

Abortion law reform in Britain 1964-2003:

**A PERSONAL ACCOUNT
by David Paintin**

Hon FFSRH MB ChB FRCOG
Emeritus Reader in Obstetrics and Gynaecology, University of London

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Special thanks are due to my publishers, British Pregnancy Advisory Service, and especially to Ann Furedi, who made this possible. The text has benefited greatly from the editing skills of Jennie Bristow.

But I would not have been able to give so much of my time to the pro-choice cause without the willing support of my wife. For the past 50 years Avril has accepted my frequent absence from home to attend committees or lecture in various part of the United Kingdom, recognising that supporting women's right to regulate their fertility is an essential part of my life. She is my loyal and loving partner – my essential other half.

Foreword.

By Ann Furedi, Chief Executive, British Pregnancy Advisory Service

All women owe a debt to David Paintin for his work with parliamentarians to achieve a liberal abortion law, and with his profession to increase abortion's acceptability and promote innovative good practice. He was one of the group from the Abortion Law Reform Association (ALRA), led by (Lady) Vera Houghton and including Diane Munday, Madeleine Simms and Alastair Service, that supported David Steel (now Lord Steel of Aikwood) during the parliamentary debates that resulted in the Abortion Act of 1967.

The use of early medical abortion is now so widespread that it is easy to forget how so many providers in Britain dismissed 'abortion pill' as impractical when, in 1988, it was first licensed in France. It was David Paintin, and his long-term collaborator, Dilys Cossey – as Chair and Director of the pro-choice charity Birth Control Trust – who organised the first national meeting to draw attention to mifepristone and so established the framework for the following debate and service developments.

As a former Director of Birth Control Trust and current chief executive of British Pregnancy Advisory Service, I owe my own extra debt of gratitude to David Paintin, since he led me to change career, leaving journalism to work in abortion care and joining the group of provider advocates he has inspired.

I first met David in 1990 when, working as a feature writer for a women's glossy magazine, I was commissioned to write a supplement on abortion. Knowing next to nothing, I sought a doctor to talk me through the clinical issues and was told that Mr Paintin, a consultant at London's Samaritan hospital, was the man I should see. He agreed, if I could meet him after his operating list.

And so on an agreed day, at an agreed time, I waited and waited and waited while Mr Paintin completed a very late running list. He explained, by way of apology, that sometimes more time is needed; that an operating list is not like a factory where things can be timed precisely; and that women deserve the best care that can be given, even when other people (such as myself) were inconvenienced. Despite what must have already been an exhausting day, he talked to me for almost three hours and at the end of our discussion produced a folder of notes that he had prepared for me in advance, to help me describe procedures accurately.

It has always mattered to David that everything about abortion – whether it be its history, the law, clinical practice or the reason it is necessary – is told truthfully and accurately, without sensational hype or sanitising.

We see the past through the eyes of the present and so it is easy to interpret what happened then according to how we see things now. The trends that influence contemporary society shape what we look for in history, and this makes it hard not to shape history in the image of 'now'. There has been a strong tendency for this revisionism in our discussions of the abortion law.

Often the story of abortion reform is couched in terms of an emerging women's rights movement battling for sexual liberation but, while it is true that 'free abortion on demand' became a central demand of the Women's Liberation Movement, that was not until the 1970s. The reforms that led to the Abortion Act 1967 were the result of work in earlier times and different ways of thinking by men and women who, like David Paintin, did not see themselves as firebrands or radicals of any description.

Many of the men who worked alongside David were of a very conservative disposition, wishing to end the increasing numbers of abortions provided outside official medical practice and limit its provision to what they saw as proper circumstances. Many of the women, more "blue-stocking" than "bra-burning", were concerned by the inability of poverty-stricken women to raise their children responsibly.

The abortion reform movement, as described by these memoirs, is located by David in the traditions of public health and social responsibility, an increasing orientation of the clinical profession towards a concern with general well-being rather than simply physical infirmity, and, over recent decades, in reliance on 'evidence' and best practice.

David Paintin's memoirs of the struggle for abortion law reform have great value to those of us who want to understand the context in which the current law and regulations have been constructed. Those of us who seek to influence the future need to understand why past was as it was, and why the present is as it is. Aspects of the law and regulations that seem irrational to us today, were almost always introduced with specific intent. A key question is whether the intentions of the sixties remain valid half a century on.

David Paintin always describes his contribute to abortion law reform as 'modest' – which is itself an especially modest assertion. This book is, itself, a huge contribution to our understanding of the past and we are grateful to David for allowing us to publish it.

Ann Furedi
April 2015

Chapter 1. Forming an opinion, 1955 – 1963

The provision of legal abortion slowly became the central interest of my professional life, an interest that began when I became a junior member of Professor Dugald Baird's team in Aberdeen. Induced abortion had been mentioned during my undergraduate course as necessary only on rare occasions when serious illness threatened the life of a pregnant woman: the term "abortion", qualified by "threatened", "incomplete" or "septic", was used whenever woman had abdominal pain and uterine bleeding in the first half of pregnancy. As a student, I assumed that these terms usually referred to the miscarriage of a wanted pregnancy and that deliberately induced abortion was uncommon. This was discussed only in forensic medicine where the emphasis was on the danger to the woman, particularly from infection, poisoning and injury to the uterus, and the importance of obtaining a dying declaration if the woman seemed unlikely to survive.

As a gynaecological house officer at the Bristol General Hospital in 1955, when on call for emergencies (every third day), I usually admitted between one and three women with incomplete abortions – representing, probably, about 14 to 21 each week from the central and southern half of Bristol, the catchment area of the General Hospital. It is likely that a similar number from the northern suburbs were treated at Southmead Hospital. Few of these women had serious infection and none had obvious genital tract injury. Some were distressed by the loss of their pregnancy and were clearly having a miscarriage but no attempts were made to assess the woman's social circumstances or whether the pregnancy had been unwanted – medical and nursing staff focused on managing the immediate clinical situation, and showed no awareness that possibly 50 per cent of these women had had their abortion induced. No enquiries were made about their use of contraception and no attempts made to refer the woman for family planning advice.

Dugald Baird (1899–1986) was Regius Professor of Obstetrics & Gynaecology in Aberdeen from 1937 to 1964. He received a knighthood in 1959. I joined Professor Baird's team in Aberdeen in September 1956 and was surprised to find that most gynaecological operating lists included at least one termination of pregnancy, often at gestations of 14 to 18 weeks – abdominal hysterotomy was combined with sterilisation by tubal ligation. These women all had several children and were usually from the fishing communities living in the most deprived districts of the city.

Professor Baird explained that these were women who felt they had all the children they could cope with and that many of them would have resorted to unsafe illegal abortion if he had not been willing to help. They had great difficulty in preventing unwanted pregnancy. Typically the husband was a fisherman on a trawler and at sea for a week or so; the time of his return was unpredictable and was sometimes during the night; the men were paid at the end of each trip and could be drunk by the time they reached home; sex was often a priority and barrier contraception, even if available, was impracticable unless he was unusually cooperative. The Aberdeen City Public Health Department had been providing a free family planning service since the late 1930s but the only methods – diaphragms and condoms – were relatively ineffective and almost impossible to use when verbal communication about sexual feelings and the risk of unwanted pregnancy was inhibited or non-existent.

Dugald Baird had become aware of the effect of socioeconomic deprivation on health when he was a medical student and junior doctor in Glasgow from 1920-36. In particular, he was aware that people from the poorest homes were stunted in height, and had the largest families and the highest rates for infant and maternal mortality. He made the investigation of the effects of social class on obstetric outcomes the main theme of his research when he was appointed Regius Professor in Aberdeen in 1937.

Professor Baird organised a maternity records system that included every woman having a baby in Aberdeen City, whether at home, in hospital or a private nursing home. Since the late 1940s, the data had been extracted by special clerks and coded on 12-column Hollerith punched cards. In 1945, he started to offer post-partum sterilisation to women who had had four or more children and, sometime later, let local family doctors know that he would be prepared to terminate the pregnancies of women with several children and who felt they could not cope with another addition to their families. By 1956, in favourable contrast to other Scottish cities such as Dundee and Glasgow, family size for Aberdeen women with unskilled husbands had fallen significantly and there had been a progressive fall in perinatal and infant mortality.

Dugald Baird believed that he was acting within the law in terminating these pregnancies. Before 1967, Scottish common law regarded induced abortion as a crime but the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929 applied only in England and Wales (with similar statutes in force in Northern Ireland); no case had used the defence that abortion was medically necessary. Dugald Baird had discussed medically induced abortion with the local procurator fiscal and had been told that a gynaecologist of good repute would not be prosecuted when he considered that the pregnancy posed a serious threat to the woman's health.

Dugald Baird's research had led him to understand that health results from the interaction of physical, mental and socioeconomic factors. He had no moral concerns about the destruction of the foetus and was sure he was right to terminate an unwanted pregnancy when a woman already had as many children as she wanted and would otherwise seek a dangerous illegal abortion. He also regarded her as deserving because of the difficulty many couples have in using contraception. He was more selective when women with smaller families or better social circumstances requested termination: there had to be other pressing reasons such as stress due to poverty, a violent partner, poor mental health or the need to provide care for an existing, seriously disabled child.

Few young single women in secure circumstances had their pregnancies terminated in Aberdeen at that time. I do not know how many requests for termination were refused because I did not ask – outpatient referrals from general practitioners were seen only by consultant staff.

I was persuaded by Dugald Baird's reasons for providing safe abortion and agreed with him that the moral value of the foetus was small when compared with the health and wellbeing of the woman and her children. Years later, I realised that he had been influenced as a young man by the eugenic ideas expressed by intellectuals such as Bertrand Russell and Julian Huxley. As a gynaecologist, his

concern was the needs of individual women with unwanted pregnancies but, as a social scientist, his objective was to improve the health of the community as a whole.

Dugald Baird had also been influenced by Sir Eardley Holland (1879-1967), consultant gynaecologist at the London Hospital and president of the Royal College of Obstetricians and Gynaecologists (RCOG), who in the late 1920s had spoken about the abortions he had provided both for the poor women of the East End of London and for the patients who consulted him in Harley St¹. Most of the abortions at the London Hospital itself were because of medical conditions that would have threatened the life of the woman if the pregnancy had continued. Many of the women seen privately also had a serious medical problem but some had social reasons for not going on with the pregnancy, indications that he classified as “debatable”; Sir Thomas Watts Eden of St Thomas’s Hospital supported Sir Eardley and said his practice was similar. I found out some years later that Sir Eardley had been a member of the Medico-Legal Council of the Abortion Law Reform Association (ALRA) since the 1930s (as had Dugald Baird).

During the two-thirds of each year when I was gynaecological registrar in Aberdeen, I performed about 20 terminations by hysterotomy and sterilisation and an occasional first trimester abortion by dilatation and curettage.

Providing induced abortion in London, 1963 – 1967

Professor Ian MacGillivray was already terminating pregnancies for social reasons for two or three local women a month when I joined his unit at St Mary’s in 1963. He too had worked with Dugald Baird and had been convinced that this was a service his unit should provide; as his lecturer I was pleased to follow his lead, as was my co-lecturer Doreen Rothman². All the women had to have their request for termination supported in writing by the referring doctor, usually their general practitioner (GP) but sometimes a psychiatrist. Terminations provided in this way were virtually unheard of in the National Health Service (NHS) in London, but obtainable quite easily in private practice where a small number of gynaecologists specialised in such cases and charged high fees.

The Offences Against the Person Act (OAPA) of 1861 made the “unlawful” induction of abortion a criminal offence but did not define when it would actually be lawful. Legal cases had established that abortion was lawful if the life or health of the woman was at serious risk and it had become good practice only to terminate such a pregnancy when this was supported by the honest written opinions of two doctors. The gynaecological establishment in general took a narrow view of the law and terminated very few pregnancies, mainly because they considered that the destruction of the foetus could be justified morally only when the woman’s life was at risk but also because it was uncertain if case law would give sufficient protection from prosecution if wider indications were accepted.

The NHS gynaecologists at St Mary’s and the Samaritan Hospitals did not support Ian MacGillivray’s liberal views but took no steps to prevent his abortion work. Indeed, I discovered years later that

¹ Holland E. ‘Discussion of the medical indications for the induction of abortion and premature labour.’ *Transactions of the Medical Society of London* 1929; 52: 284-300.

² Doreen Rothman left our department to become a senior medical officer at the Department of Health. She was the medical secretary to the Lane Committee’s Enquiry into the Working of the Abortion Act and subsequently represented the Department of Health during the committee stages of the series of private members’ Bills that attempted to restrict the abortion law during the 1970s. She was awarded an OBE in 1975, and died in the early 1980s. Her backroom sympathy for the Abortion Act is a regrettable omission from the history of abortion law reform.

one of the older gynaecologists who had his obstetric beds at another London teaching hospital did provide abortion occasionally for his private patients, although he was highly critical of Academic Unit provision in the NHS at the Samaritan Hospital.

At the end of 1965, Ian MacGillivray left St Mary's to become Regius Professor in Aberdeen on the retirement of Sir Dugald Baird, and the senior lecturer, Denis Davey, left to become professor at Groote Schuur Hospital in Cape Town. I was promoted to senior lecturer and honorary consultant. Peter Huntingford was selected as the next professor. At that time, Peter was ambivalent about the need for abortion law reform and uneasy that Doreen Rothman and I were providing a service for local women – I was able to continue to do so only because of my new status as an honorary NHS consultant.

It was not until the late 1960s that Peter became a militant supporter of “A woman's right to choose”. His change of mind followed a visit with a World Health Organisation (WHO) working party to abortion services in Yugoslavia and a subsequent visit to California where he met Harvey Karman³. He returned from the USA full of enthusiasm for early termination by vacuum extraction: he persuaded Rockets of Watford to manufacture and distribute the cannula as a sterile disposable in a range of sizes. Vacuum aspiration by Karman cannula rapidly became the standard method in the first trimester. Peter and I worked in parallel rather than together – there was no suggestion from him that we should organise a departmental abortion service, and we each saw and treated our own patients.

Becoming a member of the Abortion Reform Association (ALRA)

I joined ALRA and first attended the Annual General Meeting in 1964. ALRA was founded in 1936 and might have achieved a liberal abortion law in the early 1940s if war with Germany had not supervened. During the 1930s there had been an increasing awareness of the need for abortion law reform in several European countries, including Britain. More permissive laws had come into force in Sweden, Denmark and Norway. In Britain in 1939, the Joint Home Office/Ministry of Health Committee (the Birkett Committee) had recommended that medical abortion should be available to a woman if “the continuance of the pregnancy is likely to endanger her life or seriously impair her health”.

The aging Executive Committee of ALRA kept the organisation running during the war years but by 1945 had lost the energy necessary to push for change. The organisation had been invigorated in 1963 by the election to the executive committee of Diane Munday. Diane had been motivated by her own recent experience of a legal “Harley St” abortion. She encouraged Madeleine Simms to join her and they persuaded Vera Houghton to put herself forward as chairman. Dilys Cossey was employed subsequently to do secretarial work. The displaced officers of the society were surprised by this takeover by a younger generation, but failed to be re-elected to office.

Madeleine was secretary of the newsletter of the Fabian Society and a gifted writer of letters to the

³Harvey Karman (1924-2008), a Californian psychologist, controversial pro-choice activist, and the inventor of the flexible suction cannula.

press – she initiated and edited the ALRA newsletter⁴. Vera was about 10 years older than the others and been the executive secretary of the International Planned Parenthood Federation (IPPF) for its first 10 years. She was married to Douglas Houghton, a Labour MP since 1949, a strong supporter of abortion law reform and, in 1964, a minister in the Labour Government with a deep knowledge of parliamentary procedure and many political contacts; he became Life Peer in 1974. Vera's clear thinking and organising ability were crucial to the passing of the Abortion Act. In this she was ably assisted by Dilys, who remained deeply involved in the politics of fertility control: she chaired the Family Planning Association (fpa) in the 1980s and Brook Advisory Centres in the 1990s.

Diane Munday was not only an influential member of the Executive for many years but also an effective public speaker and, in this role, did more than any other ALRA member to explain the need for legal abortion in television and radio interviews and at public meetings throughout the country. Diane was general secretary of ALRA from 1970; her national influence increased when, in 1974, she became press and publicity officer for Birmingham Pregnancy Advisory Service.

Other ALRA members had an essential role during the parliamentary debates on abortion. Among these was Alasdair Service, a young publisher and writer who had joined ALRA after hearing Diane speak when he accompanied his wife, Louise (already a member), to a meeting in North London. Personable and articulate, Alasdair spent much time at Westminster lobbying MPs and peers. Another influential member was Dr Malcolm Potts, a Cambridge reproductive scientist. In 1969, Malcolm became the first Medical Director of IPPF, and went on to direct Family Health International in Chapel Hill North Carolina; he then became the founding Director of the Bixby Center for Population, Health, and Sustainability at the University of California at Berkeley. Professor Glanville Williams, Quain Professor of Jurisprudence at Cambridge, was a member of the Medico-Legal Council of ALRA, and author of *The Sanctity of Life and the Criminal Law* (1958): he was the draftsman of Lord Silkin's Bill and provided legal advice throughout the parliamentary debates.

The Executive Committee of ALRA directed policy throughout the parliamentary debates of 1965-68. They were guided by objectives that had evolved since ALRA was founded. When necessary they consulted members of the ALRA Medico-Legal Council, an invited group of doctors or lawyers who were willing to have their support for ALRA known to the public. This was usually by an exchange of letters with the chairman but, occasionally, involved going with members of the Executive to meetings with politicians and the media.

Relationships were much more formal in the 1960s. Titles – Mrs, Mr, Dr – were used in committee and in correspondence and first names only on informal occasions with people of similar age who one knew well. I was not on first names terms with Vera Houghton until sometime in the 1970s.

⁴Madeleine Simms was co-author of the definitive account of how the Abortion Act became law (Simms M, Hindell K. *Abortion Law Reformed*. 1971, London: Peter Owen.

Chapter 2. Lord Silkin's Medical Termination of Pregnancy Bills, 1965 – 1966

I became directly involved in the work of ALRA in September 1965 when I accepted Mrs Houghton's invitation to go with her, Mrs Munday and Professor Williams to meet Lord Silkin in his office in Storey's Gate, Westminster, to discuss his proposal to introduce a private member's Bill to reform the abortion law in the House of Lords.

