slight discomfort um. And I think it's ok to reflect that back to a patient and say 'I am feeling uncomfortable about this for the following reason'. You know, not fair to say I'm feeling uncomfortable because I'm from some religious group and we just don't tolerate this kind of thing, you know. You know, so I I think in that case I said to them 'look your reason for not wanting to proceed with this pregnancy is something you may regret um because you could accommodate this baby, you could look after it, you know'. [GP12, male]

In the extract from the interview with GP12, it is notable that he distinguishes his expert "discomfort" concerning his middle-class patients' decision to end their pregnancies from what would constitute an unfair judgment, namely one based in religion and a general intolerance of abortion. When I went on to ask what had happened to the couple in question, he said that he had refused to refer them initially, and couldn't remember whether or not they had eventually been given access to the procedure. It is important to contrast this with the practice of the two GPs that I interviewed who *did* hold objections to abortions based in religion (see Chapter Four). While they may have disagreed with their patients' actions, neither of these doctors suggested that they had any right to prevent them from terminating their pregnancies.

In the quotation from GP11 above, "older" women are added to the description of those who should be having babies rather than abortions. The use of

age as a means to stratify women into groups who should or should not become mothers has often been critiqued by feminist researchers. One of the most well-known examples of this form of reproductive stratification is the representation of teenage motherhood as a pressing social problem (Phoenix, 1991; Lawson & Rhode, 1993; Ward, 1995; Luker, 1996). This type of motherhood is often depicted as intrinsically dangerous for mother and child, and is positioned as the direct cause of social inequalities such as poverty (Luker, 1996).⁶² The readiness with which HCPs depicted abortion as an acceptable course of action for ‘the young’ (see section 6.3) suggests that they also defined motherhood as something which should not happen ‘too early’ in a woman’s life.⁶³ This distinction is reinforced by the emphasis which they placed on “older” women as a group who *should* continue with their pregnancies.

In drawing attention to the problem of “older” women who request abortions, HCPs also introduced another form of reproductive stratification, by suggesting that motherhood was a course of action that some women pursue *too* late:

I: And does what you, what you would have talked about with different women, would it vary very much? I’m thinking maybe if someone’s quite direct that this is what I want to do, I’m decided or?

P: It would probably vary, yeah. Yeah well, no, it would probably vary more depending on their age and their circumstance. You know it would be very different with a fifteen-year-old who clearly that was very much the best way to go compared with somebody, you know, somebody who’s thirty-eight who felt that this just wasn’t the right time to have a baby or, you know, that, that sort of thing. [Consultant 6, female]

And then of course it would depend on how old they are. If we were having this discussion with somebody who was thirty-three and they said yes they would want to have a child in this relationship but now isn’t the right time, I would then have an entirely different conversation about how, ‘well thirty-three is getting on a bit and if you have this pregnancy terminated and then you can’t get pregnant subsequently and it does get harder as you get older, you know, why, why, why do this now and possibly consider getting pregnant next year or the year after. There often

⁶² As numerous researchers have pointed out, for many teenage women living in poverty, motherhood is the most positive and rewarding opportunity that is available to them (e.g. Macintyre & Cunningham-Burley, 1993; Ward, 1995; Luker, 1996).

⁶³ Interestingly, within the related context of maternity care, Breheny and Stephens (2007) have argued that “adolescence” and “motherhood” operate as two irreconcilable discourses in HCPs’ accounts.

is no right time to be pregnant, it's a difficult decision to make, to, to, that now is the time to be pregnant.' But if somebody was nineteen I wouldn't have that conversation with them. Um, so it does very much depend on what the individual and what their circumstances are.
[Consultant 4, female]

When they suggest that, in contrast to teenagers, women in their thirties should be dissuaded from abortion, these doctors do not simply suggest that older women make more appropriate mothers. In both extracts, they also imply that the time-frame within which women make suitable mothers is limited.

Although the reasons for this are left ambiguous in the first extract, in the second extract, Consultant 4 cites the time-limited nature of female fertility as the basis for her concern about a thirty-three year-old woman who requests an abortion. In doing so, she makes two troubling suggestions. Firstly, she implies that women do not realise that their fertility declines with age (which seems incredibly unlikely given that stories concerning the 'tragedy' of women who wait 'too long' to have babies, and who must be 'rescued' by reproductive technologies, have become a media staple).⁶⁴ Secondly, she assumes that this knowledge is *relevant* to a woman who has decided that she does not want to (or is unable to) have a baby at this point in her life.

Nevertheless, it should be remembered that many of the HCPs who I interviewed work in a specialty (obstetrics/gynaecology) which centres on women's ability to reproduce. In this context, it is perhaps only to be expected that they articulate concerns about those who appear to be waiting 'too long' to start their families.

6.5 Conclusion

The importance of contextualising HCPs' accounts in relation to the discursive contexts within which they are speaking is a point that I want to reiterate in this concluding summary. In Chapter Three I suggested that one of the benefits of a discourse analytical approach is that it makes it possible to theorise the speaking

⁶⁴ For detailed analyses of the British media's representation of this, and related, issues see McNeil (2007) and Hadfield *et al.* (2007).

subject as simultaneously creative, yet constrained by the discursive resources available to her or him. From this perspective, the troubling “prescriptive ontologies” which emerge through HCPs’ claims to expertise about abortion must also be viewed as evidence of the limited and limiting resources available for ‘imagining reproduction’ (Ginsburg & Rapp, 1995) in twenty-first century Scotland.

I began the chapter by drawing attention to the way that contemporary public discussions of abortion frame the practice as an intervention which can and should be prevented through the use of contraception. In this context, it is unsurprising that HCPs perpetuated this framing of abortion, by positioning themselves as experts who must teach their patients how and why to avoid future unwanted pregnancy.

However, I went on to illustrate that there were some situations in which HCPs depicted the repeated use of abortion as a more acceptable practice. I revealed that women from “other countries”, the young and (particularly) those living in poverty were depicted as incapable or unwilling contraceptive users. I suggested that HCPs’ tolerance of these women’s use of abortion might reflect the negative value assigned to particular types of reproductive futures. This suggestion gains weight when HCPs’ acceptance of certain women’s use of abortion is contrasted with the situations in which they criticised their patients for requesting the procedure. With disturbing regularity, HCPs argued that it was acceptable to try to discourage financially secure (read, middle-class) women from having abortions. This argument was also applied to those women who were said to be waiting too long to start their families.

I have suggested that these processes of differentiation can be described as practices of reproductive stratification, through “which some categories of people are empowered to nurture and reproduce, whilst others are disempowered” (Ginsburg & Rapp, 1995: 3). Through HCPs’ accounts, the reproductive opportunities available to women become entangled with structural systems of inequality such as socioeconomic class, ethnicity and age. However, as emphasised above, individual HCPs are not simply *creating* a world where the possibilities open to women are

structured in this way. The emergence of this world from their accounts is simultaneously indicative, as well as an indictment of, the society within which they are speaking.

Chapter Seven: Timing is everything - The reappearance of the fetus

7.1 Introduction

As noted in Chapter Five, one of the contexts in which HCPs were most likely to position themselves as experts in relation to women with unwanted pregnancies was when they discussed requests for abortion made at later gestations. When describing their interactions with women in the second trimester of pregnancy, HCPs were far more likely to suggest that they would discourage or refuse a woman's request for abortion. In this chapter I will illustrate the claims to expertise which HCPs mobilised as they discussed decision-making about the provision of later abortion. As in the previous chapter, my analysis of these claims centres on the ontologies prescribed (Wynne, 2001) when HCPs attempted to position themselves as experts in relation to their pregnant patients.

The chapter is structured around three different claims to expertise which HCPs made during their accounts of decision-making about later abortion. In most of the interviews HCPs drew upon at least one of these claims, and in some cases they combined them. Firstly, echoing public debates on the subject, some HCPs suggested that, as gestational time passes, they automatically become better placed than pregnant women to assess the moral significance of the fetus and the 'necessity' of abortion. In other cases, they argued that, as gestational time progresses, their knowledge of the methods involved in terminating pregnancies becomes increasingly essential to abortion decision-making. Finally, some HCPs suggested that those who are involved in *performing* later abortions possess experiential knowledge that is relevant to decisions about how 'late' the procedure should be provided. My analysis will reveal that, when HCPs frame decision-making about later abortion in terms of each of these three knowledge claims, the lives of pregnant women disappear from view.

While the following discussion represents a critical analysis of HCPs' attempts to define the meaning of later abortion, I also aim to continue the approach

developed in previous chapters by acknowledging the contexts from which HCPs are speaking. In Chapter Two, I argued that Haraway's (1991; 1992; 1997) work provides a useful means of treating the material world seriously as an active presence in human life, in a manner that also emphasises that human encounters with material entities are always *situated*, and are also *mediated* through human discourse. This work becomes particularly important during the final section of this chapter, which deals with HCPs' embodied accounts of their involvement in performing later abortions. I will use it to treat HCPs' accounts of their physical involvement in later abortion work sensitively, whilst refusing to privilege their accounts as an objective source of knowledge concerning the meanings of aborted fetuses.

As described in Chapter Two, another critical feature of Haraway's approach to human relationships with materiality is that she focuses on the kinds of reality that are created through this process. Her work thus enables me to ensure that, in keeping with the rest of the chapter, my analysis of HCPs' definitions of their encounters with aborted fetuses remains focussed on political questions concerning the ontologies that this process prescribes.

As the following discussion will reveal, my participants did not collectively agree upon a single point in time beyond which abortion suddenly becomes a different kind of decision because it is 'late'. This is one of the reasons why I have chosen to employ the relational terms 'later' and 'earlier' abortions in the analysis that follows, rather than the absolute terms, 'late' vs. 'early'. However, my use of this more ambiguous terminology also represents an attempt to undermine the assumption that there are a distinctive set of abortions which can be classified as 'late' and then discussed as a qualitatively different kind of issue from 'early' abortion. In her analysis of the 1988 Alton Bill (see Chapter One) and the terms in which it was debated in Parliament, Steinberg argues that Alton and his supporters effected "a significant shift in the broader cultural meaning of abortion" (Steinberg, 1991: 178) by demarcating 'late' abortion as a particularly problematic practice. The repercussions of this definitional shift are clearly visible in the terms of contemporary media and parliamentary discussions of the subject. As described in

Chapter One, pro-choice MPs appear to have conceded that the legitimacy of women's access to 'late' abortion is an entirely different question from their access to 'early' abortion. 'Late' abortion is now seldom discussed as a question of women's rights, and access to the procedure has become dangerously contingent on medical professional opinion concerning the gestations at which premature babies can be kept alive.

7.2 Expertise concerning the meaning of gestational time

The discussion in Chapter One summarised the recent history of abortion law, as well as feminist critiques of the ways in which abortion has been debated and legislated in the UK. As part of this discussion I highlighted two key assumptions which underpin the amendments to the 1967 Abortion Act that were passed in the 1990 Human Fertilisation and Embryology Act. Firstly, the law implies that the status of the fetus in relation to the woman who is pregnant is dependent on medical consensus concerning the lowest gestation at which a fetus is 'viable' (with medical intervention) if born prematurely. In 1990, this consensus led to an upper time limit of twenty-four weeks' gestation being placed on those abortions carried out on the grounds that:

the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family (Human Fertilisation and Embryology Act, 1990, section 37, clause 1a).

There is no upper time limit on the other three grounds under which abortions can be provided (see Chapter One, p.15). This reflects the second assumption which is embedded within the law, namely, that 'exceptional' circumstances are required to make the abortion of later gestation fetuses a legitimate course of action. In the following section, I will illustrate how these two, interrelated arguments were mobilised by some HCPs when they explained why gestational timing matters *before* the twenty-four week limit that appears in the law.

However, before exploring the distinctive status which HCPs grant to fetuses at later stages of gestation, it is useful to consider Franklin's analysis of the ways in which scientific discourses about the fetus facilitate its personification. In addressing

the ways that these discourses have been mobilised by the anti-abortion lobby in public debates about abortion, she argues that:

the construction of fetal ontology in the scientific literature, scientific photography and in the anti-abortion literature invites identification with the fetus on the basis of its morphological individuality and personhood. (Franklin, 1991: 200)

Another key feature of scientific accounts of fetal development is that they position the embryo/fetus as an entity which contains the biological *potential* to become a human being from the moment of conception onwards. Through this narrative of potentiality we are encouraged to view the fetus's future as synonymous with its present state of being. In other words, this:

...teleological construction of the fetus opens up the possibility of identifying with its developmental personhood, its entire imagined life course and its future as a human adult. (Franklin, 1991: 200)

Franklin argues that, through these discourses, biological explanations first eclipse and then come to signify the social meanings of reproduction and kinship. She highlights the individualistic definitions of these processes that are embedded in biological accounts of fetal status. Attempts to define the fetus as a separate person on the basis of its 'biology' obscure the physical relationships between pregnant women and their fetuses, as well as their social relationships with one another and with other human beings (Franklin, 1991).

Both of the aspects of biological discourse which Franklin identifies (i.e. "fetal ontology" and "fetal teleology") were central to HCPs' claims to expertise concerning the meaning of gestational time. However, as the following discussion will reveal, the potentiality of the fetus was depicted as particularly significant.

7.2.1 Accounting for a twenty week time limit

As described in Chapter Five, at each of the hospitals where I conducted interviews, a time limit below twenty-four weeks' gestation is enforced. Women who arrive at a hospital after its chosen cut-off point are informed that they have to travel to England to one of the charitable abortion providers (usually, the bpas). The precise cut-off point varies from hospital to hospital, but the highest limit that an interviewee

reported was twenty weeks' gestation.⁶⁵ Explanations of this particular time limit centred on the issue of fetal viability, and the inaccuracy of the ultrasound scans which are used to date pregnancies:

...a twenty-four week fetus has, I think has to be presumed capable of being born alive and certainly um widespread practice in this part of the country um is that you will struggle to find a Consultant who's willing to terminate a pregnancy other than on the grounds of fetal abnormality, if the pregnancy is beyond twenty weeks. Now that's partly based around um, a presumpt- our presumption of viability is about the twenty-three week mark, yeah that's, as far as I'm aware that is the earliest gestation at which a baby has been born and has lived. The ultrasound scan that we use to date a pregnancy has about a two-week error at that stage of pregnancy. So a pregnancy which is by ultrasound evaluation twenty-three weeks could be anywhere from twenty-one weeks to twenty-five weeks. So I think you have to assume that a twenty-three week pregnancy on the scan is a twenty-one week pregnancy potentially, um and therefore we have a kind of um, by mutual agreement amongst a group of consultants, an undertaking that we tend not to want to go beyond twenty weeks unless as I say there um, there is a fetal abnormality. [Consultant 2, male]

In this account, Consultant 2 constructs the measurement of gestational time as something which is essential in order to avoid aborting a fetus that is old enough to be kept alive (with medical assistance) *ex utero*. In doing so, he portrays medical consensus, rather than the Abortion Act, as the source of authoritative knowledge which determines the threshold in time that is deemed significant (twenty-three weeks). However, simultaneously, he reveals the complexities involved in treating this event as a particular, identifiable 'point' in time. Because the date of conception is never known precisely (except, perhaps, to the couple in question), the 'age' of a fetus is only knowable through the conventional methods used to date and thus *attribute* gestational time to fetuses. Through these methods, the age of these entities (including those which HCPs have successfully 'kept alive') can only ever be known as an approximation.

Rather than drawing attention to the technical difficulties involved in measuring the 'point' at which a fetus becomes an entity that might be kept alive *ex utero*, it is perhaps more important to problematise Consultant 2's assertion that this

⁶⁵ This mirrors the highest time limit found by Lee *et al.* (2004), who surveyed the upper gestational limits of abortion provision at twenty-one (randomly selected) NHS sites across the UK.

measurement is relevant to decision-making about abortion. As McNeil (1991) points out, the significance which is attributed to fetal 'viability' in public debates about abortion causes our attention to shift away from the fetus's relationship to the woman who is pregnant. Focusing on the earliest point at which a fetus can be kept alive using medical technology ensures that its 'life' is defined in terms of biological function, rather than in terms of women's:

...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 – emphasis added)

It is important to note that several of my participants also questioned the relevance of medical professional consensus concerning fetal 'viability' to decisions about abortion. Like McNeil, Consultant 3 suggested that the gestation at which fetuses can be kept alive by doctors is irrelevant to the question of whether a woman feels able to continue with her pregnancy:

I: ...there's been a bit of debate lately about the upper time limit on terminations-

P: Sure.

I: I just wondered if you have any opinions or views about that?

P: Um I, I suppose the, the discussion about it I think has got sort of quite muddled and it seems to have got mixed up with viability and, and with pregnancies now surviving, some surviving at twenty-four weeks' gestation. I think it's entirely different, I don't really see that the two things are, are part of, of the same argument [...] And just thinking of people that I've seen that have been at that gestation, they often have um quite dire circumstances that are leading them to request such a late termination. Whether it be, you know, a relationship that's maybe split up in, in very difficult circumstances, often maybe domestic violence in the background, or young people that have concealed a pregnancy, or someone that's just been too frightened to, to acknowledge that they were pregnant [...] So I personally would, would keep the gestation limit as it is. [Consultant 3, female]

However, more often, when HCPs raised questions about the definition of viability, they did so in a very different manner from the kind of feminist reframing that McNeil advocates:

There's been a lot of debate about that and I don't do obstetrics. Or at least I did obstetrics but years ago um so I don't see premature babies delivered. But a colleague who did do the clinic with us for quite some time and who was involved in obstetrics used to say 'don't ask how many babies survive at twenty-two weeks and twenty-three weeks. Ask how many of them pick up a schoolbag and go to a normal school, healthy and well, four or five years down the line.' And maybe those are the questions you ought to be asking. Because the success rate of, of keeping very prem babies alive and normally or reasonably normally functioning, nobody has perfect babies um but that is, is perhaps the question rather than can they survive for six months or a year or in some damaged fashion for a three, three or four years. Um you wonder about that. But as I say that's, that may change with time and... But there must be a limit beyond which you obviously just cannot resuscitate these babies.
[Specialist Registrar 3, female]

In this extract, Specialist Registrar 3 reframes the question of viability as an issue of the long term, rather than immediate 'life' potential of neonates. Interestingly, similar moves were made by MPs who defended the current twenty-four week time limit on abortion during the Committee stage of the 2008 Human Fertilisation and Embryology Bill:

The current clinical evidence shows that although there have been medical advances in caring for premature babies, only a small number of babies born at under 24 weeks' gestation can survive. For those that do, there may be many questions about their quality of life—most have severe problems—whereas the situation improves markedly at 24 to 25 weeks, which reaffirms why the limit of 24 weeks was chosen. [Dawn Primarolo, Hansard Columns 245-6, May 20th 2008]

Like Specialist Registrar 3's account, such defences do little to open up the discursive space in which to talk about later abortion. This is because they fail to challenge the assumption that medical judgments about the functionality of fetal/neonatal bodies are the crucial basis for making decisions about its availability. At the same time, these alternative accounts of 'viability' do reveal that it is a more complex issue than "the earliest gestation at which a baby has been born and has lived".

Nevertheless, there are good legal reasons why HCPs may be working with this incredibly narrow definition of 'viability' in practice. As noted in the intermission between Chapters Three and Four, medical abortion induces the premature delivery of a pregnancy. However, an issue which I did not include in this

description is that, when conducted at later gestations, this method of abortion sometimes produces a fetus that shows signs of ‘life’ (such as a heartbeat or respiratory attempts). As Vadeyar *et al.*, (2005) point out:

Legally, a fetus that is born alive becomes a child and a deliberate act that causes the death of a child is murder, even if that deliberate act precedes the birth. Consequently, a doctor could be accused of murder if he performs a termination that results in the live birth of a child that is capable of survival and the child then dies of prematurity. (Vadeyar *et al.*, 2005: 1159)

In other words, the legality of an abortion can, somewhat paradoxically, become dependent on events which post-date it. It is for this reason that the Royal College of Obstetricians and Gynaecologists recommend the performance of feticide (the ultrasound-guided injection of potassium chloride into the fetal heart to stop it beating *in utero*) before abortions carried out beyond twenty-one weeks and six days (Royal College of Obstetricians and Gynaecologists, 2001; Vadeyar *et al.*, 2005). This is treated as the conventional limit of clinical viability, i.e. it is the threshold above which a fetus is deemed capable of independent survival with medical assistance if it shows the ‘life’ signs mentioned above, upon delivery (Vadeyar *et al.*, 2005). Feticide ensures that a medical abortion *cannot* produce a fetus showing these signs, and means that HCPs are not faced with the professional/legal obligation to try to keep it alive.

