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**Memorandum submitted to the House of Commons  
Science and Technology Select Committee inquiry:  
Scientific developments relating to the Abortion Act 1967  
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## **About us**

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For further information on the passage of the 1967 Abortion Act, see the Centre for Contemporary British History witness seminar available at: <http://www.icbh.ac.uk/icbh/witness/abortion/index.html>, or contact Mel Porter for a hard copy version.

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## Summary

This memorandum outlines the historical background to the current state of the law on abortion in Britain as based on the 1967 Abortion Law Reform Act and describes:.

- The various legal enactments under English law affecting abortion
- The historical origins of the requirement for two doctors' signatures and its current effects, notably delays in treatment.
- How moral rather than medical factors often effect doctors judgements on abortion
- Why the illegality of abortion pre- 1967, led to the proliferation of dangerous 'backstreet' abortions or self-administered attempts at termination, as well as the remunerative exploitation of loopholes in the law by a small group of medical practitioners.
- How pre-1967 arguments against abortion were rooted either in a perception of the risk it posed to the women concerned, or to attitudes which associated it with sexual immorality.
- Some suggestions about possible changes to the existing situation In the light of this historical evidence and more recent medical developments

## 1. The historical background to the 1967 Abortion Act

### 1.1 The long perspective

1.1.1 For many centuries women have endeavoured to implement retroactive birth control by means of abortion. Surviving materials from a long range of historical periods and different cultures record numerous substances reputed to be abortifacients and practices believed to induce miscarriage.

1.1.2 The weight of the traditional concept of 'quickening' in defining the remit of the law for many centuries and the persisting conceptualisation by women of the problem as "bringing on" menstruation, suggests that the idea of pregnancy as an absolute, either/or, state, has historically had little purchase on women's own sense of this experience, and this can be seen as late as the mid-twentieth century.

## 1.2. The development of English abortion law

1.2.1 Prior to 1803 in Britain, procuring an abortion was an offence dealt with in the ecclesiastical or common law courts and often assumed (prior to “quickening”) not to be a crime. In 1803 Lord Ellenborough’s “Wounding and Maiming Bill” criminalized the “malicious using of means to procure the miscarriage of women”: after quickening this became a capital offence. The woman herself was not defined as criminal, leaving a loophole for self-abortion.

1.2.2 In 1838 abortion was removed from the tally of capital offences but the quickening distinction dropped.

1.2.3 The 1861 Offences Against the Person Act made the woman herself liable for prosecution and fixed the penalty for procuring abortion as life imprisonment. It included a clause aimed at checking the supply of “noxious things” and “instruments” for procuring miscarriages. The introduction of the concept of an “unlawful” abortion enabled medical practitioners to stake out a claim to clinical judgement concerning “lawful” therapeutic abortion, though this remained contested.

1.2.4 The Infant Life (Preservation) Act of 1929 made a rather ambiguous concession towards terminating a pregnancy to save the mother's life, by stating that the destruction of a child “capable of being born alive” (i.e. the pregnancy had lasted over 28 weeks, then considered the absolute limit of viability) would not be a felony if “done in good faith for the purpose only of preserving the life of the mother”. However, this did not address the question of terminating pregnancies at an earlier stage.

## 1.3. Medical attitudes towards abortion

1.3.1 Some doctors quietly performed therapeutic abortions under the assumption that intervention by a registered medical practitioner to save a woman’s life was “lawful”, but the subject was seldom debated within the profession.

1.3.2 In 1896 counsel to the Royal College of Physicians gave the opinion that “the law does not forbid the procurement of abortion... [if] necessary to save the mother’s life.” However, doctors were continually advised by writers on medico-legal matters and in textbooks of obstetrics, that to prove that the operation was a necessity they should always obtain a second opinion – the two doctors requirement that later became law in the Abortion Act 1967.

1.3.3 Doctors were under pressure from police and the judiciary to obtain information on illegal abortionists by interrogating patients whom they suspected had undergone this

operation. In 1914 the Royal College of Physicians passed a resolution stating the “moral obligation” to respect the patient’s confidence. Without consent a doctor would not be “justified in disclosing information obtained in the course of his professional attendance.” If a woman refused to make a statement, the doctor was under no obligation to take further action except that which was medically necessary.

1.3.4 The extent to which registered medical practitioners performed abortions is impossible to establish. There was a long tradition of allegations concerning a group of specialists for whom it was a remunerative, if covert, area of practice. Some cases involving registered medical practitioners did reach the courts, and it was an offence for which a doctor could be struck off the register.