I was probably chosen because ALRA had very few consultant gynaecologist members in London and I had had a long conversation with Diane Munday at the previous Annual General Meeting (AGM). I was made a member of the Medico-Legal Council a few weeks later. Peter Diggory, a consultant gynaecologist since 1963 at Kingston upon Thames (and Harley St), was invited to join towards the end of the debates on Lord Silkin's Bill.

Lord Silkin's First Bill

Lord Silkin's support for abortion law reform had been triggered by a conversation with an older ALRA member, Mrs Scholefield Allen⁵, who had arranged for him to be sent a collection of ALRA publications. He had no in-depth knowledge of induced abortion but was eager to learn – remarkable in a 75-year old solicitor who had been a Labour MP in the Attlee Government, the first Minister of Town and Country Planning and an active peer since 1955. He said he would use a draft from Professor Williams as a basis for his Bill.

Lord Silkin's principal interest was in clarifying the law so that doctors would feel secure from prosecution and extending it to cover pregnancies resulting from sexual offences and those when the foetus was likely to be severely abnormal (he had the thalidomide disaster of 1961 in mind). He appreciated the need to widen that law to permit abortion for social reasons but was uncertain how this might be achieved: he regarded the social clause drafted by Professor Williams as flawed, and only as starting point for the parliamentary debate. Lord Silkin's final comment was the Bill would not apply to Northern Ireland. It was agreed that Lord Silkin would discuss the details of the Bill with Professor Williams and Mrs Houghton.

The Second Reading of Lord Silkin's Bill⁷ was on 30 November 1965. Mrs Houghton, Mrs Munday, Professor Williams and I sat at the front of the public gallery for the whole five and a half hours. The principal clauses were:

- 1. It shall be lawful for a registered medical practitioner to terminate pregnancy in good faith -**
 - (a) — in the belief that if the pregnancy were allowed to continue there would be a grave risk of the patient's death or of serious injury to her physical or mental health resulting either from giving birth to the child or from the strain of caring for it, or**
 - (b) — in the belief that if the pregnancy were allowed to continue there would be a grave**

⁵ Wife of Sydney Scholefield Allen, QC, Member of Parliament for Crewe 1945-74 (Labour).

⁶ Lord Silkin and Professor Williams, and probably Mrs Houghton, knew that, since 1921, it had been accepted that the Westminster Parliament would pass legislation applicable in Northern Ireland only if it had been established it would be acceptable to the Northern Ireland Assembly.

⁷ HL Deb 30 November 1965 vol 270 cc1139-24

risk of the child being born grossly deformed or with other serious physical or mental abnormality, or

- (c) — in the belief that the health of the patient or the social condition (including the social conditions of her existing children) make her unsuitable to assume the legal and moral responsibility for caring for a child or another child, as the case may be, or**
- (d) — in the belief that the patient became pregnant as the result of intercourse which was an offence under sections one to eleven inclusive of the Sexual Offences act 1956 or that the patient is a person of unsound mind.**

2. A termination under paragraph (c) or (d) of section 1. of this Act shall not be performed after the end of the sixteenth week of pregnancy.

Lord Silkin began by explaining the uncertainty doctors had in interpreting existing case law on abortion and the need for some widening of when abortion would be legal. He emphasised the frequency and dangers of illegal abortion. His low-key presentation implied that he was expecting criticism and hoped that revision of the Bill would enable a consensus of support. He acknowledged the help of ALRA in drafting the Bill and said:

The Bill before the House is designed, first, to make the law on abortion clear and certain, so that no medical practitioner need fear prosecution if in good faith he carries out an abortion on a patient whose circumstances fall within the provisions of this Bill. I want to make it clear at this stage that the conditions in the Bill are carefully circumscribed, and it is not a general licence to a medical practitioner to carry out abortions on anybody who desires an abortion. There are considerable categories of women who might desire an abortion but would not be able to get it under this Bill. Nor does the Bill compel any medical practitioner to carry out an abortion. If he has a conscientious objection to doing so, he is under no obligation at all to carry out an abortion at the request of a patient. Secondly, the Bill has for its purpose to extend the cases where abortion is legal to the three kinds of cases mentioned in paragraphs (b) (c) and (d) of Clause 1 of the Bill.

He went on to explain the purpose of each of the clauses.

Lord Dilhorne, recently Lord Chancellor (formerly Sir Manningham Buller QC), spoke next. His manner was adversarial. He was “in favour of a Bill on this subject” but condemned the present Bill as “badly drawn, wholly inadequate and most disappointing”. He presented his problems with each clause. He accepted 1(a) as necessary to confirm existing case law but felt it would be interpreted too broadly if not more tightly worded – he feared that this would lead to an undesirable increase in abortions as had happened in 1956 in Denmark, where he claimed that many illegal abortions had continued even though legal abortion had been made more available.

Lord Dilhorne supported the concept of preventing the birth of children with abnormalities so

severe that they could not live a reasonable life, but questioned whether this could be predicted with sufficient certainty during pregnancy. He rejected termination of pregnancy following sexual assault because this would make the doctor the judge of whether the assault had occurred, as the abortion would have to be done before the case came to court. He did not accept that abortion was appropriate when social circumstances made a woman unsuitable to be a mother, arguing that the child could be removed from her care at birth; and he said the Bill should require the need for abortion to be certified by two doctors and all terminations to be notified to the local health authority.

Lord Dilhorne also opposed clause 3, which transferred the onus of proving “good faith” to the Crown, saying that such proof was so difficult that abortion would become too available. Rather surprisingly, he opposed the suggested limit of 16 weeks for some abortions, saying it was illogical that an extra week of pregnancy should make an action criminal.

Lord Stonham (Under-Secretary of State at the Home Office) supported clarification of the law and the need for the Bill to be revised. He announced that the Government was neutral on this topic and would allow a free vote but made clear his personal opposition.

Lord Denning questioned the scope of the Bill, saying:

I am afraid that they [1(a) and 1(b)] go far beyond the medical sphere. As to belief that the social conditions in which she is living may make a woman unsuitable to assume responsibility for a child, that ceases to be a medical question and becomes a social one. Is it right to entrust that question to any body of persons to decide? It may mean opening a gap through which all the world may go.

He agreed with Lord Dilhorne that lack of “good faith” was very difficult to prove.

The medically qualified peers, Lady Summerskill, Lord Braine, Lord Amulree and Viscount Waverly, gave the Bill qualified support; Lady Summerskill in the most vehement speech of the afternoon. All had reservations about the wording, were concerned that interpretation would be too liberal, and suggested that social support would often be preferable to abortion. Lord Braine shared Lord Dilhorne’s view that certification should be required from two doctors. Lord Amulree was “... shocked that this Bill should make it possible for every registered medical practitioner to perform an abortion himself”. Rather, certification should be by the woman’s general practitioner (GP) and by the consultant gynaecologist who performed the operation.

In all, 26 peers spoke. Several who opposed the Bill on religious or moral grounds introduced an amendment that would have prevented the Bill proceeding further. This was defeated: Content 8, Not content 67. Then, after a brief summary by Lord Silkin, the Bill passed its Second Reading by assent. The debate ended at about 9pm and had lasted almost 6 hours.

Planning amendments for the Committee Stage

Lord Silkin spent the autumn of 1965 developing amendments for the Committee Stage. He consulted fellow peers, the British Medical Association (BMA), and the Royal College of Obstetricians and Gynaecologists (RCOG), and invited written comments from the members of the ALRA Medico-Legal Council (including Professor Glanville Williams, Sir Dugald Baird, Professor Ian MacGillivray, Professor Douglas Hubble and Professor WCW (Will) Nixon)⁸. He also considered reports from the Church of England and the Medical Protection Society.

The most relevant comment was from Dugald Baird (retired Professor of Midwifery, Aberdeen):

... this Bill is a great improvement on any of the others.

In 1(a) I should prefer to omit the adjectives “grave” and “serious”, so that doctors would be in no doubt that it would be legal to terminate pregnancy in cases where the advent of another child would cause serious distress and hardship without having to prove “serious’ injury to her physical or mental health. In the stress and strain of living both physical and mental factors are very closely inter-related and both connected with social conditions generally. Many women who seek relief in these circumstances are good mothers and highly intelligent and do not come into the category catered for in 1(c).

Douglas Hubble (Professor of Child Health, Birmingham) wrote:

I have always hoped the Bill eventually accepted would include the legalisation of abortion for social reasons, although I agree that it is good tactics for ALRA to stick to its present objectives. However, it seems that public opinion is changing so rapidly in this country that if a Labour Government persists for a few years we might get a really liberal Bill on the Statute Book.

Will Nixon (Professor of Obstetrics and Gynaecology at University College London) wrote:

Section 2 limits termination to the end of the 16th weeks of pregnancy. From this it would seem so far as 1a and b are concerned, there is no limit for the duration of pregnancy during which termination can be performed. You will remember the figures I gave you when we went to see the Home Secretary which showed that in the Scandinavian countries the mortality for the operation was much higher “because they perform it after the 12th week” than in the Iron Curtain countries who limit the operation to the 12th week.

We met in Lord Silkin’s office in the Palace of Westminster on 13 December 1965. The meeting had been planned to review his amendments for the Committee Stage but, in the meantime, there had been an exchange of letters between Lord Silkin and Professor Williams that had led Professor Williams to write to Mrs Houghton: “I have the gravest doubts about how things are going”. Professor Williams had been particularly irritated by Lord Silkin having said in the Chamber that the Bill was

⁸ See the Paintin papers, to be held in the Wellcome Trust archives.

“unsatisfactory in many respects”, and by his proposal that the Committee Stage should be delayed until the BMA had responded to his request for further comments on specific points. Professor Williams felt that ALRA should consider dissociating itself from the Bill.

The meeting was surprisingly amicable. It was agreed that a further response from the BMA was unlikely to be helpful, that Lord Silkin’s suggested amendments were appropriate, and that the Committee Stage should proceed. We felt that any parliamentary debate would be valuable in bringing reform of the law to the attention of the public, even if the outcome did not extend the provision as fully as we believed necessary.

There was some additional discussion of the wording of the social clause: I had written to Mrs Houghton on 9 December that:

I think we should encourage Lord Silkin to continue with his Bill even if it merely clarifies the present situation and reassures the gynaecologist. I think it is important that the wording of the Bill should suggest a broad concept of health – health being a condition of physical, mental and social wellbeing, rather than a mere absence of disease.

I hoped that a social clause, based on the preservation of health rather than inadequate motherhood, would enable abortion at the discretion of the doctor but the others, although interested in the idea, did not agree, probably because the existing clause had been central to ALRA policy for so many years.

Lord Silkin proposed to meet the major criticisms made during the Second Reading by the following amendments:

Leave out clause 1 (a to d) and insert:

1. Subject to the provisions of this Act it shall be lawful for a registered medical practitioner, after obtaining a concurring opinion from a second registered medical practitioner, to terminate a pregnancy, provided that such two registered medical practitioners certify in writing that in their opinion the termination of the pregnancy is necessary on the ground that -

- (a) — the continuance of the pregnancy would involve serious risk to the life or grave injury to the health whether physical or mental of the pregnant woman whether before at or after the birth of the child; or**
 - (b) — the child if born would be likely to suffer from such physical or mental abnormalities as to deprive it of any prospect of reasonable enjoyment of life; or**
 - (c) — the pregnant woman is or will be physically or mentally inadequate to be the mother of a child or of another child as the case may be; or**
 - (d) — the pregnant woman is a defective or became pregnant when under the age of sixteen**
-

or as the result of rape or of intercourse which was an offence under section 128 of the Mental Health Act 1959 or section 97 of the Mental Health (Scotland) Act 1960 (relating to sexual intercourse with patients).

[At the insistence of the medical and legal peers, the BMA and the RCOG the Bill now required two doctors to certify the legality of the abortion; re-worded (c) toned down the concept of the unsuitable mother who lacked social or moral responsibility; (d) had been revised to incorporate changes in the law on sexual assault.]

Leave out clause 2 and insert the following new clauses:

- (1) In determining the matters referred to in sections 1(a),(b) or (c) of this Act the registered medical practitioners may take into consideration the total environment actual or foreseeable (of the pregnant woman.**
- (2) In a termination under section 1 of this Act performed on the ground of rape shall require a certificate of a registered medical practitioner but no such certificate shall be given unless the woman who alleges she has been raped has consulted the said registered medical practitioner as soon as practicable after the alleged rape and the was then medical evidence of sexual assault upon her.**
- (3) Before terminating a pregnancy a registered medical practitioner performing the termination shall obtain the consent in writing of the pregnant woman or, if under sixteen years of age, of one of her parents or her guardian.**

[New (1) made clear that health is affected by a woman's circumstances and was suggested in a draft Bill proposed in *Abortion: an Ethical Discussion* from the Church of England Board for Social Responsibility. New sub-clause (2) attempted to meet the legal peers' point that the courts rather than doctors must decide if a sexual offence has been committed.]

After clause 2 insert:

- (1) The registered medical practitioner who terminates a pregnancy shall within seven days thereof notify the Chief Medical Officer of the Ministry of Health in a form to be prescribed by the Minister and containing such information as he may prescribe of such termination.**
 - (2) The information contained in such notification shall not be made public or divulged by the Chief Medical Officer of the Ministry of Health to any person other than a police officer duly authorised to obtain such information.**
 - (3) Failure to comply with the requirements of subsection (1) of this section shall be punishable.....etc.**
-

[Legal experts advised that notification was necessary to provide evidence that a termination was legal]

Leave out clauses 3 and 4 and insert the following new clauses:

(3) The Infant Life (Preservation) Act 1929 shall be read as subject to the provision of this Act.

[Suggested by Glanville Williams; in effect, defines the gestational limit for termination of pregnancy as “when the child is capable of being born alive”, which in the IL(P)A is regarded as self-evident when the gestation is 28 or more weeks]

(5) Provides definitions for “defective” and “registered medical practitioner”

These amendments were approved. The ALRA members, including Professor Williams, were reassured that Lord Silkin really did want to extend the law and we confirmed our support.

The Lords met as a Committee of the Whole House on six occasions: 1, 6, 7, 22 and 28 February and 7 March 1966⁹. Most of the time was occupied discussing blocking amendments and changes that would have restricted the scope of the legislation. There was considerable rearrangement and rewording of many of the clauses. There were several successful amendments. The significant changes were:

- two doctors to certify that the termination was legal;
- new sub-clauses 1 (a and b) were accepted;
- new 1(c) (the revised social clause) and 1(d) (termination following sexual assault) were deleted;
- the phrase “to take into consideration the total environment actual or foreseeable of the pregnant woman” was deleted and a new clause inserted that read:

(3)...a registered medical practitioner may take into account such circumstances, whether past, present or prospective, as are in his opinion relevant to his patient’s physical or mental health.

- terminations to be certified two doctors (except when immediately necessary to save the life of the woman);
- all terminations to be notified to the Chief Medical Officer at the Department of Health and access to notification allowed to a senior policemen when investigating an alleged illegal abortion;
- a new 1(2)(a) required that “the treatment must be carried out by or under the supervision of a consultant holding an appointment under a hospital board, being an appointment involving the practice of gynaecology”;

⁹HL Deb 01 February 1966 vol 272 cc284-355

- the abortion to be performed only in an NHS hospital or a place approved by the Secretary of State for Health;
- the amendment that the Infant Life (Preservation) Act (ILPA) 1929 should be cited to provide a gestational limit was accepted without debate, probably because it is a statute that applies in any pregnancy in which “the child is capable of being born alive” and makes any procedure in which a living foetus is deliberately destroyed a felony after 28 or more weeks.

The fall of the Bill and an analysis of its shortcomings

Agreement had been reached on all the amendments when the parliamentary session ended prematurely. Consequently, there was no Report Stage and the Bill fell. (The Wilson Government, elected in 1963 with a majority of 4, had called a General Election to test public support and was returned with a majority 96).

In effect, the amended Bill defined when abortion would be legal, but within narrow limits, and would not have extended the law sufficiently to meet the ALRA’s principal objective of eliminating the need for illegal abortion. I supported the requirement for a consultant gynaecologist to be or to supervise the operator. This was accepted reluctantly by the others in the ALRA group. I also proposed that the consultant should work in the NHS and should one of the signatories. This was strongly opposed by Peter Diggory: he felt NHS gynaecologists would remain very conservative in their interpretation of the law and that wider interpretation would be possible only through private care. He proved to have been right in this.

This outcome was very disappointing for ALRA but Lord Silkin was surprisingly optimistic. He was now deeply committed to changing the abortion law and said he would introduce a new and revised Bill when the new parliament opened in April.

My thinking at this time is shown by my response to a letter in *The Lancet* from a Birmingham gynaecologist, Wilfred Mills, in which he stated that the existing case law on abortion was adequate and reform unnecessary. Mills was a supporter of Professor Hugh McLaren, a vehement opponent of abortion law reform. My letter¹⁰ read:

Mr Wilfred Mills was right when he stated (5 February, p. 355) that the present law permits the medical profession to perform all necessary abortions. But I think he was wrong when he inferred that there was no need for reform of the law. At present the law seems uncertain and threatening, and consequently is frequently interpreted narrowly; health, in the context of a request for abortion, usually means an absence of grave physical or mental disease that will be aggravated by the pregnancy. In other situations in medicine it has become usual to consider health positively as a state of wellbeing, rather than as non-illness. Thus a pregnant woman living in one room with an inconsiderate husband and four children often has her request for abortion refused because she is merely tired and unhappy and cannot be labelled with a diagnosis such as “depression” or “renal failure”. Such a woman is not in a state of

¹⁰*Lancet*, 19 February 1966, (i), p.482

positive health and her pregnancy will cause further serious deterioration.

The unpleasantness gynaecologists associate with abortion is mainly due to the attitudes of their teachers and the aura of illegality that surrounds the subject. Interrupting a normal pregnancy is always done with regret, but this can be tolerated provided the surgeon and his assistants believe that the operation is justified. Reform of the law, as proposed by Lord Silkin, would encourage women made miserable by unwanted pregnancy to request abortion and would reassure doctors that abortion could be performed in deserving cases with safety from prosecution. The attitude of the medical profession would not change overnight but a liberal move would have been made that would ultimately improve the health of many women.

I am, etc, D.B. Paintin.