However, although an entirely legal method of abortion (feticide, plus medical abortion) is available for pregnancies that are dated as being between twenty and twenty-four weeks’ gestation, this method does not appear to be utilised in Scotland. Rather, a ‘margin of error’ system is employed to ensure that Scottish HCPs cannot ever become *involved* in the abortion of a fetus that is more than twenty-two weeks’ old. If an ultrasound scan indicates that a woman is twenty weeks’ pregnant⁶⁶ or more, then she is directed to a charitable abortion provider in England.

⁶⁶ Given the two-week error in scanning mentioned previously, ‘twenty weeks’ implies that the woman in question is somewhere from eighteen to twenty-two weeks’ pregnant.

As well as drawing on arguments concerning the distinctive status of post-twenty week fetuses, Consultant 2 also invokes the idea that the abortion of these fetuses requires unusual circumstances to be justifiable (see p.193). In describing an exception in cases of fetal abnormality, he echoes the distinction made by the 1990 Human Fertilisation and Embryology Act, which removed an upper time limit on abortions in situations where there is “a substantial risk that if the child will be born it would suffer from such physical or mental abnormalities as to be seriously handicapped” (clause 1d). In recent years, this exception has generated considerable legal and media controversy, with disability rights activists arguing that it represents discrimination against disabled fetuses, and devalues disabled lives (see Statham *et al.*, 2006 for a review of this controversy).⁶⁷

However, as feminist scholars have long argued (Science and Technology Subgroup, 1991; Sheldon, 1997), special case arguments about fetal abnormality are not simply problematic because of the way that they construct disability. Additionally, these arguments contribute to the belief that decisions about later abortions should be based upon HCPs’ definitions of fetal status, rather than upon individual women’s understandings of what their pregnancies mean.

7.2.2 And, by extension...

My analysis of Consultant 2’s account of the twenty week time limit at his hospital has revealed how he mobilises both of the assumptions about later abortion which underpin the twenty-four week time limit in current UK law. Later abortions are held to be problematic because of the status of later gestation fetuses, and only HCPs are qualified to define the exceptional circumstances (such as the diagnosis of fetal abnormality) where the abortion of these fetuses becomes justifiable. In the remainder of this section, I will briefly illustrate how other HCPs mobilised identical

⁶⁷ HCPs involved in termination for fetal abnormality also recognise that this is a potentially discriminatory distinction, but argue that it is important to be able to provide abortions at later gestations on these grounds (Statham *et al.*, 2006). This is because most diagnostic tests cannot be carried out until well into the second trimester, and the imposition of a twenty-four week limit on these decisions would force patients to make them very rapidly (Statham *et al.*, 2006). Additionally, the likely severity of some fetal conditions cannot be properly assessed until the *third* trimester of pregnancy (Statham *et al.*, 2006).

arguments when they explained why abortion becomes a problematic decision at gestations far below twenty weeks. In doing so, I want to highlight the major ramifications of debating and legislating later abortion within a narrow discursive framework which grants authority to HCPs' definitions of fetal status.

In many HCPs' accounts, fetal viability was characterised as a much blurrier and more ambiguous threshold, which was expanded to encompass the time period during which a fetus *approaches* a point where it might be capable of independent life:

I: Ok. Um and you said that um it would, that it's up to about twelve/fourteen weeks it's um pretty much open access. But um could you explain why it becomes a bit less so after that time period.

P: Um, I suppose, I suppose it's just as the, as the fetus gets closer towards viability. I mean I know fourteen/sixteen weeks they're not – and we would usually, certainly when I did the TOP clinic, usually women would have a termination up to twenty weeks, um but certainly around nineteen/twenty and above then, then. And it's to do with, it's to do with viability, yeah. [Consultant 6, female]

I think there's no doubt that uh the longer time goes on uh the more uh uh a fetus uh becomes, uh the closer it comes to, to viability uh the less uh the less you wish to interfere, mmm. [GP16, male]

When I went on to try and clarify the kind of timescale that this second HCP was referring to, he said that the later abortions which concerned him were those occurring after roughly the first twelve weeks (i.e. the first trimester) of pregnancy.

Arguments concerning the lack of justification for the abortion of later gestation fetuses were also central to these and several other HCPs' accounts. In many cases, it seemed that they were not criticising the weakness of women's grounds for abortion *per se*, but rather their grounds for having failed to request the procedure at an earlier point in gestation. In other words, the fact that women 'allow' gestational time to pass before requesting an abortion became treated as evidence that the procedure is not really necessary:

I think as I say, because abortion is so readily available and publicised and, you know, such easy access and certainly in this hospital, particularly, the service here is incredibly well-run and organised. And I don't think there's any reason why people shouldn't come up earlier on

in their pregnancy, and make their decision earlier on in their pregnancy. Except in the rare occasions. [Specialist Registrar 1, male – discussing his reservations about abortions beyond the first trimester]

And I, yeah, I suppose part of the logic is that in this city, there is, for most women there is quite easy access to termination, and so you, you feel for most women they should have been able to get here, you know, unless there are unusual circumstances by fourteen weeks really, so. But I suppose that, I mean I suppose that's a bit judgemental. But that - you wonder how seriously, well I don't know – you just feel a bit more uncomfortable as, as the gestation gets, gets later. [Consultant 6, female]

Concern about how “serious” women are when they request abortion later in pregnancy was expressed by a number of HCPs. Some argued that this would lead them to assess their patients' decisions much more carefully than they would if a request for abortion was made earlier in pregnancy.

However, GP16 took this argument a step further, and suggested that, when women allow too much gestational time to elapse before requesting an abortion, it is safe to assume that they do not really want the procedure:

P: Really uh in my experience um the only reason for people presenting late is because something has been found on a, on a scan or a MAFP check which means that uh there's serious trouble anyway. And in that situation uh you'd go ahead and refer. Uh but in other situations, people who let a pregnancy go on and on or they uh fail to come to a decision uh in a way subconsciously they're making their decision.

I: Mmm. So they're, by, by letting the pregnancy go on they're?

P: They're, they're saying, well um uh 'I don't want to end it,' mmm. [GP16, male]

In this, as in the extracts considered above, there is no sense that, just as pregnancy takes place over time, a woman's circumstances and feelings about (not to mention her awareness of)⁶⁸ her pregnancy might also change. GP16's reluctance to acknowledge this possibility is particularly interesting, because he does suggest one particular set of circumstances where a pregnancy might run into the kind of “serious trouble” that justifies later abortion, i.e. because of the results of diagnostic tests. In

⁶⁸ Studies which have explored women's reasons for requesting abortion later in pregnancy suggest that many women simply do not realise that they are pregnant at an earlier point in gestation (Robotham *et al.*, 2005; Ingham *et al.*, 2007). Amongst the factors which might make it more difficult to recognise a pregnancy are a history of irregular menstruation, or using hormonal methods of contraception, which can produce erratic bleeding, and also make it less likely that a woman will suspect pregnancy because she believes she is having ‘protected’ sex (Robotham *et al.*, 2005; Ingham *et al.*, 2007).

contrast to a woman's own understanding of her pregnancy, the knowledge generated through medical testing is presented as an entirely straightforward and legitimate basis from which to proceed with an abortion at this point in gestation.

In some cases, HCPs engaged in more explicit boundary work and set up a direct contrast between "medical" (or justifiable) and "social" (or unjustifiable) grounds for later abortion.

I: So what's kind of the latest that you will refer women on for, for a termination?

P: I don't think you can answer that question.

I: No, ok sure.

P: Um for a so-called social termination oh, I'd be reluctant to do it any later than sixteen weeks, possibly earlier. Um but I mean, clearly if there were dreadful birth defects found on an ultrasound scan or something then it's a completely different kettle of fish.

I: And um, 'social' uh terminations what, how do you kind of um I'm just trying to understand what that term means cos I've heard it from quite a few people.

P: Well, there are a, a group of terminations performed for pregnancies that are, are not proceeding as, as as would normally be anticipated, so there's going to be disastrous fetal anomalies and it would be wrong to push somebody towards the end of a longer gestation for all kinds of reasons of physical delivery uh injury to the mother, psychological reasons uh where you wouldn't want that pregnancy to go ahead, so you know dreadful chromosomal abnormalities, or something like that. And those things [*inaudible word*] be picked up early in pregnancy. Um whereas a social termination, if you're looking for an off the top of my head definition, a pregnancy that would have produced a healthy baby if it had been left to its own devices probably, in all probability. But the environment that the baby's going to be delivered into is maybe going to be less than ideal. [GP12, male]

In separating the 'social' from the purely 'medical' in this way, GP12 does not have to address the way in which the 'social' is inextricable from the medical practice of prenatal diagnosis. This practice rests upon and perpetuates the construction of disability as a medical problem for individuals to deal with through the abortion of affected fetuses, and silences questions about society's collective responsibilities for the support of the disabled (Lippman, 1991; Shakespeare, 1998).

As described in Chapter Five, GPs tended to avoid stating directly that they would refuse to refer a patient who requested an abortion. However, when GP12 says that it would be wrong to “push” a woman to continue her pregnancy if she was carrying a fetus with an abnormality, he seems to imply that, if her fetus is “healthy,” such “pushing” becomes acceptable. In several of the interviews GPs produced similarly ambiguous, and troubling, accounts of their interactions with women requesting later abortion. This often left me wondering whether some patients are being dissuaded from abortion, or even being refused access to the procedure by GPs. Women who reach a hospital after its local gestational cut-off point will at least be given the opportunity to access a charitable abortion provider in England. In contrast, those who are prevented from accessing secondary care facilities by a GP may have no other option than to carry their pregnancies to term. Alternatively (and ironically), if they do eventually manage to gain access to the procedure, this process will inevitably be delayed by encounters with GPs who dismiss them for being ‘too late’.

7.3 Expertise concerning the method of later abortion

As described in the introduction to this chapter, in nearly all of the interviews, HCPs suggested that decisions about later abortions were qualitatively different from decisions about earlier abortions. However, their explanations for this difference did not always involve claims to expertise about the status of the fetus. In this section I will reveal that some HCPs’ concerns about later abortion centred entirely upon the woman in question. I will illustrate how HCPs construct the method used to terminate later gestation pregnancies as a course of action that is potentially more physically and emotionally damaging than carrying an unwanted pregnancy to term. Through this analysis I will argue that, as they mobilise claims to expertise about the ‘risk’ posed by this procedure, HCPs again impose particular definitions of the meaning of abortion, and cause the future lives of their pregnant patients to disappear from view.

Before embarking on this discussion, I will re-summarise some of the critical background ‘information’ concerning abortion methods that was provided in the

Intermission following Chapter Three. Through this summary I aim to illustrate that, in Scotland, women have no choices concerning the method used to terminate their pregnancy once they enter the second trimester of pregnancy.

7.3.1 The time-limited availability of surgical abortion

Guidelines from the Royal College of Obstetricians and Gynaecologists (2004) state that, if doctors possess the requisite skills, it is possible for them to perform surgical abortions up to the legal time limit. From seven to fifteen weeks' gestation, this involves the use of a suction curette to aspirate the contents of the uterus (sometimes aided by blunt forceps). After fifteen weeks, a woman's cervix must be dilated more extensively before a surgical abortion, because this involves the use of instruments to dissect a larger fetus into smaller parts *in utero*, in order to make it possible to remove it through the vagina. This procedure is known as dilation and evacuation.

However, I was informed that dilation and evacuation does not feature as part of Scottish abortion practice. Moreover, at most hospitals, gynaecologists will not conduct even conventional suction surgical abortions beyond approximately thirteen weeks' gestation. This means that most women are unable to have a surgical procedure in the second trimester of pregnancy, and must undergo medical abortion instead.

As described in the Intermission between Chapters Three and Four, the medical method of abortion can be performed across the first and second trimester of pregnancy and utilises two drugs – mifepristone and misoprostol – to induce abortion. With increasing gestational time, greater quantities of misoprostol must be administered to the patient, in order to generate the stronger uterine contractions and greater degree of cervical dilation which are necessary in order for a larger fetus to be expelled through the vagina. Unlike surgical abortion (which, in Scotland, is performed under general anaesthesia), medical abortion requires the patient to be conscious throughout.

Gynaecologists often explained the time-limited basis of surgical abortion provision by stating that second trimester surgical abortions are technically more difficult to perform, as well as generating a higher risk of post-operative complications. One Consultant also argued that, because later surgical procedures are rarely performed, there are few specialists who can train other gynaecologists to do them. However, other participants suggested that a more active rejection of later surgical abortion provision also takes place in Scottish practice. For example:

P: So it's more - but it's also there's the yuk factor, you know, chopping up fetal parts at sixteen weeks is pretty horrible. I've seen it done once for a woman who had um, she was about seventeen weeks and had, she had a cervical suture in to prevent recurrent miscarriage. And the Consultant um actually did a destructive procedure in order to get the baby out without, cos she couldn't, you couldn't remove the suture cos it was an abdominal suture, and otherwise she would have needed a hysterotomy. And it's not pleasant you know.

I: Yeah

P: So and, you know, good on him for doing it. Um but that, that was out of a medical necessity. Um but you know I wouldn't, I think it's a horrible thing to do, yes. [Consultant 7, male]

In her research into women's experiences of amniocentesis and abortion in the US, Rapp (2000) links the limited availability of second trimester surgical abortion to hierarchies in the hospital workforce. She suggests that doctors are able to forgo the training necessary to be able to perform later surgical abortions because they are in a position to delegate medical abortion work to their nursing colleagues. Doctors' refusal to perform surgical procedures also delegates work to the women undergoing medical abortions, because their bodies are actively involved in this process (Rapp, 2000).

7.3.2 Demarcating 'later' medical abortion

Although the medical abortion method involves the same drugs across the first and second trimesters (albeit in different quantities), my participants tended to emphasise differences, rather than similarities, between earlier and later medical abortion. For example, in explaining why it was better if patients requested an abortion earlier in pregnancy, one GP characterised earlier medical abortion very matter-of-factly:

And uh we try and get them earlier now because they get the medical terminations done, you know, take your pills and the job's done. [GP15, male]

In contrast, he stated that he was more cautious about referring women beyond twelve weeks' gestation and placed an "embargo" on referrals at gestations of sixteen weeks and over (see Chapter Five, p. 150) because:

I think in in, well in practice terms I mean if somebody comes in, you know, a late termination, I suppose between sixteen and twenty, well I suppose sixteen and twenty, you know, a young lassie with a concealed pregnancy then there maybe some issues around, you know, whether she requires to go through a mini-labour or whatever rather than just a straight suction termination. I think that's probably why we use the sort of twelve, sixteen week, you know, cut off time. Cos the termination technology is different if you like. You know, once you've gone past sixteen it's no longer just out with the suction machine and get on with the job, it's quite different, you know, intra-amniotic termination and so on and so forth, it's, it's a different process altogether. So that's why. [GP15, male]

In GP15's account second trimester medical abortion is characterised as a unique and complex procedure in relation to the straightforward methods of earlier medical and surgical abortion. Indeed, it is depicted as something so problematic that patients must be prevented from going through it. Unfortunately, this interview was conducted under considerable time pressure, and because of this, I did not follow up precisely what GP15 considered to be so troubling about second trimester medical abortion. However, his account suggests that his concerns stem from his definition of the *process* that his patients will have to undergo, which is likened to childbirth (a "mini-labour").

This suggestion is supported by the emphasis which other HCPs placed on the importance of informing their patients about the traumatic 'nature' of second trimester medical abortion:

I: Ok. Um and the, the issue of time limits is something that I've come across before and um, some GPs have said that they make a distinction between first and second trimester terminations and is that something you're aware of or?

P: Um yes I mean I think because trimester, second trimester's a bit more traumatic to go through the procedure um people actually do have to have almost like a mini-labour. When you explain that to people it sometimes does affect their decision. But I don't think it would affect my decision, I mean I think I would counsel the person, but I would explain

very carefully about the procedure so that they absolutely understood what they were going to have to go through and more people do change their mind, the later it is more people change their mind.

I: But for example if a woman was in the second, at some point in the second trimester and she was adamant that that's what she wanted, you would still refer?

P: Yeah I would still, yep. I would explain very carefully what was involved and make sure she did understand that there were higher risks um that it was a more prolonged procedure, you know, more traumatic for her, more pain involved, so I would explain that very carefully. But if she still felt that was the right thing for her to do I would refer her.

[Consultant 1, female]

As I acknowledged in Chapter Five, HCPs do have a legal obligation to obtain informed consent from patients before they conduct any medical intervention. At the same time, I argued that, as they define what constitutes a decision that is “informed”, or which has been “thought through”, HCPs are inevitably producing particular definitions of the meaning of abortion. In the remainder of this section I will consider the definitions produced by HCPs as they lay claim to expertise about the method of second trimester medical abortion.

I was particularly struck by the frequency with which HCPs problematised the second trimester medical procedure by describing it as like a “mini-labour” or “delivery”. The first time that I encountered this expression, I barely heard the word “mini” and what I imagined was full-blown *childbirth*. To me, this term connoted not simply the (imagined) physical pain of labour, but simultaneously, the social significance of this process as something which would normally result in the birth of a new human person. Indeed, some HCPs’ unease about the ‘trauma’ caused by this method slipped between a concern with the bodily pain of vaginal delivery, and anxiety about the significance which their patients might attach to the fetus delivered at the end of this process. The following extract is quoted at length, because the Consultant provides a particularly detailed description of the information that she deems relevant to decision-making about second trimester abortion:

I: Um and some GPs have described the medical, the second trimester termination as a kind of like a mini-labour – is that um how you, you would see it or describe it?

P: Yeah I mean I think, again I think you in some ways you have to be quite explicit with people what that will actually involve um because they

have, people have to know what to expect before they agree to undergo a procedure. Um I think uh, I mean I wouldn't just say to someone it's a mini labour, I think I would qualify it with um probably more of a discussion about what will actually happen. But I think that um is a reasonable opening gambit to, to describe it to someone. And I think people are often quite shocked when they realise that they are actually going to have to deliver the fetus out through the vagina. I mean I would say to them obviously it's much, what you're delivering is much smaller than someone having a baby at the end of, end of a pregnancy. But the process is not dissimilar to that and particularly if someone's maybe fifteen, sixteen weeks um or more I would be sort of explaining to them that, you know, the [*inaudible technical term*] will come away and it's like someone's waters going it'll feel, feel wet and probably quite, and explain to them it's likely to be quite sore. Um I think they also have to, uh don't have to give a vast amount of detail but explain to people that if you were to look at what you're passing it is going to be recognisable as a, a pregnancy. Because again, people will come with a belief, or some people will come with the belief that there's basically some, a bunch of cells and some blood that you're going to pass and if they then look at a fifteen week fetus they'll get the fright of their life if that's not what they're expecting so, I use- I would normally say to people it will look like what it is, a developing pregnancy, and it would be recognisable as that. So if you don't want to see something like that, you have to be very sure that you don't look at the point where you, where something's coming away from you. So I think, I usually say to people 'I'm sorry to give you this amount of detail, but you do have to know what to expect, I can't send you into hospital to have this done without having an understanding about what we're, we're talking about.' [Consultant 3, female]

This extract reveals the complexity of the situation that HCPs are faced with when consenting patients for medical abortion procedures. With surgical operations, patients must be informed of likely 'risks' (the definition of which is, of course, also situated), but while the abortion is happening they will be under general anaesthesia. Because of this, there is no need to tell them what the procedure itself "will feel like". In contrast, when it comes to medical abortions, patients are conscious and will experience the entire abortion from start to finish. As a result, the extent of the information that must be provided is far greater, as is the potential for HCPs to impose particular definitions of the meanings of pregnancy and abortion upon their patients. Although she does not reflect explicitly on this potential, Consultant 3 seems to be aware of it throughout her account. On the one hand, she emphasises the importance of ensuring that her patients are aware of what they will feel and see, particularly if they are beyond fifteen to sixteen weeks' gestation. On the other, she

is apologetic and hesitant as she tries to find words to define what this experience will be like.