1.3.5 The findings of a British Medical Association Committee set up to enquire into the medico-legal aspects of abortion were published in 1936, revealing a wide range of opinions and practices among its members, from those who believed that relatively minor complaints such as nervousness and sleeplessness in the woman justified abortion, to those who were reluctant to intervene even when there were obvious life-threatening implications for the continuation of pregnancy.

1.3.6 In Aberdeen during the 1930s, the gynaecologist Dugald Baird took advantage of the differences in Scottish law to perform “social” abortions for disadvantaged women.

1.3.7 In 1938 Aleck Bourne, a gynaecological surgeon, performed an abortion at St Mary's Hospital, London, on a girl of fourteen who had been gang-raped, and then informed the local police, in order to test the law. His successful defence was that continuing the pregnancy seriously threatened her mental health. This established an important case-law precedent under which doctors could legally perform abortions, though medical nervousness persisted about the precise limits of this ruling.

1.3.8 A 1948 case involving Drs Bergmann and Ferguson established that, provided the doctor acted in good faith, it did not matter whether he or she was actually correct about the grounds for abortion.

1.3.9 The provision of abortion by the medical profession remained to a great extent "Law For the Rich" and was not widely available under the National Health Service to any women who needed it, while birth control was still not routinely provided under the NHS (except in cases of severe threat to health from further pregnancies).

**1.3.10 Conclusion: The ambiguous legal status of abortion pre-1967 had an adverse effect on clinical decision-making by the medical profession.**

*1.4. The movement to reform the law*

1.4.1 There were a large number of illegal, ‘backstreet’ abortionists, who only came to the attention of the police and the courts if a woman died or became seriously ill as a result of their treatment. In several cases they were described in court as good neighbours motivated by the urge to assist fellow women. Most individuals could readily locate a backstreet abortionist via local networks of relatives, neighbours, or workmates.

1.4.2 Backstreet abortion or attempts to self-abort caused a significant number of deaths and also contributed substantially to female ill-health. The rise of a birth control movement raised the profile of women’s resort to abortion, and concerns over the high rate of maternal mortality and morbidity also brought the topic into debates about the health of nation.

1.4.3 Following medical and surgical advances since 1861, by the 1920s abortion had become a relatively safe operation if performed under surgical conditions.

1.4.4 High Court Judge, Mr Justice McCardie, speaking from the bench at Leeds in 1931, argued that the law should be amended to explicitly permit doctors to perform abortions, in the light of medical and surgical progress and social changes.

1.4.5 During the 1930s a number of women’s organisations demanded a change in the law to enable women to have safe surgical abortions; and an amnesty for women in prison for performing illegal operations.

1.4.6 In 1936 the Abortion Law Reform Association was established by a group of women on the radical wing of the birth control movement, to campaign for safe abortion to be made available to all women, in consultation with their medical practitioners.

1.4.7 In 1937 the government finally set up an Interdepartmental Committee on Abortion, which heard extensive evidence. Its 1939 report opposed “any broad relaxation of the law”, though its very moderate suggestions were the cause of considerable conflict among the committee.

1.4.8 Several Abortion Bills were put before Parliament by allies of the Abortion Law Reform Association during the 1950s and 1960s, on the grounds that as it stood, the law was causing death and disability for many women, and financial exploitation of others by greedy doctors.

1.4.9 In the early 1960s the thalidomide scandal again brought the topic of abortion into wider public debate.

1.4.10 Providing it was performed in appropriate conditions, the operation had by this time become extremely safe and much safer than childbirth, though this point was not always appreciated by opponents to legalisation.

1.4.11 In 1967 an Abortion Act was finally passed, initially put forward as a Private Member's Bill by Liberal MP David Steel, but granted government time and official drafting assistance. It legalised abortion up to 28 weeks, under medical control where women's physical or mental health was threatened, taking into consideration adverse social conditions. It also incorporated and gave the force of statute law to the existing 'two doctors' provision, essentially codifying existing medical practices. The effects of this requirement are considered below (2.2.7)

## **2. From the 1967 Act to the present**

### 2.1 Responses to the change in the law

2.1.1 The overt inscription of the right to abortion in law provoked a vigorous backlash. Even before the law changed a vociferous anti-abortion lobby sprang up, which agitated for restriction of the law once it had failed to prevent the Bill passing.

