I would urge that feminists engaged in the development of a sexual politics of sterilisation should be extremely wary of formulating policies in terms of such rights – for fear of being drawn on to territory long dominated by ideologies and practices inimical to feminist objectives. There is a serious risk that the appeal to a woman's right to reproduce will be appropriated by those who would invoke a general right to reproduce or a human right to reproduce. Appealing to this more general right may in turn be a less than innocent practice, if the alleged general right is identified, covertly or not, with a man's, or worse, a husband's, right to reproduce. There are, furthermore, additional and independent reasons for not framing policies in terms of rights, and it is to this issue that the next section is addressed.

Policies

Two recurrent features of the literature on sterilisation provide the impetus for a review of the various policies which feminists might adopt. First, a good deal of research in the last decade or so has shown that there is increasing demand for sterilisation for contraceptive purposes. In 1972 it was found that hospitals which deliberately adopted a favourable attitude to sterilisation experienced a dramatic increase in spontaneous requests for sterilisation.[41] Two years later, a survey of 1,079 women in Coventry during their confinement produced the estimate that the potential demand for sterilisation was between 60 and 80 per 1000 confinements.[42] Two surveys by M Bone from the Social Survey Division of the Office of Population Censuses and Surveys on behalf of the Department of Health and Social Security showed a marked increase in favourable attitudes towards sterilisation for contraceptive purposes in the 1970s. Briefly, in 1973, of the total sample of women interviewed:

> only 20% said they would think about it if they had about the number of children they planned to have and most thought it only appropriate in more extreme circumstances, for example if further pregnancies would endanger their health or if they had had several more children than they wanted.[43]

The survey was admitted to give only a sketch of women's attitudes but it was surmised that the irrevocability of sterilisation made it 'very much a method of last resort for most women' (see *ibid*). In 1978, however, the picture had changed. The results of this survey suggested that:

> sterilisation was becoming less of a last resort for the desperate and more of a chosen method for couples who had just achieved the number of children they thought sufficient … Sterilisation was therefore not only spreading but increasingly impinging on young couples who had had few pregnancies and, it seems, quite soon after they had decided that their second or third baby was to be the last.[44]

Additional evidence for the demand for sterilisation for contraceptive purposes has been collected, and explanations for its increased popularity are available.[45]

The second recurrent feature of the literature on sterilisation has not been so thoroughly researched. It concerns a practice which is generally frowned on (or

41 AER Buckle and KC Young in (1972) *New Society*, 24 February, p 402.

42 LJ Opit and ME Brennan, in (1974) *New Society*, 18 July, p 157.

43 M Bone, *Family Planning Services in England and Wales* (Office of Population Censuses and Surveys, 1978).

44 *Ibid*, p 62.

45 *Birth Control Trust* (1978), Chapter 1.

at least seen as one which has to be justified) and about which it is extremely difficult to be precise. It is the practice which has come to be known as 'the package deal'. Briefly, a woman's request for an abortion is met on condition that she agrees to being sterilised at the same time. In 1974 the Lane Report on the working of the Abortion Act 1967 noted that, although the Committee had been unable to establish the facts in this matter, it was concerned by comments it had received about the large number of young unmarried women who had been sterilised as a condition of getting an abortion. The Report recommended that sterilisation should never be a condition for terminating an existing pregnancy nor be performed as a result of any other pressure.[46] In 1981 I Allen noted that fears were often expressed about women being pressurised into sterilisation when they had an abortion, although she was unable to find evidence to support those fears.[47] On the other hand, a 1971 survey of gynaecologists' attitudes showed:

> respondents to be evenly divided on the question, those in favour thinking that the abortion patient should accept sterilisation if there were medical or psychiatric indications, if the situation leading to abortion was unlikely to change, where there was multiparity, low IQ, 'irresponsibility', a previous abortion or other problems.[48]

In spite of the fact that evidence of the package deal is largely anecdotal, references to it persist, and it would appear that the practice continues.[49]

It is reasonable to suppose that, in responding to these trends, feminists will present their policies in terms of women's rights. Indeed, the package deal has been described in these terms. K Greenwood and L King connect it to the central demands of the Women's Liberation Movement for freely available contraception and abortion, observing that women have no right to abortion.[50] P Hewitt sees the package deal as a violation of a woman's right to choose, and she asserts that right on the basis of its relation to other rights, proposing that 'the freedom of a woman to control her own fertility is inextricably linked to fundamental principles of human rights'.[51] In this connection, too, it is worth recalling that in *Re D*, described above, it was held that the operation proposed was one which involved 'the deprivation of a basic human right, ie the right of a woman to reproduce'.