However, Consultant 3 then went on to suggest that fetal ultrasound represents a straightforward means of ensuring that patients are fully ‘informed’ before undergoing abortion at later gestations:

And I think um quite a lot of people, not everyone but a number of people um want to see the scan, they obviously scan everyone to check their dates when they’re in the clinic, and they’ll have the machine set such that the screen is turned away from the patient um but usually at the end of the scan they’ll say, ‘I’m finished doing the scan measurements, if you want to see the scan tell me and I’ll turn it round’. And it’s surprising the number of people that do actually want to see it. And sometimes that’s quite helpful, if someone is going to be, particularly a later termination, because it’s then more obvious what you’re, you’re talking about and you can say ‘now you’ve seen, on the image on the screen that, you know, that’s going to be delivered through the, the vagina, so’. And obviously for some people it won’t be the right thing to look at the scan, and they’re quite clear they don’t want to see anything, that, that’s fine, they don’t see it but...*[does not finish sentence and changes topic]*

[Consultant 3, female]

In this extract, it is unclear whether it is seeing the ‘size’ of what has to be delivered through the vagina, or visualising what the fetus looks like that is being defined as the crucial issue. However, what is clear is that the ultrasound image of the fetus is positioned as an objective source of information upon which women should base their decisions about whether or not to have an abortion. There is no acknowledgement of the issue highlighted by a large body of feminist scholarship, namely, that fetal imaging technologies *produce* a particular vision of the fetus, in which it appears as an individual that ‘lives’ outside of a pregnant woman’s body (Petchesky, 1987; Franklin, 1991; Duden, 1993; Hartouni, 1997; Stabile, 1998; Taylor, 1998; Zechmeister, 2001). Moreover, the process of ultrasound scanning has become ritualized as an important social event through which *wanted* fetuses are welcomed into their prospective families (Petchesky, 1987; Mitchell & Georges, 2000; Draper, 2002). As I argued in Chapter Two, feminist analyses of these processes are valuable because they demonstrate that the meanings of fetuses are contingent upon human practices, and thus, negotiable.

In contrast, the certainty with which many HCPs claimed to ‘know’ the fetus and what seeing it would (or, should) mean to their patients, left no such discursive space:

Obviously you do have to say it is, it is going to look like a baby and the chances are you will see it um and that is going to make it more difficult for you because it does seem more real than it just being a little ball of cells. [Consultant 4, female]

What might hearing a doctor’s definition of the fetus as “like a baby”, or the experience of watching its image move on an ultrasound screen mean for a woman requesting a second trimester medical abortion? The lack of data on this topic (see below) means that it is impossible to do more than speculate, but HCPs themselves suggested that this, combined with the description of the procedure as “like a mini-labour” often convinces women not to go through with it. It also seems important to consider what these definitions might imply for a woman who *does* decide to have a second trimester abortion. How might exposure to particular definitions of this experience become interwoven with the experience itself?

In addition to considering how HCPs’ designation of second trimester medical abortion as an unusually traumatic experience may impact upon individual patients, it is also vital to draw attention to the broader process of issue definition that is taking place in the accounts considered in this section. When HCPs insist that the immediate trauma caused by second trimester medical abortion is the most pertinent ‘fact’ in decision-making about abortion, they allow the futures of women who are dissuaded or prevented from undergoing this procedure to disappear. In none of the above extracts do HCPs acknowledge that such women will have to go through full-term labour and become mothers, or else surrender their babies for adoption.

7.3.3 Some alternative accounts of the medical abortion ‘experience’

As I have argued throughout this thesis, in considering the potential for HCPs to shape women’s experiences of abortion, it is vital not to become complicit with them by depicting their patients as ignorant and passive receptacles for their definitions of ‘relevant’ knowledge. The HCPs whose accounts I considered in the previous section

make several claims about their patients. In suggesting that, as HCPs, they possess specialist knowledge concerning the medical abortion procedure (both in terms of the physical experience and in terms of what ‘seeing the fetus’ means) they suggest that women have no access to this knowledge. In constructing women’s ‘ignorance’ about the procedure, they depict their own knowledge as an ‘objective’ source of information, and imply that no alternative definitions are available to their patients. Finally, although they insist that women need to be informed of the ‘facts’, they also construct their patients as vulnerable individuals who must be protected from the ‘reality’ of medical abortion, e.g. through the injunction “not to look” at the aborted fetus. In the following section, I will draw attention to some alternative accounts (based upon my own and other’s data), in order to challenge these claims.

In a study of French women’s experiences of first trimester medical abortion, Gerber (2002) reveals that some of her participants actively sought out medical images of developing fetuses before arriving at the abortion clinic (e.g. through medical guides to pregnancy, which are widely available). Others were already familiar with these images from the media, or had encountered them through their previous experiences of pregnancy and childbirth. In many cases, this prior knowledge had made them very apprehensive about seeing aborted fetuses, but it clearly did not deter them from pursuing what they identified as the best course of action. Moreover, Gerber reveals that, through their embodied encounters with the products of medical abortion, women were able to develop new definitions of its meaning. In many cases, they described what they saw as “eggs”, as entities which had some meaning but which were too developmentally “early” to represent a fetus or baby. She concludes that listening to women’s experiences of medical abortion may provide opportunities for “challenging previous notions of fetuses and expanding the parameters of fetal discourse” (Gerber, 2002: 105).⁶⁹

⁶⁹ However, there is a fundamental difficulty with the approach that Gerber adopts towards her data. Rather than simply acknowledging that her participants are able to produce alternative understandings of abortion, she insists that, because of the “embodied” nature of these understandings, they are *more* valid or authoritative than any other interpretation. As such, she falls into the trap identified in Chapter Two, whereby feminists engage in the selective reification of female embodiment for political purposes.

Through a study of women's and HCPs' experiences during clinical trials of RU486 in the US, Simonds *et al.* (1998) also draw attention to the fact that women were able to define medical abortion differently from HCPs. Several of the HCPs they interviewed depicted first trimester medical abortion as an invasive and traumatic process, because, in contrast to surgical abortion (which was the only technique that they were familiar with) it took far longer, often produced greater pain, and required many more visits to the clinic. In contrast, women who chose medical abortion characterised this technique as less violent and invasive than surgical abortion, both in terms of the physical interventions directed at their own bodies and in terms of what happened to their fetuses. Many seemed to take comfort from the fact that the drugs they took to initiate the abortion mimicked a process that might take place 'naturally', i.e. miscarriage, which occurs when the body can no longer sustain a pregnancy (Simonds *et al.*, 1998).

It is important to acknowledge that Gerber's (2002) and Simonds *et al.*'s (1998) interviewees were all less than nine weeks' pregnant. Although their accounts challenge HCPs' constructions of women requesting abortion as ignorant and passive/weak, and highlight the potential for women's definitions of abortion methods to diverge from HCPs', they cannot be used to disrupt HCPs' specific claims concerning the 'nature' of later medical abortion. As noted above, I have been unable to find any comparable literature concerning women's accounts of second trimester medical abortion. These absent voices urgently need to be addressed, and I return to this issue as an important avenue for future research in the following chapter.

Nevertheless, even as it stands, my data does offer the opportunity to challenge HCPs' claims to possess authoritative knowledge about the experience of later medical abortion. This is because HCPs did not all characterise this procedure in the same way:

P: ...in Scotland practice is fairly uniform in the sense that very early pregnancy, so between um about six and about nine weeks' gestation would um can be terminated either surgically or medically. Medically giving drugs to induce what amounts to an early very heavy period. Um in between nine weeks and about thirteen weeks' gestation we tend to do

a suction termination of pregnancy, a simple day case surgical operation. Um and then beyond thirteen or fourteen weeks' gestation um you would do, again it's a medical termination of pregnancy – the principles are the same but the, the volume of tissue that the woman is having to um deliver from her uterus is much greater. Um, to regard it as an induction or a mini labour is quite wrong –

I: Right, ok

P: - because it's, you know, even at sixteen or eighteen weeks a fetus is, it's big but it's certainly not, you know, we're not talking a seven pound baby labour. [Consultant 2, male]

I: Um and the medical procedure I have heard also described as a sort of mini induction of labour by some people. Is that an accurate way of describing it?

P: I don't know that I would, I don't – we can take you down onto the labour, well in fact we can't but we could take you down onto the labour ward which is, let's think is that ward there. And in fact on a good day we could open the windows here and you could hear the women scream.

I: Aha, sure.

P: Right. There is no comparison between that [*gestures*], and that. However, it is sore. But there is no comparison between labour and uh sub-twenty week abortion. And we cover it with morphine anyway. [Specialist Registrar 2, male]

Whereas the extracts considered in the previous subsection emphasised the similarities between later medical abortion and childbirth, these doctors focus on the differences between these two experiences. Because of this, later medical abortion emerges as a less distinctive type of procedure; it becomes categorised as part of a continuum of medical abortion experiences, *all* of which are different from the birth of a baby.

7.4 Expertise concerning the experience of providing later abortion

The preceding sections have revealed two different claims to expert knowledge that HCPs made when they problematised women's requests for later abortion. In section 7.2, some doctors suggested that they possess privileged knowledge concerning the status of later gestation fetuses, and the grounds on which they can legitimately be aborted. In section 7.3, other doctors positioned their knowledge of the 'trauma' of later abortion methods as the basis upon which abortion decisions should be made in the second trimester of pregnancy. In this final section I will illustrate another form

of knowledge which HCPs suggested was more relevant to decisions about the provision of later abortion than women's own definitions of their pregnancies. This knowledge was said to be possessed by HCPs involved in carrying out second trimester abortions.

As outlined earlier, the use of medical rather than surgical methods in the second trimester of pregnancy means that it is nurses, rather than doctors, who are responsible for this work. The suggestion that this places an unfair burden on nurses was central to several doctors' explanations of why women's access to abortion becomes less certain in the second trimester of pregnancy:

I: Um I had heard as well that it's um a different procedure in the second trimester – I mean you don't do, there's no surgical procedures in the second trimester it would be-

P: Yeah that's right. So beyond fourteen weeks and that, I mean that does affect your thinking as a doctor as well because beyond fourteen weeks you can't do the surgical operation so you're, they get medical management and that means that nurses or, or midwives are looking after them. And that is, it's quite a um emotionally difficult thing for the staff, you know, so. [Consultant 6, female]

When I first came across these kinds of account, I heard them simply as further evidence of the ways in which HCPs were mobilising the emotional suffering of others (in this case nurses, rather than pregnant women) in order to legitimate their own practices.

Such accounts emerged regularly during the interviews. GPs often justified their reluctance to refer their patients in the second trimester of pregnancy by emphasising the emotional burden which this places on hospital staff. Gynaecologists, who were themselves involved in performing surgical abortions, sometimes contrasted their own, unemotional work with the distressing experiences of the nursing staff involved in providing later medical abortions. For example, at the end of the main interview, Specialist Registrar 2 advised me to try and interview the nurses who worked in the clinic where second trimester medical abortions took place, because they were the people who experienced the "really" difficult part of the job. He suggested that the reason I had found it hard to recruit nurses to my study (see Chapter Three) was because:

They obviously have a very distasteful time of it so they're not as open. But I think it's very important for you to get that side of it. [Specialist Registrar 2, male]

In contrast, earlier in the interview he had made it clear that his own bodily involvement in performing surgical abortions was not in any way "distasteful" or distressing:

I: Um and as somebody who's involved in the procedure – I know you're not involved in the medical ones, but the surgical ones. Could you just say a bit about what that's like?

P: Um I've got no doubt whatsoever you could probably come and watch one. [*discussion of ethics*] But from a surgical point, it's very simple, the woman comes in, she's under general anaesthetic, legs [open into] a lithotomy. We grasp the cervix, pull it forward, dilate it up, suck out the contents, make sure she doesn't bleed. That's it. Four minutes. If that.

I: And the, the tissue afterwards, would you be involved in disposing of that?

P: Goes straight in the bin. It's all very – it's not a, it's not an emotional experience I don't think for anybody. It's just, cos we do so many. In, bang, done, tissue. Rarely we send it for genetics in an extreme infertility case. But otherwise, nothing. [Specialist Registrar 2, male]

While it is perfectly possible that Specialist Registrar 2 experiences surgical abortion work as something routine and mechanical, the active way that he worked to exclude emotion from his account is very interesting. One possibility is that he was rejecting any association between emotion and surgery, where doctors are trained to approach anaesthetised bodies in a detached, emotionless manner. However, I also wondered whether he interpreted my questions as a suggestion that his work *should* be emotionally difficult. In this case, his answers can be heard as an attempt to normalise the practice of abortion, and to refute any suggestion that he (or his profession) is engaged in disturbing or morally suspect work.

Listening to these kinds of account, I became more determined to interview nurses who were involved in providing later medical abortions. I realised that in the absence of this data, the meaning of nurses' work would be defined entirely by doctors. These HCPs seemed to be particularly keen to differentiate their own,

‘unproblematic’ involvement in abortion from nursing work, which they constructed as a site of emotional and moral turmoil.⁷⁰

7.4.1 Hearing nurses’ accounts of later abortion

However, when I began to interview nurses, it appeared that doctors’ concerns about the emotional burden created by later abortion work were, in some cases, well-founded:

I: And what is it, how is it to, you know dealing with women who are going through a sort of later termination, as opposed to an earlier one. [The women sort of]?

P: They’re, they’re much, they’re sorer. They’ve got, you know when they’re, when they’re about seven, eight weeks they’ve just got a collapsed sac to deliver. When they’re at sixteen weeks you’ve got a fully-formed fetus about the size of your, you know, the palm of your hand. And then you’ve got to cut the cord, give an injection, deliver a placenta. So the ones that go through the later terminations it’s much more traumatic and it’s much more like a normal labour. The ones that are under um nine weeks it’s more like a bad period, heavy period. But [that’s early early ones]. And it’s really really distressing for the staff.

Picking up these small, perfectly formed fetuses. [Nurse 1, female]

Just as I have no way of knowing whether Specialist Registrar 2 ‘really’ experiences surgical abortion as a mechanical, emotionless procedure, I cannot claim any access to Nurse 1’s private feelings about picking up and handling later gestation fetuses (see Chapter Three). However, *I* left this interview feeling shaken and disturbed by the distress which I heard in her voice as she described this part of her job.

In a study of the provision of medical abortion for fetal abnormality in Canada, Chiappetta-Swanson (2005) describes nursing experiences which resonate strongly with Nurse 1’s account. Her participants were left entirely in charge of providing medical abortions, and Chiappetta-Swanson argues that a complete lack of institutional support for this work became interwoven with nurses’ negative experiences of their jobs. Problems ranged from a lack of physical equipment (such as adequate containers in which to dispose of fetuses) to the difficulties that nurses had in obtaining doctors’ assistance with abortions. Many nurses resented the fact

⁷⁰ Lawler (1991) argues that the construction of nursing work as difficult, dirty and morally suspect contributes to its low status.

that they were given responsibility for emotionally difficult work, and that this work was ignored by doctors, who were able to avoid the messy aftermath of prenatal diagnosis (Chiappetta-Swanson, 2005).

While none of my nurse participants described this level of institutional abandonment, their descriptions of the distressing nature of later abortion work did seem to be linked to their resentment concerning doctors' lack of involvement in the procedure:

I don't think that somebody that sits in an office counselling a patient, as opposed to somebody who's actually picking that baby up, you know, should make that decision. So that's the only thing that I feel aggrieved about. That the doctor sometimes, I sometimes feel it would be good for them actually to come in and deliver the babies. [Nurse 1, female, gynaecology ward]

Throughout her account, Nurse 1 used the terms "perfectly" and "fully formed," as well as "babies" to characterise the later gestation fetuses (c. twelve-sixteen weeks) that she was involved in delivering and then packaging for disposal. At one point, she also described these fetuses as "perfectly healthy". I do not want to suggest that she drew upon these terms in a calculated way; it may be that Nurse 1 encounters these fetuses *as* perfectly formed babies. However, it remains interesting to relate this characterisation to the "fetal-centred" (Steinberg, 1991: 179) framework through which later abortion is discussed in public, as well as by many doctors. As described in section 7.2, doctors often focussed on the current or potential status of "healthy" fetuses, and in doing so, eclipsed the personhood of the woman who requests an abortion. This process was assisted through their critiques of the past 'inaction' of these women, which allowed them to characterise later abortions as avoidable, and thus, unjustifiable. Similarly, Nurse 1 also focussed on the possibility that later abortions could be avoided:

Yeah on a daily basis we have patients who are um over twelve weeks um gestation delivering. So that's one thing I would like is to [for women], if they're gonna have a termination is to get themselves to that GP and get it sorted sooner, rather than later. [Nurse 1, female]

However, for Nurse 1, the failings of pregnant women are compounded by the ignorance of doctors who, she suggested, only give women access to later abortions because they never have to confront the reality of "delivering babies". While she

concurred with doctors that women are not best placed to define the status of the fetus involved in later abortions, Nurse 1 thus made a significantly different claim to expertise concerning these fetuses. She argued that only those who are physically involved in delivering and handling them possess the relevant experiential knowledge to determine whether and how late abortion should take place.

Likewise, Nurse 8 also criticised doctors for their ignorance of second trimester abortion work:

I: And from a nursing perspective is it any different caring for women going through later ones as opposed to early ones?

P: Yeah it's, it's not nice to deliver a, a baby that, you know, you're delivering somebody that's twenty weeks and you walk and there's a two week error in scans, plus or minus two weeks – so in theory they could be twenty-two weeks. You walk up one flight of stairs and through to the neonatal unit and they're resuscitating babies at twenty-three weeks who may be small for dates and this might be quite a chubby, and you're sometimes. So it's quite distress- it's more distressing and I don't think that people think of the effect it has on the staff. Don't think the medical staff think about it, they're very much 'oh well we're only providing a service'. But they're not the ones delivering the babies. [Nurse 8, female]

Without dismissing the emotional significance of Nurse 8's encounters with later gestation fetuses, it is again useful to explore the discursive framework through which she describes her relationship with these entities. Once more, later abortion is constructed as an avoidable course of action; it is a situation which nurses are faced with because of other people. While she does not blame women explicitly in her account, they are implicitly rendered culpable as producers of the fetuses that she finds so distressing to deliver.

Another interesting feature of Nurse 8's account is the emphasis which she places on the similarities between fetuses which are aborted and babies which are born prematurely. The scenario that she describes has become a standardised narrative form which dates back at least to the late 1980s, when David Alton attempted to reduce the upper time limit on abortion to eighteen weeks. The Science and Technology Subgroup (1991) draw attention to the way in which Alton's supporters juxtaposed the resuscitation of premature babies with the disposal of fetuses aborted at comparable stages of gestation. However, as suggested in section

7.2, the juxtaposition of fetuses which are aborted and babies which are resuscitated only remains powerful if the relationship of these entities to the woman who delivers them is rendered irrelevant. As I pointed out in section 7.2, some doctors insisted that the relationships between fetuses and pregnant women cannot be so easily ignored (see p. 194). In the following subsection I will reveal that some nurses who were involved in provision of later abortion were also able to challenge fetal-centred framings of this practice.

Before exploring these alternative nursing accounts however, it is important to note that medical abortion methods may generate particularly acute similarities between aborted fetuses and living babies for the nurses who are involved in delivering the former. As described in section 7.2.1, the Royal College of Obstetricians and Gynaecologists recommends that feticide be performed in all cases where a medical abortion is being carried out beyond 21 weeks plus 6 days' gestation (Royal College of Obstetricians and Gynaecologists, 2001; Vadeyar *et al.*, 2005). This ensures that fetuses which are old enough to be deemed 'clinically viable' with medical assistance are not delivered showing any signs of 'life,' e.g. a heartbeat, or respiratory attempts (Vadeyar *et al.*, 2005). Below this threshold, feticide is not essential, because even if aborted fetuses show signs of 'life' following delivery, they are not deemed capable of sustained survival with medical assistance and HCPs are not legally or professionally obligated to try and keep them alive (Royal College of Obstetricians and Gynaecologists, 2001; Vadeyar *et al.*, 2005). However, they do have to deal with them during the interim period while signs of life cease. Additionally, regardless of gestational age, an aborted fetus which is delivered showing 'life' signs must be registered as a live birth, and then as a neonatal death when these signs cease (Vadeyar *et al.*, 2005).

This scenario was described by one of my nurse participants, who talked about her distress at having to deal with a second trimester fetus which "lived" for some hours (as evidenced by a faint heart beat) following a medical abortion. This fetus was aborted below eighteen weeks, i.e. several weeks below the threshold at which an attempt could have been made to keep it alive *ex utero*. Because of this, the

only option open to Nurse 9 and her colleagues was to wait for signs of fetal ‘life’ to cease following the abortion before packaging the fetus for disposal.⁷¹

This was the only occasion on which one of my participants described a medically aborted fetus as something that “lived” for a short time following the procedure. However, it is unclear whether what Nurse 9 described was an unusual occurrence, or whether it is in fact quite a normal aspect of being involved in second trimester medical abortion work. This second possibility seems quite likely, given that around half of Chiappetta-Swanson’s (2005) forty-one nurse participants had witnessed this outcome of medical abortion at least once. Both the small size of my nursing sample (only six of my nurse participants were/had been regularly involved in medical abortion work), and nurses’ potential reluctance to discuss this issue with a stranger may account for the fact that I was only told about one such incident.