2.1.2 It was around this time that opposition to abortion began to be expressed specifically in terms of the 'right to life'. Arguments had previously focussed either on the danger to the woman herself, or the immoral desire to evade parenthood. It is perhaps relevant that contraception was not universally available under the National Health Service until 1974.

2.1.3 As a result of the vehement opposition, the Lane Committee was set up in 1971 to enquire into the working of the Act and concluded that, apart from commercial sector abuses, the Act worked well and as intended. Considerable variations in the availability of abortion in different regions led to the establishment of charitable clinics performing abortions at a low cost, as well as private clinics where the charges were higher.

2.1.4 During the 1980s there were several attempts by MPs, with the support of organisations opposed to the Act, to introduce bills to restrict the law, none of which succeeded in modifying the terms of the 1967 Act.

2.1.5 Attempts by various women's groups, in particular the National Abortion Campaign, to liberalise the system further, for example by enabling abortion on request during the first trimester, and doing away with the 'two doctors' provision, also failed.

2.1.6 Medical personnel are permitted to 'conscientiously object' to assisting with abortions except in cases where the woman's life is seriously threatened. It is reported that some

doctors' own moral (rather than medical) views lead them to refuse or delay abortions that would be in accordance with the existing law and, although abortion is legal, obtaining one under the National Health Service is very much a 'postcode lottery' with distinct inequalities of provision in different areas.

**2.1.7 Conclusion: In many instances, moral rather than medical factors have influenced judgements over abortion.**

*2.2 Medical changes and their legal impact*

2.2.1 As a result of advances in neonatal medicine leading to the survival of very premature babies, a reduced time-limit of 24 weeks was incorporated as Section 37 of the 1990 Human Fertilisation and Embryology Act, except in cases where the woman's life is in danger, continuing pregnancy would involve grave permanent injury to her health, or the child would suffer from severe mental or physical handicap. This time-limit continues to be contested, given continuing progress in neonatology, although very premature babies appear to suffer from significant developmental problems.

2.2.2 There are increasingly sophisticated means of diagnosis available to ascertain the state of the developing foetus, although some, such as ultrasound scans, cannot be reliably used until partway through the second trimester or even later in pregnancy.

2.2.3 There have been developments in medical, rather than surgical, means of abortion, with the advent of the 'abortion pill' (mifepristone and misoprostol), which is an extremely safe and effective method of terminating a pregnancy of less than eight weeks, without the potential dangers of surgical intervention.

2.2.4 Surgical abortion remains considerably safer than childbirth although a number of risks remain, which increase the later in pregnancy it is undertaken.

2.2.5 While various alarmist claims have been made about the long-term physical and mental repercussions for the woman, most of these are not supported by reliable and credible medical evidence, and may even be contradicted by it.

2.2.6 Setting a strict upper limit or restrictions on specific operations would create a number of problems. Many rare but serious conditions, affecting both mother and child, that necessitate termination, only manifest or are diagnosable at a relatively late stage of pregnancy, by which time the effective options are limited.

2.2.7 It has been suggested that the administrative requirement for the signature of two doctors causes undesirable delays. This provision, based in the long-standing pre-1967

concern to protect doctors from prosecution, does not apply to any other lawful operation and it is hard to see who exactly it is protecting now that termination is legal. Given the time constraints involved in abortion and the evidence for the increase in risk the later it is performed, it is not clear what medical purpose this requirement serves. The new developments in medical abortion raise the possibility that these might reasonably be carried out under the supervision of trained nurses or midwives.

**2.2.8 Conclusion: The ‘two doctors provision’, rooted in doctors’ needs to protect themselves prior to the 1967 Abortion Act. is outdated now and causes potentially harmful delays.**

### **3. Conclusions**

3.1 The numbers of abortions performed is now recorded and statistics tabulated, but there are no reliable figures for the numbers of abortions performed under less safe conditions before 1967. The number of abortion-related deaths and the amount of injury to women's health have, however, declined dramatically after 1967.

3.2 It can be argued that the current system creates delays which can lead to adverse outcomes, and these could be significantly ameliorated by enabling the majority of abortions to be performed as early as possible, in particular by non-invasive means such as the abortion pill.

3.3 There is little evidence that abortions would necessarily be any fewer if illegal; only that they would be more dangerous, and the availability of the operation more erratic and inequitable with a considerable likelihood of financial exploitation.

**Lesley A. Hall**

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