In the previous section, I drew attention to the risks of appealing to rights, such as the right to reproduce, when they are associated with ideologies and practices inimical to feminist objectives. In this section, I show that, even if feminists do present their policies in terms of rights, it is far from obvious that they will on that account be united in their policy preferences. On the contrary, I argue that appealing to women's rights can mask serious differences between feminists and can, in so doing, be an obstacle to the development of detailed policies and strategies in relation to sterilisation. To support this argument, I identify three

46 *Report of the Committee on the Working of the Abortion Act* (Cmd 5579) (1974).

47 I Allen, 'Family Planning, Sterilisation and Abortion Services' (1981) 595 *Policy Studies* Institute 65.

48 J Aitken-Swan, *op cit*, p 158.

49 Y Roberts (1988) *Independent*, 18 May.

50 K Greenwood, 'Contraception and Abortion', in *Cambridge Women's Studies Group (*1981), p 174.

51 P Hewitt, 'Women's Rights and Human Rights', in Birth Control Trust, *Abortion Ten Years On* (1987), p 29.

different ways in which feminists might take up the issue. For convenience, I label them as follows: Policy A: Deregulation; Policy B: Mandatory Provision; Policy C: Safeguards.

Policy A: Deregulation

Some feminists might respond to the trends outlined above by demanding the complete deregulation of sterilisation, meaning by this the abolition of all restrictions on it. Only in this way, it might be argued, can a woman enjoy genuine freedom to control her own fertility. That freedom cannot be enjoyed under present social conditions, since the existing legal and medical institutions and practices are necessarily geared to capitalist and patriarchal interests. It is therefore not merely futile or misguided to look to these institutions for recognition of a woman's absolute right to control her own body; it is to advocate reformist measures and, in so doing, to oppose the revolutionary demand for women's rights. The regulation of health care now is oppressive of women, and a socialist society will remove the need for that regulation. In the absence of socialism, but in order to advance towards it, women should concentrate their efforts on demystifying medicine and exploring alternative forms of health care by setting up self-help groups. In the specific matter of sterilisation, a woman's right to choose is both the expression of women's refusal to allow men in general, and doctors and lawyers in particular, to control women's fertility and the expression of their refusal to participate in social practices which support that control.

Clearly, this response has much in common with the way in which some feminists took up the issue of abortion in the USA and in this country, and I have already discussed some of these issues in the previous chapter, in relation to a woman's right to choose. As we have seen, the deregulation response has been forcefully pressed by Victoria Greenwood and Jock Young.[52] It was just as forcefully resisted by Paul Hirst.[53] Hirst's attack focuses on the absurdity of supposing that socialist states have or will have no need of regulation in the areas of health care, and he demonstrates the problematic politics of arguing for a woman's right to choose in the context of forming general social policy. He points out the dangers of demanding the demonopolisation of medical competence: 'Demonopolisation would mean that anyone was free to perform abortions; there would be no limit to personnel, methods or facilities. The possibility created by this laissez-faire is of a return to the era of the 'knitting needle', in the guise of alternative medicine and self-help.'[54] Hirst concludes that 'socialist states should take the control of medical competence and the determination of means of intervention more and not less seriously'.

Faced with this sort of criticism, proponents of deregulation might reply that nobody would seriously propose that personnel other than qualified surgeons should perform operations of sterilisation. It is worth noting, however, that there are continuing attempts to find a substitute for surgical sterilisation. One such attempt involves the relatively simple procedure of infusing a solution of quinacrine into the interior of the uterus.[55] Informal sources suggest that this sort of procedure could be performed very simply and that the kit could be

52 V Greenwood and J Young, *Abortion in Demand* (Pluto Press, 1976).

53 PQ Hirst, 'Law, Socialism and Rights', in eds P Carlen and M Collison, *Radical Issues in Criminology* (Martin Robertson, 1980).

54 *Ibid*, p 102.

55 Cf B Viel and J Walls, *The Demographic Explosion* (New York: Irvington, 1976), p 148.

marketed for a dollar. It would not be surprising if understandable apprehension at the implications of such a development led feminists to adopt an alternative to deregulation, namely mandatory provision.