Lord Silkin's Second Bill

Lord Silkin began his consultations immediately, with the medical organisations, Professor Williams, the ALRA Executive and members of the Medico-Legal Council. The social clause was the focus of the discussions. In a letter to Mrs Houghton of 6 April, I suggested this could read:

– the economic or social circumstances of the woman are such that the continuation of the pregnancy would result in her experiencing undue hardship.

But, I continued:

Obviously, this is much too wide to attract useful support [i.e. in parliament] but I find the concept of “undue hardship” valuable in assessing the women I see. I suppose Dr Williams's clause about the circumstances of the woman's existing children may be the widest that can be introduced at present. Mental health will have to continue to be our excuse in the cases where social factors are primary.

In a letter to Mrs Houghton, Ian MacGillivray emphasised that a wide variety of women needed help – not just the married and socially deprived. He wrote on 21 April 1966 that:

One point I would like to comment on now is the statement by Professor Williams that most abortions are requested by married women with several children. I would like to point out that 25 per cent of all first pregnancies in this country are prenuptial conceptions and presumably quite a proportion of the marriages are of the “shot-gun” type. Furthermore, 4 per cent of all babies in this country are illegitimate. Presumably if there was a liberalisation of the abortion law less of these illegitimate pregnancies would be allowed to continue.

As I see it, there are four groups of women to be considered –

- (1) Women who are quite clearly and severely mentally or physically ill;
- (2) Women with several children who have partly medical but mostly social reasons and do not wish to have another child;
- (3) Women who are likely to produce an abnormal child;
- (4) The unmarried woman.

The fourth group is a large one, I feel, and the one which is most difficult but is nonetheless deserving of treatment.

Ian MacGillivray.

Lord Silkin and Professor Williams decided to persist with a modified version of the social clauses they had proposed previously, but were divided as to whether the version selected should be based on the social circumstance that limited a woman's ability to cope with a child or on her adequacy to be a mother – I preferred the former, and Professor Williams and the rest of the ALRA group, the latter.

We were surprised when the Bill was printed for the Second Reading to find that the social clause had been omitted (Lord Silkin explained subsequently that he planned to introduce this as an amendment). The entitlement to abortion when “defective” or “when under the age of 16” had been reinserted

The Second Reading of Lord Silkin's Second Bill took place on 10 May 1966¹¹. Silkin introduced the Bill by saying, among other things:

I feel that the House ought to have, with this Bill, another opportunity of expressing its views on the difficult question of what I call the inadequacy of the mother. It may be that I did not formulate this provision as happily as I might have done. I have given much more thought to it now. It is a difficult conception to put into an Act of Parliament, but what I am groping for, and I hope I shall eventually reach something which will be acceptable, is the case of 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, but about whom it cannot be said that her life would be endangered or that there would be serious injury to her health. That is the kind of person I want to cater for, and I should like to inform the House that in the course of the Committee Stage I will put down an Amendment in an effort to give the House an opportunity of considering it once more.

Other speakers, including Lord Braine, a medical peer making his maiden speech, gave the Bill a cautious welcome. The Second Reading was unopposed.

¹¹ HL Deb 10 May 1966 vol 274 cc577-605

Committee Stage took place on 23 May 1966¹². The first amendment was proposed by Lord Braine and was to the clause 1(b) dealing with foetal abnormality. His suggestion was to substitute "...be seriously handicapped" for "...deprived it of any prospect of reasonable enjoyment of life." This was accepted without discussion.

Lord Silkin then introduced his new social clause:

– that the pregnant woman's capacity as mother will be seriously overstrained by the care of a child or of another child as the case may be.

He went on to say:

This is the third attempt that I have made – I hope this time a successful attempt – to introduce into the Bill a concept which I think most of your Lordships would like to have in the Bill. It is the concept of a woman who is pregnant, and who feels that she is unable to cope with the child when born or with another child I have in mind, particularly the case in regard to which I have had so much correspondence, that of the woman with a large family, some of them grown up, who finds herself pregnant at the age of 40 or more, and who feels that life will be impossible with another child which, once more, she has to rear. In some cases she may even be a grandmother. Such a woman is quite unable to give such a child the care and attention that it should have, or to bring it up as it should be brought up. She is the judge of that.

There are some women who have had large families and who can quite well cope, and no difficulty arises. But where a woman herself feels that she cannot cope – I would submit that she is the best judge of that – she should be entitled to go to her doctor and, if he is satisfied, and the consultant is satisfied, that it is the case that she would be severely overstrained by the care of a child, then it should be possible for her to get an abortion.

I am not now, as I did earlier, putting forward the case of a woman of bad character or inadequacy. In deference to the views of the House on an earlier occasion, I have withdrawn from that. It is now largely a physical matter. It is not a case of a woman, whose life is endangered, or who would be gravely affected in health by having another child; it is simply the case of a woman who feels that she just cannot cope and cannot do justice to another child, or, in special cases, even to one child. But in all these cases she has to satisfy two doctors. She has to make the application and, if having regard to her condition and her circumstances they are satisfied that she is not in a fit state to do justice as a mother, then I submit that that is a proper case for an abortion.

Lord Silkin intended this "social clause" to provide most of the abortions that were being obtained illegally. He hoped that being "severely overstrained by the care of a child..." would be interpreted as equivalent to "... being unable to cope", and that doctors would recognise that only the woman

¹²HL Deb 23 May 1966 vol 274 cc1208-50

herself could be “...the judge of that”.

Lady Summerskill welcomed this recognition that the views of the woman should have priority but went on to say that medical social workers were available in most hospitals to assess the circumstances of that woman’s life. Other peers raised the problems of defining “capacity” and “seriously overstrained”. The house divided and the new social clause was accepted: Contents 60, Not-contents 15.

The other significant amendment deleted the reference to a registrar providing the abortion and substituted **“under the supervision of a consultant holding an appointment under a hospital board being an appointment involving the practice of gynaecology.”**

The Bill was agreed without a division but did not proceed to the Report Stage. It was withdrawn by Lord Silkin when David Steel agreed to make it the foundation for his private member’s Bill in the House of Commons.

Chapter 3. Supporting David Steel's Abortion Bill, 1966 – 1968

Prior to the Second Reading of the Silkin Bill there was relatively little interest in abortion law reform in Parliament or in the media – only 75 peers voted at the end of the Second Reading and, of the 132 voting during the Committee stage, only 57 voted on each of the amendments. The debates in the Lords were informed by statements from the BMA, the RCOG, the Church of England Assembly, the Methodist Conference and the General Assembly of the Church of Scotland.

The campaign for reform of the law was immensely strengthened when David Steel drew third place in the ballot to present a private member's Bill. His initial intention was a Bill related to Scottish affairs but, after finding that this would not receive Government support, decided to accept Mrs Houghton's suggestion that he should introduce an abortion reform Bill. She asked both me and Peter Diggory to write to him. The relevant paragraphs in my letter of 9 June 1966 were:

Dear Mr Steel,

An abortion Bill will only be of value to our community if it both clarifies and liberalises the existing law. The underlying aim should be to save women from stress. At present abortion can be done to preserve the life of the mother or if the pregnancy is likely to harm seriously the mother's physical or mental health. Almost all gynaecologists are prepared to abort a pregnancy that is likely to result in the death of the mother but this is a very small group as modern knowledge and methods have made successful pregnancy possible even for women with quite severe disease. No new law is needed to save these lives. But most gynaecologists interpret danger to a woman's health in a narrow and negative manner; health is regarded merely as an absence of disease. The woman whose life is made desperately difficult by the pregnancy or by the care of the resulting child cannot be included; her health in this narrow sense is not threatened; she has no recognisable disease. This type of case, in which the basic problem is socio-economic, could be dealt with legally by abortion if health was defined more positively. I like the definition of health given in the constitution of the World Health Organisation: "Health is a state of complete physical and mental and social wellbeing and not merely an absence of disease and infirmity" (quoted by Sjoval in a paper on Sexual Human Relations in the Report of the Fourth European Regional Conference of the IPPF June 1964). A Bill similar to Lord Silkin's would be much improved if such a definition were included under "Interpretation" on page 3 of the version approved at the Second Reading. My personal view is the inclusion of this definition would make a further social clause, such as (c), unnecessary (added to Lord Silkin's Bill on 23 May). As it stands Lord Silkin's Bill needs 1(c) if it is to help the large group of women with gross socio-economic difficulties that at present often resort to illegal abortions.

Compared to those with socio-economic or psychiatric problems the other classes of

abortion dealt with in the Silkin Bill are numerically small. It is important that they should be included; the woman who has a reasonable probability of having a malformed child should have a right to abortion – as should the immature girl or the severely subnormal woman. Nevertheless, Lord Silkin's Bill would hardly have been worthwhile if it had merely made abortion available in these relatively uncommon situations. In fact, without the social clause 1(c) it might have restricted the practice of the more liberal gynaecologists.

In abortion Bill should be as unrestrictive as possible. The restrictions imposed in the Silkin Bill are workable although the notification clause causes me concern and sets a dangerous precedent. No other surgical procedure is notifiable – also spontaneous abortion is not registered and the aborted foetus requires no certificate for disposal. The written statement of two doctors that an abortion is necessary should prove a sufficient safeguard. Notification would inevitably make doctors excessively cautious in their interpretation of the Bill and might be susceptible to the same sort of artificiality as the psychiatric certification at present used by many doctors to cover abortions that are desired for social reasons.

David Paintin. (Copy to Mrs Houghton)

A working party was organised that included his 12 MP sponsors (of whom Michael Winstanley, John Dunwoody and David Owen were medically qualified), Lord Silkin, Mrs Houghton, Professor Williams, Mrs Munday, Peter Diggory and myself. David Steel showed unexpected determination to seek wide advice and to retain control over the wording of his Bill.

David Steel's Bill for the Second Reading was based on the second Silkin Bill. He appreciated that a new law would have to be capable of wide interpretation. My suggestion that health should be defined using the WHO definition of health received only minority support. After three lengthy meetings of the Working Party, the changes to Lord Silkin's Second Bill were:

- two registered medical practitioners would be required to certify that the abortion would be legal;
 - a revised version of the social clause was retained because of pressure from Glanville Williams. David Steel, aware that women who feel compelled to abort unwanted pregnancies were not always mothers failing to cope with large families, recognised that amendment would be necessary if the Bill progressed to Committee Stage;
 - rape was reinserted as a ground but would "require the certificate of a registered medical practitioner consulted by the patient freshly after the alleged assault that there was then medical evidence of sexual assault upon her";
 - the abortion must be carried out in an NHS hospital vested or in a registered nursing home or in a place approved for this purpose by the Secretary of State;
 - the regulations would not apply when a registered medical practitioner considered abortion immediately necessary to save the life of the woman.
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The Second Reading was on 22 July 1966¹³. The key clauses in the Bill were:

- 1. (1) — Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if that practitioner and another registered medical practitioner are of the opinion, formed in good faith —**
 - (a) — that the continuance of the pregnancy would involve serious risk to the life or of grave injury to the health, whether physical or mental, of the pregnant woman whether before, at or after the birth of the child; or**
 - (b) — that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped; or**
 - (c) — that the pregnant woman’s capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be; or**
 - (d) — that the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape.**
- (2)—Except as provided by subsection (3) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State for Scotland under the National Health Service Acts, or in a registered nursing home, or in a place for the time being approved for the purposes of this section by the Minister or the Secretary of State.**

Vera Houghton, Diane Munday, Madeleine Simms, Dilys Cossey and I attended, as advisors sitting before the bar and beneath the public gallery.

David Steel opened the debate by describing the existing law on abortion:

In England and Wales, the law is governed by the Offences Against the Person Act, 1861, which in Section 58 refers to the unlawful administering of any poison or noxious thing or the unlawful use of any instrument with intent to procure a miscarriage. Although the word “unlawful” appears in that Act, nowhere in our Statute Law is there any reference to what would be lawful. Therefore, the law in England and Wales has been built up over a series of cases.

In Scotland, the situation is slightly better ordered – as it frequently is. There the procuring of an abortion is a Common Law offence; there is no Statute Law. But criminal intent must be proved. The Scots law therefore recognises that in certain circumstances it may be necessary, in the interests of the mother and in good faith, to carry out an abortion – something which English law does not specifically recognise...

... But there is total uncertainty about the exact legal position. It is left far too much to the judgment of individual practitioners whether they are or are not within the law. Moreover – a point which is sometimes not noted – neither in England and Wales nor in Scotland does the law

¹³HC Deb 22 July 1966 vol 732 cc1067-1

require any conditions under which this operation may be carried out. This is something that my Bill seeks to introduce.

David Steel pointed out that Scots Law enabled Sir Dugald Baird and his colleagues to help a fairly large proportion of those desiring medical terminations of their pregnancies. But, south of the border, whether an abortion was legal depended on how broadly the gynaecologist was prepared to interpret risk of the woman becoming a physical or mental wreck – the ruling of the judge in 1938 when Alec Bourne was found not guilty of criminal abortion. Most NHS and private gynaecologists in England and Wales were cautious, with the result that legal abortion was “almost impossible” to obtain in most parts of the country.

He went on to explain that in England and Wales abortion was available legally only through the NHS or through private practice. It was obtained illegally with a covering of legality, if the woman could afford to pay fees of 100 to 200 guineas to a pair of medical practitioners prepared to certify that continuing the pregnancy would reduce her to a physical or mental wreck. Most abortions were obtained illegally were either self-inflicted or done by some other unqualified person, usually for cash. He had reviewed the various estimates for the number of illegal abortions, which was probably somewhere between 40,000 and 200,000 a year; and he said that one law for the rich and another for the poor is in itself unsatisfactory and should be examined.

David Steel believed that a strong argument for bringing forward the Bill at this time was a growing tide of public opinion in favour of such a change that had emerged in the 1930s and that culminated in the report of the Joint Interdepartmental Committee of the Home Office and the Ministry of Health in 1939. The chairman, Lord Birkett, had commented: “...the urgency of the problem of the misery and heartbreak which at present prevail, of the need for clear thinking on the problem, and of the strong necessity for making the law clear and intelligible and in accordance with public opinion – the only ultimate sanction of the law.”

David Steel went on to discuss the effect of the Bill:

- Clause 1 demands that a pregnancy can be terminated only on the opinion confirms existing of two registered medical practitioners.
 - Sub-section (1,a) confirms the existing law.
 - (1,b) extends the law to include pregnancies in which the foetus is seriously abnormal and is justified by the availability of the antenatal diagnosis of foetal abnormality.
 - (1,c) refers to the pregnant woman’s capacity as a mother being severely overstrained by the care of a child or of another child – the “social’ clause” that tries to define the circumstance which would justify termination rather than leaving it to a wider interpretation of “risk to physical or mental health”. But, Steel argued, this would leave open far too much interpretation to the medical practitioners and would place too great responsibility on them. If we in Parliament want cases of severe social hardship to be considered, we ought to say
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so. An alternative way of doing it, although possibly slightly dubious, would be to leave it out and to put in another interpretation of the word “health”. It has been suggested that the definition of “health” contained in the World Health Organisation’s constitution is so worded as to include, as it does, social wellbeing, so that the cases which we have in mind could be covered. But, again, that is not as satisfactory as being absolutely clear what we mean.

- (1,d) Allows abortion when a pregnant woman being a defective, or under the age of 16 or as a result of rape. This defines the situations in which abortion would be legal but which does not allow an open gate under the pretext of sexual offences. David Steel believed that the Committee dealing with the Bill must look very closely at the whole question to see whether the wording can be improved.

In summing up, David Steel used the abortion law of Sweden, where prompt decision is hampered by requiring each case to come before a committee, as an example of legislation that was onerous for the women delayed the abortion so that it became more dangerous and had not prevented illegal procedures completely. But some form of notification would be useful of those cases not carried out in NHS hospitals and there would need to be a penalty if this was not done. He went on to say:

The difficulty in drafting a Bill of this kind is to decide how and where to draw the line. We want to stamp out the back-street abortions, but it is not the intention of the Promoters of the Bill to leave a wide open door for abortion on request. The difficulty of finding wording in the Bill which will satisfy both those requirements is clear.... We have to avoid in the Bill wording which is so restrictive as not to have the effect which we are seeking – namely, the ending of the back-street abortions.

After a five-hour debate the Bill was passed at Second Reading by 223 to 29. This success was very largely due to the outstanding political and debating skills of David Steel, but was also dependent on Alastair Service, a member of the ALRA Executive Committee, who had spent many hours at Westminster lobbying MPs. On the day itself, an important role was played by Alastair with John Silkin (Labour and Lord Silkin’s son), Sir George Sinclair (Conservative) and Peter Jackson (Labour), who, as unofficial whips, were tireless in rounding up known supporters before each division.

Preparing for the Committee Stage

The two private members’ Bills ahead of the Steel Bill took longer in the Standing Committee for Private Members’ Bills than had been anticipated. Some suspected deliberate protraction to obstruct abortion law reform and we became concerned that the Abortion Bill might run out of parliamentary time.

Fortunately, several members of the Wilson Government were tacitly sympathetic to our cause, particularly Roy Jenkins (Home Secretary), Kenneth Robinson (Minister of Health), Richard Crossman (Leader of the House), and John Silkin (Government Chief Whip). They were able to convince the Government that this particular Bill had strong majority support in the Commons and that full

consideration of its terms was in the national interest. This enabled them to arrange that Standing Committee F would become available for as long as necessary after the Christmas recess. The Steel Bill also had the considerable advantage of being supported by the senior Members of Parliament Douglas Houghton and Charles Pannell, and several medical MPs – Michael Winstanley, John Dunwoody and David Owen.

In retrospect, the long delay allowed David Steel to mould the Bill into the liberal measure that was to make legal abortion widely available, as well as being acceptable to Parliament, the medical profession and the Department of Health. David Steel's thinking was informed by the reports from the Royal Medico-Psychological Association (RM-PA)MA¹⁵, the BMA¹⁶, the RCOG¹⁷, the Medical Women's Federation (MWF)¹⁸ and, particularly by the joint 1966 report from the BMA and RCOG¹⁹, that was sent to David Steel in typescript some weeks before it was published in the *British Medical Journal*²⁰.

The medical establishment accepted that existing case law should become statute law and showed some awareness that social circumstances affected health. They also supported limited availability of abortion when there was a substantial risk the foetus was seriously abnormal (the thalidomide disaster of the early 1960s and the recently discovered effects of maternal infection with rubella were very much in mind).