7.4.2 Opening up nurses’ accounts of later abortion work

My nurse participants’ distress and resentment concerning the practice of later medical abortion becomes particularly troubling when it is remembered that they may find it difficult or impossible to avoid it by exercising their legal right to ‘opt out’ of providing the procedure (see Chapter Four). However, there are several reasons why it is important to be cautious in representing nurses as a powerless group of HCPs.

In the first place, it is clearly wrong to imply that nurses are ‘forced’ to provide abortions. While it may be difficult for them to opt out through the conscience clause, nurses *can* choose to work in a job which doesn’t involve carrying out the procedure. One of the nurses I interviewed had found later abortion work to be too difficult. Because of this, she switched to working in the outpatient clinic where patients were scanned and received counselling before being given a date for their procedure:

⁷¹ Although this was an entirely legal course of action, I have decided not to include any extracts from this interview in my thesis. This is because the specific details of Nurse 9’s account might make it possible for her to be identified, for example, by her colleagues.

Yeah, I worked here for maybe [number] years, just terminations but um I didn't like it very much! It was just too much. So I left. So no I don't have anything to do with that side of it. But then that was years ago it wasn't very nice, I used to have to take these babies you know, to a fridge after the mother had terminated it, oh it was just [...] I'm talking about second trimester babies that are, from twelve weeks onwards. You know they're quite big babies. So that wasn't very nice. [Nurse 3, female]

As well as choosing jobs which do not involve providing the procedure, it was clear that, in some settings, nurses were capable of imposing their claims to expertise concerning the 'reality' of later abortion upon doctors. At one hospital, a nurse explained to me that an absolute time limit of fifteen weeks was in operation, owing to the total, co-ordinated refusal of the nursing staff to participate in abortions beyond this point in gestation. This example provides an important reminder that hierarchies in the hospital workforce are contextual and fluid, rather than universal and fixed. It also points to the potential which nurses have to occupy a position of power in relation to women with unwanted pregnancies, who, if they arrive later than the agreed time limit, must attempt to access the procedure elsewhere, or continue with their pregnancies.

A third reason that it is important not to depict nurses as a powerless group of HCPs who are unable to mobilise support for their claims to expertise is that this group has recently gained parliamentary representation in the form of Nadine Dorries, Conservative MP. Dorries has spearheaded recent campaigns to lower the upper time limit on abortion provision, and in doing so, has drawn extensively on accounts of her own embodied involvement in later abortion provision:

I first became concerned about and interested in the issue of abortion when I worked as a nurse. I worked for nine months on a gynaecology ward, and assisted in many terminations and late terminations. I also went to witness a late surgical abortion six weeks ago. I became interested in abortion when it became apparent to me, as a nurse, that far more botched late abortions were taking place than should. The first one that I witnessed was a prostaglandin termination. A little boy was aborted into a cardboard bedpan, which was thrust into my arms. When I looked into the cardboard bedpan, the little boy was gasping for breath through the mucus and amniotic fluid. I stood by the sluice with him in my arms, in the bedpan, for seven minutes while he gasped for breath. A botched

abortion became a live birth, and then, seven minutes later, a death. I knew when I stood with that little boy in my arms that one day I would have the opportunity to defend babies such as him. I thought that we committed murder that day. [Nadine Dorries, Hansard Columns 258-259, May 20th 2008]

Articulated from the floor of the House of Commons, a nurse's claim to expertise concerning the 'reality' of second trimester abortion suddenly gains the potential to impact upon *all* British women's access to the procedure.

Fortunately, however, my data, in combination with that from other studies, provides a means to challenge nurses' claims that their embodied involvement in later abortion work gives them privileged insights into its 'true' meaning. As Haraway (1991) argues, while the material world should be conceptualised as an active presence in human life, this presence is never encountered outside of human discourse. The ways in which the meanings of later gestation fetuses are shaped by the discursive frameworks in which nurses situate them was suggested throughout the analysis in the preceding sub-section. I argued that nurses were only able to constitute aborted fetuses as 'babies' because they did not acknowledge the social relationships between these entities and the women that produce them. In the discussion that follows, I will go on to illustrate alternative frameworks through which HCPs described their encounters with later gestation fetuses.

The interweaving of the 'social' or 'discursive' with HCPs' encounters with fetuses is implied by the findings of several existing studies. For example, Casper (1998) reveals how the fetus is constituted as a different "work object" by HCPs who specialise in different areas of medicine. While fetal surgeons are primarily concerned with the health of the fetus, obstetricians argue that the fetus is always a secondary "work object" in relation to the body and health of the woman who is carrying it. In another study, Williams *et al.* (2001) reveal how individual HCPs working in the arena of reproductive health constitute fetuses as different entities depending on the particular contexts in which they encounter them, for example, as part of fetal surgery, miscarriage, or abortion for fetal abnormality.

However, neither Casper nor Williams *et al.* address the experiences of HCPs who handle and dispose of aborted fetuses. This issue is considered by Simonds (1996) in her ethnography of a feminist abortion clinic in the US. In this clinic, later abortions (up to twenty-six weeks' gestation) were performed using surgical rather than medical methods. However, although doctors were brought in specifically to perform these procedures, the clinic health workers (the subjects of Simonds's study) were faced with the task of checking the fetal parts following the abortion, in order to ensure that it was complete. Health workers talked about their visceral reactions to seeing and handling recognisable, baby-like fetal parts (e.g. hands, feet, and faces), and criticised pro-choice rhetoric for failing to create space for their messy and sometimes saddening work (Simonds, 1996). However, while they may have found their work difficult at times, all of Simonds's participants held fast to their (self-defined) feminist beliefs that women should be able to determine whether they became mothers, whatever their stage of gestation.

Simonds suggests that health workers were able to bring these principles to bear on their involvement in later abortions and that, because of this, the aborted fetuses that they handled never eclipsed the personhood or importance of individual women. She argues that, through this feminist practice, the fetuses that health workers encountered became quite literally, *different entities* from the fetal persons of anti-abortion rhetoric:

The anti-abortionists have chosen to make fetuses central: take notice, they say, fetuses look like babies; hence, they are babies. Centre workers replied that there is a difference between looking like a baby and being a baby. Fetuses get to be babies only if women choose motherhood.
(Simonds, 1996: 101)

Likewise, while some of the nurses that I interviewed clearly resented their involvement in "delivering babies", two of my participants characterised second trimester medical abortion work so differently that it was almost as though they were describing another practice. These nurses worked in different hospitals, each of which had a time limit of twenty weeks' gestation.

Nurse 4 worked on a ward which provided medical abortions and did not want to be tape-recorded (see Chapter Three). She said that later abortions

(particularly those which came right up against the twenty week cut-off point) could be distressing, because of the baby-like fetus that had to be handled and disposed of. However, as she described her work she returned repeatedly to women's need for later abortions, and highlighted the importance of being able to provide the procedure. In doing so, she characterised later abortion work as difficult, but ultimately worthwhile, because it involved providing help and support to women who really needed it.

Nurse 6 articulated an even less "fetal centred" (Steinberg, 1991: 179) account of later medical abortion practice. Throughout the interview, she only *ever* discussed fetuses in relation to women going through abortion. She considered the different ways in which her patients might respond to these entities (for example, the circumstances in which they might want to see and hold their fetuses) but did not suggest that fetuses had a particular meaning for her, as the person who routinely delivered them. Likewise, in describing the difference between earlier and later abortion work, she focussed simply on what the size of the fetus might mean for the experience of the woman aborting it, and the level of nursing care that patients might require as a result:

I: Ok. And you said when you were thinking about going back into it that it was something that you thought about having to do the later ones. So is it a diff- does it feel any different or?

P: Just because the fetus is bigger so the procedure for the woman is a bit different, it can be more like going through a sort of labour for some women but again not for all. A lot of women have, have no pain and you think 'how can that be?' Um but then other women do go through definite sort of contractions and you know, their cervix is dilating, even though it doesn't have to dilate very much. Um but you can sort of see that process happening and their membranes can rupture and they'll deliver the fetus and sometimes you need to aid that delivery. So there is a lot more to it from the nursing point of view I would say um.

I: Yeah

P: But and from the woman's point of view as well, from the medical side certainly we don't, the doctors aren't involved at all unless there's a major complication that I can't deal with cos most things I can do um within the unit. Um so it's really only if the placenta gets completely stuck and I can't deliver it. Cos usually, usually I can get it! *[laughs]*
[Nurse 6, female]

There is an interesting contrast between nurses' earlier complaints that doctors do not have to get their hands dirty with "delivering babies" and the way in which Nurse 6 describes the absence of doctors from the abortion procedure. She argues that there is generally no need for doctors to become involved because she herself possesses the skill necessary to care for women undergoing later abortions. Indeed, throughout her account, the freedom that she had to exercise her own skills was depicted as a positive source of pride and satisfaction. Chiappetta-Swanson (2005) suggests that the isolation of nurses who are involved in later abortion work may, ironically, become the basis for any satisfaction that they derive from their job. Such isolation provides them with the opportunity to develop skills and determine the parameters of their work in a way which is not always possible when nursing work is medically supervised (Chiappetta-Swanson, 2005).

Although she did not describe any distress about handling fetuses, Nurse 6 did suggest that later abortion work could sometimes be "upsetting". However, she went on to normalise this response, and thus later abortion work, by linking it to other areas of nursing:

So in general it's much much much more um impact on the nursing staff than the medical staff. So it was just that point of view really that I had to think about. Cos it's, you know, it's it can - I don't, it can be upsetting sometimes um but then anything can, you know. If you're looking after somebody with cancer you can have days when you can look after lots of people and not really be emotionally affected and then you'll have one day that you just get really sad and it really sort of hits home to you. So I would say that from that point of view it's just nursing, you know, it's just part of nursing and you'll have the odd day when one person really gets to you and other days you're ok. [Nurse 6, female]

In describing the difficult aspects of later abortion work as simply part of the experience of "nursing", Nurse 6 went on to explain why she thought that later abortion provision *should* fall within the parameters of nursing work:

But I don't think you can do that without thinking about it and getting your head round where you are um not as a person, well yeah as a person a bit, but more as a nurse and I just, I was at a big abortion conference in [omitted for anonymity], it was amazing and that really it was really good in a way, oh that sounds really bizarre! [laughs] But you know that the bottom line is that if there's not access to safe abortion women die. Bottom line. And you know, abortion happens, you know, where there's laws, where there's not laws. If there's not laws women'll do it

themselves or they'll get somebody else to do it, you know, that was really powerful message hearing round the world things that happened, not just the negative but the sort of positive things that happened when places did have good laws and good access to services. And so yeah, I think, if I'm ever wavering I just think 'no, women die and that, you know that deprives kids of their mother or daughters or sisters or whatever and that's not right!' [*laughs*]. [Nurse 6, female]

Nurse 6 was unusual in suggesting that she had actively sought out and thought through a basis from which to rationalise her involvement in abortion work. In this respect, her account shares a great deal with those of Simonds's (1996) participants, who claimed to bring their feminist principles to bear on their practice in the abortion clinic.

While she acknowledges that good systems of abortion provision can have positive results for women, Nurse 6 draws primarily on the negative legitimacy framework of suffering/necessity which I have critiqued throughout this thesis. She argues that the "bottom line" which enables her to continue with her work is the belief that abortion is the outcome of absolute necessity; without it women with unwanted pregnancies will be driven to desperate measures, and death.⁷² Listening to her account led me to question my own certainty about the problems with this discursive framing of abortion. If Nurse 6 is motivated to continue with later abortion work because she believes she is helping women in desperate circumstances then this framing of abortion clearly has positive, as well as problematic, implications.

However, it is again important to reflect upon the limits of the claims which can be made about research participants' emotions and experiences. Do Nurse 6 and Nurse 4 'really' get positive satisfaction out of their work because they believe that they are helping women who desperately need later abortions? Or are they simply positioning me as an outsider who must be convinced that the nursing profession is engaged in worthwhile and important work, as opposed to a morally dubious practice? There is no way of knowing. All that can be concluded is that, at least within the interview setting, these nurses constitute later abortion work very

⁷² Interestingly, while many of Simonds's (1996) participants characterised later abortion in positive terms (e.g. as a matter of women's right to determine when they become mothers), she also notes that several seemed unable to justify the provision of later abortions without referring to the desperate circumstances in which individual women requested the procedure, for example, following rape.

differently from some of their colleagues. The ways that they do so are simply *suggestive* of the possibility that nurses' physical encounters with later gestation fetuses might be transformed by the discursive frameworks in which they situate these entities.

7.5 Conclusion

The preceding discussion has outlined three claims to expertise which HCPs mobilised as they described the decision to terminate later gestation pregnancies. The first claim centres on the passage of gestational time. HCPs argued that, as time passes, they become better placed than pregnant women to assess the moral significance of the fetus. HCPs defined the significance of this entity in terms of medical knowledge about its development, including the likelihood that it will eventually become a "healthy" human baby. The passage of gestational time is also used by some HCPs as evidence that women lack commitment to ending their pregnancies. This contributes to their depiction of later abortions as unnecessary in the absence of medically-defined, 'exceptional' circumstances.

The second claim to expertise mobilised by HCPs concerns their knowledge of the medical method used to conduct abortions at later stages of gestation. This is constructed as potentially more damaging to a pregnant woman than carrying a fetus to term. HCPs' third claim to expertise is also related to the abortion method employed at later gestations, and concerns the experiential knowledge of the nurses involved in delivering and handling the fetuses produced through this method. Doctors define nurses' physical involvement in later abortion work as emotionally difficult and cite this as a factor in their reluctance to give patients access to the procedure at later gestations. Likewise, some nurses claim that their embodied involvement in later abortion work gives them privileged insights concerning the acceptability of the procedure, and argue that these insights should be taken into account in decisions about whether to provide abortion.

I would suggest that the variation between the gestational cut-off points at different hospitals might best be understood in terms of this third claim to expertise.

The accounts of both gynaecologists and gynaecology nurses seemed to reflect serious tensions produced through a division of labour which leaves nurses with sole responsibility for carrying out later abortions. Two of my nurse participants articulated major resentment about this situation, and most of the hospital doctors I interviewed expressed concern about the fact that nurses were left to deal with later medical abortions. One way of interpreting local hospital time limits on abortion provision is thus as the outcome of negotiations between these two groups of HCPs. In some sites it seems that nurses are particularly well organised, and that they may act collectively to determine how 'late' their medical colleagues are able to offer the procedure to their patients. Clearly, this has major implications for pregnant women, whose access to later abortion then becomes entirely dependent on their geographical area of residence.

Throughout this chapter, I have tried to do more than explain why HCPs argue that "timing is everything". To simply re-describe HCPs arguments would be to uncritically reinforce their claims to expertise. Such reinforcement becomes particularly problematic when set in the wider context of UK debate about abortion, which looks increasingly to HCPs to decide when abortion becomes too late. In view of this, throughout this chapter I have drawn on the critical approach to expertise advocated by Wynne, by exploring knowledge claims in terms of the forms of existence that they make possible and impossible. From this perspective, HCPs' first claim to expertise becomes a means by which, echoing broader public debate on the subject, "women's needs or lives" (Science and Technology Subgroup, 1991: 214) are eclipsed by arguments about the status of the fetus. Through HCPs' second claim to expertise, women are allowed to re-enter the discussion, which centres on HCPs' concerns about the experience of second trimester medical abortion. However, women's presence in these discussions remains extremely limited. They are depicted as ignorant and vulnerable individuals who must be protected from the 'trauma' of second trimester abortion, and no consideration is given to the futures of those who are prevented or dissuaded from accessing this procedure. Finally, pregnant women are once more made completely invisible by HCPs' third claim to expertise, which centres on the insights generated by the embodied experiences of nurses.

As in previous chapters, during my analysis of the data I have tried to remain sensitive to the contexts from which HCPs are speaking, and the ways that these might be entangled with the accounts that they produce. For example, I have paid attention to the medico-legal context in which the ‘viability’ of neonates has emerged as a pressing issue, and the ways in which the medical abortion method complicates questions of patient consent. Likewise, I have tried to give serious consideration to the significance which HCPs may attribute to later gestation fetuses. This approach has been facilitated by adopting a theoretical perspective which allows the material world to be considered as an active presence in HCPs’ lives.

At the same time, in engaging with the emotions expressed by some nurse participants as they describe their encounters with aborted fetuses, it becomes tempting to treat their accounts *too* compassionately, thus allowing their claims to expertise to go unchallenged. The recent use of such claims as part of parliamentary attempts to curtail UK women’s access to abortion points to the dangers involved in yielding to this temptation. Haraway’s (1991) arguments concerning the discursively mediated basis of human encounters with ‘the world’, as well as her focus upon the political ramifications of these encounters, have helped me to negotiate these dangers. Mindful of her insights, I have tried to analyse nurses’ accounts in the same manner as those of doctors’, i.e. in terms of the realities that they make possible for pregnant women.

In doing so, I have also pointed out that participation in later abortion work is characterised as more than one type of encounter with the material world. In some cases, the aborted fetus is positioned as human kin, and the primary focus of later abortion work. Simultaneously, pregnant women are depicted as responsible for creating work that is constructed as distressing and unnecessary. In this context, nurses argue that they have a right to contribute to decisions about whether or not the procedure is provided. However, in other cases, nurses place women undergoing abortion, rather than fetuses, at the centre of their accounts. In doing so, they are able

to construct later abortion work as a positive and worthwhile occupation that improves the lives of women.

Clearly, it is impossible to access nurses' private realities concerning their experiences of delivering and handling later gestation fetuses in the clinic. However, when considered collectively, their accounts suggest that these experiences *might* be shaped by their ability to approach later abortion in a "woman-centred", rather than a "fetal-centred" manner.

Chapter Eight: Concluding discussion

8.1 Introduction

The current framework of UK abortion law has been subjected to extensive feminist critique (e.g. Brookes, 1988; Fyfe, 1991; Boyle, 1997; Sheldon, 1997; Lee, 2003b) because of the relationship that it constructs between the medical profession and women with unwanted pregnancies. In the first place, the law allows HCPs to opt out of abortion provision on the grounds of conscience, thus implying that it is not something which HCPs have an automatic duty to provide to their patients. In the second place, the law gives doctors the authority to decide whether an abortion can legally take place. The procedure is only legal if two doctors are prepared to sign a certificate that states an abortion is necessary on the grounds of a pregnant woman's health or that of her fetus. By positioning doctors as experts who must regulate women's uses of abortion, the law suggests that pregnant women are not capable of determining the circumstances in which they should become mothers (Boyle, 1997; Sheldon, 1997). Moreover, in constructing women's desire to *terminate* their pregnancies as an intrinsically problematic decision which must be subjected to medical scrutiny, the law depicts *motherhood* as the normal outcome of pregnancy (Boyle, 1997; Sheldon, 1997).

However, while feminist analyses have highlighted a number of problems with current UK law, little is known about how HCPs involved in contemporary abortion practice position themselves in relation to women with unwanted pregnancies. This thesis has addressed this gap in the literature by exploring the subjectivities which Scottish HCPs construct for themselves and their pregnant patients as they account for their day-to-day involvement in, or conscientious objection to, abortion provision.

In this concluding discussion I aim to draw together, and reflect upon, the key contributions of my thesis. My findings are grouped together in two separate sections, each of which explores the relationships which HCPs construct between

themselves and another key group of actors. The first section of the discussion addresses HCPs' depictions of their interactions with their pregnant patients. The second section then moves on to consider HCPs' portrayals of their relationships with their colleagues. Through my discussion of these empirical findings, I argue that my analysis has highlighted several key problems with the current system of abortion provision in central Scotland. In addition to summarising these problems, I also make recommendations about the routes through which they might be addressed in the future. I will also reflect critically upon some of the limitations of my analysis.