Policy B: Mandatory provision

Resistance to the argument that law is necessarily oppressive of women, and alarm at the serious effects of deregulation in the sphere of health care in general, and sterilisation in particular, might make feminists adopt a different approach. This may invoke the rhetoric of a woman's right to choose, since it is a potent political slogan. But for these feminists it is not a knowingly unrealisable demand under capitalism and an unnecessary one under socialism. Instead, it is a convenient means of focusing attention on a particular area of health care the provision of which is currently disadvantageous to women, which on that account should not be tolerated now, and which certainly should not be tolerated under a socialist State committed to the removal of obstacles to women's full enjoyment of social benefits.

We have seen that there is a rising demand for female and male sterilisation as a form of birth control. One of the main sources of dissatisfaction with the present NHS sterilisation service, however, has been its uneven availability. In 1981, a survey of 30 area health authorities showed that in only six authorities was the average waiting time for female sterilisation three months or less, that in eight authorities it was two years or more, and that in one authority it could be four years. The average waiting time for vasectomies was just as uneven as between authorities, but generally it was shorter than for female sterilisation.

A major factor in this uneven availability was found to be the manner of its funding. Authorities and district management teams set aside money for item-of-service payments. The discretionary nature of this funding meant that doctors and health authorities were in a position to give priority to other operations and procedures in preference to sterilisation. It also allowed great scope for doctors and gynaecologists to exercise their personal as well as their professional judgements in relation to the moral aspects of sterilisation.

How can this situation be remedied? One obvious strategy would be for feminists to point to the cost-effectiveness of sterilisation in comparison with other forms of contraception, abortion, ante-natal maternity care and child care. WA Laing has estimated that, taking into account failure rates and the cost of unplanned conception, there is a break-even point of a little over a year for vasectomy.[56] Laing concludes that it seems illogical to restrict NHS sterilisations rather than reversible methods of contraception. It has also been shown that savings in in-patient costs are greatly reduced by the use of modern methods of female sterilisation, such as mini-laparotomy, and that the greatest savings would be effected by setting up special sterilisation units or clinics, perhaps in hospital wards closed as a result of financial cuts.

The argument for units specialising in sterilisation, contraception and abortion has been put forward by Wendy Savage. It is a powerful argument, since there is evidence that, for contraceptive and related matters, women would rather go to a specialised clinic than to their GP's surgery.[57] But that sort of provision would not by itself solve the problem of uneven availability, since the provision of such clinics would again be a matter of the political will of the relevant authorities to

56 WA Laing, 'Family Planning: the Benefits and Costs' (1982) 607 *Policy Studies* Institute 32.

57 Women's Health and Reproductive Rights Information Centre (1990).

fund them, and there is recent evidence of the reluctance of National Health Service regions to give priority to family planning services and Well-Woman Clinics.

To ensure even availability, it might be argued that it is necessary to effect a change in national legislation governing the provision of the health services. This would require close and expert scrutiny to identify the most effective legal reforms, and a difficulty here is the typical form of health service legislation. The National Health Service (Family Planning) Act 1972 allowed local health authorities to provide voluntary vasectomy services on the same basis as other contraceptive services. Interestingly, it made no reference to types of female sterilisation, provoking speculation about the role of that Act in the unevenness of sterilisation services as between women and men. But that Act is now repealed, and although it allows male and female sterilisation clinics to be held under the general provisions of family planning, the National Health Service Act 1977 makes no special mention of sterilisation. As in the National Health Service (Scotland) Act 1978 there is just the general requirement that the Secretary of State make such arrangements for contraceptive services as he considers necessary.

Feminists might want to look into how it would be possible to rectify this situation, with a view to making this sort of provision mandatory rather than discretionary, in the same way that they have argued for the mandatory provision of abortion facilities, and perhaps to have a minimal level of funding. Formidable obstacles to this sort of feminist intervention are apparent from commentaries on the passage of the National Health Service and Community Care Bill. The Women's Health and Reproductive Rights Information Centre (WHRRIC) has reported that:

> in the early days of the White Papers, five core services were mentioned … Labour put forward an amendment listing the five core services: accident and emergency, geriatric, psychiatric, public health community-based services and services for the elderly and mentally ill. They also added maternity, gynaecology and family planning which had been left off the original list… the amendment was defeated, with the Conservatives arguing that market forces would ensure such services were provided![58]

Against this sort of political backdrop, the demand for mandatory provision begins to look Utopian. Also, it has to be said that even if mandatory provision could solve the problem of uneven geographical availability of sterilisation services, it would not necessarily deal with the problem of uneven availability as between women and men.