Considered in retrospect, the RM-PA showed most foresight, emphasising “...the emotional distress resulting from conception in a young unmarried woman or from sexual assault” and, when considering the need for abortion “that in addition to traditionally accepted medical and psychiatric criteria, all social circumstances should be taken into account”. The RM-PA made the radical suggestion that all the grounds listed in clause 1(1) should be replaced by: “It shall be lawful to terminate a pregnancy in the interests of physical and mental health of the mother, taking into account her whole family situation and circumstances past, present, and future”.

But the larger and more influential medical professional organisations showed little or no understanding that all illegal abortions were a consequence of personal and social problems, that women themselves are best placed to make their own decisions about whether a pregnancy should continue and that no woman takes lightly the decision that she must end her pregnancy.

David Steel faced a dilemma: a Bill that would satisfy the doctors would not satisfy ALRA, as it could not contain some of the clauses that had been central to their campaign for several years. This may have been resolved for him in November 1966 when he went to Aberdeen to discuss the Bill with Sir Dugald Baird and Malcolm Miller, Professor of Mental Health. Dugald Baird convinced him that social circumstances and health are directly linked and cannot be separated when considering a woman's need for an abortion, and that social and medical factors should be combined in one clause.

David Steel's thoughts on amendments for the Committee Stage were further clarified in November by a *Joint Statement by the BMA and RCOG*⁴. The contents of the statement had been released in confidence to David Steel and Dr Winstanley, one of the sponsors of the Bill. They outlined the most

¹⁵ RCOG. Legalised abortion. *BMJ* 1966; 1: 850-852.

¹⁶ BMA Special Committee on therapeutic abortion. *BMJ* 1966; 2: 40-44.

¹⁷ RCOG. Legalised abortion. *BMJ* 1966; 1: 850-852.

¹⁸ Abortion Law Reform: memorandum from the Medical Women's Association. *BMJ* 1966; 2(17 Dec): 1512-1554.

¹⁹ The views of the BMA and the RCOG on The Medical Termination Bill. *BMJ* 1966; 2(31 Dec): 1649-1650.

²⁰ The views of the BMA and the RCOG on The Medical Termination Bill. *BMJ* 1966; 2(31 Dec): 1649-1650.

important points to Mrs Houghton and me at a meeting on 14 November. We came away aware that the BMA and RCOG had made important comments but feeling that we needed to see these on paper before we formed an opinion.

A few days after our meeting, Mrs Houghton received a copy of the *Joint Statement* from Dr Havard, Under-Secretary of the BMA. This was specifically to inform ALRA and was prior to its approval by the BMA Council at its December meeting. The approved report, with identical wording, was published on 31 December.

Mrs Houghton wrote to me on 28 November:

The enclosed joint statement by the BMA and RCOG has just come to hand. It clarifies what David Steel and Dr Winstanley told us on 14 November. If the word “wellbeing” could be tacked onto “physical or mental health” in clause 1(1)(a) of the Bill, would the following extension of the “total environment” rider give us that we need?

In determining whether or not there is a risk of injury to health or physical or mental wellbeing account may be taken of the patient’s total environment, actual or reasonably foreseeable or of the child if born.

The word “wellbeing” appears in the Church Assembly’s recommended Bill and the words underlined are those used by the RCOG in its report (p. 853, BMJ, item 2 under “The terms of a New Abortion Bill”).

I would welcome your comments.

Thank you very much for turning up on 14 November. I felt as if we were being steam-rolled by a BMA spokesman which is, after all, what Dr Winstanley is – official spokesman for the North-West region.

With best wishes, Vera Houghton.

The most important points in the joint statement were as follows:

1 Safeguards

- Clause 1(1): the abortion should be performed by a consultant gynaecologist rather than by any registered medical practitioner.
 - Clause 1(2): the reference to the abortion being carried out in “any registered nursing home” should be deleted so that the operation has to be carried out in an NHS hospital or other place approved for this purpose by the Minister.
-

2 Indications

- Provided the above safeguards are incorporated, it is unnecessary and undesirable to frame the indications for termination too narrowly. The requirement that risk has to be serious and injury grave are capable of causing considerable difficulties in practice and may mean that terminations that are accepted under current medical practice become questionable in future.
- The indications should be framed in the interests of the health of the mother or because of the substantial risk of serious abnormality in the foetus.
- Clauses 1(c) [the social clause] and (d) [sexual assault and when under 16] are objectionable in specifying indications that are not medical and might well lead to an excessive demand for termination on medical grounds that would be unacceptable to the medical profession.
- Each case has to be assessed on its own merits – express reference to sexual assault and youth would inevitably lead to the public to believe that termination would be automatically carried out in these instances.
- On the other hand, we would like a sub-clause that, when considering whether to terminate in the interests of the health of the mother, would allow “account to be taken of the patient’s total environment, actual or reasonably foreseeable” – wording taken from the draft Bill recommended in the *Report of the Church Assembly Board for Social Responsibility* (p 67, clause 1(2)).

3 Emergency

- Clause 1(3) that permits emergency termination only where the life of the woman is in immediate danger should be extended to cover the discovery in the course of some other operation, such as for cancer of the ovary, that it is necessary to remove the pregnant uterus to improve the prognosis.

4 Notification

- Clause 2(1): it should be mandatory rather than permissive for the Minister to make regulations on the way in which notification is made.
- Clause 2(1)(a): the certificate of the doctors recommending termination should include the medical practitioner who actually terminates the pregnancy.
- Clause 1(1)(b): should require notification of all terminations and not just those done outside a hospital.
- Clause 2(1)(c): should permit disclosure for the purpose of bona fide research, but in no circumstances should any disclosure to the police except upon an order by a Court of Law.
- Clause 2(2) notification should be to the Chief Medical Officer of the Ministry of Health (or his opposite number in Scotland) and rather than to the Ministry of Health as a whole.

I wrote to Mrs Houghton on 2 December, responding to the queries in her letter and the contents of the joint statement:

Dear Mrs Houghton,

You wrote to me on 28th November asking for my opinion of a proposed rider to Clause 1(a) of the Bill.

From my point of view, the rider, if passed in the form in which you stated, would enable me to perform all necessary abortions; for example, a single girl in difficult social circumstances would be catered for both by "mental wellbeing" and by "of a child if born"; the otherwise healthy mother would also be covered as would be the girl of 16 and the physically-healthy mental defective.

Clause 1(b) would still be necessary to cover the abnormal foetus. I think too that a clause 1(a) of the form you suggest would indicate clearly to the lay public the sort of abortions that were possible.

You sent me a copy of the BMA's view of the Bill. With regard to the safeguards, I would support Mr Diggory; I think that abortions should rank with every other surgical procedure, and that it should be left to the discretion of the practitioner to decide whether he is competent to perform the operation. I do feel, however, that the operation should only be performed by those with experience of abortion, but providing the Bill is sufficiently liberal, there should be no incentive for the inexperienced doctor to perform the operation himself, which is, of course, the situation at present.

I do not have strong feelings about the BMA's views on the place where abortions should be carried out. I can accept their suggestion quite readily, but of course I do not do any private work.

With regard to the indications for abortion, I am with the BMA in their desire to delete "serious" and "grave"; but it is apparent that their view of social factors and health is not mine. They say that an excessive demand for termination would be unacceptable to the medical profession, this may be true, but betrays an old fashioned view of the nature of health.

Their comment about an amendment to emergency termination is valid, but deals with a very exceptional occurrence.

I am opposed to notification, but feel with the BMA that if notification is required it should be to the Chief Medical Officer rather than to the Minister himself, and that the police should have no direct right of access to the record.

Miss Kerlake has agreed to lecture at St Mary's and show her film on 16th March next year. This will be advertised in the medical journals in due course.

With best wishes,

Yours sincerely, David Paintin.

I appear to have dictated this letter in a hurry. In fact, my references to the "BMA's views" were actually those in the *Joint Statement of the BMA and RCOG*.

Professor Glanville Williams wrote to David Steel on 12 December explaining why he was "very

disappointed by the joint statement”. In summary, his reasons were:

- The social and sexual offence clauses are wrongly rejected because they do not provide medical reasons for termination. Morality and social policy do not require surgical operations to be performed only on medical grounds. As an example, an ugly nose can be changed by surgery without the justification that it was causing depression.
- The view that “excessive demand for terminations on social grounds would be unacceptable”. It may be that termination on social grounds is unacceptable to some, perhaps to the majority of doctors, but is not true for all.
- The object of restricting termination to consultants is motivated more by a desire to restrict availability than to protect the patient from unskilled persons. It does not look forward to the time, which will certainly come, when termination can be procured without special skills, for example, by a drug or paste. The known attitude of many consultants and the high demand for their services would mean that this Bill would not greatly increase the number of abortions.
- The proposal to limit the number of nursing homes where pregnancy can be terminated is intended to improve the quality of care but, by closing many small establishments, would defeat the object of this legislation, of increasing the availability of abortion.
- The provisions for notification of terminations are designed to curtail the operation of the Bill by scaring the more adventurous or liberal practitioners.
- The addition of “account to be taken of the patient’s total environment, actual or reasonably foreseeable”, may do far less than a casual reading might indicate. It does not introduce social grounds except as those that bear on the health of the woman. It does not add to legal effect of the measure.

The December crisis

The Working Party met at short notice on 21 December primarily to consider policy for the Committee Stage. David Steel came with his sponsors, MPs Mr Eadie, Mr Marquand, Dr Miller and Dr Winstanley. ALRA was represented by Mrs Houghton, Mrs Munday and Mrs Chataway and the medico-legal advisors Professor Williams, Mr Diggory and Dr Neustatter (I was not able to attend)²¹. David Steel disclosed the amendment he had decided to propose. This would replace sub-clause 1(a) with the following wording:

- (a) (i) — that the continuance of the pregnancy would involve risk to the life or of injury to the health or wellbeing, whether physical or mental, of the pregnant woman whether before at or after the birth of the child;**
(ii) — in determining whether or not there is risk of injury to health or wellbeing account may be taken of the patient’s total environment actual or reasonably foreseeable; or,

He explained that he had been influenced by the views of the Church Assembly, the Joint Report

²¹ See the Paintin papers. This account of the meeting is based on a letter of 3 January 1967 from Mrs Houghton to the Executive Committee of ALRA.

and a discussion with Professor Sir Dugald Baird. Sir Dugald had told him it would be wrong to try to separate social and medical factors, saying that “man is a social animal and his physical and emotional health, and his response to stress is profoundly affected by his social environment”. The new sub-clause made clear that abortion would be legal only when the pregnancy was endangering life, health and wellbeing and gave doctors clinical freedom to interpret the risk in the context of the woman’s life. He believed that this amendment would make unnecessary sub-clauses 1(c) [the social clause] and (1d) [sexual assault or when under 16]. He said these changes would obtain significant support from the medical profession, the Church of England, the Church of Scotland (who had produced a good report largely influenced by the C of E) and the Methodist Church, and were essential if a very challenging private Bill was to be acceptable to Parliament.

The ALRA group were dismayed at what they saw as the loss of the core of the Bill and a surrender to the views expressed in the joint statement. This feeling of being let down was increased when it became apparent that the amendment was not open to discussion and had already been tabled in the Commons. They became angry when, on the way home, they discovered from the headlines in the evening papers that the amendment had been released to the press that afternoon.

Mrs Houghton wrote to David Steel on 4th January 1967 to express the concern felt by ALRA:

Dear Mr Steel,

As Professor Williams mentioned to you in his letter of 22 December, we were very concerned at the report that appeared in *The Guardian* (22 Dec) following the meeting with ALRA representatives, yourself and other MPs the previous day. In particular we were alarmed to read that, “The sponsors ... would be willing to consider withdrawing two other possible grounds for abortion if the amendment were accepted.”

We were unaware at the meeting that you intended to release your amendment to the Press later than afternoon. The result is that a different interpretation is being placed upon the amendment, and deductions are being made – with or without foundation – to the effect that it is your intention to regard the amendment to the sub-clause (a) as replacing (c) and (d).

You made no suggestion of this at the meeting. In fact, you gave us clearly to understand that you intended to test the opinion of the Standing Committee on the insertion of “wellbeing” in (a) without reference to (c) or (d). We pointed out that there was no evidence that the inclusion of “wellbeing” in (a) would have the support of the BMA, and Professor Williams offered to make some personal enquiries as to what the BMA’s reaction was likely to be.

I enclose a batch of press-cuttings received this week from which you will be able to see how widely your amendment is being interpreted, for example –

“A CLIMB-DOWN by MPs campaigning for the reform ... after pressure from doctors and religious groups ... The sudden change of front was made yesterday by Mr David Steel...

...Mr Steel has redrafted the main criteria ... and intends to drop the idea of specifying cases in which it would have to be undertaken ..." (*Scottish Daily Mail*, 22 Dec)

"The critics of Mr David Steel's Abortion Bill ... have won the day.

Mr Steel yesterday tabled an amendment ... intended to widen the scope of the present sub-section A so that the two subsections C and D can be withdrawn.

... the sponsors of the Bill consider that their proposed amendment will be sufficiently wide to include all cases envisaged in the original draft..." (*Glasgow Herald*, 22 Dec)

"Substantial changes were ... were proposed yesterday by Mr David Steel ...

...Rape, mental defection or age under 16 may be dropped ...

Mr Steel ... table amendments yesterday which provide in effect to leave all grounds for abortion within the discretion of doctors" (*Birmingham Mail*, 22 Dec)

"Out go 'offending' abortion clauses...

These (amendments) will have the effect of removing clauses 1(c) and (d)..." (*Medical News*, 23 Dec)

What makes it all the more unfortunate is the inference that the sponsors of the Bill ("Liberal, Labour and Conservative", states *The Guardian*) have accepted your amendment before the Committee stage has even begun.

This puts us in a very difficult position. We shall have to consider at our Executive Committee meeting on 12 January what our attitude shall be if by inserting "wellbeing" in sub-clause (a), the other sub-clauses are lost.

Sub-clause (c) was passed by the House of Lords by 60 to 15 votes. It is one to which the Association attaches great importance because this is really the only significant reform having regard to the latitude now given to the medical profession under case law to terminate a pregnancy in all circumstances that can relate to the patient's health.

We are certainly most concerned that your amendment to clause 1(1) (a) shall not prejudice the fullest consideration of the later clauses in the Bill.

David Steel replied on 8 January. Two paragraphs (shown below in bold) reveal his thinking and the soundness of his judgement. These make clear that his intention was a liberal Bill that would give doctors wide discretion when considering legal abortion, particularly, that health should be defined broadly, as in the WHO definition, and that the wording of his amendment should ensure that an assessment of the risk to health would include the social circumstances of the pregnant woman. He believed this would make ALRA's social clause unnecessary and would cover termination after sexual assault, when under 16 or 'defective'. The letter (emphasis added) read:

Dear Mrs Houghton,

Regarding your letter of the 4th January, I quite agree that the Press cuttings made depressing reading. I had not myself seen them before. I am afraid that this is a subject which

is easily open to intentional or unintentional misrepresentation in the Press and I am not really disturbed by it so long as the Bill itself ends up by catering for all the points which we wish.

You said in your letter that you were unaware that I intended to release my amendments to the Press than afternoon. I thought it better to do so rather than let them pick it up from the Order Paper the following morning without explanation.

I still hold to my view that we should test in the Committee my new wording of sub-clause (a). Certainly if it this was not acceptable we should have to stick to (c) and (d) but I believe that (a) will be more acceptable than (c) or (d) and will make the difference between support and opposition from the BMA. I already have had a letter from Dr Havard of the BMA welcoming the amendment. I readily concede that they may not have appreciated the full implications of the amendment but that is their problem and not ours. The amendment generally has been very well received by the supporters of the Bill I have spoken to since coming back to Scotland and in particular there was an excellent article in yesterday's Scotsman by Professor MacGillivray of Aberdeen.

I do not attach much importance to the fact that sub-clause (c) was passed by the Lords by 60 to 15 votes. There has been a much closer examination of the proposed legislation since the House of Lords' Bill and I do not think sub-clause (c) has any virtue of itself providing that the intention contained therein remains in the Bill (we must of course ensure that this would be so by the wider wording of sub-clause (a) and we might have to strengthen this by including the W.H.O. definition of "health" in clause 3). If by sticking rigidly to sub-clause (c) we arouse needlessly the opposition of the BMA and therefore of more public opinion and of more MPs then we are merely creating needless difficulties for ourselves that could be avoided. I am certainly persuaded of that the merits of the argument lie with the wider wording of 1(a) since this will enable much wider discretion to be exercised by the future generation of doctors. The McLaren's and the Donalds²² of this world are not going to be persuaded to change their policy no matter how many detailed indications we write into the Bill. In view of the fact that the Home Office originally advised that "wellbeing" would open the door very widely, I feel sure that the Association should regard this as a satisfactory alternative to sub-clause (c).

Regarding your last sentence, I certainly do not think my proposed amendment to (a) will prejudice full debate on (c) and (d).

Best wishes for '67.

Yours sincerely, David Steel.

Mrs Houghton wrote on 3 January to the London-based medico-legal advisors (Peter Diggory, Lindsay Neustatter²³, Eliot Slater²⁴ and myself) enclosing comments by Professor Williams and

²² Professors Hugh McLaren, University of Birmingham, and Ian Donald, University of Glasgow, prominent opponents of abortion law reform.

²³ W Lindsay Neustatter MD, MRCP, Senior Physician in Psychological Medicine, Royal Northern Hospital and Consultant Psychiatrist, Horton Hospital, Epsom.

²⁴ Eliot Slater, CBE, MD, FRCP, DPM Director, MRC Psychiatric Genetics Research unit, Maudsley Hospital, London.

requesting detailed comments not only on the Steel amendments but also on the 11 other amendments so far tabled by the MPs on the Committee that were opposing the Bill – Bernard Braine, James Dunn and Jill Knight. She had requested these in time for an emergency meeting of the Executive Committee was being arranged for 12 January. I have no copy of my response, which was probably hand-written – only pages of rough notes that have survived. However, my comments are included in the ALRA brief of 11 January that links the amendments to the comments of the several advisors.

Comments on the amendments tabled for the Committee Stage of the Abortion Bill

New clause 1(1)(a) (i), (ii) (the principal change -see p 36 above): Mr David Steel

Professor Glanville Williams and Mr Peter Diggory:

There is no objection to this amendment but it will not cover all the grounds in the later clauses and it is not a real exchange for (c) and (d).