In considering the potential for this research to be used as a means of generating changes in Scottish abortion practice, I will also return to the question that I posed at the end of Chapter Three. What position have I constructed for myself in relation to my participants through my analysis, and how might this impact on the future research interventions that I can engage in? I began this thesis by depicting STS as an analytical tool that would enable me to challenge the epistemological authority which is granted to the UK healthcare profession in decisions about the use of abortion. I have drawn in particular on Wynne's (e.g. 1996a; 1996b; 2001; 2003) theorisation of 'expertise', which reveals that *any* claim to expert (i.e. authoritative/legitimate) knowledge is entangled with normative definitions of society, and thus represents an attempt to delineate the forms of existence available to humans (and nonhumans). When this is acknowledged, it becomes possible to ask critical questions about the subjectivities made possible through any knowledge claim, including those articulated by practitioners of technoscience and medicine, such as the HCPs in my study.

However, throughout this thesis I have also tried to draw attention to some of the complexities involved in engaging in this kind of critical analysis. As summarised in section 2.3.2, other analysts have argued that important insights and opportunities are lost when social researchers set out to engage in the critical theorisation of HCPs' practices. For example, Mol (2002) argues that when social researchers position HCPs as objects for critical study, they close down the possibility of working collaboratively *with* HCPs to produce positive changes in

clinical practice. In view of these insights, I have tried to avoid producing an account that would antagonise and alienate HCPs, and which would make it impossible to engage with them. In the following discussion, I will highlight my attempts to leave open the possibility of future dialogue with HCPs. At the same time, I will reveal my ongoing concerns about the dangers posed by engaging in entirely uncritical forms of analysis which simply legitimate the discursive practices of HCPs.

During the discussion in the first two sections of this concluding chapter, I will position my thesis as a piece of research which can contribute to attempts to change abortion practice in accordance with feminist goals (i.e. opening up the possibilities of female subjectivity). However, in the final section I will move on to reflect upon the potentially *unwanted* repercussions of this study. Specifically, I will consider whether I have created a useful resource for anti-abortion groups by providing an arena for HCPs to voice various ‘objections’ to women’s uses of abortion. In addressing this issue, I will defend my original decision to conduct a study which centres upon the voices of HCPs, but will also point to the importance of developing this research in alternative directions in the future.

8.2 HCP- patient relationships: Women’s (limited) legitimacy as reproductive decision-makers

One of the key findings of this thesis is that, whether they opt in or out of abortion work, Scottish HCPs often construct the provision of abortion to women who request it as an *obligation*. In other words, although the law appears to grant complete discretion over decisions about the provision of abortion to HCPs, those that I interviewed suggested that their rights to determine pregnant women’s uses of abortion are limited. The following discussion begins by summarising the evidence from the empirical chapters which supports this assertion. It then goes on to argue that, although they may have conceded a certain amount of authority to pregnant women, HCPs also demarcated troubling limits around women’s legitimacy as reproductive decision-makers. In summarising this process, I highlight a second critical finding of this thesis, namely, the potential inequalities generated by the

current system of Scottish abortion provision. I end this section by reflecting on the types of intervention through which these problems might be addressed.

8.2.1 Constructing obligations

One of the rights granted to HCPs by UK law is the ability to opt out of involvement in abortion provision on the grounds of ‘conscience’. Chapter Four argued that HCPs’ discussions of the practice of ‘conscientious objection’ represent a useful means to explore how they define their rights to act as individuals vs. their obligations towards their patients as members of the healthcare profession. The analysis in this chapter revealed that, although individual HCPs construct the boundaries between these rights and obligations slightly differently, there is a broad consensus that HCPs do not have unlimited rights to abstain from involvement in abortion provision. Participants concurred that HCPs working in hospitals must provide treatment for patients in an emergency situation and that GPs must facilitate their patients’ access to an abortion.

The consensus concerning the first of these responsibilities is perhaps unsurprising, given that the Abortion Act explicitly removes the right to conscientiously object if a woman’s life or health is in immediate danger. However, HCPs’ clear insistence upon the second of these responsibilities is intriguing, given that the legal obligations of GPs who object to abortion remain ambiguous (Sheldon, 1997). In light of this ambiguity, it is also interesting that the GPs who described themselves as conscientious objectors concurred that they had no right to impede their patients’ access to abortion services.

However, it is important to acknowledge a weakness of this part of the data, namely, that I only interviewed two GPs with self-proclaimed ‘conscientious objections’ to abortion. It is clearly possible that other GPs who exercise their right to act as ‘conscientious objectors’ interpret their responsibilities towards their patients very differently. This possibility is underlined by the fact that, although the two GPs I interviewed agreed that they could not impede a woman’s access to the abortion clinic, they claimed very different degrees of involvement in facilitating this

process. One of them stated that he would refer all patients directly to a hospital clinic but refused to sign the legal documentation. The other said that he did not feel able to give women direct access to hospital services and that he instead pointed them in the direction of alternative primary care facilities.

The analysis in Chapter Five provided further evidence that, in the context of twenty-first century Scottish practice, HCPs' curtail their own rights to determine women's uses of abortion. The law appears to grant HCPs the right to "decisional control" (Sheldon, 1997: 58) over whether or not an abortion takes place. However, when my participants described the process of decision-making about abortion, they frequently positioned themselves as illegitimate decision-makers in relation to women with unwanted pregnancies. Section 5.2 revealed that, in adopting this position, HCPs sometimes drew on feminist discourses. For example, some argued that a pregnant woman's social and embodied situation makes her best placed to know whether an abortion should take place (sections 5.2.1 and 5.2.2), and that this situation also gives women moral ownership over the decision (section 5.2.3).

However, more commonly, HCPs' attempts to grant legitimacy to women with unwanted pregnancies took place within entirely de-politicised discursive frameworks. One way in which HCPs depoliticised their obligation to provide women with access to abortion was to argue that autonomous patient choice about medical treatment is simply a normal part of contemporary medical practice (section 5.2.3). I have suggested that HCPs' tendency to avoid representing abortion as a positive political right should be understood in the context of the history of UK abortion law. This has long framed abortion as a decision that should be made on the basis of the threat that pregnancy poses to individual women's 'health'.

Although Chapter Five provided examples of HCPs' attempts to grant authority to women with unwanted pregnancies, I also argued that this process cannot be treated as straightforward evidence that HCPs' view pregnant women as legitimate reproductive decision-makers. I suggested that HCPs' claims concerning their patients' legitimacy can also be understood as a mechanism through which they

devolve their own responsibility for abortion decision-making. This aspect of the analysis echoes Davis and Davidson's (2005) characterisation of the 1967 Abortion Act as a piece of legislation which created responsibilities that were not always welcomed by HCPs. It indicates that, like those working in the immediate aftermath of the passage of this legislation (Davis & Davidson, 2005), HCPs involved in contemporary abortion practice continue to try to find ways to avoid these responsibilities.

A final aspect of the data that illustrates HCPs' reluctance to claim the right (and thus, responsibility) to determine pregnant women's uses of abortion is that, even in cases where participants questioned women's decisions about abortion, they were unwilling to state explicitly that they might refuse a woman's request for the procedure. Nevertheless, Chapters Five to Seven *also* revealed that, while (in most contexts) HCPs avoid suggesting that they block women's access to abortion, they often do position themselves as experts who can assess their patients' reproductive decisions. In the following subsection, I will summarise the subjectivities that become possible for pregnant women when HCPs lay claim to expert knowledge about the correct use of abortion.

8.2.2 Constructing inequalities

As outlined in Chapter One, studies of women's experiences of accessing abortion reveal that their descriptions of 'negative' encounters with HCPs repeatedly centre on situations where they are asked to explain the basis of their requests for abortion (Macintyre, 1977; Allen, 1985; Harden & Ogden, 1999; Kumar *et al.*, 2004; Lee, 2004). Lee (2004) suggests that most women approach HCPs simply to ask for access to abortion, and do not want to have to account for, or receive advice concerning, reproductive decisions which they made for themselves in non-clinical contexts. In contrast, this thesis has provided evidence that some HCPs represent the assessment of women's requests for abortion as a routine aspect of abortion work (section 5.4). I have argued that these HCPs positioned women with unwanted pregnancies as intrinsically unreliable reproductive decision-makers who

automatically require their expert guidance. They thus perpetuate the problematic constructions of femininity which are embedded in the terms of UK abortion law.

As described above, the discussion in Chapter Five also revealed that, although some HCPs seem to favour the position of ‘expert’ as a default, others are more likely to draw upon alternative subject positions which remove them from the decision-making process (sections 5.2 and 5.3). Nevertheless, while most HCPs suggested that they do not routinely assess or question their patients’ decisions about abortion, this thesis has revealed that there are certain situations where HCPs are particularly likely to position themselves as experts in relation to their pregnant patients. By exploring HCPs’ claims to expertise in Chapters Five, Six and Seven, I have revealed troubling uniformities in the subjectivities that they construct for women who are, or could become, pregnant.

As highlighted in Chapter Two, a key feature of my analysis of these claims is that it has been informed by feminist STS research which illustrates the importance of avoiding essentialisms and exploring how binary categories of meaning, such as what is to count as ‘social’ or ‘medical’, are constructed in practice (section 2.3.2). This has enabled me to avoid the pitfalls of several existing feminist critiques of UK abortion law and provision (e.g. Macintyre, 1973; Boyle, 1997; Sheldon, 1997). Such critiques reify what is to count as a ‘social/moral’ vs. ‘medical’ knowledge claim about abortion, in order to criticise the ease with which the law allows doctors to step outside of the boundaries of their ‘actual’ (i.e. ‘medical’) expertise about this practice. However, in reifying these categories, they perpetuate a rhetorical binary which can itself be *utilised* by HCPs, e.g. to suggest that while ‘social/moral’ judgments can be made and contested by any member of society, they alone have the epistemological authority to make and assess (what they define as) ‘medical’ knowledge claims.

As well as revealing the political problems perpetuated by this binary, in Chapters One and Two I illustrated the theoretical difficulties involved in demarcating ‘medical’ or ‘scientific’ knowledge as something that is not amenable to

sociological analysis. STS illustrates that *any* knowledge claim can be analysed in terms of the version of ‘society’ that it co-produces. Recognising this insight, this thesis has eschewed attempts to classify what is to count as an ‘appropriate’ vs. ‘inappropriate’ (or ‘social’ vs. ‘medical’) claim to expertise on the part of HCPs. Instead, I have explored *all* of HCPs’ claims to possess authoritative knowledge about abortion in the manner illustrated by Wynne (e.g. 1996a; 1996b; 2001; 2003), i.e. as political acts that co-produce normative visions of society.

One of the key knowledge claims articulated by HCPs is that abortion can and should be prevented through patient education about the ‘correct’ use of contraception (section 6.2). In describing this process of patient education, HCPs constructed the control of fertility through contraception as something which is technically possible, and depicted the achievement of such contraceptive control as a reproductive obligation rather than a choice. Additionally, by emphasising the importance of educating women about so-called ‘female’ methods (e.g. the pill, hormonal implants, etc.), HCPs often suggested that this obligation is something that falls naturally to women, rather than to men. Finally, in describing how they correct patient ‘misunderstanding’ about the relative ‘risks’ of abortion and contraception, they depicted abortion as a course of action which is automatically emotionally and physically damaging. One important consequence of the construction of abortion as an act that should be prevented wherever possible is that women who return to request subsequent abortions become positioned as particularly ‘problematic’ patients. HCPs argue that these patients have failed to understand, or have deliberately ignored, HCPs’ attempts to educate them concerning the unacceptable ‘risks’ of abortion.

HCPs’ concerns about ‘repeat’ abortion echo Luker’s (1975) analysis of the depiction of this ‘problem’ within US family planning discourse in the 1970s. Luker attempts to challenge the assumption that women who make repeated use of abortion are ignorant or deliberately destructive individuals by illustrating the rational reasons why women do not use contraceptive technologies to control their fertility. However, in Chapter Six I argued that explanations of women’s reasons for constructing

abortion as a lesser risk than contraception do not necessarily destabilise HCPs' definitions of these reproductive practices. Using my participants' accounts, I illustrated their acceptance of women's 'alternative' definitions of the relative risks posed by contraception and abortion. I then demonstrated how this can become the basis from which HCPs try to educate patients about the 'correct' (e.g. HCP-defined) meanings of these practices.

HCPs' constructions of abortion as an emotionally and physically damaging procedure are often interwoven with another claim to expertise, namely, that they know how women should *feel* about their decisions to end their pregnancies. Several HCPs suggested that they expect their patients to display an appropriate level of 'suffering' when they request the procedure (Chapters Five and Six). In the absence of such emotional display, some HCPs suggested that they attempt to educate patients about how they should behave during a consultation about abortion.

Finally, HCPs made claims to expertise about the significance of gestational timing, through which they constructed 'later' abortion as an entirely different kind of decision from 'earlier' abortion (Chapter Seven). Some doctors argued that they possess expert knowledge about the status of the fetus and that, beyond a certain point in gestation, 'healthy' fetuses cannot legitimately be aborted. They also argued that they possess important knowledge about the methods used to terminate later gestation pregnancies, and constructed this process as something that is potentially more risky to a woman than carrying an unwanted pregnancy to term. Finally, some nurses argued that they gain important expertise through the experience of providing later gestation abortions, which gives them legitimate grounds to be involved in decisions about precisely how 'late' the procedure is offered to patients. I have suggested that, through each of these claims about the unacceptability of 'later' abortions, HCPs co-produce a vision of society where pregnant women's personhood is eroded naturally by the passage of gestational time.

The above examples reveal how HCPs' claims to expertise about abortion construct normative femininities, i.e. they attempt to prescribe the subjectivities

available to those whose bodies are categorised as female. However, the analysis in Chapter Six revealed that HCPs' claims to expertise about abortion perpetuate social relations of inequality other than gender, specifically, those of socio-economic class, ethnicity and age. I have argued that, in contrasting 'acceptable' and 'unacceptable' uses of abortion, HCPs are engaged in practices of "reproductive stratification" (Ginsburg & Rapp, 1995), through which certain forms of motherhood become valued more highly than others. Abortion is deemed to be an unproblematic course of action for ethnic minorities from "other countries", for women who are young, and particularly, for those who live in poverty. In contrast, it seems that women who are defined as members of the middle-class, or who are thought to be 'running out of time' to reproduce are more likely to have their requests for abortion questioned.

8.2.3 Avenues for 'real-world' reform?

Throughout this thesis, I have pointed to the dangers involved in simply accepting HCPs' interview accounts of their attempts to assess and regulate their patients' reproductive behaviour. To take such accounts at face value is to ignore the multiple means by which women might refuse to comply with HCPs' attempts to intervene in their decisions. Such an approach also ignores a key aspect of the interview data, specifically, that it was generated through HCPs' attempts to account for their actions to me, a professional outsider. The subjectivities which HCPs delineate for themselves and their patients can thus be heard as an attempt to construct their practice as 'acceptable', i.e. as in accordance with perceived norms. In this sense, HCPs' interview accounts could be said to provide an important opportunity to witness the construction of these norms, rather than providing concrete evidence of 'what actually happens' in the abortion clinic.

However, although it is necessary to acknowledge this limitation of interview data, it seems equally important to consider the possibility that HCPs' accounts *might* resemble the practices which they actually engage in during consultations with their patients. If this is the case, then it seems that Scottish HCPs may be attempting to prescribe the subjectivities available to their patients in a manner that has very troubling implications for women's access to and experience of abortion.

One response to these findings would be to argue that I should try to persuade HCPs to reflect upon and problematise the “prescriptive ontologies” (Wynne, 2001: 479) produced through their own and their colleague’s claims to expertise. For example, I could illustrate how abortion is constructed as a ‘last resort’ course of action, and suggest that this framing of the procedure leaves no space for those patients who make repeated use of it. In arguing that ‘repeat’ abortion might be conceptualised differently, I could point out that many HCPs already *do* accept the repeated use of abortion in certain circumstances, i.e. for those who are young or living in poverty. In turn, this finding raises further questions, for example, about the distinctions which HCPs are making between different ‘classes’ of patient.

In spite of the logistical difficulties involved in organising them, focus groups might represent a useful route through which to pursue the dissemination of these findings. In this environment, HCPs could discuss and also respond to my analysis at length. Alternatively, I could offer to present my work at hospital departmental seminars, or GP practice meetings. However, whichever method I adopt, it is clear that I will have to negotiate the problems highlighted in the introduction to this chapter, i.e. attempting to engage in a ‘critique’ of HCPs’ current practices without alienating those whom I am trying to convince.

With a view to the importance of this future dialogue, this thesis has attempted to analyse HCPs’ accounts without engaging in a hyperbolic critique which demonizes the practice of individuals. In addition to closing down the possibilities for communication with HCPs, this kind of critique fails to acknowledge how HCPs’ practices may be shaped by the discursive resources available to them. I have tried to keep this issue at the forefront of the analysis by illustrating how HCPs’ accounts resonate with the way in which abortion is constructed in public discourse (i.e. in law, in parliamentary debate and in the media).

For example, in Chapter Five, I suggested that the current law could be said to encourage HCPs to act as ‘responsible experts’ in relation to pregnant women,

whilst simultaneously providing them with justification for the adoption of this subject position. In Chapter Six I argued that, in the UK, abortion is constructed as a ‘last resort’ method of fertility control, which can and should be prevented through the use of contraception. I suggested that the public construction of HCPs as gatekeepers to contraception and abortion means that they are often held accountable when women use abortion in a way that does not accord with this normative definition. Additionally, I pointed out that the discourse of ‘prevention through contraception’ is materially entrenched in Scottish abortion practice, as evidenced by the forms which HCPs must complete during abortion consultations (see p.166). In Chapter Seven, I argued that HCPs’ tendency to focus on later abortion as a question of their expert assessments of the status of the fetus cannot be separated from the fact that this is the narrow discursive framework through which decisions about later gestation abortion are depicted in UK law and debate. Finally, I have argued that the overwhelmingly negative constructions of abortion (i.e. as a ‘desperate’ and/or painful act) that emerge from HCPs’ accounts must be contextualised in relation to the medicalised framework through which the procedure was legalised in the UK.

In acknowledging the discursive context within which HCPs are working, I have been forced to question whether it is sufficient to try and generate positive changes in abortion provision by encouraging individual HCPs to reflect upon their practices. This point was first raised in Chapter Three, where I drew attention to Wetherell and Potter’s (1992) analysis of Pākehā New Zealanders’ racist constructions of Māori identity. Wetherell and Potter (1992) argue that, while it is possible to hold individuals to account for engaging in racist practices, it is not necessarily useful to focus on racism as a problem generated by individuals. To do so is to de-politicise the issue, drawing attention away from broader social relations which shape the discursive resources available for constructing human identity.

Likewise, while it might prove useful to encourage HCPs to reflect upon their individual practices, it is vital not to ignore the fact that HCPs are working in a society which shapes the subjectivities available to women, and thus, to those who work as abortion providers. In this sense, my analysis of HCPs’ interview accounts

illustrates the narrow range of resources available for constructing abortion in the UK, and the correspondingly oppressive constructions of femininity (not to mention socio-economic class, age and ethnicity) that are perpetuated in this discursive context. It thus points to the continuing relevance of earlier feminist critiques (Science and Technology Subgroup, 1991) of the narrow discursive space within which abortion is discussed in the UK, and suggests that feminist campaigns should be focussed upon attempts to open up this space.

One important direction for such campaigns is to challenge the construction of abortion as an exceptional, deviant act by emphasising that it is an extremely common event in women's lives. If even those who *support* women's access to abortion continue to depict it as a controversial course of action that should be prevented wherever possible, it seems unlikely that HCPs will refrain from trying to persuade their patients to avoid it. Likewise, if pro-choice groups accept their opponents' framing of 'later' abortion as a distinctive act which requires special justification, then why would HCPs treat this procedure any differently?

Another obvious avenue through which to challenge public discourses on abortion would be to attack the framework of the current Abortion Act, which, as outlined in Chapter One, has long been a focal point of feminist critique. Legal reform could be used to destabilise the problematic femininities constructed through the current Abortion Act. For example, both the construction of abortion as a 'deviant' act, and the notion that women requesting it are unreliable reproductive decision-makers, could be challenged through the removal of the requirement that doctors certify the legality of an abortion.

However, it is obvious that legal change should not be depicted as a straightforward solution to the problems that I have highlighted in this thesis. As Sheldon (1997) notes, although feminists can campaign to change the letter of the law, they cannot control the ways in which new rules are then enacted in medical practice. This problem would also be predicted by the Sociology of Scientific Knowledge's finitist account of scientific classification (Barnes *et al.*, 1996).

According to this account, no attempt to articulate a rule with which to classify the world can determine how this rule will be interpreted on future occasions.