It is clear that the objective of a mandatory and non-discriminatory NHS sterilisation service requires close attention to the most effective means of changing existing legislation and medical practices, whether or not the objective is pursued in the name of a woman's right to choose. But this could hardly be more different from the use of that slogan to advocate deregulation of sterilisation services. A further contrast is that, even if the policy of mandatory provision is fought for in the name of a woman's right to choose, that right will have been converted, as it were, into a number of specific objectives. These objectives raise questions not of the rights of individual women but of general social policy in the sphere of health care, such as priorities in NHS spending. It is in this context that a third feminist response might be developed.

58 *Ibid*, p 18.

Policy C: Safeguards

Feminists might well be concerned that the setting up of special sterilisation clinics on the grounds of cost-effectiveness would not be in women's (or men's) interests. Local authorities would have strong incentives to ensure that such clinics were not under-used and, in consequence, they might be inclined to cut back their funding of existing contraceptive services, thereby reacting the scope of contraceptive choice. Further, the policy of mandatory provision of such clinics might not be implemented in full. Local authorities might be required to offer sterilisation services but not be required to do so through special sterilisation clinics. If, in addition, there were no change in the system of funding through items-of-service payments, there could be greater pressure than now on surgeons to make abortion conditional on sterilisation.

To prevent a resurgence or increase in the package deal, feminists might consider a policy which concentrates on strengthening safeguards in present and future provision. At least two such measures would be appropriate. Firstly, a case could be made for mandatory counselling before any decision to sterilise is made, given the mostly irreversible nature of sterilisation and the consequent social and moral questions peculiar to that form of contraception. While it would be difficult to enforce a policy of mandatory counselling, it would certainly be possible for the Department of Health and Social Security to toughen up its guidelines to local authorities on the provision of sterilisation. At present, the guidelines state only that full counselling is 'particularly important'. Allied to this, close attention should be given to the precise legal and practical meaning of 'consent' and of the distinction between 'consent' and 'agreement' as discussed above. Pressure could be brought on medical practitioners to ensure that consent is genuinely informed, in the sense of giving information both about what is known or believed to be the case regarding the possible effects of sterilisation but also about what is not known. For example, women should be advised about the uncertain state of knowledge concerning the effect of sterilisation on menstruation. Further, great care should be taken to define what counts as pressure or persuasion in the getting of a patient's consent and, where applicable, the agreement of the spouse. Secondly, feminists might consider the introduction of a compulsory period of time which must elapse – a breathing space – between a patient's having an abortion and her having an operation for sterilisation. This might be done by pressing for an amendment to the Abortion Act 1967 or by including the provision in a new Act concerned with sterilisation.

There are good reasons why feminists who supported these measures would think it inadvisable to campaign under the aegis of the slogan of a woman's right to choose. That slogan is clearly associated with pro-choice abortion campaigns. Insofar as abortion is thought not to be a desirable form of contraception, and because the breathing space is intended to dissociate abortion and sterilisation, it would be unfortunate if the two campaigns became identified with each other. Further, pro-choice campaigners have not been predominantly concerned that women would be pressured into having abortions, whereas the main burden of the safeguards under consideration here is to guard against women (and presumably men) being pressurised into operations of sterilisation by cost-conscious, disturbingly enthusiastic, or just plain busy medical practitioners. To that end, a much more appropriate slogan, if one were needed and if it had to be in terms of rights, would be a woman's right to refuse.

This outline of policy options open to feminists in the sphere of sterilisation provision and practice is obviously not exhaustive, although, under the present

attack on the National Health Service and on such contraceptive services as exist at present, it may seem overly optimistic. Even so, the description of Policies A, B and C provides a basis for assessing different types of feminist response, especially where these policies are framed in terms of superficially similar appeals to women's rights.

