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Expecting motherhood? Stratifying reproduction in twenty-first century Scottish abortion practice

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Abstract

This article illustrates how Scottish health professionals involved in contemporary abortion provision construct stratified expectations about women's reproductive decision-making. Drawing on 42 semi-structured interviews I reveal the contingent discourses through which health professionals constitute the 'rationality' of the female subject who requests abortion. Specifically, I illustrate how youth, age, parity and class are mobilised as criteria through which to distinguish 'types' of patient whose requests for abortion are deemed particularly understandable or particularly problematic. I conceptualise this process of differentiation as a form of 'stratified reproduction' (Colen, 1995; Ginsburg and Rapp, 1995) and argue that it is significant for two reasons. Firstly, it illustrates the operation of dominant discourses concerning abortion and motherhood in twenty-first century Britain. Secondly, it extends the forms of critique which feminist scholarship has, to date, developed of the regulation of abortion provision in the UK.

Keywords

abortion; feminist theory; health professionals; motherhood; stratified reproduction

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 and Rapp, 1995: 1-2)

Introduction

A growing field of feminist scholarship has illustrated how reproductive medicine, as the gatekeeper to most technologies of fertility prevention and promotion, is regularly implicated in the production of future cultures (for a recent review see Inhorn, 2006). Exploiting this 'entry point to the study of social life', feminist analyses have revealed how intersecting processes of social stratification such as gender, race, and class are locally and variably constituted in relation to a wide variety of reproductive medical practices, for example, those surrounding childbirth (Martin, 1989), infertility (Bell, 2010; Thompson, 2005), prenatal diagnosis (Rapp, 2000), surrogacy (Ragoné, 1994), contraception (Sargent, 2007) and abortion (Ginsburg, 1998; Petchesky, 1984).

As Ginsburg and Rapp have argued, a central theme of this body of research is its concern with the 'arrangements by which some reproductive futures are valued while others are despised' (Ginsburg and Rapp, 1995: 3). Such concern, they suggest, is usefully captured using the expression 'stratified reproduction' (Colen, 1995; Ginsburg and Rapp, 1995). In this paper I apply this concept as an analytical tool with which to explore a hitherto under-researched issue: contemporary UK¹ health professionals' accounts of their role(s) in abortion provision (in the absence of diagnosed foetal impairment). My analysis offers critical insights concerning the construction of stratified expectations about motherhood in twenty-first century Britain. In doing so, it extends the forms of critique which feminist scholarship has, to date, developed of the regulation of abortion provision in the UK.

UK abortion law and feminist theory: Critiques of the 'normalisation' of motherhood

Qualitative studies of women's experiences of abortion within the UK suggest that, while they are generally able to access the procedure, they sometimes experience very difficult interactions with the health professionals they encounter (Allen, 1985; Harden and Ogden, 1999; Kumar et al., 2004; Lattimer, 1998; Lee, 2004; Lee et al., 2004; Macintyre, 1977; Robotham et al., 2005). A consistent finding of this body of work is that most women decide to end their pregnancies before entering the clinic, and that they approach health professionals for information and support in accessing the procedure. Where such support is provided, women report positive experiences, but describe feeling 'over-counselled' and judged when they are questioned about their decisions.

Feminist theorists (Jackson, 2001; Lee, 2004; Sheldon, 1997) have linked the difficulties that women experience when requesting abortion to the gate-keeping framework through which the procedure is regulated in the UK. Currently, abortion is regulated through the 1967 Abortion Act, as amended by the 1990 Human Fertilisation and Embryology Act. This makes its legality contingent upon two doctors' agreement that it is necessary on the grounds of a pregnant woman's health or that of her foetus. This construction of abortion decision-making has been widely criticised (Boyle, 1997; Fyfe, 1991; Jackson, 2001; Lee, 2003, 2004; Sheldon, 1997) for its portrayal of femininity. By positioning the rationality of doctors as central to abortion decision-making, the law constructs women as irrational and incapable of judging the circumstances in which they should become mothers. Moreover, by depicting abortion as an exceptional, deviant act justified only by doctors' assessments of 'the individual circumstances (or inadequacies) of individual women' (Sheldon, 1997: 42) it implicitly normalises motherhood.