Mr David Paintin:

This amendment is desirable even if (c) and (d) are retained, but even if these clauses are deleted the Bill with this amendment will be an improvement on the existing law. But if this happens some abortions with a strong social indication involving a woman who had no physical or mental illness will only be possible if the law is “stretched”. Much depends on the word “wellbeing”. If this word was deleted and (c) and (d) were lost the Bill would not be worth supporting. The following case history illustrates this point:-

A single woman aged 20 came to see us requesting abortion. She had already had a child by the same man two years earlier and was marginally managing to care for this child; she was working as a clerk while the child was in a day nursery. A social worker said that the child sometimes seemed neglected. The woman herself had lost all social and emotional contact with her parents and her relationship with the man had only persisted because she was lonely and he found her sexually available. She felt that marriage with him would be impossible. She seemed quite intelligent and came from an English middle class background; he was a semi-literate Jamaican plumber's mate. She was physically healthy and had no psychiatric illness.

We terminated the pregnancy because we considered that her health (i.e. her physical, mental and social wellbeing) was seriously threatened by the pregnancy. This is an interpretation of health that most gynaecologists consider too broad. I think, however, that most would consider the pregnancy threatened her wellbeing. The situation would have been clearer if we could have justified abortion on the grounds that she lacked the capacity to be

a mother of another child (for the present). The average gynaecologist might not perform such an abortion if (c) were omitted from the Bill and almost certainly would not do so if “wellbeing” was omitted from the amendment.

I do not think that an amended 1(a) would deal with the pregnant defective (although she could be covered by 1(c), but rape and the girl under 16 could be covered by “wellbeing”.

The deletion of sub-clause 1(c) (the “social clause”) – Mr Bernard Braine and Mrs Jill Knight

Professor Glanville Williams (supported by Mr Peter Diggory) (summarised):

Some have objected to this paragraph on the ground that it would permit abortion on general “social” indications and allow “abortion on demand” ...Severe overstrain is a very specific question, and could not be found merely ... when “the woman does not wish to continue the pregnancy”.

The opposite objection ... is “that it is unnecessary because it can apply only to cases that come within paragraph (a)”. This is true “only when the “expected severe overstrain would amount to an injury to the woman’s health or impairment of her wellbeing.” The typical case is that of a problem family where the woman, who already cannot cope, finds herself again pregnant; if the pregnancy continues and another child is born the position of the family, particularly of the existing children, will still further deteriorate. Another case is that of a woman of low intelligence who already has difficulty in bring up one child. It may be impossible to say that an addition to her family will affect her but it will certainly affect the remaining child.

[Paragraph 1(c) had been accepted in Lord Silkin’s Bill by 60 to 15 votes in the House of Lords.]

Dr Eliot Slater:

Psychiatrists are constantly having their advice sought re termination by women whose cases are exactly covered by clause 1.(1)(c). It would be most valuable for the practising psychiatrist if the clause could be retained intact, regardless of the exact formulation of 1.(1)(a). Quite apart from the mentally subnormal and the happy-go-lucky feckless mother, who are unlikely to suffer personally in health from another confinement, there are considerable numbers of women of intelligence, character and stability who, as a result of a contraceptive failure, find themselves facing a potential addition to their family which could be a cause of prolonged strain.

I was recently consulted by woman of 43 who had inadvertently become pregnant. Her husband was 20 years older, and in a couple of years would be drawing the old age pension; he regarded the future of having to tolerate a baby in the family, and having to support it through school during his old age, with such horror that he was making scenes with his wife which were torturing her. They already had children of 17 and 13, girls. The attitude of Mrs X was that it would be

impossible to have the child adopted when born, since she had already brought up her girls in the conviction that babies must be brought up by their mothers. Nevertheless, if she was to do this, she would have to give up her job – and the family home in a tied flat. These circumstances, though in their nature social, represented a great psychological strain on the mother which any psychiatrist would recognise as properly to be taken into account in a psychiatric opinion.

Mr David Paintin:

... the deletion of 1(c) would seriously weaken the Bill.

The insertion into 1(c) of a requirement for the local medical officer of health to provide a written report on the circumstances of the pregnancy and the services available to her: proposed by Mrs Jill Knight and Mr James Dunn

Professor Glanville Williams:

... an attempt to introduce undue formality and rigidity into the procedure. It may be more convenient to use the services provided by the hospital almoner.

Dr Eliot Slater:

... this is intended only to make things more difficult. It will ... cause delays which might make all the difference between termination at an early and relatively unobjectionable stage and termination at a stage which causes everyone great distress.

Mr Peter Diggory:

... formalities of this type have been adopted in Sweden ... where the operation is in general carried out much later than is desirable ... and is attended by an abnormally high mortality and morbidity.

Mr David Paintin:

The hospital medical social worker is the best person to gather the social information ... the services of such a person are essential both for assessing cases when abortion is requested and for doing the follow-up case work. I hope hospitals will appoint special social workers for this function ... the person concerned should be part of the hospital team.

The deletion of sub-clause 1(b)(termination for foetal abnormality): Mrs Jill Knight and Mr James Dunn

Professor Glanville Williams:

The removal of this paragraph would simply compel the medical profession to continue the benevolent hypocrisy that is expected of them under the present law.

Mr Peter Diggory:

... I am prepared to carry out termination where the mother has had rubella in early pregnancy ... without obtaining a recommendation from either a psychiatrist or any other practitioner ... technically I am breaking the law... [I do not claim that] ... having a deformed child would disturb her mental health. ... if this clause is rejected ... it will more or less compel the prosecution of people like myself to whom at present the authorities turn a blind eye.

Mr David Paintin:

... the original 1(b) is essential ... I agree with Smithells²⁵ that a 20 per cent risk of serious malformation is substantial enough to justify abortion

The deletion of sub-clause 1(d) (when under 16, following rape or when subnormal): Mr Bernard Braine

Professor Glanville Williams and Mr David Paintin:

The rationale of this paragraph is that the women gave no consent ... or is not regarded by the law as competent to give it. ... there may be other grounds for terminating a woman who is defective i.e. severely subnormal and ... the woman is unlikely to fulfil her responsibilities as a mother. There is no [other] provision for this in the Bill and it may be thought that a new paragraph should be added to cover it.

Mr Peter Diggory:

... I do not feel it is quite reasonable to group these three arbitrary indications. I have always pressed for the inclusion of incest ... usually admitted to the doctor ... whereas virtually never true of rape.
... termination specifically for rape is attractive in theory but impossible in practice ... her mental state a perfectly adequate reason whether the allegation of rape was legally true or not.

The protection of doctors with a conscientious objection from a charge of negligence or being penalised when refusing to perform an abortion: Mrs Jill Knight, Mr James Dunn and Mr Bernard Braine

Professor Glanville Williams:

Unobjectionable providing the amendment requires the conscientious objection to be expressed as the reason for refusal.

Mr Peter Diggory:

... a strong supporter of this amendment with the proviso made by Professor Williams... there are many Catholic doctors and other who oppose abortion on other grounds who believe that they will lose patients and livelihood ... we should take all steps to protect them.... it must be

²⁵Smithells R. The paediatrician and the termination of pregnancy. (Letter). *The Lancet* 1966; 7427(1 Jan): 1-5

accepted that a selection committee choosing a single gynaecologist for an isolated district may feel a gynaecologist unable to carry out terminations is unsuitable for their needs.

Dr Lindesay Neustatter:

I thoroughly disagree that no claim for negligence should ever arise if a doctor refuses to terminate on conscientious grounds alone. an immediate operation may be necessary to save life.... if this amendment is accepted the words should be added that it is obligatory for a practitioner who has a conscientious objection to inform the patient that it is on these grounds that the refusal is based ... it must be made clear that another practitioner might be prepared to do the operation, and that conscientious grounds alone will not exonerate the practitioner ... where there is imminent danger to life.

Mr David Paintin:

I should be sorry to see a conscience clause in the Bill although it would undoubtedly reassure some gynaecologists. The Bill permits abortion under certain circumstances and does not compel a doctor to perform abortion The responsibility ... rests entirely with the doctor and it should not be implied that it extends to assistants. This is particularly true with regard to nursing staff. If all Catholic nurses were encouraged to exercise a legal right to give no assistance with abortion many Health Service units would be unable to terminate pregnancy.

To make one of the registered practitioners a consultant gynaecologist: proposed by Mr Bernard Braine

Professor Glanville Williams:

There has been no precedent in the present law, which allows all lawful operations to be carried out by any practitioner. At present terminations are performed efficiently by doctors other than gynaecologists. Even if this is now thought to be undesirable, the time will certainly come when termination of pregnancy will be a much simpler matter, perhaps merely a question of a pill or a paste.

Dr Eliot Slater (summarised):

... this is a wrecking amendment ... there is no need for such specialist skill if the pregnancy is terminated, as it should be, at an early stage.... Judging by the present climate of opinion among gynaecologists we can expect very great resistance to any large encroachment on their operating lists... consultant gynaecologists are among the most conservative of their profession in their attitude towards termination ... there is an emotional resistance to destroy a potential human being ...

Mr Peter Diggory (summarised):

... If the objection underlying this amendment is that abortion is so technically difficult as to require a consultant with special skill it must certainly fail ... the degree of skill required... is not

of this order of magnitude ... if it is considered that only gynaecologists are capable of deciding whether a woman requires a termination ... I am not aware of any special training ... which would so equip them... The patient's own doctor is in a better position to judge this... the clause is basically restrictive. It implies that the generality of doctors are or may be deliberately dishonest in their dealings with this particular problem (why gynaecologists should be excluded from this slur, I cannot possibly conceive).

... if abortions are done... in the future ... (for what) the great majority of doctors would consider inadequate indications ... this will also be true of circumcision, tonsillectomy and a host of other operations for which I presume no similar legislation is yet contemplated.... There are many areas of the country where no gynaecologist is readily available and many of these will for religious or other reasons, totally object to abortion. As I know personally all too well it is not possible for a liberally-minded gynaecologist to accept cases from outside his area in these circumstances.

Mr David Paintin:

If the Bill proves to be a liberal measure that will permit abortions for social as well as medical reasons I do not think that the rank and experience of the doctor performing the procedure should be specified. But if social reasons ... are inadequately covered, the temptation will exist for the inexperienced practitioner to perform an abortion himself out of sympathy or for money. Abortion with existing techniques is potentially dangerous and does require skill. A Bill that was inadequate from the social point of view would be safer if one of the practitioners was specified as a consultant gynaecologist.

To limit the provision of legal abortions to hospitals in the NHS: Mr Bernard Braine

Professor Glanville Williams & Mr David Paintin:

With great reluctance the sponsors of the Bill have accepted the limitation that "any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State for Scotland under the National Health Service Acts or in a registered nursing home." [The amendment would delete the words underlined.]

It is unprecedented for an Act of Parliament to require a medical operation to be performed in a particular place. We look forward to the time when the procedure will become much simpler than now, and any restrictions will seem absurd. At any rate no restriction greater than those already in the Bill should be accepted.

Dr Eliot Slater:

This again is only aimed at making things more difficult. If registered nursing homes are cut out and the list of places "approved" is a restricted one, the ordinary woman is going to find it difficult to get it done. Even if still possible the operation would run up against additional delays. For the sake of humanity this is something to be guarded against.

Mr Peter Diggory:

I feel this amendment is obnoxious. It again implies that private practice abortion is reprehensible. This is not necessarily my experience and I carry out both public and private terminations. So long as private practice in any branch of medicine is to be tolerated in this country, there would seem to me no justification whatever for forbidding termination of pregnancy being done privately. Secondly, in point of practical politics, it is estimated that probably less than 3000 abortions are done annually under the NHS, and probably 20,000 privately. Unless we assume the present Bill is going to reduce the number carried out in a year, the enactment of this amendment is going merely to reduce other gynaecological surgery which already, as a speciality, is notorious for its long waiting lists.

The role of ALRA, and the medico-legal advisors

The Executive Committee of ALRA met on 12 January 1967 to discuss the *Joint Report of the BMA and RCOG* and the amendments that had been tabled by David Steel and his sponsors, and by the MPs who were hostile to the Bill – Bernard Braine, Jill Knight and James Dunn. They also considered Mrs Houghton’s paper listing the amendments and the responses to them of the medico-legal advisors (summarised above). There was heavy criticism of David Steel’s omission of the clauses that had been central to ALRA’s policy for some years and of his failure to consult before announcing his amendments – some suggesting that ALRA should withdraw its support. Mrs Houghton persuaded them that the amended Bill was a considerable advance on current law and that there would be scope for further amendment during the Standing Committee.

ALRA was relieved that the BMA’s proposal that abortions should be carried out by or under the supervision of an NHS consultant in an NHS hospital, and the RCOG’s requirement of a consultant gynaecologist, were not included in the Bill.

A long statement was prepared for the press. This expressed qualified support for the changes to the Bill – the loss of the social clause was regretted, and new sub-clause 1(a) was thought not broad enough to include consideration of the welfare of the woman’s children (this was to be corrected during the Standing Committee). The statement mentioned the WHO definition of health, stating this was what was being practised when “A good family doctor looks at the patient’s whole situation in making a diagnosis and prescribing a remedy”, with the implication that this was how health should be interpreted in the Bill.

ALRA and the medico-legal advisors took time to appreciate that they had largely achieved their objective once they had succeeded in persuading David Steel to introduce his Bill. ALRA had convinced him that this was necessary, particularly to clarify the law for doctors, to remove the need for women to seek clandestine abortion and to allow termination to avoid the birth of a seriously handicapped child.

But David Steel had realised that the Silkin Bill reflected the thinking of the 1930s and was too

prescriptive: legislation that was to be effective had to be formulated with the help of the current medical establishment and would require the support of majorities in the Commons and the Lords. He found the BMA, the RCOG and the Church of England to be in support of a law that would give doctors the clinical freedom to terminate when continuing the pregnancy would threaten the woman's physical and mental health – and that they accepted that this should be considered in the context of the woman's social circumstances. He had been confirmed in this view by Sir Dugald Baird – just as I had been convinced in the same way, in 1956, while working in his department in Aberdeen.

ALRA and the medico-legal advisors had difficulty in accepting that a law that depended almost entirely on a broad interpretation of health would meet all the circumstances under which women consider termination to be necessary. This reflected in the qualified comments of the medico-legal advisors (summarised above) on the amendments that had been tabled for the Committee Stage: none of the advisors, including me, felt confident that David Steel's amendments would be adequate without the specific inclusion of social circumstances as a legal reason for termination.

My view was that without such a clause, the law would have to be “stretched” if it was to be interpreted broadly – if all abortions considered necessary by the women themselves were to be included. I was concerned the opponents of legal abortion would challenge the use of the WHO definition of health as idealistic and inappropriate in the context of an abortion request, and that the woman should always have a definite physical or mental illness, even when she clearly had social reasons for having the pregnancy terminated.

I differed from the other advisors in my opinion on the hostile amendments that sought to require that one of the doctors should be a consultant gynaecologist and that legal abortion should be restricted to NHS hospitals. My views are expressed in the following exchange of letters with Mrs Houghton:

17 February 1967

Dear Mr Paintin,

The following amendment has been put down by Leo Abse, Angus Maude and William Deedes:-

Clause 1, page 1, line 24, at the end insert “by a person who is or had been a consultant holding an appointment under a hospital board involving the practice of gynaecology or by a practitioner who holds such an appointment and is nominated either generally or for the purpose of the treatment in question by such a person, and must be carried out”.

A further amendment bearing on this:-

Clause 4, page 3, line 15, at the end insert –

“hospital board” means a regional hospital board or the board of governors of a teaching hospital.

The Executive Committee feels that these amendments must be fought at all cost and

were are hoping that we can get the same group in the Committee which voted solidly in favour of amending David Steel's amendment to clause 1.(1) (a) to bring in the wellbeing of the child or other children, to stand by us on maintaining the freedom of any doctor to perform an abortion.

If you have any additional comments or suggestions on this section of the Bill, I would be grateful for them as soon as possible. I don't think the amendments will be reached on 22 February, but we need as much time as possible to whip up support.

I hope you are as pleased as we are with the final results of clause 1.(1) a. It will be interesting to see whether the BMA or RCOG have anything to say about it. I am afraid the opposition of the Roman Catholics and the Society for the Protection of the Unborn Child will not be any less at the Report Stage, and it will be a fight to the death.

Yours sincerely, Vera Houghton.

I replied as follows:

Dear Mrs Houghton,

Thank you for your letter; congratulations on the result of the deliberations on 1.(1) (a). This should prove a very useful clause – depending of course on the Report Stage.

I understand the Executive Committee's opposition to the Abse, Maude, Deedes amendment but am not opposed myself. I have outlined my reasons before. I do think abortion requires some special experience and fear that a Bill that is unrestricted will encourage abortion outside the Health Service. As a result less pressure will be applied to the Health Service to provide facilities for abortion and for social aftercare. I want to see requests for abortion considered by a sympathetic medical team of gynaecologist, social worker and, possibly, psychiatrist, aided by the family doctor; appropriate aftercare should be provided. I cannot believe this will happen if abortions are easily and cheaply obtainable outside the Health Service. Also, by suggesting that all doctors should be allowed to perform abortions, ALRA may appear to be giving support of those who at present do "legal" abortions for extortionate fees. I was rather worried about this at the press conference with Malcolm Potts. I am sure that those who spoke charge reasonable fees but I thought the stress was directed too strongly towards private practice.

Madeleine Simms has a good letter answering Hemphill in today's *Lancet*.

With best wishes, David Paintin.

I was naïve and unrealistic in hoping that legal abortion could be provided through the NHS freely enough to remove the incentive for abortion either, clandestinely, by the woman herself or a back street abortionist, or by a private gynaecologist charging exploitive fees. I was deeply committed to the NHS which I believed should meet all the medical needs of the population and remove the incentive for private provision that I disapproved of on principle.

The other medico-legal advisors, particularly Peter Diggory, realised that a rapid expansion of legal abortion by the NHS was unlikely because of the entrenched negative views of most of the

consultant gynaecologists and the length of their waiting lists: any marked increase in the numbers of legal abortions could come only from the private sector. He had the insight to realise that a liberal law would expand private abortion provision, and that this would improve the standard of care and that competition would remove the incentive to charge excessive fees. He was right in this – although he did not anticipate the development of large scale non-profit-making provision by the charities BPAS, in Birmingham, and PAS, in London.