'WHO IS THE MOTHER TO MAKE THE JUDGMENT?': CONSTRUCTIONS OF WOMAN IN ENGLISH ABORTION LAW[59]

Sally Sheldon[60]

1. Introduction

The title of this paper comes from the 'Parliamentary Debates on the Medical Termination of Pregnancy Bill (later to become the Abortion Act 1967). Kevin McNamara MP speaking with respect to the decision to abort a handicapped foetus, poses the question 'who is the mother to make the judgment?'.[61]

The continuing refusal of the law to recognise the decision of whether or not to terminate a pregnancy as one fundamentally belonging to the pregnant woman, forms the focus of this paper. I will argue that the reason why it is so unthinkable to give women self-determination (in the real sense of allowing them the final word in a decision to abort) is because of the constructions of woman upon which this law is predicated.

This paper conceptualises the legal subject as an internal construct of a given law, and as embodying certain characteristics. Law creates its own fiction of the subject that it seeks to regulate. Feminist texts have often discussed the construction of this subject as essentially male, existing either as a male universal legal subject, or as a construct of one particular law.[62] Abortion legislation, however, is one of the instances where law can be seen to posit a female legal subject.

This paper sets out to 'deconstruct' the Abortion Act 1967 to reveal the female legal subject created within it. It does not enter into the discussion of the morality of abortion, or the debate around the competing rights of foetus and woman. It will already be clear, no doubt, what my position within that debate would be. This paper also implicitly rejects the centrality normally granted to the foetus. It is often assumed that if we can accord the foetus one intrinsic ontological status (personhood or non-personhood) this in itself will provide a definitive solution to the problem of whether to allow abortion. Rather, I seek to recentre the notion of woman within discussions of abortion. She has been, in many accounts, the forgotten party.

59 [1993] 1 *Feminist Legal Studies* 3. (Footnotes edited.)

60 At the time of writing, University of Keele

61 McNamara, HC Debates Vol 730, Col 1129, 1966 (22 June).

62 N Naffine, *Law and the Sexes* (London: Unwin and Hymnan, 1990); K O'Donovan, 'Defences for Battered Women who Kill' (Summer 1991) *Journal of Law and Society* at 219–40. O'Donovan argues that the traditional defences to murder of provocation and self-defence have been constructed with regard to stereotypically male patterns of behaviour. R Holtmaat 'The Power of Legal Concepts: The Development of a Feminist Theory of Law' (1989) 17 *International Journal of the Sociology of Law* at 481–502. Holtman argues that the concept of employee supports the male model of paid labour, whilst excluding women who cannot or will not participate on the same footing as men.

This paper concentrates on the debates leading to the introduction of the 1967 Act, as played out in Parliament. It is beyond the scope of this paper to explore the exact relationship between the content of Parliamentary debates, and the final text of a debated statute. To say that the law is the product of debate within Parliament is obviously simplistic, not least because any new Bill is presented in draft form before ever coming under discussion (the text of the Abortion Act derives in large part from David Steel's original draft of the Medical Termination of Pregnancy Bill). Neither do I seek to deny the impact of extra-Parliamentary groups and in particular in this case, the medical profession on the formulation of statute. Rather, I content myself with a minimum assertion (that Parliamentary debates are in some way indicative of the predominant social discourses around the concept of woman which form the context within which the Abortion Act was conceived) and a more ambitious suspicion (that the statements made by MPs in this context provide particularly important and powerful 'telling instances' of this social and political discourse).[63]

This paper represents an attempt to draw out the way that the pregnant woman seeking abortion is constructed within these debates – to bring together dispersed comments of MPs to present a more unified account of the sort of general assumptions about the 'type' of woman whom the legislation must address (what kind of woman would seek to terminate a pregnancy?). I then very briefly outline the way that the figure of the doctor was constructed within the debates before examining how these constructions and the assumptions upon which they are predicated are reflected in the text of the Abortion Act itself.

Although the major thrust of this paper will be a criticism of the 1967 Act and the way that woman is constructed within it, I will at least begin to draw some more general conclusions about feminist strategies with regard to the law.

2. The Constructions of Woman Employed in Parliament

From my reading of the Parliamentary debates which preceded the passing of the Abortion Act 1967, two major constructions of the 'type' of woman who would want an abortion emerge. Both accounts reflect this woman as marginal and deviant, standing against a wider norm of women who do not need/desire abortion. These constructions reflect strategies used by the proponents and opponents of increasing access to abortion, and on a broader level, reflect images of women that were/are predominant in other social discourses. Both typifications are extreme – they are predicated partially on stereotypes, and partially on real and concrete examples which continually recur within the debates as *leitmotivs* to become generalised as representing the reality of the woman who seeks abortion.