Similarly, my thesis has illustrated that, although Scottish HCPs are currently acting within a common legal framework, this has not prevented localised differences in practice from emerging. For example, I have shown that, while some HCPs routinely position themselves as experts in relation to their pregnant patients, others argue that it is inappropriate for them to attempt to assess women's decisions (in most circumstances). Another key difference between HCPs' practices is the gestational thresholds which they construct as relevant to decisions about abortion provision. In the final section of this concluding discussion, I will return to this localised construction of abortion 'time limits' as one of the most significant findings of this thesis.

The discussion in this section has drawn attention to an important and positive aspect of Scottish abortion practice, namely, that HCPs do accord a considerable degree of legitimacy to their pregnant patients. At the same time, it has highlighted the troubling subjectivities which are perpetuated by Scottish HCPs' claims to expert knowledge about abortion. However, to what extent can I make claims concerning the wider relevance of this research for the way in which abortion is provided elsewhere in the UK? I have illustrated that Scottish HCPs' accounts resonate with public discourses on abortion that are not specific to Scotland. For example, the current legal framework, as well as parliamentary discussion of it, concerns the provision of abortion in Scotland, England, and Wales. On the basis of this common discursive context, it seems likely that the accounts of HCPs working in England and Wales would, at the very least, *overlap* with the ones that I have explored in my study.

At the same time, as noted in Chapter Three, there are important geographical differences in the way that abortion is provided across the UK. Historically, the majority of abortions in Scotland have always been provided on the NHS (Abortion Law Reform Association, 1997). In contrast, while abortion provision in England

and Wales is primarily NHS-funded, it is carried out primarily on non-NHS premises, i.e. the service is, by and large, not provided *through* the NHS but by specialised charitable/private agencies (Abortion Law Reform Association, 1997). The existence of these agencies also means that women have the option of bypassing NHS gatekeepers entirely, and paying for their abortions. This key difference in service provision does raise questions about the relevance of my analysis outwith Scotland. For example, are Scottish HCPs' concessions of legitimacy to their pregnant patients related to the specifically Scottish framing of abortion as something that should be provided as part of a free, and (relatively) equitable State healthcare service? In the future, I hope to address this and other questions by conducting comparative empirical work with HCPs working in England and Wales.

8.3 Relationships between HCPs

In the previous section, I explored the subjectivities which HCPs construct for themselves and for women with unwanted pregnancies when they describe their interactions with their patients. Although HCP-patient relationships represent the primary focus of this thesis, I have also considered individual HCPs' depictions of their relationships with other members of the healthcare profession. The following discussion aims to provide a summary of this aspect of the data, as well as highlighting its potential implications.

8.3.1 Destabilising dichotomies

In giving HCPs the right to opt out of abortion provision, current UK law defines two possible subject positions for HCPs; either they are opposed to abortion on the grounds of conscience, or they are not. At first glance, it does seem that my participants can be classified in this dichotomous manner. Indeed, in Chapter Four I revealed that HCPs actively engage in this process of classification. I illustrated that some HCPs claim that they opt out of abortion provision in order to exercise important moral objections to this practice (section 4.2.2). By representing themselves in this way, they often developed implicit or explicit critiques of those HCPs who are involved in abortion provision, depicting the latter as morally lazy. In

contrast, a second group of participants (the majority) distinguished themselves from HCPs who hold ‘conscientious objections’ to abortion. This group of HCPs characterised ‘conscientious objectors’ either as unusual individuals who possess distinctive worldviews that must be tolerated within limits (sections 4.2.1 and 4.4), or else as HCPs who fail to recognise their responsibilities to their patients and their colleagues (section 4.3). Through both of these constructions of conscientious objection, HCPs normalized their own participation in abortion provision. Additionally, HCPs who criticised ‘conscientious objectors’ for failing to recognise their responsibilities were able to position themselves as morally superior individuals who *did* recognise these responsibilities.

However, although my participants clearly recognised and made rhetorical use of a distinction between HCPs who ‘conscientiously object’ to abortion and those who do not, my analysis also suggests that important complexities are concealed by the construction of this binary. In the previous section, I described how HCPs who participate in abortion provision articulate various claims to expertise about the correct and incorrect uses of abortion. Although these HCPs do not claim to object to abortion on the basis of their ‘consciences’, they nonetheless identify *some* uses of abortion as ‘objectionable’ and suggest that they enact these objections (e.g. by trying to dissuade women from certain practices). In many cases, the discourses which they employ resonate strongly with the discourse of HCPs who state that they opt out of abortion provision on the grounds of conscience.

For example, in explaining why he opts out of abortion provision, but accepts the use of emergency contraception, GP7 draws on medical discourse concerning the bodily functionality of fetuses in order to depict a six/seven week old fetus as an entity that is morally different from the entity produced immediately after fertilisation (see p.122-3). However, many HCPs who are involved in abortion provision (particularly doctors), *also* draw on descriptions of fetal functionality (e.g. concerning thresholds of ‘viability’ or definitions of fetal ‘health’) in order to explain why abortion becomes less acceptable beyond a particular threshold. As the quotations in Chapter Seven reveal, there is no consensus concerning this threshold;

individual HCPs argued for significant thresholds as being twelve weeks, fourteen weeks, fifteen weeks, sixteen weeks, eighteen weeks, twenty weeks, etc. When this complexity is acknowledged, the notion that there is a clear distinction between those HCPs who possess ‘conscientious objections’ to abortion and those who do not becomes hard to sustain. Instead it could be argued that HCPs are drawing upon a shared yet flexible discourse, through which abortion becomes constructed as an act whose acceptability is dependent on (varying degrees of) gestational time.

Another important point of resonance between the discourse of those who identify as conscientious objectors and of those who do not concerns the critiques which HCPs developed of women with unwanted pregnancies. The most striking overlap is between the account of Nurse 10, who opts out of abortion provision on the grounds of conscience, and Specialist Registrar 2, who participates. Nurse 10 argues that some women “grossly abuse” the NHS by using abortion as a method of fertility control, and suggests that women should not be allowed more than one NHS abortion (p.109). Similarly, Specialist Registrar 2 argues that women should be forced to “pay attention” to their contraception via the introduction of financial penalties for those who request more than one abortion (p.170).

In addition to this specific example, the more general tendency of HCPs to blame women for the way in which abortion is utilised in the UK seems to be an approach adopted by those who identify as conscientious objectors and those who do not. Both ‘groups’ of HCPs criticise women for failing to accommodate pregnancies which they define as merely “inconvenient”. The key difference is that conscientious objectors draw very broad boundaries around the kinds of pregnancy which women should be able to accommodate (any pregnancy in the absence of immediate physical danger – see p.106-7), whereas those who participate in abortion provision suggest that only *certain* kinds of women should be carrying their pregnancies to term (see Chapter Six).

On the basis of these findings, one implication of this thesis is to highlight the extremely limited information generated by quantitative surveys that allow HCPs to

articulate only one of two polarised ‘attitudes’ to abortion. A recent example of this type of work is Francome and Freeman’s (2000) survey of GPs, which attempted to measure the percentage who identified as “broadly anti-abortion” or “broadly pro-choice”. Rather than engaging in research which simply reinforces the assumption that there are some HCPs who object to abortion and some who do not, I would argue that it is necessary to explore the *multiple forms* of ‘objection’ to abortion which are expressed by HCPs, and to consider their implications for women requesting the procedure.

8.3.2 Situating HCPs within the workplace

In addition to highlighting the multiple objections to abortion that are articulated by HCPs, this thesis has also problematised the law’s construction of ‘the conscientious objector’ as an individual who can exercise his/her right to ‘opt out’ independently of social context. One aspect of this context was addressed earlier in this chapter; I described how HCPs define limits around the ‘right’ to opt out of abortion provision on the basis of their obligations to their patients. However, the analysis in Chapter Four revealed that some HCPs also cite workplace relationships as a key factor that shapes an individual’s ability to opt out of abortion provision. In the following discussion I will reflect upon this aspect of the data.

Some of my participants argued that, although they would like to opt out of abortion work, they could not do so because this would place an unfair burden upon other HCPs. This comment was made regularly by those who worked in hospitals, where HCPs have to co-operate to accomplish particular tasks, such as the timely completion of surgery lists, or the provision of nursing care to patients in an outpatient clinic or a ward. In this context, if an HCP tries to assert their individual ‘right’ to opt out of abortion provision, they risk being perceived as someone who is not prepared to work as part of a team, and who creates extra work for other people. Several of the conscientious objectors I interviewed noted spontaneously that this accusation had been directed towards them by their colleagues.

During the analysis in Chapter Four I acknowledged the rhetorical dimensions of HCPs' accounts of the difficulties generated by their relationships with their colleagues. When HCPs emphasise the ways in which they are constrained by their obligations to others, they depict themselves as individuals who face up to their responsibilities by engaging in difficult work. Similarly, conscientious objectors' accounts of the hardships which they face in the workplace can be heard as their attempts to assert their moral superiority; they are individuals who work hard in order to be able to live up to their moral convictions.

At the same time, I have argued that my analysis does highlight the *potential* difficulties that HCPs may face in enacting objections to abortion via the conscience clause. In doing so, I have built upon the historical work of Davis and Davidson (2005) by illustrating that, in contemporary Scottish practice, HCPs theoretical 'rights' as individuals continue to be constructed as co-existing uneasily alongside the healthcare profession's collective responsibilities for abortion provision. Additionally, this thesis has also made a novel contribution by illustrating another way in which HCPs' relationships with one another might impact upon their ability to enact individual objections to abortion. In Chapters Four and Seven, I suggested that the scope for HCPs to determine their involvement in abortion provision is also interwoven with power relations in the workplace.

For example, Nurse 10's account of the problems that she experiences in enacting her objection to abortion (p.109-10) draws attention to the situation of trainee/junior HCPs as one in which individuals may be misinformed about and/or feel unable to exercise their 'rights' to opt out of abortion provision. The potentially more vulnerable position of trainees is also highlighted by an anecdote which recurred during several of the interviews. My participants utilised stories of doctors who performed abortions at more junior stages of their career and who 'opted out' at a more senior level as a means of critiquing others' lack of 'moral consistency' in relation to abortion (see section 4.2). However, if 'switching sides' is indeed such a regular occurrence, it could be argued that this is less a reflection of 'inconsistency', than of the differential ability of junior gynaecologists vs. Consultants to insist that

they will not conduct abortions. However, a major limitation of this study is that I did not interview any junior HCPs who were still in training (i.e. all of my participants were fully qualified doctors and nurses), and I was also unable to gain access to the HCPs whom my participants criticised for ‘switching sides’. As such, it is impossible to do more than speculate about the influence of seniority on HCPs’ ability to exercise their objections to abortion, and to suggest that this represents an important area for future research.

Stronger evidence for the influence of workplace hierarchies on HCPs’ ability to enact objections to abortion is provided by HCPs’ interview accounts of later abortion work. As described in Chapter Seven, gynaecologists offer several different explanations for the fact that, in the second trimester, it is routine in Scottish practice to offer the medical method of abortion rather than the surgical one. Whatever the reason for this practice, it is clear that its *outcome* is the delegation of responsibility to gynaecology nurses, who provide care for all medical abortion patients. Scottish abortion provision is thus characterised by a division of labour that gives gynaecologists an automatic ‘opt out’ from later abortion work, whilst ensuring that this form of abortion is a routine part of nursing work. Several of my nurse participants expressed major resentment about this work, arguing that it was extremely distressing to deliver and handle fetuses that are aborted at later gestations. They stated that they felt unable to avoid later abortions by opting out on individual grounds of conscience because of the situation described previously, i.e. that they would then place an impossible burden on their colleagues.

In describing their resentment about later abortion provision, nurses also criticised the fact that, although they are the ones who have to carry out this procedure, it is doctors who are empowered to decide how ‘late’ it is offered to patients. Without dismissing the possibility that my participants are genuinely angry about this situation, it is interesting to note that their accounts of their ‘powerlessness’ to determine how abortion is used reflect a pattern that emerged elsewhere in the interviews. Members of all of the ‘groups’ of HCPs that I interviewed (GPs, nurses and gynaecologists) minimised their own responsibility for

the procedure by emphasising the roles played by other HCPs. For example, Chapter Five revealed that when GPs describe referrals that they feel ambivalent about, they position gynaecologists as the HCPs who are ultimately responsible for whether or not the procedure takes place. In contrast, HCPs who work in hospitals often stress the fact that every woman they see will already have had a previous consultation with a primary care doctor/nurse, which makes it unnecessary for them to become involved in assessing women's reproductive decisions. Additionally, when hospital gynaecologists discuss how they deal with women whom they consider 'too late' for an abortion, they refer to the role played by yet another group of HCPs – those working in abortion charities in England. Scottish gynaecologists argue that these HCPs are ultimately responsible for decisions about the time limits that are placed upon women's access to abortion in the UK.

In noting that doctors and nurses utilise the same rhetorical mechanism to "relocate responsibility" for decisions about abortion provision, it remains vital to acknowledge that nurses expressed distress and anger about their lack of involvement in the decision-making process in a way that doctors did not. Although I cannot claim any access to participants' private emotional realities, I have argued that it is important not to dismiss the possibility that some nurses do feel unfairly burdened by their colleagues' actions. To treat these nurses' accounts of the difficulties that they face as 'mere' rhetoric would be highly insensitive and runs the risk of creating the kind of alienation that would generate barriers to any future dialogue.

Furthermore, to refuse to acknowledge the possibility that some nurses face emotional difficulties because of their involvement in abortion provision is to refuse to try and address this situation. One means of doing so would be to disseminate my findings concerning later abortion to doctors, in order to highlight the way that this work impacts disproportionately on nurses. However, as I explained in Chapter Seven, and will reiterate below, there are several problems with the suggestion that the solution to current problems is to simply *amplify* the voices of nurses who express objections about later abortion work.

In the first place, it was clear from the interviews that many doctors are already aware of these objections; concern about the impact on nursing staff was one of the key explanations provided for decisions to impose particular gestational time limits on women's access to the procedure (see section 7.4). In other words, nurses have already had some success in persuading their colleagues to listen to their claims to expertise about the meaning of later abortion, with major ramifications for women with unwanted pregnancies. A second, and related, difficulty with amplifying these nurses' accounts in an uncritical manner is that this implies my acceptance of their claims to expertise, i.e. that they know the 'true' meaning of later abortion.

In Chapter Seven I argued that this treatment of the data can and should be contested on theoretical, political and empirical grounds. Drawing on Haraway's (1991) theorisation of materiality, I have suggested that, while it is important to conceptualise the material world as an active presence in human life, this presence is always mediated through human discourse. As a result, it is impossible for anyone to claim to speak the 'truth' about material entities such as fetuses. Historically, however, those who have regulated abortion provision in the UK have failed to recognise the contingency of human encounters with fetuses, and have allowed the medical profession to act as the interpreter of their 'true' meaning. To concede the same status to nurses involved in later abortion work is equally problematic, because this silences the alternative perspectives of women with unwanted pregnancies, and suggests that they should not be allowed to determine the circumstances in which they should carry a pregnancy to term. Finally, I have argued that this treatment of the data is *empirically* problematic because findings from my own and other studies (Simonds, 1996) illustrate that not all HCPs construct their involvement in later abortion work in the same way. While some nurses describe it as a job that centres on the distressing process of handling aborted fetuses, others define this work as the provision of a vital service through which they are able to help women out of difficult circumstances.

This empirical finding points to an alternative means of framing the question of 'what to do?' Rather than asking how best to remove the burden from nurses by

making it easier for them to opt out of later abortion work, I would like to ask how it could become *easier* for nurses to participate in this work. While acknowledging that the more positive nursing accounts that I heard might represent participants' attempts to depict the nursing profession as engaged in worthwhile work, they do suggest that there are circumstances in which this work becomes more rewarding. Although I do not have sufficient data to make detailed claims about what these circumstances might be, this seems to be a crucial avenue for future research. Are there particular working environments (for example, in which nurses are granted greater professional freedom and recognition in exchange for the work that they do) that enable nurses to gain satisfaction from their involvement in later abortion work? Alternatively, are there contexts in which this work becomes particularly difficult? What training do nurses undergo concerning abortion provision and how does this training impact upon their experiences of this work? For example, are trainee nurses encouraged to view later abortion as a vital service that is necessary for the health and lives of women (as described by Nurse 4 and Nurse 6), or as an unnecessary act which results from the actions of women who fail to access hospital services earlier in pregnancy (as implied by Nurse 1 and Nurse 8)?

Finally, rather than focusing on the ability of nurses to opt in or out of later abortion work, an alternative means to address the difficulties highlighted in this discussion would be to problematise the division of labour which places sole responsibility for this procedure with nurses. As I pointed out in Chapters Three and Seven, guidance from the Royal College of Obstetricians and Gynaecologists (2004) states that, if gynaecologists are sufficiently skilled in the technique, abortions can be conducted surgically as well as medically throughout the second trimester of pregnancy. Although my participants described this procedure as risky and technically difficult, it is clear that there are doctors in the UK (particularly those working for abortion charities in England) who are prepared to conduct it. In future research, I aim to interview some of these doctors. I could then use this data in an attempt to open up conversations with Scottish gynaecologists about the possibility of providing second trimester surgical abortions to women in Scotland.

8.4 Unwanted interventions? Speaking to ‘the time limit debate’

Throughout this thesis I have positioned my research as something that is intended to contribute to the fulfilment of a particular political goal, namely, the destabilisation of oppressive co-constructions of abortion and femininity (not to mention age, ethnicity, and socio-economic class). However, in this final discussion I want to reflect upon an issue that I highlighted in the introduction to this thesis, namely, the lack of control that an author has over her own text once it exists in the public domain. While this clearly applies to any piece of research, the ease with which feminist discourse on abortion can be subverted by those with oppositional political goals (Science and Technology Subgroup, 1991) means that it is vital to reflect upon the potentially *unwanted* political ramifications of my research.

In Chapter One, I justified my decision to study the voices of a group of professionals who, in the UK, have been granted extraordinary epistemological authority to determine the ways in which abortion should be used. I argued that, precisely because of the potential for HCPs to exercise power over their pregnant patients, it is vital to understand the roles which they are constructing for themselves. As noted in the introduction to this chapter, I also depicted my use of STS theory as an analytical tool through which I could ensure that I critically analysed the knowledge claims that HCPs make about abortion, rather than simply legitimating these claims. However, even when HCPs’ claims to expertise are being critically deconstructed, it could be argued that the publication of interview quotations nonetheless amplifies these claims. This becomes especially problematic when HCPs are voicing various objections to women’s uses of abortion; such ‘expert’ opinions potentially provide important ammunition to groups who want to restrict women’s access to the procedure. In the remainder of this discussion, I will reflect upon this problem, with reference to the aspect of my data which seems most amenable to such ‘capture’.

Clearly, it is important not to overstate the impact which a piece of academic research, published primarily in social science journals, might have on the world beyond this immediate context. However, one aspect of my data seems to ‘speak’

particularly easily to a debate about abortion which has re-opened in the UK in recent years, namely, the dispute over the legal time limit on the procedure. The arguments of those who wish to lower this time limit have gained increasing momentum, as evidenced by the fact that the issue was subjected to full-blown parliamentary debate during the passage of the 2008 Human Fertilisation and Embryology Bill. In many cases, my participants' accounts map smoothly onto the arguments made by MPs and lobbyists who seek to reduce the current limit from twenty-four weeks' gestation. For example, when HCPs explain why they place restrictions on women's access to abortion in the second trimester, they often argue that pre-twenty-four week fetuses are significant entities that should not be aborted. Additionally, nurses define the significance of these entities in terms of their embodied experiences of later abortion work. As noted in Chapter Seven, the first-hand narratives of HCPs who find later abortion provision distressing are a favoured rhetorical strategy utilised by those involved in current campaigns to lower the time limit. Finally, some of my participants emphasise the 'trauma' that might be caused to women by undergoing later abortion. Although the HCPs who make this argument are emphasising their concerns about patient well-being, such supposedly woman-centred discourse has long formed part of attempts to lower the legal time limit on abortion (see Steinberg, 1991).