Peter Diggory was Mrs Houghton's principal medical advisor during the remaining stages. This was probably because she recognised that his view of how abortion provision would be made available to women was more realistic than mine. He was also able to attend all sessions of Standing Committee F but I had clinical and teaching duties that made this difficult or impossible. I was kept informed of deliberations by being sent the daily Hansard but was not directly involved as an advisor.

Standing Committee F: January to April 1967

There were 12 meetings from 18 January to 5 April, each lasting two and a half hours. The Committee had 30 members, of whom about 20 were consistent supporters and 5 determined opponents of the Bill (the proportions of Ayes and Noes at Second Reading determines selection for the Committee). Mrs Houghton and Peter Diggory were at all the meetings and other members of the ALRA Executive were usually in the public seats. More than 90 per cent of Committee time was occupied considering and rejecting blocking amendments proposed by the opponents of the Bill – Bernard Braine, Jill Knight, Simon Mahon and Norman St John Stevas (who had their own advisors from the Roman Catholic Church and the Society for the Protection of Unborn Children (SPUC) in the public seats)²⁶.

The Committee made the following changes:

- The amendment that one of the doctors should be a consultant gynaecologist was defeated.
- The new clause 1(1)(ii) tabled by David Steel in December was passed with sub-clause 1(a i) strengthened by the insertion of the phrase shown below in italics.

Clause 1.(1), the essential core of the Bill, now read:

1.— (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if that practitioner and another registered medical practitioners are of the opinion, formed in good faith —

(a)(i) that the continuance of the pregnancy would involve risk to the life or of injury to the physical or mental health of the pregnant woman or the future wellbeing of herself or the child or her other children;

ii) in determining whether or not there is such a risk of injury to health or wellbeing account may be taken of the patient's total environment actual or reasonably

²⁶ The Society for the Protection of the Unborn Child (SPUC) was formed by Phyllis Bowman and Elspeth Rhys Williams in January 1967 to oppose the Steel Bill. It soon had far more members than ALRA, with groups in many constituencies. The aim was to pressurise MPs to vote against the Bill – its parliamentary lobby was ineffective when compared to ALRA. SPUC was interdenominational – RCs were excluded from the executive committee but welcome as members. The professors of gynaecology, Hugh McLaren (Birmingham), JS Scott (Leeds) and Ian Donald (Glasgow) acted as advisors.

foreseeable; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Sub-clauses (1)(c) [social] and (1)(d) [rape, under 16 and if “defective”] were deleted together with the associated sub-clauses (4) and (5).

Clause 1.(2) was amended to read:

(2) Except as provided by subsection (3) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the Minister or the Secretary of State.

Notification (clause 2.(2)) was to be to Chief Medical Officers of the Ministry of Health or the Department of Health in Scotland, rather than to the Minister of Health or the Secretary of State for Scotland. A new clause 3 was inserted at the suggestion of the Home Office to make clear that abortions for members of visiting armed forces would be regulated by British law rather than that of their own country

A new clause 4 (the conscience clause) was approved. The wording proposed by Mr Bernard Braine was rejected on the grounds that its intention was to reduce the provision of legal abortion, and the following paragraph approved:

4. No doctor, nurse, hospital employee nor any other person shall be under any duty, nor shall they be in any circumstances be required, to participate in any operation authorised by this Act to which they have a conscientious objection, provided that in any civil or criminal action the burden of proof of conscientious objection shall rest on the person claiming it.

ALRA accepts the aims of the Steel Bill

The Committee Stage was followed closely at Westminster and in the country as a whole, and it soon became apparent that those who opposed all liberal reform were spreading misleading statements about the intentions of the sponsors and the likely outcome if the Bill became law. The following letter was circulated by Mrs Houghton to counter these rumours.

13 March 1967

Dear Member of Parliament,

We write this letter in the hope that it will help to dispel some of the misunderstandings and misrepresentations about clause 1. 1 (a) of the Bill as now amended in Committee. We also hope it will help to reassure Parliament that there is overwhelming

support for a really liberal measure.

The latest survey conducted by National Opinion Polls shows that public support for the inclusion of social factors (where the woman is unable to cope with any more children) had risen from 36 per cent, in 1965, to nearly 65; for abortion where there is serious risk of foetal abnormality from 58 to 80 per cent, and where the pregnancy results from a sexual offence, from 61 to 80 per cent. All these indications are now covered by the amended subsection (a) which reads –

- (i) that the continuance of the pregnancy would involve risk to the life or of injury to the physical or mental health of the pregnant woman or the future wellbeing of herself and/or the child or her other children.
- (ii) in determining whether or not there is such a risk of injury to health or wellbeing account may be taken of the patient's total environment actual or reasonable foreseeable.

Opponents of reform, and those who wish to see a law enacted which would be even more restrictive in its effect than the present case law, are intent on persuading Parliament and the public that the Bill is now so wide as to amount to abortion on request.

This is simply not so.

The criticism levelled against the two so-called “social” clauses, sub-sections (c) and (d), which have now gone from the Bill, took two forms. On the one hand it was claimed that they would now open the door to “abortion on demand”: that doctors would find it difficult to withstand the pressure from patients who alleged that they were suffering from severe overstrain, and that of a girl who became pregnant while under age of 16 would have an automatic right to abortion. On the other hand it was argued by members of the medical profession that it was wrong to separate health and social factors.

Both points of view have been met in the amended subsection (a).

This change has been noted with relief by Sir John Peel, President of the Royal College of Obstetricians and Gynaecologists, in a letter to the *Times* of 7 March of which Sir Dugald Baird is a co-signatory. The writers acknowledge that, “Due consideration for the effects of environment and social influences upon the physical and mental health of patients is an integral part of modern medical practice.”

In an earlier letter to the *Times* of 13 January, Sir John Peel and Dr E. A. Gerrard, chairman of the BMA Committee on Therapeutic Abortion, stated “all the factors affecting health should be considered, including age, social problems and the circumstances under which the pregnancy started.”

The critics of the Bill have now moved on to attack the inclusion of the word “wellbeing”. They argue that it has too much meaning; that its meaning is not clear. They ignore the good authority on which this word has been included. It appeared in the report “Abortion: an ethical discussion” of the Church Assembly where it was stated, “our view is that, in reaching this conclusion (that in certain circumstances abortion can be justified), her

life and Wellbeing must be seen as integrally connected with the life and wellbeing of her family". It has since been "deliberately recommended" by the Law Society; and the British Academy of Forensic Science in their Joint Memorandum on Therapeutic Abortion.

The Bill is purely permissive: it merely states under what circumstances a registered medical practitioner, with the concurrence of another registered medical practitioner may perform a lawful operation. Its safeguards are in the integrity of the medical profession as explained by Sir John Peel and Sir Dugald Baird in the concluding paragraph of their letter of 7 March –

"We think it necessary for the law to show clearly the broad lines within which doctors may act, but it should interfere as little as possible in the practice of medicine, since the standards should be guarded by the profession itself."

Everything that has been said that can be said, in report after report from religious, medical; and legal bodies (see our leaflet enclosed). The setting up of a Royal Commission will solve nothing: there will be the same divergence of opinion as exists now; its only purpose will be to delay reform.

If you are in favour of reform, we hope that you will encourage Parliament to see this Bill through without further delay, and without amendments which may weaken it, and that you will watch out for the date fixed – for the Report and Third Reading stages and make a point of being present.

Yours sincerely, Vera Houghton, Chairman, Abortion Law Reform Association.

This letter shows an acceptance by ALRA that the Bill drafted by David Steel had the potential to be an effective Abortion Act and an appreciation of the value of the support of senior members of the medical establishment. In effect, the clauses ALRA had developed over the years had been abandoned.

The Report Stage and Third Reading took place from June to July 1967. We were very concerned that filibustering by the opponents of abortion law reform might result in the Report Stage not being completed in the time for the Bill to be passed by the Lords, reviewed by the Commons and then to receive Royal Assent. The Report Stage²⁷ began at 11.35 am on 2 June and many amendments were still to be considered when the debate was adjourned at 4 pm. Fortunately, a majority of the Cabinet supported the Bill and it proved possible to arrange an all-night debate starting at 10.35 pm on 29 June²⁸, and a further all-night debate on 13 July²⁹.

With this extra time, the Report Stage was completed and the Bill was passed on its Third Reading in the Commons by 168 to 83 at 10.45 am the following day. There had been 26 divisions each involving from about 150 to 300 members (suggesting the more than 200 who did not vote were indifferent to the outcome).

The only significant amendments had been made by David Steel: in the crucially important sub-clause 1.(1)(a)(i) **...future wellbeing** was deleted and **...the child or her other children** was replaced

²⁷ HC Deb 02 June 1967 vol 747 cc448-50

²⁸ HC Deb 29 June 1967 vol 749 c895-1054

²⁹ HC Deb 13 July 1967 vol 750 cc1159-385

by **...any existing children of her family, and ...** Legal experts at the Department of Health had advised that “wellbeing” was vague and had no agreed definition. For David Steel and his advisors this had been why it had been inserted – to a broad interpretation of “health”. Fortunately, when the Abortion Act became effective the references to “her children” and to “her family” made clear that health was to be considered in relation to the woman’s social circumstances.

The Steel Bill in the Lords

There were debates on 26 July³⁰ and 23 October³¹, and the Bill was finally passed at 12.10 am on 24 October 1967. As in the Commons, many blocking amendments were listed but were all unsuccessful. Three constructive amendments to the Bill were made in the Lords:

- A definition of risk was added to subclause 1.(1)(a)(i) which now ended “**... risk greater than if the pregnancy were terminated.**” This amendment was proposed by Lord Dilhorne and accepted by the Lords, probably because they believed that induced abortion would always be more dangerous than continuing a healthy pregnancy, an opinion held at that time by many senior British gynaecologists. In fact, data from Eastern Europe were available that showed a death rate for abortion in the first trimester of about 2/100,000 abortions compared to about 12/100,000 for pregnancies that resulted in the birth of a child. In effect, the Lords had made abortion available on request providing two doctors would certify that the pregnancy was a threat to mental health.
- The conscience clause was replaced by new wording drafted with the help of the Home Office. This read as follows:

4. (1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection; provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in subsection (1) of this section shall effect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

(3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

This was necessary because the version passed by the Commons could have given protection to a wide range of hospital staff such as receptionists and porters who did not “participate” directly in “any treatment authorised by this Act” and by objecting could have prevented abortion being provided in some institutions. An addition sub-clause specified that conscientious objection could not be claimed if abortion was necessary in an emergency because of serious risk to the life or of grave permanent damage to the physical or mental health of the woman.

- The title was changed from the **Medical Termination of Pregnancy Act** to **The Abortion Act**. This had been Lord Silkin's original choice: the change was to indicate that the Act was concerned only with ending a non-viable pregnancy and not with obstetric procedures necessary later in pregnancy to improve the outcome for both mother and baby.

Final approval by the House of Commons

This was on Wednesday 25 October 1967³². David Steel made a small number of minor editing amendments. Norman St John Stevas made an unsuccessful attempt to delete Lord Dilhorne's definition of risk, which he had realised would make abortion more rather than less easily available. An attempt to strengthen the conscience clause was defeated by 188 to 94. The Lords' amendments were then accepted and the Bill passed without a division. Royal Assent was given on 27 October, immediately before the end of the parliamentary session. The Abortion Act became effective six months later, on 27 April 1968.

A buffet lunch was held in the Palace of Westminster on 9 April 1968 to celebrate that the Act was about to come into effect. There was a large attendance that filled three linked rooms, so large that it was impossible to circulate and meet many of those who had given most help.

³²HL Deb 23 October 1967 vol 285 cc1394-509

Chapter 4. Implementing the Act

The Act (section 2) required the Minister Health and the Secretary for Health in Scotland to make statutory regulations for the certification and notification of legal abortion by doctors to the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department, respectively, and to prohibit the disclosure of the data to all except a strictly limited list of persons. Regulations such as these have to be placed “on the table” in both Chambers for a limited period and become law, unless sufficient MPs object and persuade the Speaker that there should be a debate. New regulations are necessary whenever the wording of the forms has to be revised or the rules on disclosure are changed.

In November 1967, the Department of Health consulted professional organisations including the BMA and the RCOG on the content of the form. The BMA asked ALRA for its views and, at Vera Houghton’s request, I wrote to Dr J. D. J. Havard, General Secretary of the BMA. My letter of 29 November listed my suggestions for the information that would be sufficient to establish the identities of the woman and the doctors involved, the grounds under the Act, where and how the abortion was done, the gestation, and sufficient information to allow the investigation of abortion epidemiology. My most relevant comments were:

.... The information written on the notification form should be brief; each question should be answerable on one or two words. The Minister should resist the temptation to ask for too much information. Questions requiring lengthy answers and much detail would be completed to a varying standard and would be difficult to analyse on a national scale.

Detailed research into the abortion problem requires a prospective study by a trained team of workers who have mutually agreed methods for assessing psychological and sociological factors such as intelligence, personality, overcrowding, knowledge of contraception, etc. The Minister should not attempt to obtain this type of information on the notification form.

My intention, as a practising pro-choice gynaecologist, was to counter any tendency for politicians to seek facts they could quote selectively to support their view that the law was being misinterpreted. I did not see Dr Havard’s official BMA response to the consultation but it is likely that he (and the Chief Medical Officer) shared my concerns: the notification form that was published met most of my recommendations.

The Abortion Regulations 1968

These were published on 15 March, put before Parliament on 1 April and became law on 27 April. Certificate A (“the green form”, HSA1) had to be signed by the two doctors certifying the abortion would be legal. The form required the names and addresses of the doctors, their signatures, the name of the woman and her address, and the grounds for the abortion had to be “ringed” on a printed list. It was anticipated that a GP referring a patient for consideration of abortion would, if he

supported the application, enclose a signed green form with his letter. The doctor who terminates the pregnancy has to ensure that the green form is kept in the case records and remains available for 3 years.

The notification from (“the buff form”, HSA4) was to be filled in by the operating doctor and sent within seven days to the CMO of the Department of Health. The first section had clearly expressed short questions. The second section collected data on the reasons for the abortion, the method used and any complications. Most questions were well designed but two were ill-considered and difficult to answer.

Question 11 asked the doctor to specify the reasons for the abortion under the headings: *Obstetric disease, Non-obstetric disease, Suspected medical condition of foetus* and *Non-medical grounds for the termination*, even though the legal grounds for abortion were listed verbatim in the first section of the form and required only an answering tick. The space for the answer was too short for more than one or two words. Most doctors felt obliged to put “depression” or “anxiety”: Glanville Williams had suggested that the appropriate answer should usually be “social factors threatening mental health” (an opinion later supported by the Medical Defence Union). The data collected from these questions proved to have little value except for the small minority of abortions done because the woman was seriously ill or the foetus was abnormal.

Question 14 listed complications as: *none, sepsis, haemorrhage, death or other*, and but did not define sepsis or haemorrhage, or ask when the complications occurred – during the operation, before leaving hospital, etc. As the completed notification forms had to be sent to the CMO at the Department of Health within 7 days, the forms were usually filled in before the surgeon left the operating theatre. This meant that the complications reported tended only to be those occurring during or immediately after the procedure: complications occurring after returning home or requiring emergency admission to an NHS were completely missed by this system – including, it was discovered later, some deaths. Almost meaningless tables of complications were published annually for many years.

The recognition of approved premises

The Act stated (section 1(2)) that any treatment for the termination of pregnancy must be carried out in an NHS hospital “...or in a place approved for this purpose of this section by the Minister or Secretary of State.” A notice inviting applications for approval was placed in the national press and professional journals, with a closing date of late November to ensure inspection and recognition by 27 April. The requirements for approval were at the discretion of the Minister and, in practice, were drawn up by the officials at the Department of Health.

The Department of Health presumed that private abortion practice would follow the protocol long established for private surgery: the management of the nursing home/private hospital would provide the facilities and employ the nursing staff; the medical care – pre-abortion assessment, the

operation and follow-up – would be the responsibility of the woman’s private gynaecologist and the woman would pay both separately; the women would be referred to the private gynaecologists by their general practitioners. The Department of Health turned a blind eye to the fact that, before the Act, many women referred themselves to the “Harley St” gynaecologists – phone numbers were obtained by word of mouth from close friends or relatives.

The Secretary of State’s basic requirement for an abortion clinic was that it should have been registered by the local authority as a nursing home with a specified number of inpatient beds for patients having surgery under general anaesthesia. In addition, the proprietors were required to give “assurances.” The assurances for 1967-68 were not published but were probably limited to:

- keeping a register containing the date and time of admission, discharge and the abortion of all patients admitted;
- these records, and the premises, to be available for inspection by an official from the Department at any time and without notice.

By 31 December 1967, 53 nursing homes had been approved, six had been rejected, one application had been withdrawn and four were under consideration³³. Many private nursing homes with established facilities for both obstetrics and gynaecology were approved but, in practice, the consultants who had admitting rights proved to be reluctant to provide legal abortions and to risk becoming known as abortion specialists. Some applications were from entrepreneurial doctors who wished to establish abortion clinics in which assessment and the abortion would be by in-house staff, often by the proprietors themselves. Such applications were accepted by the Department of Health but it was these clinics that soon led to public and parliamentary concern about standards of care and unethical advertising of abortion services.

An unanticipated problem was the opening of agencies that advertised their services and charged a fee for referral to a private gynaecologist or abortion clinic. Some of the advisory services were charities with the object either of helping women to obtain a legal abortion, or of deterring them from have a termination – sometimes offering support if the pregnancy were continued. Most were commercial: the women paid fees for a referral to private gynaecologist and some were alleged to have a commercial agreement that directed the women to newly-approved entrepreneurial clinics.