While feminist analyses of UK abortion law concur about its problematic constructions of femininity, there are nonetheless important differences in the forms of critique which have been developed. For example, Jackson positions legal reform as the key issue, arguing that abortion law should be brought in line with contemporary medical law's respect for the 'guiding principle of patient self-determination' (Jackson, 2001: 72). Drawing on Jackson, Lee's (2003, 2004) concern is also with the letter of UK abortion law, specifically its failure

¹In using the term UK I am, perhaps problematically, excluding Northern Ireland, which is subject to a different set of abortion legislation from Scotland, England and Wales.

to provide, '[A] clear and overt intention to view reproductive control as a "good", that should be upheld and promoted in society' (Lee, 2004: 302).

However, as Smart (1989) argues, a narrow focus upon legal change as an automatic solution to problems that affect women's lives creates a number of further difficulties. Firstly, it reifies law's account of itself, upon which its claim to power rests, namely, that it is a 'superior and unified field of knowledge' (Smart, 1989: 4), rather than a 'plurality of principles, knowledges, and events,' (Smart, 1989: 4) enacted in specific contexts. Secondly, and following from its sociologically inadequate account of law, this approach fails to consider that the meaning of any new legislation will be determined by the specificities of its enactment(s) in practice (Smart, 1989). Acknowledging these concerns, Sheldon (1997) articulates her critique of UK abortion law in slightly different terms. Notably, she emphasises the importance of exposing and addressing the gendered processes which have produced, and in turn sustain, law's problematic constructions of women who request abortion. A related approach is adopted by Boyle (1997), who explores how psychology – as a discipline – has historically supported such constructions.

Nevertheless, through the analysis that follows, I reveal that even these, more nuanced, feminist critiques contain important limitations. Specifically, I suggest that their focus on processes of gendering has prevented them from engaging with the complexities of processes of 'stratified reproduction', and the ways in which these are inevitably entangled with the regulation of abortion provision in the UK.

'Stratified reproduction' in UK abortion practice

In describing how women requesting abortion were represented in the debates that preceded the 1967 Abortion Act, Sheldon notes in passing that these representations 'might productively be analysed in terms of class' (Sheldon, 1997:35). However, because her overarching concern is with processes of gendering, she does not engage any further with the implications of this significant insight. In contrast, the ways in which gender intersects with other stratifying systems of social classification in the regulation of abortion is central to Macintyre's (1977) analysis of the processes via which single women reached particular 'outcomes' of pregnancy in 1970s Scotland. As part of her study she discovered that doctors' expectations about the outcome of women's pregnancies were determined by patients' accounts of their anticipated marital status. In cases where women were planning to marry their partners, doctors treated motherhood as an inevitable pregnancy outcome. However, if questioning revealed that a woman was unlikely to marry, doctors became actively supportive of outcomes other than motherhood (adoption or abortion). In an extension of this analysis Macintyre highlights that, in addition to referencing (anticipated or actual) marital status, doctors also utilised class, age and parity (number of previous births) in 'attributing a desire to have, or not have, babies' (Macintyre, 1976: 190) to their patients.

Another, more contemporary, illustration of the perpetuation of stratified expectations about motherhood in abortion practice is provided by analyses of health professionals' accounts of counselling in the context of prenatal diagnosis (Alderson et al., 2004; Statham et al., 2006; Williams et al., 2002a, b, c). A critical point demonstrated by this literature is that healthcare practice in this field has normalised the expectation that motherhood should be rejected

following a diagnosis of foetal impairment (see also Ettorre, 2000; Farrant, 1985; Lippman, 1991; Shakespeare, 1998). However, of the 189,574 abortions conducted in England and Wales in 2010, only 1% were conducted on the grounds of such a diagnosis (Department of Health, 2011: 3). In other words, although important, current sociological interest in the 'high tech' context of prenatal diagnostics means health professionals' roles in the vast majority of abortion work – which does not occur within this context – has become a critically neglected topic.