The resonance between some HCPs' accounts of their concerns about later gestation abortion, and the arguments put forward by anti-abortionists, continues to concern me. However, having reflected deeply on the unwanted ramifications of publishing my data, I have come to the conclusion that it remains important to address HCPs' accounts of the significance of gestational timing for several reasons. In the first place, my analysis suggests that it is necessary to confront problems with Scottish women's *current* access to/experience of later abortion, rather than focussing on attempts to defend an already-imperfect system from anti-abortion attack. Chapter Seven revealed that, while UK law and public debate construct 'twenty-four weeks' as the nation's upper time limit on abortion provision, this is a theoretical maximum which is never reached in Scottish practice. Instead, what is to count as an appropriate gestational time-limit on abortion provision is being

constructed on an entirely localised basis, differing between GP consulting rooms within the same building, as well as between hospitals within the same NHS Board. A woman who goes to consult GP12 may be turned away if he thinks that she is more than sixteen weeks' pregnant, whereas GP11 would automatically refer any patient to the hospital for a second opinion, even if she personally thinks that the patient is 'too late'. Likewise, if this patient is sent to hospital A for an abortion, she will be provided with the procedure at up to twenty weeks' gestation, whereas at hospital B, she is already 'too late' if she is beyond fifteen weeks. Ultimately, all women who are suspected of being more than twenty weeks pregnant are 'too late' to have abortions in Scotland, and must travel to access the procedure from charitable providers in England.

As well as revealing the inequalities generated by the current system of Scottish abortion provision, my analysis provides a potentially useful resource to those who are attempting to challenge anti-abortion attacks upon the current legal time limit. One argument which anti-abortion MPs have made during recent debates is that, if NHS doctors and nurses are not willing to provide abortions beyond certain gestations, then we should reform the law so that the upper time limit accords with 'current practice'. Obviously, this argument should, first of all, be challenged on the grounds that it assumes that the healthcare profession should be allowed to determine women's uses of abortion. However, it can also be challenged because (as revealed by my data) there is actually *no* consensus between HCPs concerning the threshold in gestational time beyond which abortion becomes 'unacceptable'. In other words there is *no* "current practice", but rather multiple (Mol, 2002), localised practices. Moreover, I have revealed that, when HCPs explain why they, or their hospital, place particular time limits on women's local access to abortion, they often emphasise that it is perfectly acceptable for *someone else to conduct the procedure*. In other words, HCPs' individual decisions about their willingness to be involved in later abortion provision should not be treated as evidence that they want the State to prevent women from accessing this procedure entirely. This echoes the findings of a survey conducted by Savage and Francome (1989), who found that most gynaecologists

accepted that abortion should be legally *available* at gestations at which they themselves were not prepared to take part in it.

Another aspect of the data considered in Chapter Seven provides further evidence that there is no professional consensus about the ‘unacceptability’ of later abortion. Although HCPs tended to draw on one of three claims to expertise in order to depict later abortion as a problematic decision that requires their assessment, I illustrated counter-examples from the interview data which problematised each of these claims. Some doctors argue that their assessments concerning the functionality of developing fetal bodies are irrelevant to a woman’s decision about whether she wants to continue with her pregnancy. Others undermined their colleagues’ claims to possess ‘the facts’ about the trauma caused by undergoing a later gestation abortion. Finally, as noted above, some of the nurses I interviewed constructed later abortion provision as a vitally important service that they were glad to be able to provide to their patients.

On the basis of this concluding discussion, I would continue to defend my decision to conduct a study that addresses the accounts of a profession which is granted enormous epistemological authority in public debates about the regulation of abortion. I would argue that the opportunity to address the various problems which I have highlighted throughout this thesis outweighs the dangers involved in publicising HCPs’ troubling discursive practices.

Nevertheless, the process of reflecting upon these dangers has made me aware of the need to develop my research in alternative directions in the future. In particular, I have come to reconsider the importance of researching the perspectives of women who have had, or have tried to access, abortion. When I embarked on this project, I was aware that several recent empirical studies on this issue already existed, and throughout this thesis I have drawn on this work in an attempt to counterbalance the ‘voices’ of HCPs. However, during Chapter Seven I highlighted an important gap in this literature. I have been unable to find any qualitative research which addresses women’s experiences of attempting to access and/or undergo second

trimester medical abortion in the absence of fetal abnormality. Whilst writing my analysis of HCPs' claims to expertise concerning this practice, I became acutely aware of these absent voices, and the importance of addressing them. Given that Scottish HCPs seem to be able to avoid confronting the repercussions of defining patients as 'too late' for abortion, it seems vital to discover and publicise what happens to women who are being refused access to and/or dissuaded from undergoing the procedure.

For similar reasons, in future research I also intend to try and access the accounts of women who have undergone second trimester medical abortion. As I acknowledged in Chapter Seven, legally, HCPs have an obligation to 'inform' their patients about what the experience of this procedure 'will be like' before they can allow them to undergo it. However, it is clear that individual HCPs are constructing this experience very differently, with some placing it on a continuum with earlier medical abortion and others positioning it as a radically different and traumatic 'type' of abortion. Giving voice to women's own experiences of this procedure, and the meanings which they attach to it, might prove a useful basis from which to train HCPs concerning the best way to provide such 'information' to their patients.

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Appendix A

Laws relating to abortion, c.1800-1990

Year	Legislation	Description
1803	The Malicious Shooting or Stabbing Act.	This Act made abortion a statutory offence for the first time. A distinction was made between the penalties for pre- and post- quickening abortion, with the latter being punishable by death. (Keown, 1988) <i>This Act did not apply to Scotland, where abortion continued to be regulated under Scottish common law until 1967 (see Chapter One).</i>
1828	Lord Lansdowne's Act (9 Geo. IV c.31)	These Acts amended and clarified the crime of abortion and its punishment. The distinction between pre- and post-quickening abortions was removed in 1837, as was the death penalty. However, the punishments for abortion remained severe. The 1861 Act, which currently regulates illegal abortion in the UK, carries a maximum penalty of life imprisonment (Keown, 1988). <i>This legislation did not apply to Scotland.</i>
1837	The Offences Against the Person Act	
1861	The Offences Against the Person Act	

1929	The Infant Life (Preservation) Act	This Act created the offence of ‘child destruction’, which refers to the destruction of a fetus capable of being born alive. (Brookes, 1988) <i>This law does not apply to Scotland</i>
1967	The Abortion Act	This Act provided exemptions to the 1861 Offences Against the Person Act, and makes abortion legal in certain circumstances. <i>This law applies to Scotland, England and Wales.</i>
1990	The Human Fertilisation and Embryology Act	This Act decoupled the Abortion Act from the Infant Life (Preservation) Act and removed the upper time limit on all abortions except those carried out under ‘clause a’. <i>This law applies to Scotland, England and Wales.</i>

Appendix B

Schedule 1 of the Abortion (Scotland) Regulations 1991

The following is Schedule 1 of “Statutory Instrument 1991 No. 460 (S.41) - The Abortion (Scotland) Regulations 1991”, which is reproduced from the Office of Public Sector Information - <http://www.opsi.gov.uk/> - (© Crown Copyright 1991).

IN CONFIDENCE	SCHEDULE 1	Regulation 3(1)
PART I		
ABORTION ACT 1967		
Certificate to be completed in relation to an abortion under Section 1(1) of the Act		
I (Name and qualifications of practitioner : in Block Capitals) of (Full address of practitioner) Have/have not* seen/examined* the pregnant woman to whom this certificate relates at (Full address of place at which patient was seen or examined) on and I (Name and qualifications of practitioner : in Block Capitals) of (Full address of practitioner) (*delete as appropriate) Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at (Full address of place at which patient was seen or examined) on We hereby certify that we are of the opinion, formed in good faith, that in the case of (Full name of pregnant woman : in Block Capitals) of (Usual place of residence of pregnant woman : in Block Capitals) ☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated, ☐ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman. ☐ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman. ☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman. ☐ E 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. Tick appropriate box This certificate of opinion is given before the commencement of treatment for the termination of pregnancy to which it refers. Signed Date Signed Date		

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IN CONFIDENCE

PART II

Certificate B

Not to be destroyed within three
years of the date of the operation

ABORTION ACT 1967
Certificate to be completed in relation to an abortion
performed in emergency under Section 1(4) of the Act

I, ...
(name and qualifications of practitioner : in Block Capitals)
of
.....
(full address of practitioner)

hereby certify that I *am/was of the opinion, formed in good faith, that it *is/was necessary
immediately to terminate the pregnancy of

.....
(Full name of pregnant woman : in Block Capitals)
of
.....
(Usual place of residence of pregnant woman : in Block Capitals)

Tick
appropriate
box

- ☐ F to save the life of the pregnant woman; or
☐ G to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:

Tick
appropriate
box

- ☐ 1 before the commencement of treatment for the termination of the pregnancy to which it relates;
or, if that is not reasonably practicable, then
☐ 2 not later than 24 hours after such termination.

Signed

Date

*Delete as appropriate

Appendix C

Schedule 2 of the Abortion (Scotland) Regulations 1991

The following is Schedule 2 of "Statutory Instrument 1991 No. 460 (S.41) - The Abortion (Scotland) Regulations 1991" and is reproduced from the Office of Public Sector Information - <http://www.opsi.gov.uk/> - (© Crown Copyright 1991).

IN CONFIDENCE

SCHEDULE 2

Regulation 4

ABORTION ACT 1967
ABORTION (SCOTLAND) REGULATIONS 1991
NOTIFICATION OF AN ABORTION PERFORMED UNDER SECTION 1
OF THE ACT
(All questions to be answered to the best of the notifying practitioner's knowledge and belief)

BLOCK
CAPITALS
PLEASE

I
(name and qualifications of practitioner)

of
(full address of practitioner)

hereby give notice that I terminated the pregnancy of

.....
(full name of pregnant woman)

of
(usual place of residence)

Post Code

Date of birth Hospital Case Reference Number

THE PREGNANCY WAS TERMINATED AT (to be completed for all terminations):-

Name of hospital/approved place/other place (address)

on (date)

Consultant in nominal charge

Signature of practitioner who terminated pregnancy

In all non-emergency cases, particulars of the practitioner(s) who joined in giving the certificate required for the purpose of section 1 should be shown below in the appropriate space(s):

1. To be completed in all cases

2. Do not complete if the operating practitioner joined in giving Certificate A

Name

Permanent address

Did the practitioner named at 1 certify that he saw/and examined* the pregnant woman before giving the certificate?

☐ YES ☐ NO

Did the practitioner named at 2 certify that he saw/and examined* the pregnant woman before giving the certificate?

☐ YES ☐ NO

*Delete as appropriate

NOTE

THIS FORM TO BE COMPLETED BY THE OPERATING PRACTITIONER AND SENT WITHIN SEVEN DAYS OF THE TERMINATION OF THE PREGNANCY IN A SEALED ENVELOPE MARKED "IN CONFIDENCE" TO THE CHIEF MEDICAL OFFICER, SCOTTISH OFFICE HOME AND HEALTH DEPARTMENT, 27 ANDREW'S HOUSE, EDINBURGH EH1 3DE.

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THE STATUTORY GROUNDS CERTIFIED for terminating the pregnancy were :

1. OTHERWISE THAN IN EMERGENCY

(Tick appropriate box(es))

☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.

Please specify as precisely as possible

The main indication(s)

.....

.....

☐ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.

The main indication(s)

.....

.....

☐ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.

The main indication(s)

.....

.....

.....

☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman.

The main indication(s) and number of children in the family

.....

.....

.....

☐ E 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.

For Ground E Complete the Appropriate Column below

EITHER

1 State diagnosis

2 Method(s) of diagnosis (tick appropriate box(es))

☐ 1 Amniocentesis

☐ 2 Chorion Villus Sampling

☐ 3 Ultrasound

☐ 4 Other

Specify

OR

State condition in pregnant woman causing suspected condition in fetus (complete 1 and 2 below)

☐ 1 Condition in pregnant woman

Specify

☐ 2 Suspected condition in fetus

Specify

2. IN CASE OF EMERGENCY

☐ F it was necessary to save the life of the pregnant woman;

The main indication(s)

.....

or

☐ G it was necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman

.....

.....

Was this a selective reduction?

☐ 1 YES

☐ 2 NO

Original number of fetuses

Reduced to

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CURRENT PREGNANCY

Gestation in Weeks based on ☐ 1 LMP ☐ 2 Ultrasound
(tick appropriate box(es))
☐ 3 Other Specify

Over 24 weeks.
If the pregnancy was terminated after it had exceeded its 24th week, please give below a full statement of the suspected medical condition of the pregnant woman and/or fetus.

ADDITIONAL PARTICULARS OF PATIENT

MARITAL STATUS ☐ 1 Single ☐ 2 Married ☐ 3 Widowed
(tick appropriate box) ☐ 4 Divorced ☐ 5 Separated ☐ 6 Not known

PREVIOUS OBSTETRIC HISTORY (Enter number)	Total Pregnancies	Live Births	Still Births	Abortions	
				Spontaneous	Therapeutic

Date of Admission Date of Discharge

Was this a planned Day Case ☐ 1 Yes ☐ 2 No
(tick appropriate box)

METHOD OF TERMINATION (tick appropriate box(es))

Cervical preparation ☐ 1 Yes ☐ 2 No
Surgical ☐ 1 Vacuum Aspiration ☐ 2 Dilation and Evacuation/Curettage
☐ 3 Hysterotomy ☐ 4 Hysterectomy
☐ 5 Other Surgical Specify
*Medical (tick all appropriate boxes)
☐ 6 Prostaglandins
☐ 7 Oxytocics
☐ 8 Antiprogesterones (see below)
☐ 9 Other medical agents Specify

+ DO NOT enter an Evacuation of retained products of conception as a further method of termination

If Antiprogesterone was used:-

Antiprogesterone	Prostaglandin	
Date of administration	Date of administration	Date termination confirmed
give name and address of place of treatment	give name and address of place of treatment	
Type of premises ☐	Type of premises ☐	

STERILISATION ☐ 1 Yes ☐ 2 No
(tick appropriate box)

IN CASE OF DEATH Specify cause

Appendix D

Letter of invitation/information pack.

It should be noted that slightly different versions of the following letter and associated information were developed for different groups of HCPs, and that the practical details were altered as the project progressed (for example, more time was requested from HCPs during the initial round of recruitment).

Dear X.

Re: Healthcare practitioners and termination of pregnancy – Views on abortion practice and regulation in central Scotland.

I am writing to ask if you would be willing to take part in the above study, which I am conducting for my PhD at the Research Centre for Social Sciences at the University of Edinburgh.

Current UK law requires that women seeking termination of pregnancy obtain the signature of two doctors who have decided that they have grounds for the procedure. However, research suggests that many women seeking termination are not aware of this legal requirement, and that they believe they have the right to decide to have the procedure. My PhD aims to use qualitative research methods to explore healthcare practitioners' (HCPs') views about this situation, and their experiences of the way that the law is managed in practice.

I am writing to members of all the groups of HCPs in central Scotland who are likely to encounter patients seeking this procedure, in the hope that they will agree to be interviewed about their experiences. I am keen to ensure that I address a wide range of viewpoints, and this includes HCPs who object to termination on the grounds of conscience.

My PhD is being funded by the Economic and Social Research Council, and I have attached an information sheet which provides further information about the study. If you have any questions about it, please feel free to contact me on [*contact details*].

I appreciate that HCPs have extremely busy schedules, and am very flexible as to where and when the interview would take place. I would be grateful if you could indicate your interest in taking part on the enclosed form and return it to me in the prepaid envelope.

Thank you.

Yours sincerely,

Siân Beynon-Jones

Participant Information Sheet

Healthcare practitioners (HCPs) and termination of pregnancy -Views on abortion practice and regulation in central Scotland.

Please read this information sheet carefully and take your time in deciding whether to participate.

The purpose of the study

Current UK law requires that women seeking termination of pregnancy obtain the signature of two doctors who have decided that they have grounds for the procedure. However, research suggests that many women seeking termination are not aware of this legal requirement, and that they believe they have the right to decide to have the procedure. My PhD aims to explore healthcare practitioners' (HCPs') views about this situation, and their experiences of the way that the law is managed in practice. I am keen to ensure that I address a wide range of viewpoints, and this includes HCPs who object to termination on the grounds of conscience.

I am interested in the following questions:

- 1) What role do HCPs see for the expertise of doctors in decision-making about termination?
- 2) What role do women seeking termination play in the decision-making process? What role do HCPs think these women should play?
- 3) What impact does the current law have on HCPs' interactions with women seeking termination?
- 4) What are HCPs' views about the law?
- 5) What are HCPs' personal views about termination, and how do they manage these in their professional practice?

To answer these questions, I'm planning to conduct interviews with HCPs in central Scotland who encounter patients seeking termination. By making use of this qualitative research method, I hope to gain a more in-depth understanding of HCPs' perspectives than has hitherto been possible using quantitative surveys.

What is involved in participation?

If you do decide that you would like to take part, you will be asked to participate in an interview, which would primarily address the questions outlined above. The interview would be audio-tape recorded, with your permission. Ideally, we would have around 40 minutes for the interview, but if this is more time than you can spare then it can be shortened. I appreciate that HCPs have very busy schedules, and the interview could take place at any time that's convenient to you, including evenings or weekends if these are more suitable. You will also be able to choose where the interview takes place i.e. at your workplace, your home etc.

If you are interested in participating, please complete the expression of interest form and return it to me in the prepaid envelope - I will then contact you to arrange an interview. Alternatively, you can contact me directly either by phone or email.

Even if you decide to take part you will be free to withdraw from the study at any time without giving a reason. If you decide to withdraw from the study, I will destroy any data pertaining to you (e.g. audio tapes or transcripts) if you so wish.

Possible risks or disadvantages of participation?

Your involvement in the study will be treated with the strictest of confidence, as will any information that I collect from you. All audio tapes and the written transcripts of them will be given a code so that you cannot be identified from them, and they will be stored in a secure location. Audio tapes will be wiped clean at the end of the study.

When I write up my PhD, I will use excerpts from the interviews in order to illustrate and support my findings. However, as outlined above, all of the interviews are anonymised and your name will not appear in connection with anything that you say to me. If I present material from your interview in my PhD or in the publications which result from it, I will ensure that it cannot be traced back to you.

Although my study is addressing HCPs' views about abortion law, it will not attempt to assess the legality or illegality of abortion practice. The only circumstances in which I would feel obligated to break confidentiality would be in the unlikely event that I receive information that patients are at risk.

You will not be asked to disclose any information about patient identity. However, during interviews you may find it useful to draw upon real-life examples to illustrate a point. If this occurred, I would make every effort to remove identifying details in publications that arise from the study.

Possible benefits of participation?

Taking part in this research will not benefit you personally. However, by conducting this research, I hope to shed light on the issues that are important to HCPs involved in providing termination of pregnancy, and on the types of problems they encounter.

Results of the study

My PhD will not be completed until September 2009. When it has been written up, parts of it will be published as articles and presented at conferences. All participants will receive a brief summary of my findings by post.

Organisation and funding

My PhD is being funded by the Economic and Social Research Council.

I am based at:	My supervisors are:	
[contact details]	Dr Nina Hallowell [contact details]	Dr Sarah Parry [contact details]

Ethical approval

Advice was sought from the local NHS Research Ethics Committee, who decided that my PhD did not require ethical approval from the NHS.

Contact details for further information

Siân Beynon-Jones [contact details]

Thank you for taking the time to consider participating

Expression of interest form

Healthcare practitioners (HCPs) and termination of pregnancy -Views on abortion practice and regulation in central Scotland.

Name:

Please complete as appropriate:

I have read the information sheet and I confirm that I am happy to be contacted about participating in the study.

☐

I do not wish to participate, but I will pass the details of the study on to others.

☐

I do not wish to participate in the study.

☐

If you are interested in participating, please complete:

Contact Telephone Number:

Best time to contact you?

Contact email:

Contact address:

Please return to:

Siân Beynon-Jones

[address]

Appendix E

Topic Guides

Guide 1 - GPs

Time? Any questions? Consent form? Tape recorder? Qs non-compulsory.

Background information: age/time in job/specialty/ where trained?

1) One of my aims is to understand what it is like for healthcare practitioners to encounter termination as part of their work. I wondered if you could begin by just telling me a bit, generally, about your experiences with termination in your work?

Could you say roughly how often you come across requests for termination?

2) Could you give me an idea of some of the different ways that the subject of termination might come up in a consultation?

If straight, very directly – How do you feel about this?

If mention difficult/sympathetic cases only, are there other women for whom it's much more straightforward?

3) What kind of things do you talk about with a woman who requests a termination?

WHY

Does what you talk about with different women vary much? i.e. women who are quite direct that this is what they want?

Three possible routes with pregnancy?

If mention risks: What are these?

Importance to women: Do you think that the information women receive in the consultation has an impact on their decision-making?

Relationship between 1st and 2nd consultations?

If mention 'making sure women are really sure': Why is this important? How do you go about it?