The Department of Health responded by increasing the number of assurances required when an approved place was inspected and making more frequent unannounced visits by the inspecting team. These changes in the assurances were introduced without publicity in the early 1970s and mentioned in Parliament by the Secretary of State only as evidence of Government action when responding to hostile questions about the effects of the Act. The full list of assurances was published in the report of the Lane Committee in 1974; the following had been added to those formulated in 1967:

- a book of numbered receipts to be kept, each receipt to show the name and address of the

³³ Sec of State for Health (Mr Kenneth Robinson) HC Deb 16 July 1968 vol 768 cc1236-7.

patient and the nursing home;

- it is highly desirable that patients should not be discharged before the day following the abortion;
- the number of beds stated in the application must not be exceeded;
- the number of terminations carried out in any 24-hour period should not be greater than the number of registered beds;
- arrangements for dealing with emergencies must have been made;
- any deaths of patients having abortions must be reported to the Department of Health within 24 hours;
- a fee will not be demanded directly or through an advisory bureau unless two doctors had signed the certificate required by the law;
- if the patient has had a long journey, the abortion should not take place until the following day;
- nursing homes should not advertise their facilities in foreign countries and should not admit patients introduced by agents who have done so.

The beneficial and harmful effects of the extended list of assurances

The beneficial outcome was that almost all the newly-opened private clinics owned wholly or in part by the doctors who provided the abortions were closed, either because poor medical care had resulted in an unacceptable number of women with serious complications or they had advertised their services. Some referral agencies went out of business because clinics could no longer accept their clients. Conventional private practice was not affected – the gynaecologists assessed the women in their private consulting rooms and arranged to perform the abortion at an approved private clinic to which they had admitting privileges.

But the extended assurances were a problem for the abortion-providing charities – Birmingham Pregnancy Advisory Service (BPAS) and Pregnancy Advisory Service (PAS). Both had been founded as referral agencies and were in the process of acquiring and running their own abortion clinics. The Department of Health interpreted the expanded assurances to mean that referral bureaux and abortion clinics should be independent: that they should have separate medical and administrative staff but could be managed by the same general manager and board of trustees. This meant that the counsellors and the doctors who certified the legal abortion would be legal in the bureaux could not be directly involved in the actual termination (although the gynaecologist who notified the abortion could act as the second signatory on certificate HSA1). This resulted in the formation of two groups of doctors; the sessional assessing doctors who worked only at the bureaux and the sessional gynaecologists who worked only in the clinics – their only link through the case notes.

A harmful result of the assurances was that day-care was heavily discouraged in spite of the published evidence from England and Eastern Europe that it was safe. In this, the Department of

Health was following the guidance of the RCOG, particularly of its president, Sir John Peel. This added significantly to the inconvenience for the women and to the cost of a first trimester abortion. Day-care in approved places was not permitted until 1976, in spite of the fact that it had been standard practice in some specialised NHS services since 1969.

Provision by the NHS

The Abortion Act was drafted to meet the need of women living in Great Britain – in England, Wales or Scotland. The exclusion of Northern Ireland, which had been written into the Bill presented to the House of Lords in 1965, was not questioned during the subsequent debates in Commons in 1966-67. The possibility that the Act would make legal abortion available to women living outside the United Kingdom was not considered at all.

With the exception of Sweden, Denmark and Norway, the laws of the countries of Western Europe were as restrictive as they had been in Britain. The relatively liberal abortion laws in the Scandinavian countries and Communist-dominated Eastern Europe specifically excluded women resident outside their borders. The numbers of legal abortions notified each year increased steeply until 1973, when there were 110,568 for women resident in England and Wales and 56,581 for non-resident, “foreign”, women. Only 50 per cent of the resident women received care free of charge in the NHS.

The Department of Health expected that legal abortion would be provided through existing gynaecological services without any additional funding; the extra case load was expected to be small. In practice, referrals increased rapidly and competed with the care of other gynaecological patients. Many general practitioners were relieved that the law now allowed legal abortion in circumstances that, previously, would have resulted in dangerous clandestine procedures – they understood and sympathised with the needs of their women patients.

Consultants had mixed feelings. A minority with a conscientious objection refused any involvement, increasing the pressure on their colleagues. Relatively few welcomed their freedom to consider social factors. Most were reluctant providers and felt harassed by the difficulty of fitting legal abortion into gynaecological services for which there were substantial waiting lists. Many consultants limited the number of requests they would see to two or three each week. Some would consider only women whose pregnancies were less than 13 weeks on the day of the termination. Others would accept women with more advanced pregnancies but only if they agreed to be sterilised at the time of the abortion.

Women, whether or not they obtained an abortion, often complained that the doctors had been unsympathetic and judgemental. This can be seen as a consequence of their training: they had been taught that abortion was moral only when health was gravely threatened, could not be justified when requested for “social” reasons and should not be available “on request”. In addition, NHS gynaecologists were uncertain about how to interpret “health” in the context of the Act: they tended to regard a woman as healthy unless she had an illness with a diagnosis they could aim.

Although the Act required only that there should be a threat to health, and that her actual and foreseeable circumstances could be taken into account, NHS gynaecologists felt obliged to use their professional skills to specify the condition that was likely to occur of the pregnancy continued; they felt the statutory need for their approval implied that some requests would be refused.

In the first years of the Act, even the doctors who believed that abortion should be available on request feared they risked prosecution if their use of the WHO definition health were to be challenged. These concerns led NHS gynaecologists to develop personal criteria for deciding whether a woman should have a legal abortion for social reasons. These reflected the moral conditioning and social experience of the gynaecologists: they failed to appreciate that no woman wants to have a termination and will already have made a realistic assessment of the likely effects of having a child at this point in her life.

In fact, the majority of gynaecologists coped with the new law, controlling the flow of women by having waiting lists for assessment in their outpatient clinics and, sometimes, refusing to consider termination if the pregnancy would be more than 12 weeks at the time of the operation. General practitioners, aware of the waiting times for NHS care, referred women who could afford the fees to private gynaecologists. The number of legal abortions provided by the NHS and by private gynaecologists increased rapidly until 1973 when notifications for women resident in Britain from the NHS and the private gynaecologists were 55,456 and 55,612, respectively. At that time, only a small minority of well-to-do women chose to use private health care for other gynaecological problems.

The fact that 50 per cent of women had to pay for their abortion is a measure of the inadequacy of the NHS. The NHS gynaecologists were able to improve their services sufficiently to keep pace with the increase in the abortion rate but, in 1981, the 61,103 they provided was virtually unchanged at 49 per cent of the total for women living in England and Wales.

Abortion provision at the Samaritan Hospital, 1963 – 1972

In 1961, when Professor MacGillivray began providing terminations at the Samaritan Hospital – the Gynaecological Unit for St Mary's Hospital, London W2 – he arranged for the existing full-time medical social worker to help with the assessment process. There were three outpatient clinics each week, attended by the professor, the senior lecturer Dennis Davey and the lecturer Doreen Rothman, respectively (Dennis Davey did not usually see women requesting abortion). The gynaecologist in charge of the clinic began the assessment with a short interview in which the facts in the referral letter were checked with the woman and she was examined to confirm the pregnancy, its duration and her physical health. She was told that the decision about the pregnancy would be made after she had been interviewed by the medical social worker – this usually followed immediately.

The woman was seen again towards the end of the clinic. By this time the social worker had written a brief report that described her circumstances, her feelings about the pregnancy and

her relationship with her partner. If the gynaecologist considered that abortion was possible, the method and the possible complications were explained and a date for admission arranged (at that time termination was by dilatation and curettage under general anaesthesia and the women spent two nights in the ward). All were offered an appointment at a local Family Planning Association clinic. If the pregnancy had to continue, the reasons were explained and the woman was offered antenatal care and delivery in the maternity unit at St Mary's Hospital.

This system worked well; the Samaritan Hospital already had a full-time medical social worker who was glad to be involved; the woman had time to explain her circumstances to a sympathetic, non-judgmental listener, who was a woman rather than a man in a white coat, and who could arrange support from the local social services; the gynaecologist could see more new gynaecological patients in each 3-hour clinic session.

Doreen Rothman and I continued this system in 1965, when Professor MacGillivray returned to Aberdeen and I became senior lecturer and honorary consultant. His successor, Peter Huntingford, did not support the termination of unwanted pregnancy during his first four years in the chair. The progressive increase in referrals for abortion that began during the abortion debates at Westminster overloaded the system. It proved possible to have second social worker available for each outpatient session but it was also necessary to limit referrals to local women and to no more than three for each clinic. It was important not to allow terminations to displace women with other gynaecological problems – the Professorial Unit had an obligation to them, and to provide training in all aspects of gynaecology for medical students and junior medical staff.

Peter Huntingford adopted the same clinic protocol when, in 1969, he decided that women had a right to choose abortion. In late 1969, he and I gained insight into our own abortion practice when we compared the decisions we had made during the previous few months. We had both felt that to justify termination the woman must be facing “undue hardship” if the pregnancy continued: because we were concerned that our public support for legal abortion would attract the critical attention of anti-abortion activists and the cautious officials at the Department of Health, but had become dismayed by the disappointment and, often, the anger of the women whose requests we refused.

We were surprised to find that our view of what constituted “undue hardship” differed considerably. I tended to sympathise with the women in poor circumstances, particularly if they already had children, and felt that those with more affluent backgrounds would usually be able to cope; Peter tended to consider the latter more worthy of help and that women from poor homes, unlikely to use contraception efficiently, would soon become pregnant again and would expect a further termination.

Specialised NHS services that separated abortion provision from routine gynaecology

By 1970, it became apparent to Peter Huntingford and me that legal abortion and routine gynaecology should be separated and the abortion service staffed by health professionals who had

sympathy for women having terminations. We reserved an outpatient and an operating session each week for providing legal abortion.

We reorganised our outpatient procedure. The consultations had been impeded by the women's fear of being refused and their perception that they had to convince us that they had convincing reasons for ending their pregnancy – they saw us as male and likely to be judgmental and authoritarian. As before, the consultation included an assessment of the woman's general health and the duration of the pregnancy. Providing the gestation was clearly less than 24 weeks, she was told how the abortion could be done and the possible complications. She was assured that she would be given an appointment for admission after she had explained why her pregnancy was unwanted with a female medical social worker. The social worker saw her some minutes later. By now the woman had relaxed and was more able to talk about their social circumstances, the relationship with her partner and the reasons why she could not allow the pregnancy to continue.

The social worker went into counselling mode if the woman was ambivalent or had problems with her relationship with her partner – she was assured that the abortion could be postponed until she was certain. Some women saw the social worker more than once. About 90 per cent decided to have the termination; the remainder continued their pregnancies, usually attending our antenatal clinics at St Mary's Hospital in Praed St.

The other innovation in 1969 was the use of day-care vacuum aspiration for all first trimester abortions with the option of local or general anaesthesia (most women chose to be unconscious).

The annual numbers of legal abortions at the Samaritan Hospital are shown in Table 1, below.

Table 1. Legal abortions at the Samaritan Hospital (NHS).

1964	1965	1966	1967	1968	1969	1970	1971
47	71	75	138	293	581	763	962

Almost all provided by the Professorial Unit but, after 1969, a small but increasing number were by terminated by the NHS consultants.

The first account of an NHS abortion service organised to serve local residents was published in 1970 by Buckle *et al.* from Lewisham in London³⁴. They described 409 first trimester abortions by vacuum aspiration under general anaesthesia, of whom about three-quarters returned home the same day. The same year, Peter Diggory, with the aid of a grant of £2,000 from Pregnancy Advisory Service, established an NHS day-care unit in Kingston upon Thames in which, on two days each week, specially trained general practitioners provided vacuum aspirations under local anaesthesia. Diggory, in a letter to *The Lancet*, pointed out that an NHS gynaecologist who ran a specialised service risked being overwhelmed by referrals and that such services were desirable but would need

³⁴Buckle A, Anderson M, Loung K. Vacuum Aspiration of the Uterus in Therapeutic Abortion. *British Medical Journal* 1970; 2(23 May): 456-457.

extra staff and more money from the Government³⁵.

An important clinical study of a specialised first trimester vacuum aspiration service was conducted in 1970 by Richard Beard while he was still a senior lecturer at Kings College London³⁶. Counsellors had a major role in the assessment process and supported the women during the vacuum aspiration under local anaesthesia – the study was noteworthy because pain and blood loss were estimated, the experience of the women was assessed and long term follow-up, as well as from help with contraception, included the psychological outcome. Richard Beard, when he became professor at St Mary's Hospital Medical School in 1972, organised an extension of his study at the Samaritan Hospital, replacing for a year the service I had been providing alone since Peter Huntingford's resignation at the end of 1970³⁷. The resources available during the day at the Samaritan Hospital limited the number to 10 each week – an evening follow-up session was financed and largely staffed by the community family planning services.

The services described above were planned to demonstrate the effectiveness and safety of vacuum aspiration for first trimester day-care terminations. Vacuum aspiration was rapidly adopted by all the NHS gynaecologists who provided legal abortions through their routine operating lists, but did not see that it was a development that would allow them to be organised as day-care abortion services provided by part-time medically qualified clinical assistants with experience of abortion or who had been given training themselves. They could provide a day-care service, firstly, if a local consultant gynaecologist was willing to oversee the clinical work and provide inpatient care for women with serious complications, and secondly, if the local NHS administration would provide funding and suitable premises. In such a service assessment and follow-up could be integrated into the local community health family planning clinics. In the 1990s, the RCOG created a sub-specialty of community gynaecology that would include all aspects of sexual health.

Abortion “counselling”

Before 1967, counsellors were professionals trained to help people that were failing to come to terms with serious life situations. Their role was not well defined but most had some training in psychology or psychotherapy: their role was to help clients to identify the factors that were disturbing their emotions and to work with them to a solution. These professional skills are rarely necessary when women are deciding to have an abortion. Nevertheless, abortion “counsellors” have been part of the assessment process since the Act became effective: they seldom have a recognised qualification but, in the absence of an alternative name, counsellor has become accepted as their job description.

The use of social workers as counsellors in our NHS service arose because our gynaecological unit already had the services of a medical social worker. She was on the staff of the Social Work Department at St Mary's Hospital that had links with the social service departments of the local authorities. The social workers as a group welcomed this new role. When we established the District Pregnancy Advisory Service in 1981, we were allocated three workers for each of the three abortion assessment clinics held each week.

³⁵ Diggory P. Outpatient abortion. *The Lancet* 1971; 2(727): 767-768.

³⁶ Lewis SC, Lal S, Branch B, Beard RW. Outpatient termination of pregnancy. *British Medical Journal* 1971; 4: 606-610.

³⁷ Hull MGR, Gordon C, Beard RW. The organization and results of a pregnancy termination service in a national health service hospital. *Journal of Obstetrics and Gynaecology of the British Commonwealth* 1974; 81: 577-585.

Most politicians consider counselling an essential part of abortion provision. They hold the traditional belief that women need to be protected from impulsive decisions that they would later regret and that guilt might lead to long-term mental distress. This resulted in the Department of Health making “counselling” one of the several licensing conditions for private abortion services. Abortion providers knew from their clinical experience that most requests for abortion are well-considered; the need for the abortion may be regretted, and that most women cope without needing professional help. There is convincing evidence from many long term studies that induced abortion is not a risk factor for mental illness³⁸. Professional counselling skills can help women unable to come to a decision about their pregnancy or who need to resolve their feelings about a disturbed or failed relationship with their partner. However, in the context of legal abortion, it is accepted that counsellor is the job description for the staff that interview the clients.

The role of the counsellors in our service at the Samaritan Hospital was to provide sympathetic support and to define the adverse social circumstance that would provide evidence that continuing the pregnancy would threaten the mental health of the woman or of her family – to record the circumstance that would allow the doctors to certify that the abortion was legal. An important secondary function was to help women who were ambivalent come to a decision, to identify circumstances where social services could be made available, and to help the woman to report conceptions due to sexual abuse.

Making abortion available free of charge

Provision in NHS units run by NHS staff peaked at 88,410 in 1996 and fell to 64,399 in 2012. The increase up to 1996 was due to the creation of community day-care services that are largely independent of local routine gynaecological facilities. Such services were run by community gynaecologists and staff appointed because of their willingness to help women in this way. The day-care units usually have an arrangement whereby serious complications are managed by the local hospital gynaecology unit, which may also provide the second trimester procedures. Community services may include contraception, complementing prescription by GPs and with special sessions for the insertion of IUDs and implantable/injectable methods.

Three important initiatives between 1968 and 2002 made legal abortion accessible, free of charge to all women living in England and Wales.

The founding and growth of the low-cost pregnancy advisory services

In the autumn of 1968, members of ALRA in Birmingham and London, aware that there NHS would fail to meet the needs of women, opened services that would make legal abortion available for fees that did little more than cover their costs – fees that were a small fraction of those charged by private gynaecologists. The charities, Birmingham Pregnancy Advisory Service (BPAS) and Pregnancy Advisory Service (PAS) in London, were launched in 1968 and 1969; Marie Stopes International (MSI) opened in London in 1976. The success of BPAS and PAS in providing a low cost but high standard of care resulted in the opening of small commercial clinics with closely similar fees; such as the

Calthorpe Clinic in Birmingham, the Fairfield in Buckhurst Hill, Essex, in the 1970s, and the South Manchester Private Nursing Home in Stockport in 1980.

PAS and BPAS began as referral bureaux that used counsellors, as we did in our NHS service at the Samaritan. They provided the assessing doctor with the evidence that allowed them to certify that the abortion was legal so that the woman could be referred to a private gynaecologist for the termination. The operating gynaecologist relied on this information when providing the second signature. The first PAS and BPAS counsellors were family planning nurses, health visitors or social workers motivated to help women access legal abortion; few had professional training as in the counselling process. These counsellors learnt on the job and, as the case load increased, organised training programmes for new appointees. Both charities introduced head counsellors to supervise recruitment and training.

To meet a nationwide need, BPAS and MSI made their services more accessible by acquiring more clinics in different parts of the country. By 1981, the independent providers, as a group, ran a total of eight clinics containing a total of 220 beds, all of which were approved for first trimester day-care procedures. In 1980, these clinics, working at about 95 percent of full capacity, can be estimated to have provided at least 50,000 terminations – 79 per cent – of the 68,333 for which women resident in Britain paid for themselves. Private gynaecologists experienced a marked decrease in their incomes. Many became willing to be employed as surgeons by the low-cost independent providers for fees per clinical session, similar pro rata to those earned paid to consultants in the NHS. The decrease in the numbers of private patients led to the sale of several private nursing homes to the expanding low-cost organisations.

The introduction in 1981 of agency arrangements by the Department of Health

These enabled district health authorities in which NHS gynaecologists were either unwilling or lacked the resources to provide an adequate abortion service through agency arrangements – contracts between district health authorities³⁹ and one of the independent low-cost providers. This innovation may have been the outcome of a conversation between Nan Smith, chief executive of BPAS, and a civil servant in the Department – the first contract in 1981 was with BPAS⁴⁰. Arrangements could be flexible – for all legal abortions in the population served by the district health authority or only for abortions in the first or in the second trimesters.