Interviewing health professionals

The discussion that follows is based on 42 interviews that I conducted with Scottish health professionals in 2007-2008 concerning their experiences of abortion practice in the absence of diagnosed foetal impairment. Prior to the recruitment of interviewees, the study was reviewed in accordance with the University of Edinburgh's School of Social and Political Studies research ethics audit process. All interviewees had the opportunity to reflect upon a written summary of the study prior to interviews, as well as to ask questions about the research, and written consent was obtained from all participants.

The lack of private/charitable abortion providers in Scotland means that, in order to access abortion, women must be referred either by a GP or by a community sexual health clinic to the appropriate NHS hospital service (typically, a gynaecology department or associated specialist service). To reflect this system of provision I interviewed GPs (20), obstetrician/gynaecologists (12 – including Consultants and Specialist Registrars) and gynaecology nurses (10). Three of the obstetrician/gynaecologists and one of the gynaecology nurses worked in community sexual health clinics. The remainder worked in hospitals where, unless they held a conscientious objection to abortion,² their work involved them in interviewing/counselling patients and/or in carrying out the procedure.

I based my recruitment of interviewees on a purposive sampling strategy (Ritchie *et al.*, 2003) designed to facilitate the qualitative exploration of contemporary Scottish abortion practice by capturing as diverse a range of accounts as possible. To this end I made every effort to obtain a sample of participants that was relatively balanced in terms of gender and which varied in terms of age as well as the geographic /organisational location of practice. As qualitative research, the findings presented here are not intended to be representative; the numbers of health professionals interviewed reflect the point at which 'theoretical saturation' was reached.

Interviews were digitally recorded (except in two cases where permission was refused), transcribed, and analysed with the aid of qualitative data management packages. Transcripts were thematically coded in terms of the empirical issues under discussion and a close reading of the coded text was then conducted. This reading was grounded conceptually in the approach to discourse analysis outlined by Wetherell and Potter (1992). It centred upon the discursive practices through which health professionals constructed subjectivities for themselves and for their patients. A crucial aspect of Wetherell and Potter's (1992)

²Of those interviewed, two GPs, two obstetrician/gynaecologists and one gynaecology nurse stated that they 'opted out' of abortion provision on the grounds of conscience.

conceptual approach is that it acknowledges the constraints of the discursive contexts in relation to which individuals develop their accounts of identity. Informed by this approach, my analysis of UK health professionals' accounts of their practice emphasises the limitations of the discourses which are available to those working within this context. It does not seek to critique the practices of health professionals as individuals.

'Stratifying reproduction': Research findings

Elsewhere (Beynon-Jones, 2012) I have described how, in accordance with popular portrayals of abortion in the UK, as well as with accounts of abortion counsellors working in the independent sector (Lee, 2003), interviewees generally framed abortion as a decision that belongs to pregnant women. At the same time I demonstrated that they invoked the case of abortions requested at 'later' gestations as an exceptional situation in which it becomes appropriate for them to question (and in some cases refuse) women's requests. In this paper I reveal that health professionals utilise other methods of classification to normalise particular requests for the procedure and problematise others. Specifically, I demonstrate that health professionals employed strikingly convergent sets of demographic criteria in constructing 'types' of patients whose requests for abortion they deemed 'rational' or 'irrational'.

In roughly one quarter of the interviews, health professionals mobilised these criteria explicitly to distinguish between categories of patient. More often, however, they made implicit distinctions between rational and irrational uses of abortion. They did so by constructing 'types' of patient whose obvious 'need' to avoid motherhood rendered a request for the procedure (as well as health professionals' involvement in providing it) particularly understandable. In the following discussion I argue that this portrayal of *certain* women's rejection of motherhood as rational implicitly constructs a set of deviant Others, whose requests for abortion are positioned as irrational.