Have you had patients who have come back with problems after terminations? What kind of problems have they had? How do you deal with it? How do you go about identifying women who are less sure about their decisions?

Do you ask women for their reasons for requesting a termination?

Can I ask why?

Obviously, there are many reasons why women request terminations, but I wondered if you could give me some idea of the range of different reasons that you encounter?

Have you ever encountered reasons that you found problematic at all or?
Why was this?

Do you discuss contraception with women in the consultation? Is it something that women want to talk about?

Are you involved in prescribing emergency contraception? How do you feel about it?

Do you come across women who have had more than one termination?

If indicate that they find repeat terminations problematic: Can I ask why that is?

Do you think that for some women, termination is maybe just their way of controlling their fertility?

4) Do you think that the law impacts at all on the consultation about termination? For example, on your interactions with women?

Do you discuss the law at all with women? WHY? Any circumstances where you would?

5) One of the issues that I'm interested in is that the law seems to say that doctors have to use their judgment to decide if a woman has grounds for a termination. And I'm trying to understand what this means in practice?

How do you view the role of the knowledge you have as a doctor, in relation to the knowledge women bring to the decision about whether a termination can take place?

If say it is the woman's decision – Can you say a bit about WHY that is?

Some people argue that the reason that termination can be seen as the woman's decision is because the woman is the person who has the expertise to kind of assess her situation. And I wondered what your views would be about that?

How does this compare with the role that patients play in decision-making about other medical procedures?

Would you always refer a woman if she requested a termination?

Do your feelings about referring women change at all depending on the stage of gestation of a pregnancy, or is it just the same process?

PROBE definitions of LATE:

Several GPs I've spoken with have said that they make a distinction between first and second trimester terminations - Is that a distinction you're familiar with?

Why do you think this distinction gets made?

Why do you think some women request terminations later on?

Procedure in second trimester?

If mention termination for fetal abnormality: Are your feelings about later termination any different in the cases when there's a fetal abnormality.

THE CERTIFICATE A FORM:

Do you always sign the certificate A form, the green form, when you refer women to the hospital?

If no: Circumstances where wouldn't.

If yes: Because I've come across a few people who will refer women, but they don't sign the green form, because they feel that signing it makes them much more involved in the process, and I wondered what your views are about that?

How do you go about deciding which of the grounds to tick?

Some historians have suggested that the abortion law left doctors in a difficult position because the reasons that women request terminations don't necessarily relate very easily to the medical grounds in the law. And I wondered what your views are about that?

[Although the law does *allow* you to conceptualise termination as the balancing of relative risks, is that how you actually think about it, personally?]

Trying to get a sense of whether doctors still see the law as something that could have repercussions for them, whether it could result in prosecution?

TRAINING?

First time you came across abortion?

THE REFERRAL PROCESS:

Could you tell me a bit about what is involved in the referral process?

Do you use a pro-forma to refer women?

What kind of information do you provide about a woman's reasons for termination – WHY?

Where do terminations take place? Views about the service?

6) Current debates about abortion

Upper time limit currently 24 weeks – some people have suggested it should be lowered.

Aware of this debate? Any views?

BMA have recently suggested that need for doctors' signatures and for medical grounds should be removed, but for first trimester abortion only – Any views?

The suggestion has been made that nurses could sign the legal documentation, and that termination services could become essentially nurse-led, including surgical terminations. How would you feel about that?

7) If not already addressed: views about the conscientious objection clause?

ANY OTHER COMMENTS/QUESTIONS?

Further contacts

CONSENT FORM

Guide 2 – Gynaecologists

Time? Any questions? Consent form? Tape recorder? Qs non-compulsory.

[Background information: age, time in job/specialty/where trained?]

Could you begin by telling me a bit about your job, and why you chose originally to specialise in this area?

1) One of my aims is to understand what its like for healthcare professionals to encounter termination as part of their work. I wondered if you could just tell me a bit, generally about your experiences with termination in your work?

What this involves in terms of seeing patients i.e. at what point in the process of a termination request would you be seeing women?

Involvement in carrying out terminations?

If yes - come back to.

2) If relevant: What kind of things do you talk about in a consultation about termination?

Does what you talk about with different women vary much, for example, if women are quite direct that this is what they want?

Discussion of 3 pregnancy options?

If mention risks: What are these?

Importance to women: Do you think that the information women receive in the consultation has an impact on their decision-making?

So far in my research GPs have often said that they see the second consultation at the hospital as where the decision to terminate a pregnancy really takes place, and that they're just referring women on. So I'd be interested to know how you see the relationship between the first and second consultations that women have?

If mention 'making sure women are really sure': How do you go about identifying if women are sure of their decisions?

Do you ask women for their reasons for requesting a termination?

Can I ask why?

Obviously, there are many reasons why women request terminations, but I wondered if you could give me some idea of the range of different reasons that you encounter?

Have you ever encountered reasons that you found problematic at all or?
Why was this?

Would you discuss contraception with women in the consultation?

Do you come across women who have had more than one termination?

If indicate that they find repeat terminations problematic: Can I ask why that is?

Do you think that for some women who have more than one termination, it's maybe just their way of controlling their fertility?

3) Do you think that the law impacts at all on the consultation about termination? For example, on your interactions with women?

Do you discuss the law at all with women? WHY? Any circumstances where you would?

4) One of the issues that I'm interested in is that the law seems to say that doctors have to use their judgment to decide if a woman has grounds for a termination. And I'm trying to understand what this means in practice?

How do you view the role of the knowledge you have as a doctor, in relation to the knowledge women bring to the decision about whether a termination can take place?

If say it is the woman's decision – Can you say a bit about WHY that is?

Some people argue that the reason that termination can be seen as the woman's decision is because the woman is the person who has the expertise to kind of assess her situation. And I wondered what your views would be about that?

How does this compare with the role that patients play in decision-making about other gynaecological procedures?

If a woman has been referred to you for an abortion, would you always agree to her request for termination?

Circumstances where haven't? What happens to women requesting abortions later in second trimester?

PROBE definitions of LATE:

Something else a lot of GPs have told me is that they make a distinction between first trimester and second trimester abortion, and they're more hesitant about referring women in the second trimester? Is this a distinction you're familiar with – why do you think it gets made?

Why do you think some women request terminations later on?

Procedure in second trimester?

If mention termination for fetal abnormality: Are your feelings about later termination any different in the cases when there's a fetal abnormality –

5) Involvement in the procedure

a) Could you tell me a bit about what it's like to be involved in carrying out the procedure ?

b) Do your feelings change at all depending on the methods used e.g. medical/surgical?

c) Would you be involved in disposal of the fetal tissue after the procedure?

Research using tissue?

LEGAL DOCUMENTATION

Were you/are you involved in signing the notification form after a termination?

The form seems to say that you have to put a specific indication for termination on the form? What kinds of things might be written?

Some historians have suggested that the abortion law left doctors in a difficult position because the reasons that women request terminations don't necessarily relate very easily to the medical grounds in the law. And I wondered what your views are about that?

[Although the law does *allow* you to conceptualise termination as the balancing of relative risks, is that how you actually think about it, personally?]

Trying to get a sense of whether doctors still see the law as something that could have repercussions for them, whether it could result in prosecution?

TRAINING?

First time you came across abortion?

Current abortion debates:

6) There's been quite a lot of debate lately about the upper time limit for terminations, and whether it should be lowered. So I'd be interested to know whether you're aware of this debate, and if you have any particular opinions about it?

There's also been a bit of debate about whether doctors should need to keep signing a form – the BMA have said that they think first trimester terminations should be available without doctors having to sign legal documentation. Views about this?

The suggestion has been made that nurses could sign the legal documentation, and that termination services could become essentially nurse-led, including performing surgical terminations. How you would feel about that?

7)If not already addressed: What are your views about the fact that doctors can choose to opt out of abortion provision through the conscience clause?

If not already clear - background info (age, time in job, specialty etc)

Contacts - NURSES?

CONSENT FORM

Guide 3 – Gynaecology Nurses

Any questions? Time available? Tape recorder? Consent form.

QUESTIONS DON'T HAVE TO BE ANSWERED

Could you tell me a bit about what your job is here, and why you wanted to specialise in this area of nursing?

1) One of my aims is to understand what it is like for nurses to encounter termination as part of their work. I wondered if you could just tell me a bit, generally about your experiences with termination?

At what point in the process of a termination request would you be seeing women?

First consultation? Pre-operatively? Post-operatively?

Were you aware that TOP would be part of your job when you began working in this area?

How would you describe the work that nurses do in termination provision in relation to the work that doctors do?

2) INTERACTIONS WITH WOMEN

If relevant: Decision-making

What kind of things might you talk about with a woman before a termination?

discussion of 3 routes/possible pregnancy outcomes?

Does what you talk about with different women vary much, for example if a woman was quite direct that that was what she wanted to do?

Do you think that the information women receive has an impact on their decision?

Everybody:

Would you talk about/be aware of women's reasons for requesting a termination?

Obviously, there are many reasons why women request terminations, but I wondered if you could give me some idea of the range of different reasons that you encounter?

Have you ever encountered reasons that you found problematic at all or?
Why was this?

Would you discuss contraception with women?

Are there some women who you'll see back here more than once?

Do you think that for some women, who have more than one termination, it's maybe just their way of controlling their fertility?

Before/during the procedure if relevant:

Any involvement in the scanning process?

Would you be able to talk me through the process of a medical/surgical termination, and what it involves? [Probe: Stages/number hospital visits/staff involved at each]

Consent? Who is involved/what is involved?

Process of disposal: What happens? Is it something that is discussed with women?

If relevant:

A major difference between surgical and medical terminations seems to be that women are conscious during medical terminations. Could you say a bit about what it's like providing care for women who are going through a medical termination?

Do women ever change their minds during the process – how is this managed?

Everybody:

Something a lot of GPs have told me is that they make a distinction between first trimester and second trimester terminations, and they're more hesitant about referring women in the second trimester? Is this a distinction you're familiar with – why do you think it gets made?

Procedure in second trimester?

Why do you think some women request terminations later on?

Some of the people I've been speaking with have said that different women will feel quite differently about having a termination, so there will be some who find the procedure difficult, but others for who it's quite straightforward because they are very clear that they don't want a baby. Does that reflect your experience of caring for women who are having terminations?

If talk about distress of staff – how is this managed? What sources of support are available?

Do you ever discuss your involvement with termination outside of the workplace? People's reactions?

3) Access to terminations/current legal framework

One of the things that I'm interested in in my study is what doctors and nurses think about the current law that regulates termination. So, at the moment, the law seems to say that two doctors have to decide if a woman has grounds for a termination. And I'm just trying to understand what that means in practice?

Who do you think should decide about TOP?

Views about the law and the suggestion that need for doctors' signatures should be removed?

[If say it is the woman's decision – Can you say a bit about WHY that is?

Some people argue that the reason that termination can be seen as the woman's decision is because the woman is the person who has the expertise to kind of assess her situation. And I wondered what your views would be about that?]

Do doctors always agree to a woman's request for TOP? What happens if they don't?

Have there ever been cases where you think doctors should have refused a request for termination? Why?

Legal paperwork: In nurse-led clinics, how are signatures obtained for the green and yellow forms?

4)Current abortion debates:

The suggestion has been made that nurses could sign the legal documentation, and that termination services could become essentially nurse-led. And I'd be interested to know how you would feel about that?

Home terminations?

There's been quite a lot of debate lately about the upper time limit for terminations, and whether it should be lowered. So, at the moment it's theoretically twenty-four weeks for most terminations – I'd just be interested to know if you have any views about it?

If not already addressed – C.O:

I'd be interested to know what you think about the fact that nurses and doctors can, in theory, opt out of termination provision?

Anything you would like to add, any questions?

BACKGROUND INFORMATION

Age, time in specialty, where worked/trained.

CONSENT FORM!!! Further contacts

Guide 4 – Conscientious objectors (GPs)

Any questions? Time available, tape recording, consent at end

QUESTIONS DON'T HAVE TO BE ANSWERED

Background info: Age, time in job, where trained?

1) One of my aims is to understand what it's like for healthcare practitioners to encounter termination as part of their work. I wondered if you could begin by just telling me a bit about your experiences with termination in your work?

Could you tell me a bit about why you choose not to be involved with abortion?

Have you always felt this way, or is it something that's changed over time?

Different situations:

Are your views about abortion affected by the length of gestation of the pregnancy at all?

Do you feel any differently depending on the grounds on which a termination is being carried out?

Ectopic pregnancies? Fetal abnormality?

If not addressed: Is religious belief something that impacts at all on your feelings about termination?

2) Although medical practitioners can opt out of providing terminations on an individual basis, I'm interested to know how you feel, more generally, about terminations being provided by the NHS?

3) Could you describe for me how the conscience clause works in practice - for example do you have to formally declare your objection anywhere?

How do you respond if a woman consults you about an unwanted pregnancy?

What would you say? Do you declare your objection?

How do women tend to react? Ever any problems?

Do you refer them to someone else?

Does it happen often?

Do you follow up what happens to these women afterwards?

Have you ever come across women who come in at later stages of gestation, who are quite near the time limit for legal abortion? What happened?

What about if a woman came in to request emergency contraception?

Do you prescribe this? How do you feel about it?

How about more routine contraceptive advice - are you involved in providing this? How do you feel about it?

4) Has your conscientious objection ever created any difficulties for you at work?

How have your colleagues reacted to it?

Have you ever felt that it's impacted at all on your career?

Do you [or have you ever] work with other HCPs who aren't conscientious objectors?

What is that like?

Have you discussed your views with them?

Are there any guidelines for healthcare practitioners who hold conscientious objections to termination?

Can you remember if you received any advice about what to do during your medical training?

5) Even though you're not personally involved in provision, I'm interested in what you think about the current abortion law in the UK?

One of the main issues that I'm interested in is that the law seems to say that doctors have to use their judgment to decide if a woman has grounds for a termination. And I'm trying to understand what this means in practice – I don't know if you feel able to comment on that?

How do you view the role of doctors, in relation to women's role, in the decision about whether a termination can take place?

If say it is the woman's decision – Can you say a bit about WHY that is?

How does this compare with the role that patients' knowledge plays in decision-making about other medical procedures?

Some historians have suggested that the abortion law left doctors in a difficult position because the reasons women request terminations don't necessarily relate very easily to the medical grounds in the law. And I wondered what your views are about that?

Trying to get a sense of whether doctors still see the law as something that could have repercussions for them, whether it could result in prosecution?

6) Current debates

Recently there has been quite a lot of debate about the upper time limit for termination, which some people have suggested should be lowered. Do you have any opinions about this?

BMA have suggested that, in the first trimester the requirement for doctors to sign legal documentation should be removed – Views about this?

The suggestion has also been made that nurses could sign the legal documentation, and that termination services could become essentially nurse-led. And I'd be interested to know how you would feel about that?

Views about who should have input into law?

Anything that you would like to add, or any questions?

CONSENT FORM/FURTHER CONTACTS

Guide 5 – Conscientious objectors (Gynaecologists)

Any questions? Time available, tape recording, consent at end
QUESTIONS DON'T HAVE TO BE ANSWERED

Background info: Age, time in job, where trained?

Could you begin by telling me a bit about your job, and why you chose originally to specialise in this area?

1) One of my aims is to get an understanding of what it's like for healthcare professionals to come across abortion in their work, so could you just tell me a bit generally about what your experiences have been?

2) Could you describe why you choose not to be involved?

Have you always felt this way, or is it something that's changed over time?

Different situations:

Are your views about abortion affected by the length of gestation of the pregnancy at all?

Do you feel any differently about abortion depending on the grounds on which it is being carried out?

Ectopic pregnancies? Fetal abnormality?

If not addressed: Is religious belief something that impacts at all on your feelings about termination?

3) Although medical practitioners can opt out of providing terminations on an individual basis, I'm interested to know how you feel, more generally, about terminations being provided by the NHS?

4) Could you describe for me how the conscience clause works in practice - for example do you have to formally declare your objection anywhere?

5) Has your conscientious objection ever created any difficulties for you at work?

Have you discussed your views with your colleagues?

How have your colleagues reacted to it?

Have you ever felt that it's impacted at all on your career?

Does your job involve you dealing with patients on the same wards where terminations are being carried out? How do you feel about that?

Are there any guidelines for healthcare practitioners who hold conscientious objections to termination?

Can you remember if you received any advice about what to do during your medical training?

6) I'm also interested in how having a conscientious objection to abortion might interact with other areas of your work, and if there are other parts of reproductive medicine that it relates to?

For example, some doctors who hold conscientious objections to abortion would not be involved in IVF provision, or screening for fetal abnormality?

Women who have infertility issues and links to abortion?

7) Even though you're not personally involved with terminations, I'd be interested to know what you think about the current abortion law in the UK?

One of the main issues that I'm interested in is that the law seems to say that doctors have to use their judgment to decide if a woman has grounds for a termination. And I'm trying to understand what this means in practice – I don't know if you feel able to comment on that?

How do you view the role of doctors, in relation to women's role, in the decision about whether a termination can take place?

If say it is the woman's decision – Can you say a bit about WHY that is?

[How does this compare with the role that patients' play in decision-making about other medical procedures?

Some historians have suggested that the abortion law left doctors in a difficult position because the reasons women request terminations don't necessarily relate very easily to the medical grounds in the law. And I wondered what your views are about that?

Trying to get a sense of whether doctors still see the law as something that could have repercussions for them, whether it could result in prosecution?]

8) Current debates

BMA have suggested that, in the first trimester the requirement for doctors to sign legal documentation should be removed – Views about this?

The suggestion has also been made that nurses could sign the legal documentation, and that termination services could become essentially nurse-led. And I'd be interested to know how you would feel about that?

Recently there has been quite a lot of debate about the upper time limit for termination, and some people have suggested it should be lowered from 24 weeks. Do you have any opinions about this?

A more general question about debates, and the law – I'm interested in your views about who should be involved in deciding what the law is – who should have an input into it.

Anything that you would like to add, or any questions?

If not already obtained: BACKGROUND INFO: Age, time in job, where worked/trained.

CONSENT FORM/ Further contacts

Guide 6 – Conscientious objectors (Nurses)

Any qs? Time available? Tape recorder? Consent form.

QUESTIONS DON'T HAVE TO BE ANSWERED

1) Could you begin by telling me a bit about what your job is here, and why you wanted to specialise in this area of nursing?

2) Could you describe why you choose not to be involved with abortion provision?

Have you always felt this way, or is it something that's changed over time?

e.g. have you ever been involved?

Are your views about abortion affected by the length of gestation of a pregnancy at all?

Do you feel any differently about abortion depending on the grounds on which it is being carried out?

What about if a woman was having a termination because of an ectopic pregnancy?

Or for fetal abnormality?

If not addressed: Is religious belief something that impacts at all on your feelings about termination?

3) Although healthcare professionals can opt out of providing terminations on an individual basis, I'm interested to know how you feel, more generally, about terminations being provided by the NHS?

4) Could you describe for me how the conscience clause works in practice – so do you have to formally declare your objection anywhere?

What happens when there are women on the ward who are here for terminations? Are you involved with them at all? In what way?

Would you discuss your views with women at all?

What is it like for you to be working on a ward where terminations are also being carried out?

Are there any guidelines for healthcare practitioners who hold conscientious objections to termination?

Can you remember if you received any advice about what to do during your training?

5) Has having a conscientious objection to abortion ever created any difficulties for you at work?

Have you discussed your views with any of your colleagues?

How have your colleagues reacted to it?

Have you ever felt that it's impacted at all on your career?

I'm also interested in whether having a conscientious objection to abortion might interact with other areas of gynaecological work, and if there are other parts of reproductive medicine that it relates to?

Some people who object to abortion also don't want to be involved in contraception provision – so I'm just interested to know how you feel about contraception? Is contraception provision or advice something you're involved in?

6) Current debates

One of the things that I'm interested in in my study is what doctors and nurses think about the current law that regulates termination. So, at the moment, two doctors have to sign to say that they agree that a woman has grounds for a termination. And I'm just interested in what you think about that, or if you have any views about it?

If say it is the woman's decision – Can you say a bit about WHY that is?

The suggestion has been made that nurses could sign the legal documentation, and that termination services could become essentially nurse-led, including surgical terminations. And I'd be interested to know how you would feel about that?

Something else that has been discussed a lot recently is the upper time limit for termination, which some people have suggested should be lowered from 24 weeks. Do you have any views about that?

Anything that you would like to add, or any questions?

BACKGROUND INFO: Age, time in job, where worked/trained.

CONSENT FORM/ Further contacts