The structure adopted within this section is to identify two major constructions of woman used within the debates which may be broadly (though not always consistently) identified with the reformer/opponent split. Thus, I would argue, whilst the reformers represent the woman who would seek to terminate a pregnancy as an emotionally weak, unstable (even suicidal) victim of her desperate social circumstances, the conservatives view her as a selfish, irrational

63 P Fitzpatrick, 'Racism and the Innocence of Law', in P Fitzpatrick and A Hunt (eds), *Critical Legal Studies* (Oxford: Blackwell, 1987), pp 11–132 esp, p 120.

child.[64] Such a schema is inevitably a simplification and imposes a unity and coherence which is doubtless lacking, but nonetheless it is useful in understanding and highlighting the kinds of constructions used in the debates.

(a) Woman as a Minor

This construction is typically adopted by opponents of abortion (although normally in their accounts the central place would be ceded to the foetus). It represents woman as a minor in terms of immaturity or under-development with regard to matters of responsibility, morality, and even to her very femininity or 'womanliness'. Her decision to abort is trivialised and denied rational grounding, being perceived as mere selfishness: she will abort 'according to her wishes or whims,'[65] for example, in order to avoid the inconvenience of having to postpone a holiday. She is immoral for being sexually active for reasons other than procreation; she is irresponsible for not having used contraception, and now for refusing to pay the price for her carelessness; she is unnatural and 'unwomanly' because she rejects the natural outcome of sexual intercourse for women: maternity. There is a hint that one day she will come to realise the error of her ways and want children, yet maybe will be unable to have them as a result of the abortion.[66]

Jill Knight plays heavily on the idea of the woman as selfish and irresponsible. She reveals an image of women seeking abortion as selfish, treating '[babies] like bad teeth to be jerked out just because they cause suffering … simply because it may be inconvenient for a year or so to its mother'.[67] She later adds that '[a] mother might want an abortion so that a planned holiday is not postponed or other arrangements interfered with'.[68] The ability of the woman to make a serious decision regarding abortion is trivialised. It is not expected that the woman will make a careful decision considering all parties, but rather (like a child) she will make a snap decision for her own convenience.

The task of the law is thus perceived essentially as one of responsibilisation: if the woman seeks to evade the consequences of her carelessness, the law should stand as a barrier. It is often stated that allowing women to take the easy way out encourages them to be irresponsible:

> People must be helped to be responsible, not encouraged to be irresponsible … Does anyone think that the problem of the 15-year-old mother can be solved by taking the easy way out? … here is the case of a perfectly healthy baby being sacrificed for the mother's convenience … For goodness sake, let us bring up our daughters with love and care enough not to get pregnant and

64 In view of Carol Smart's recent assertion that it is important to analyse how the female legal subject is constituted in classed and raced as well as gendered terms, it would perhaps be productive to view this distinction as one of class – ie the poor working-class woman fits the model of the unstable and desperate 'multi-child mother' who will have to resort to the back streets should legal relief be denied her; the rich, educated middle-class (working) woman is open to charge of selfishness for choosing to have a career rather than raise a child. See C Smart, 'Disruptive Bodies and Unruly Sex: The Regulation of Reproduction and Sexuality in the 19th Century', in C Smart (ed), *Regulating Womanhood: Historical Essays on Marriage, Motherhood and Sexuality* (London and New York: Routledge, 1992), pp 7–32.

65 Mahon, *HC Deb* Vol 750, Col 1356, 1967 (13 July).

66 See for example the comments of Knight, *HC Deb* Vol 749, Col 932, 1967 (29 June); Clover, *HC Deb* Vol 749, Col 971, 1967 (29 June).

67 Knight, *HC Deb* Vol 732, Col 1100, 1966 (22 July).

68 Knight, *HC Deb* Vol 749, Col 926, 1967 (29 June).

> not let them degenerate into free-for-alls with the sleazy comfort of knowing, 'She can always go and have it out'.