Throughout the discussion that follows, I highlight links between the ways in which health professionals construct rational/irrational requests for abortion and the insights which broader sociological literatures offer concerning the classification of normative/deviant twenty-first century (western) motherhood. In the conclusion to the paper I reflect upon the rhetorical work which health professionals are performing through their interview accounts, and the most appropriate ways of interpreting and engaging with this data.

'Youth'

Given the regularity with which cultural anxieties about reproduction coalesce in the figure of the teenage mother during public policy debates (Carabidine, 2007; Kidger, 2004; Lawson and Rhode, 1993; Luker, 1996; Phoenix, 1991; Ward, 1995; Wilson and Huntingdon, 2006), it is perhaps unsurprising that health professionals' also mobilised this figure to evidence the importance of the service that they provide. In some cases the extreme youth of those seeking abortion was presented as automatic evidence of its necessity, without any further explanation:

I: Um, and like I said I'm just trying to understand what it's like for people to come across it [*abortion*] in their work. So if you could just tell me a bit generally about how you feel about it?

P: Well I feel ok about it. I think it's a very worthwhile service, you know, because we can get young girls from twelve-years-old, thirteen-years-old so thank goodness we've got it! (Nurse 3, female)

As Ward notes, in spite of the comparative rarity of the phenomenon, the case of very young pregnant motherhood - 'babies having babies' (Ward, 1995: 147) - is often mobilised during debates about teenage pregnancy because of its rhetorical power to shock. Related discourses which position adolescents as automatically incapable of engaging in 'adequate' mothering behaviours because of their developmental age have been found to dominate health professionals' accounts of antenatal care provision (Breheny and Stephens, 2007).

However, the majority of health professionals who I interviewed did not rely upon such 'developmental discourses' (Breheny and Stephens, 2007) when legitimating young women's requests for abortion. Instead, motherhood and youth were presented as incompatible on the basis that the former would prevent young women from realising aspirations that would allow them to mother more '*effectively*' in the future. On this basis, health professionals described abortion as a course of action that was rational for pregnant women at a range of life stages including and beyond adolescence:

I mean suppose it was somebody who was kind of young, in the middle of studies um pregnant by accident um really didn't or really couldn't cope with a child at the moment um really wanted a termination just to be, get it out the way and get on with their life [...] That, you know there would be very little discussion, I would ask them whether they wanted to ask, ask me anything more about it. But if they didn't [...] I wouldn't necessarily engage them in any further discussion about it. (GP17, female)

So young women who find themselves perhaps, they may have a stable partner, they may have had casual sex. Often if it's been casual sex and they've found themselves pregnant, drink's been involved so I just don't think it's very helpful to for us to be judgmental, you know, they've found themselves pregnant and it's important to help them out [...] And so these, this group of women is often at an early stage in their career, they just can't see how fitting it um they haven't got the finances to support the child, their relationship isn't stable enough, they're living in rented flat accommodation, they want to have developed their careers to a point where they could then support a child effectively. (GP9, female)

In constructing temporary constraints upon young women's ability to mother, GP9 cites the instability of the heterosexual relationships in which they are engaged, connecting this explicitly to a state of economic uncertainty. This echoes the way in which the significance of a 'stable relationship' was portrayed more generally by interviewees: as evidence of the presence or absence of economic security. Such depictions contrast sharply with Scottish health professionals' articulations of the meaning of heterosexual relationships and pregnancy in the 1970s (Macintyre, 1977), which centred upon concerns with extra-marital

reproduction. However, this difference – as well as the emphasis which contemporary health professionals place on the importance of young women's attaining an education and a career prior to motherhood – makes sense in light of broader changes in UK policy discourse concerning 'young' motherhood. While the figure of the teenage mother has historically been used to signify concerns with extra-marital sex and the breakdown of traditional family structures, the advent of New Labour saw teenage pregnancy reconceptualised in terms of the 'threat' it represented to female participation in paid work (e.g. Carabine, 2007; Wilson and Huntingdon, 2006).

'Age'

When health professionals' utilise women's 'youth' to problematize motherhood, they automatically normalise motherhood that occurs 'later' in life. In some cases, this argument was made explicitly, with interviewees contrasting the example of patients whose youth rendered abortion an 'obvious' solution, with those whose age made its provision problematic:

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 [...] do this now and possibly consider getting pregnant next year or the year after. There often 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. (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 construct older women as more appropriate mothers than younger women. In both extracts, they also define a temporal window of opportunity beyond which the pursuit of motherhood can occur *too late* in a woman's life. Although the reasons for this are left ambiguous in the first extract, in the second quotation, Consultant 4 cites the time-limited nature of female fertility as the basis for her concern.

As Berryman (1991) notes, while the stigmatisation of 'older' motherhood is a relatively recent phenomenon, it now pervades medical literatures on childbirth which characterise

conceptions that take place after age thirty as extremely risky endeavours. This process of stigmatisation is not confined to medical discourse. It is also visible in the media's repeated portrayal of 'selfish' and/or 'ignorant' women who 'delay' childbearing in pursuit of their careers, only to find out that they have left it 'too late' and that they need to be 'rescued' by reproductive technologies in order to conceive (Campbell, 2011; Hadfield et al., 2007; McNeil, 2007; Shaw and Giles, 2009). As McNeil (2007) highlights, such portrayals fail spectacularly to acknowledge women's awareness of processes of social stratification (for example, sexism in the paid workforce), which make it difficult – or indeed impossible – for them to bear children at an earlier point in time. Such discursive erasures were echoed in the accounts of several health professionals who I interviewed, who – like Consultant 4 – portrayed older pregnant women as merely 'ignorant' of the time-limited nature of their fertility.

'Parity'

An important subtext of the preceding sections was that, in delegitimizing motherhood that occurs 'too early' (Phoenix, 1991) or 'too late' (Berryman, 1991) health professionals do not simply 'stratify reproduction' in terms of age. When they raise concerns about agreeing to terminate the pregnancies of women who may subsequently become 'too old' to reproduce, health professionals normalise biological motherhood as something which *should* be achieved (at the correct time) during the female life-course. This process of normalisation also takes place when health professionals suggest that younger pregnant women should be able *temporarily* to pursue aspirations other than motherhood, on the basis that this will enable them to mother more 'effectively' later in life.

The invocation of parity as an independent criterion for questioning or supporting women's requests for abortion was another crucial means by which femininity and maternity became equated. As described previously, the absence of existing children, in combination with the identification of a patient as being 'older', was often problematized by health professionals. In the examples considered above, however, this process of questioning was articulated in relation to older patients' expressed desire for future maternity. In contrast, in other cases, interviewees depicted childlessness (and age) as automatic criteria for questioning their patients' attempts to prevent fertility, in the *absence* of a patient's expression of interest in future maternity. For example, in describing the kinds of issues that she thought it important to talk about with women during consultations about abortion, one nurse suggested:

I mean it's I suppose what you're looking for is things like if somebody's forty and pregnant for the first time do you think it's, you know it's quite right to - you might raise with them well 'Do you realise this might be your only chance of getting pregnant, are you sure this is what you want?' (Nurse 8, female)

To this dataset concerning the normalisation of women's eventual maternity it is important to add a third figure that was routinely invoked by health professionals: that of the 'older' pregnant woman who has already borne children. A crucial feature of the way in which descriptions of this 'type' of patient were mobilised by interviewees was the sympathy with which their requests for abortion were depicted. This process is visible in the following extract, where a gynaecologist cites this situation as a rare instance in which (he claims)

women are ‘genuinely’ emotionally distressed by the fact that they are requesting an abortion:

Um the majority of pregnancies that come via the termination clinic are accidents. So it's just inconvenient [...] There are the odd occasions [...] where women are quite genuinely upset because for instance, they're mid-forties, didn't expect to get pregnant - bang got pregnant. Difficult lifestyle choice, family's complete [...]. (Specialist Registrar 2, male).