By forcing her to continue with the pregnancy then, the law will seek to ensure that the pregnant woman will be more responsible in the future. As one MP comments with regard to whether abortion should be allowed to a 15-year-old girl: 'one needs to think twice before one removes all the consequences of folly from people'. The woman who seeks abortion is also seen as morally immature, and hence undeserving of help. Simon Mahon asks who is to be given priority in terms of treatment: is it the 'feckless girl who has an unwanted pregnancy from time to time' or the 'decent married woman' who is awaiting investigation or treatment for sterility? The use of this rhetorical trick of opposing the 'girl' to the 'decent married woman', serves to emphasise that the girl is not only feckless but is also decent and unworthy of respect.

The Parliamentary debates often reflect an implicit assumption that it is wrong for women to make a distinction between sex and procreation, they should not indulge in sex, if pregnancy is not desired. William Deedes makes these sentiments clear in expressing his concern that 'science and its little pill will enable so-called civilised countries to treat sex more and more as a sport and less and less as a sacrament in love', a divine instrument of procreation. Perhaps the single most telling quotation in this instance is that of David Steel himself, defending a clause which was included in the original wording of the Bill but dropped after debate in Parliament (for reasons that will be discussed later, see section 4(b) below). The clause sought to allow abortion to 'a pregnant woman being a defective or becoming pregnant while under the age of 16 or becoming pregnant as a result of rape'. He states:

> Most honourable members would agree that to have a woman continue with a pregnancy which she did not wish to conceive, or in respect of which she was incapable of expressing her wish to conceive, is a practice which we deplore, but the difficulty is to find an acceptable wording which will enable termination to be carried out following sexual offences of this kind but which does not allow an open gate for the pretence of sexual offences.

What is startling here is Steel's correlation of 'a pregnancy which she did not wish to conceive' with conception following rape. Steel fails to imagine that the vast majority of requests for abortion will be for pregnancies that the woman did not wish to conceive – thus in using this as an argument to justify abortion in cases of rape, he implicitly equates consensual intercourse with desired conception. Wanting sex equals wanting pregnancy and motherhood. The woman who rejects maternity is seen to reject the very essence of womanhood. Kevin McNamara provides a strong account of woman's maternal instinct: 'How can a woman's capacity to be a mother be measured before she has a child? Fecklessness, a bad background, being a bad manager, these are nothing to do with love, that unidentifiable bond, no matter how strange or difficult the circumstances, which links a mother to her child and makes her cherish it.'

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

(b) Woman as a Victim

The second construction strongly present in the Parliamentary debates is that of woman as victim. This construction is typically that of the reforming forces, where the woman and her social situation enjoy a far more central place. Advantage was taken of public sympathy for the situation of women at this time, given the highly restricted access to abortion. Newspapers and books had reported horror stories of back-street and self-induced abortions, and as David Steel noted in the debates, in the years preceding the introduction of the Abortion Act, an average of 30 women per year were dying at the hands of criminal abortionists.

The woman of this construction is not 'only on the fringe, but literally, physically inadequate'.[69] She is portrayed as distraught, out of her mind with the worry of pregnancy (possibly because she is young and unmarried, but normally because she already has too many children). She is desperate, and should the doctor not be able to help her, who knows what she will stop at (suicide is often discussed). Her husband is either absent or an alcoholic, her housing situation is intolerable. She is at the end of her tether simply trying to hold the whole situation together. As Madeleine Simms, of the Abortion Law Reform Association (ALRA), later wrote: 'It was chiefly for the worn out mother of many children with an ill or illiterate or feckless or brutal or drunken or otherwise inadequate husband that we were fighting.'

The following letter to Lord Silkin (referred to in the debates) provides a good example of the 'type' of woman envisaged by the reformist forces:

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

Lord Silkin himself comments, in presenting the Bill for its second reading that:

> the vast majority of women who are concerned with this are not, as I might have expected originally, single women, but married women, of an age approaching 40 or more, with a number of children, who have become pregnant again, very often unexpectedly, and who for one reason or another find themselves unable to cope with an additional child at that age … [The kind of person that I really want to cater for is] the prospective mother who really is unable to cope with having a child, or another child, whether she has too many already or whether, for physical or other reasons she cannot cope.

The same kind of image is also drawn in the House of Commons, where one MP speaks of 'the mothers with large families and the burdens of large families very often with low incomes'. Another MP describes the illegal abortions he knows of:

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

69 V Greenwood and J Young, *Abortion in Demand* (London: Pluto, 1976), p 76.