In this extract, the abortion requests of women who have already ‘achieved’ motherhood are legitimated through a discourse of suffering, whereby ‘authenticity or genuineness is signalled by the agonistic difficulties of “making tough decisions”, of being seen painfully to ponder over antagonistic positions’ (Brown and Michael, 2002: 261). This interviewee constructs a clear distinction between such decisions and the ‘majority’ of requests for abortion, which he portrays as the result of the ‘inconvenience’ that pregnancy represents for women. As Boyle (1997) points out, such trivialisations of abortion are deeply gendered, simultaneously concealing the work involved in pregnancy/childbirth/mothering and devaluing any aspirations which women may have besides motherhood.

‘Class’

The construction of normative understandings of motherhood in relation to the ‘standard’ of middle-class women’s lives, and the corresponding devaluation of working class women’s mothering, has long been recognised as a process through which patterns of social classification are perpetuated in the UK (Hey and Bradford, 2006; Skeggs, 1997; Tyler, 2008). For example, in her study of family planning clinic practices, Hawkes (1995) illustrates how staff characterised young working class women’s requests for assistance with fertility as ‘irresponsible’ on the grounds that such patients were attempting to become mothers in circumstances other than the middle-class ideal. Likewise, health professionals interviewed for this study also reproduced idealisations of middle-class maternity through their accounts of abortion provision.

An implicit example of this process was highlighted in the preceding discussion, namely, the importance which interviewees ascribed to young women’s attainment of socio-economic stability via education and the establishment of a career and a stable relationship prior to motherhood. However, health professionals also engaged in a far more direct differentiation of the desirability of maternity on the basis of class. For example, at the outset of one interview, GP12 characterised his current practice as being located within ‘A very deprived area’, and listed a variety of reasons why his patients might request an abortion (including drug and alcohol use, involvement in sex work, large family sizes, clinical depression and/or youth) – none of which he problematized. In contrast, when I asked him explicitly if he ever encountered reasons that he found ‘problematic’ he said:

P: Yeah not actually in this practice funnily enough but when I was [*working elsewhere*] 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: ... 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 I think other practitioners would share that sort of slight discomfort. 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, so 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 because you could accommodate this baby, you could look after it, you know'. (GP12, male)

When I went on to explore what had happened to the couple in question, GP12 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. A notable feature of his account is the discursive device via which he positions a middle-class couple's request to end a pregnancy as 'irrational'. He constructs his negative reaction to this request as one that is grounded in professional, rather than personal, criteria by suggesting that it would be shared by a *community* of medical practitioners. He then reinforces the 'objectivity' of his position by contrasting it with what would constitute an 'unfair' judgement, namely one grounded in religion and a *personal* intolerance of abortion.

For the most part, however, health professionals were less confident than GP12 in positioning class as a legitimate criterion for differentiating between patients' requests for abortion:

... there [are] you know, a lot of unemployment, poverty, drug dependence, violence [...] all these things associated [...] with deprivation and, poor educational achievement and so on and 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 [...] 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 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? [...] And I probably, this, my view is probably shared by a lot of people that if the circumstances [...] are likely to be very tough then it makes, you know this enormous decision to have a termination very easy [...]. (GP19, male)

In recent decades, 'the primacy of patient autonomy has emerged as a central theme within medical law' (Jackson, 2000: 468) and an implicit prioritisation of this norm permeates GP19's self-critical account of his 'paternalistic' sympathy for the majority of women in his practice population who request abortion. Nevertheless, while he is undoubtedly less confident than GP12 in describing the socioeconomic circumstances of patients as a relevant issue in abortion decision-making, this hesitancy is ultimately undermined by his

legitimation of his approach as one that is 'probably shared by a lot of people'. A similar process takes place in the following extract:

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 professional or successfully employed middle-class, well-educated patient, mother, woman comes [...] And just wants the termination because it's sort of inconvenient, you know, 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)

As in many of the extracts considered above, women's requests for abortion are positioned as 'irrational' through the depiction of pregnancy and motherhood as trivial matters of 'inconvenience'. However, this account illustrates potentially how processes of gendering intersect with other processes of stratification in the construction of women's 'rationality'. Irrational female subjects, for whom abortion is deemed to be merely 'inconvenient', are 'classed' and 'aged' explicitly through their portrayal as individuals who have established successful careers prior to pregnancy.

In the examples considered thus far, patients' assumed socioeconomic circumstances are used explicitly to 'stratify reproduction'. More commonly however, health professionals constructed a more implicit distinction between the desirability of the fertility of different classes of women. Rather than critiquing middle-class women for requesting abortion, most interviewees' focussed only upon their support for the abortion requests of those living in poverty. This more implicit approach is illustrated by the following extract, where GP8 explains the reasons for her involvement in family planning work:

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 [...] 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 [...] I am just so aware of how unwanted fertility is a cause of such vast morbidity [...] 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? [...] They were costing Scotland six billion pounds a year or something. Now you trace them back and [...] 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. (GP8, female)

Like most of the other health professionals that I interviewed, GP8 stressed that requests for abortion are initiated by patients, who have defined their pregnancies as 'unwanted' before

they reach the consulting room. However, her account illustrates the discursive slippages which this term facilitates. While she begins by emphasising the link between the availability of methods of fertility control and patient health, it quickly becomes clear that the patient health she is referring to is that of the children who are the product of (what she defines as) a failure in fertility control. Moreover, her initial depiction of 'morbidity' in terms of its significance for children and their parents rapidly becomes a discussion of the burden which child 'morbidity' places upon the rest of society.

Conclusion

The preceding analysis has sketched the collective process of 'stratified reproduction' (Colen, 1995; Ginsburg and Rapp, 1995) that emerges from Scottish health professionals' interview accounts of abortion provision. Interviewees mobilise strikingly overlapping sets of demographic characteristics in constructing requests for abortion as particularly 'rational' or 'irrational'. As a consequence, I have suggested, their accounts normalise motherhood as a course of action that should be pursued by some women, rather than others. Repeatedly, abortion (rather than motherhood) is portrayed as understandable for those patients who are young and/or who lack stable relationships and/or who live in poverty, as well as for 'older' women who have already borne children. Conversely, health professionals problematize abortion requests made by 'older', childless and/or middle-class women and thus position motherhood as the 'expected' course of action for these women.

It is important not to oversimplify the ways in which these processes of categorisation are invoked by health professionals. In contrast to Macintyre's finding that health professionals' classifications of single women's pregnancies relied upon a clear set of 'decision rules' (Macintyre, 1977: 73), those interviewed for this study rarely mobilised all of the criteria described above and certainly did not prioritise any of these categories consistently. However, one crucial contribution of this analysis is to illustrate that such categorisations continue to be depicted as a routine and largely unquestioned part of Scottish abortion practice by those who are involved in it. While the significance of marital status as a process of classification has undoubtedly altered in the thirty years since Macintyre conducted her study, the criteria which contemporary interviewees portray as significant otherwise map precisely onto those which health professionals were using to differentiate between pregnant women in the 1970s (Macintyre, 1976).

In considering the implications of this finding, a pivotal issue is signalled by my use of the words 'depicted' and 'portrayed'. The data upon which the preceding analysis is based were obtained during the course of research interviews in which health professionals were attempting to provide 'acceptable' accounts of their practice to me, a professional outsider. The inequalities of gender, class and age which are routinely enacted through health professionals' accounting practices thus provide evidence of the operation of dominant discourses of abortion and motherhood within twenty-first century Britain – rather than direct evidence that contemporary UK abortion practice is *itself* a site of 'stratified reproduction'. In other words, they illustrate the constraints of the terms through which it is possible to construct women who request abortion as rational, reasonable subjects.

Another reason that it is important to be cautious in interpreting the data presented here is that, to accept health professionals' descriptions of their attempts to moderate women's uses of abortion at face value, is to ignore the fact that 'the patient cannot be forced to speak; he or she has the ability to remain silent, or to lie' (Lupton, 2003: 126). Additionally, in cases other than an absolute refusal of their requests women can ignore, and even challenge, health professionals' attempts to impose particular understandings of abortion upon them (for examples, see Lee, 2004).

Nevertheless, in the interests of engaging in adequately 'power-sensitive [...] "conversation"' (Haraway, 1991: 195), health professionals' interview accounts must be situated in relation to the fact that, beyond the context of research interviews, they are gatekeepers to abortion procedures. In view of this, it is vital to reflect on the possibility that the routine processes of categorisation that they engage in during interviews are carried over into their interactions with women who request abortion. Conceptualised in this manner, my interview data both have important implications for women who request abortion and, more broadly, for feminist theorisations of the regulation of abortion provision in the UK.

The data presented here clearly highlight the ongoing significance of feminist critiques of the discourses of femininity which underpin, and are sustained through, current UK abortion law. These discourses reverberate palpably in health professionals' attempts to legitimate their involvement in abortion provision by invoking 'types' of pregnant women whose circumstances can 'reasonably' be said to exempt them from the 'normal' category of 'mother'. They are also reflected in health professionals' depictions of particular women's requests for abortion as irrational, and as in need of regulation via the practices of the health profession.

At the same time, a second implication of the findings presented here is the empirical support which they lend to Smart's argument that feminists should 'avoid the siren call of law' (Smart, 1989: 160) in their attempts to address current processes of oppression. Underpinning Smart's position is a sociological approach to law: while feminists may attempt to shape the terms of legislation, she suggests, the ultimate meaning of any legislation depends upon the particular micro-level processes through which it is enacted. The female subject constructed through the letter of current UK abortion law is undoubtedly gendered in particular ways but is – on the surface – both classless and ageless. In contrast, within health professionals' accounts of abortion practice, 'rational' and 'irrational' female subjects emerge who are differentiated from one another in precisely these terms. Just as these distinctions could not be predicted from the letter of current abortion law, so the manner in which any future legislation is enacted will inevitably be under-determined by the specific contexts of its use.

Crucially, Smart's analysis does not lead her to suggest that feminist theory should abandon critical engagement with law. Instead, she argues, law's 'power to define and disqualify' (Smart, 1989: 164) creates opportunities for feminist theorists to highlight the practices upon which legal definitions of reality depend, and to articulate alternative understandings of the social world. As noted in the introduction, some theorists have developed more nuanced critiques of abortion law which accord with this approach. Both Sheldon (1997) and Boyle

(1997) provide important insights into the social processes through which constructions of the female subject of the law have been, and continue to be, sustained. However, the final and most significant contribution of the analysis presented here is that it has illustrated the limited basis of even these critiques. In concerning themselves exclusively with the ‘gendering’ of women who request abortion, feminist theorisations of the regulation of abortion in the UK have so far failed to engage with processes of ‘stratified reproduction,’ through which some female subjects’ ‘reproductive futures are valued while others are despised’ (Ginsburg and Rapp, 1995: 3). This weakness can perhaps be explained in part by the empirical materials (Parliamentary debates, statutory law, policy documents, and secondary empirical data) in relation to which existing critiques have primarily been developed. Arguably, such data make it impossible to grapple with the micro-level complexities of UK abortion *practice*. This both reiterates the significance of the present paper’s contribution and highlights the importance of developing further empirical work to explore precisely how subjectivities are created and contested within this field of reproductive healthcare.

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Biography

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