The low-cost providers competed for contracts with health authorities that were within a reasonable travelling distance from their existing clinics; PAS and MSI competed in Greater London. In some contracts, the independent provider staffed pre-abortion assessment sessions in premises owned by the Primary Care Trust (PCT) so that the women had to travel to the provider's clinic only for the termination itself. In time, in some agency arrangements, the independent provider organised a complete first trimester day-care service that was based in local NHS premises. The independent providers had to be flexible enough to adapt the model of service they had established in their early years – many fewer overnight beds were needed in their clinics, the job descriptions of some staff

³⁹ Successive NHS reorganisations have replaced District Health Authorities as purchasers of health care with, in sequence, NHS Trusts and Fundholding General Practitioners in 1990, Primary Health Care Trusts in 1999, and Clinical Commissioning Groups in 2012.

⁴⁰ Personal communication, Diane Munday 2014.

had to be changed, and some staff were employed only for the duration of a particular contract.

The abortions provided through agency arrangements increased steadily during the 1980s but only enough to compensate for the rise in the abortion rate: the proportion of abortions funded by the NHS remained about 47 per cent throughout the decade. The proportion increased steeply from 50 percent in 1991 to 96 per cent in 2010. Agency arrangements were crucial in fulfilling the vision of ALRA in 1968 that abortion should be accessible, funded by the NHS and accessible to all the women in Britain.

The National Strategy for Sexual Health and HIV: Implementation and Action Plan, 2002

It was the National Strategy for Sexual Health and HIV that enabled agency arrangement to be so effective. This was introduced by Alan Milburn, Secretary of State for Health in the Labour Government led by Tony Blair that was re-elected in June 2001, and was a continuation of the programme for NHS reorganisation that had been initiated in the previous Labour Government by Frank Dobson, Secretary of State for Health from 1997-99.

Part of this programme was a consultation paper that had been circulated in 2001 and resulted in responses from many individuals and organisations working in this field of health care. The Implementation and Action Plan was the outcome of this consultation. One of its aims was to tackle inequalities in access to abortion. This was to be achieved as follows:

- “By 2003, the District Health Trusts and Primary Care Trusts will work towards the national standard that women who meet the legal requirements should have access to an abortion within 3 weeks of the first appointment with the GP or other referring doctor (other than in exceptional cases, for example where a longer wait is clinically appropriate).”
- “A central booking and referral service (that includes self-referral) can enable women to have abortions at early gestations.”
- “Implementation will also be supported through:
 - an audit of abortion waiting times and commissioning policies
 - the development of an abortion waiting time performance indicator;
 - pilot early abortion procedure including medical abortions, in non-traditional settings that meet legal requirements for abortion provision;
 - work with the Royal Colleges to develop training for junior doctors in this area.
 - new funding will be available during 2002-03 to support implementation of this action point”.

An extra three million pounds to fund the proposals was to be available during 2002-03. This was the most positive action by any Government since the Abortion Act was clarified and extended in 1990. It met the principal requirements of the RCOG guideline on *The Care of Women Requesting Induced Abortion*. The effect was to improve abortion services by making agency arrangements to compensate for deficiencies in local in-house abortion services. The proportion

of abortions paid for by the NHS increased from 78 per cent in 2002 to 96 per cent in 2010 – the numbers of abortions provided by NHS clinicians decreased from 73,544 to 65,529, respectively.

The private provision of abortion

The private gynaecologists who had been active before the Act experienced a marked increase the demand for their services. The women, of whom a growing proportion were referred by general practitioners, were assessed in their consulting rooms and terminated in the existing private nursing homes; the second opinion was provided by either the referring doctor or the anaesthetist after the woman had been admitted to the nursing home. Anecdotally, the fees remained high when compared with other private gynaecological treatments.

The Abortion Act led to unanticipated numbers of women travelling to England from all over the world to obtain abortions that were illegal in their own countries. The number peaked in 1974 at 53,500, of which about 36,500 came from France, 6,000 from West Germany, 3,000 from Spain and 2,000 from Italy. Unentitled to NHS care, they found their way to the private gynaecologists, particularly the entrepreneurs who had set up their own clinics. Many women came to London not knowing where to get help and sought advice from staff at the stations or airport, or from the taxi drivers waiting outside. The rise in demand was met by the opening of private referral bureaux that charged a fee for directing the women to a private gynaecologist or a clinic. It was alleged that some entrepreneurial clinics paid fees to the bureaux for each referral. Such fees were illegal; as was advertising for patients in the foreign press.

The media were very critical of “abortion tourism” and were scandalised by allegations that some private abortion providers were exploiting these women for commercial gain. The overall numbers fell dramatically after abortion became legal in the first trimester in France (1975) and in West Germany (1976). The number coming from Spain and Italy increased more slowly and reached a maximum of 8,200 from Italy in 1978 and 18,300 from Spain in 1980; abortion became legal to some extent in both countries from 1978 but availability was restricted by the continued ambivalence of the politicians and the reluctance of many gynaecologists. The women who continue to come are seeking either confidentiality, or second trimester abortion – which remains relatively unavailable in most European countries.

Travelling to England remains important to women in Ireland. In 1973, about 1,000 were from Northern Ireland and about 1,500 from the Irish Republic. Since then, the annual number giving addresses in Northern Ireland peaked at about 2,000 but has decreased in the last few years and was only 802 in 2103. These totals are probably less than the actual numbers – an informal survey in the early 2000s by BPAS suggested that, of the woman identified during assessment to be living in Northern Ireland, about one third had registered from an address in England, often that of a another family member. The number coming from the Republic had increased to 4,410 in 2012 but had fallen to 3,679 in 2013. Irish abortion law, although revised in 2013 to allow abortion to save life and prevent grave injury to health, remains the most restrictive in Europe.

Chapter 5: The origins of the pregnancy advisory services

It was apparent before the Act became effective that NHS provision would be inadequate. Professors of obstetrics and gynaecology in Birmingham, Liverpool, Leeds and Glasgow had been vociferous in their opposition to the Bill and led local consultant gynaecological opinion. But there were waiting lists for gynaecological services throughout the NHS in England and Wales and it was inevitable that there would be difficulty in coping with a major increase in referrals for legal abortion. The private gynaecologists who had been quietly providing abortions of questionable legality felt liberated but saw no reason to reduce their relatively exorbitant fees – they were unlikely to meet the needs of women who were could not afford to pay.

In the autumn of 1967, groups of ALRA members led the way by organising pregnancy advisory services as charities. The object was to help women distressed by unwanted pregnancies to find sympathetic doctors willing to check that they had grounds for legal abortion, sign HSA1 certificates and then refer to an NHS doctor known to be willing to terminate pregnancies or, if necessary, to a private gynaecologist who had agreed to charge low fees. The women would be asked to pay the cost of the assessment consultation but, if their circumstances made this necessary, they would be offered an interest-free loan, to be repaid in monthly instalments during the following year.

Birmingham Pregnancy Advisory Service (BPAS)

The Birmingham branch of ALRA knew that women in the West Midlands would have considerable difficulty in finding legal abortion because of most of the local NHS gynaecologists followed the lead of Hugh MacLaren, professor of obstetrics and gynaecology in the University of Birmingham in being opposed to any liberal interpretation of the Act. Martin Cole, a botanist and a lecturer at the University of Aston, was the chair of the Birmingham branch of ALRA. He formed the group that planned the Birmingham Pregnancy Advisory Service (BPAS). This included François Lafitte (professor of social policy and administration at Birmingham University), who became the first chairman (1967-88); Nan Smith, the first chief executive (1968-81); and Philip Cauthery, a medically qualified specialist in public health, ex-RAF, and now providing student health care at the University of Aston.

It was decided that the new service should be a charity, principally as protection from critics who would allege that the service existed to profit from women in distress but also because some women would need help free of charge. Martin Cole and François Lafitte discussed the proposed organisation with the Charity Commissioners. The name Abortion Aid was rejected on the grounds that abortion was not a charitable benefit as too few women would require such help; Pregnancy Advisory Service was acceptable because it included all women distressed by unwanted pregnancy [and did not use the word *abortion*]⁴¹.

BPAS opened in April 1968, in a room in Martin Cole's home⁴², on the day the Abortion Act became effective. The demand for the service was soon apparent and office space for an advisory bureau was leased in the centre of Birmingham. The women were charged a fee that covered the costs of

⁴¹ Personal communication from Martin Cole. 16 Sept 2014.

⁴² Personal communication from Martin Cole. 16 Sept 2014.

the referral clinic. Counsellors were central to the assessment. Their role was to define the woman's reasons for requesting a termination, to inform her of how it could be done and the possible complications. The doctors were employed by the session and were either general practitioners or family planning experts – they had no clinical experience of terminating pregnancies. The assessing doctor read the reports of the counsellors, confirmed the duration of the pregnancy, checked the woman's health and took a blood sample to determine her blood group and haemoglobin level. When satisfied that the woman had made an informed decision, the doctor signed form HSA1 to confirm that the abortion would be legal. The women, with their counselling and medical reports, were referred to a selected number of private gynaecologists in London who had agreed to charge reasonable fees, sign the second certificate and perform the termination.

The need to travel to a nursing home in London was onerous for the women and a serious defect in the service: some women were being charged for “extras” in addition to the pre-arranged fee, and clinic staff were sometimes judgemental and lacking in sympathy. But the case-load increased rapidly and it became obvious that the abortions must be provided locally. Again, Martin Cole took the initiative and, financed from his own resources and contributions from three businessmen⁴³, bought and adapted the Calthorpe Clinic in Edgbaston, Birmingham. This opened in December 1969. The clinic was managed jointly by Martin Cole and Philip Cauthery, and its role was to provide abortions for the women referred from the BPAS. Calthorpe had an agreement with BPAS to provide the abortions for an all-in fee and for the costs of the initial assessment to be returned to BPAS as a rebate. First trimester abortion became available for a total of £65 (compared to £600 charged by some private clinics).

The Calthorpe Clinic was a success and enabled the BPAS to provide an integrated local service. Unfortunately, a subsequent disagreement over the details of the agreement led to Calthorpe and BPAS becoming separate organisations. Calthorpe was still willing to accept women referred by BPAS but was also a private independent abortion provider that accepted direct referrals from general practitioners.

In the early 1970s, BPAS had enough predictable income to be able to expand; Wistons Nursing Home in Brighton opened in 1972 and, a year or so later, Blackdown Clinic in Leamington Spa and the Merseyside Clinic in Liverpool. The expansion continued after Nan Smith retired in 1981 and was replaced by Ian Jones. In 1984, the Birmingham Pregnancy Advisory Service was reconstituted as the nationwide British Pregnancy Advisory Service Ltd (BPAS) with an extensive network of referral bureaux and strategically-sited abortion clinics.

Pregnancy Advisory Service (PAS)

Alan Golding, a city accountant, supported by Sara Abel and Sylvia Ponsonby, were the ALRA members who led the way in London. In the spring of 1968, he called a meeting that laid the foundations of the registered charity, Pregnancy Advisory Service, which included the psychiatrists, Lindsay Neustatter and Eliot Slater, Peter Diggory and several other members of ALRA. Alan

⁴³ See *Abortion*, by M. Potts, P. Diggory and J. Peel. Cambridge University Press, 1977, p 299

Golding, Sara Abel and Sylvia Ponsonby agreed to form a working group to plan the details of the new service. Subsequently, Eustace Chesser, Peter Diggory, Vera Houghton, Dorothea Kerlake, Lindesay Neustatter, Malcolm Potts, Eliot Slater and Lord Soper became members of the advisory panel.

The aims of the charity were:

- to provide assistance for women in distress because of unwanted pregnancy;
- to help those with legal grounds for abortion to obtain treatment within the terms of the Abortion Act;
- to promote education and research into the subject of pregnancy and abortion.

Three generous benefactors and several smaller donors contributed a total of £3,000 to cover the start-up expenses⁴⁴.

It was difficult to find a landlord willing to lease space for a service associated with legal abortion (this included the Family Planning Association). Ultimately, three rooms were rented on the third floor of 40 Margaret St, London W1. The building was old and the stairways narrow and shabby but it was affordable, and very close to Oxford Circus. The management committee was chaired by Alan Golding and among its members were Elizabeth Mitchell, Leah Harvey, and Joan Windley. The Margaret St Bureau was staffed initially by two experienced social workers, an administrative secretary who worked full time and one doctor. All staff were paid; each woman seen was asked to contribute £2 10s (£25 in 2005 values). Those who had an abortion had also to pay the fees of the private gynaecologist and the approved nursing home to which they were admitted.

There was a queue in the street when Margaret St opened in November 1968 – although many were journalists rather than clients with problem pregnancies. The women counselled in the first year were described by Joan Lambert⁴⁵. The total of about 3,000 suggests that an average of 11 women were seen each day of a five-day week. She described the service provided as follows:

Patients discuss their problem with an experienced social worker and are then seen by one of a number of doctors employed by the service on a sessional basis. These doctors are usually general practitioners or those experienced in family planning or marriage guidance. Those patients thought to have grounds for termination of pregnancy are then referred to gynaecologists, who make their own assessment and arrangements for treatment. Patients who decide to keep their babies are put in touch with the person or organisation who will give support during and after the pregnancy.

The steady increase in women seeking help was met by renting most of the rooms at 40 Margaret St, having three social workers available and holding evening sessions. The most challenging daily task was the need to find a sympathetic gynaecologist for each woman. Most liberal NHS consultants

⁴⁴ This account of first years of PAS is based on *Out of the Backstreets: 21 years of service to women*, written and compiled by Helene Grahame. Pregnancy Advisory Service, 1989, p.132.

⁴⁵ Lambert J. Survey of 3,000 Unwanted Pregnancies. *BMJ* 1971; 4: 156-160.

had waiting times for assessment of up to three weeks and would accept referrals only of women who lived in the district served by their hospital. Private gynaecologists were available, even eager, for additional patients but only minority would reduce their fees for women from PAS.

Encouraged by Martin Cole, Alan Golding approached the businessmen who had helped to finance the Calthorpe Nursing Home in Birmingham. They proved willing to buy and adapt the Fairfield Nursing Home in Russell Rd, Buckhurst Hill (about 13 miles from Margaret St), and to guarantee PAS the use of its beds at an agreed price that included a rebate for PAS. PAS was allowed to appoint Dorothea Kerslake⁴⁶ as the Medical Director and to have a say in the choice of matron. PAS was given majority control of the board of management: PAS appointed Alan Golding, Dr Harold Price and Keith Hindell⁴⁷ and the other two represented the owners of the business.

The opening of Fairfield in May 1971 solved the problem of finding sympathetic gynaecologists; a sufficient number of the private gynaecologists and their anaesthetists were willing to operate for PAS for sessional fees similar to those paid to consultants in the NHS. The 24 beds at Fairfield could provide a maximum of 24 first trimester inpatient abortions each day. PAS charged each woman £60 (£620 in 2005 values), at that time, the lowest charge in south of England. Even so, the PAS share of the surplus was £70,000 to £80,000 each year; this was used to finance the loan fund to help the women who could not afford to pay at the time of the abortion; the small minority that defaulted were written-off as a charitable benefit. (The scanty information available suggests that fees for privately-obtained first trimester abortions were £100–£200 for the gynaecologist, about £60 for the anaesthetist and about £100 for the approved nursing home.)

There was a second challenge: how to help the rapidly increasing numbers of foreign women who were travelling to London to seek legal abortion. PAS policy in its first year was that, “Foreign girls not domiciled in Britain were not seen, as they were not registered with a general practitioner and because language difficulties would have made proper assessment impracticable”⁴⁸. By 1972, the number of women arriving at Heathrow Airport was attracting unfavourable stories in the media. The airport staff did not know what advice to give and some taxi drivers exploited the bewildered women by taking them to commercial referral bureaux that were alleged to pay a fee for each client delivered.

In 1972, at the request of the Church of England Board of Social Responsibility, the Airport Authority and the Borough of Hillingdon, PAS set up a Traveller Help Unit at Heathrow. The Department of Health gave cautious support but restricted the women to be advised to those who had a referral letter from a doctor in their own country or who had made no prior arrangement for the abortion. Assurances had to be given that PAS (and Fairfield) would not advertise abroad or employ touts at the airport. The Airport Authority allowed the Unit to use its premises at Heathrow but did announce its opening to airport staff who became aware of existence by only by word of mouth. The Unit was not advertised – it escaped the notice of the media and was not announced to doctors until 1975. In spite of this limitation, the number of foreign women seen at Margaret St rose progressively.

⁴⁶Dorothea Kerslake, recently a consultant gynaecologist in Newcastle, had been the first in Britain and North America to describe the use of vacuum aspiration, having seen its value when visiting abortion clinics in Eastern Europe. [Kerslake D, Casey D. *Obstetrics & Gynecology* 1967; 30: 35-38]

⁴⁷Keith Hindell was co-author with Madeleine Simms of *Abortion Law Reformed* (Peter Owen 1971).

⁴⁸Lambert J. Survey of 3,000 Unwanted Pregnancies. *BMJ* 1971; 4: 156-160.

PAS opened a second assessment bureau to cope with the increased workload, in the basement of a house in Fitzroy Square. Counsellors were recruited who could communicate in one or more European languages – French, German, Spanish and Italian. The women were assessed by a sessional doctor who, providing they met the criteria for legal abortion, signed the HSA1 form. Overnight admission to Fairfield was arranged – the operating gynaecologist provided the second signature. The women were guided on how to find a hotel for the one to three nights before a bed was available at Fairfield.

By 1971, the growth of PAS necessitated the appointment of a full-time Director who would be responsible for the day-to-day running of Margaret Street. Myra Gainsly was the first Director (1971-78). She standardised procedures, recruited and organised training for additional staff and dealt with day to day problems. In 1973, the Director was joined by Barbara Chandler, who was Director of Counselling (1973-77) and then Director (1978-82), and Helene Grahame became part-time Press and Information Officer (1973-90). These were women of extraordinary ability who established PAS as an efficient and caring organisation.

There were other important changes. The medical leadership of PAS was strengthened when Malcolm Potts (1973-77) succeeded Alan Golding as chair of the management Committee (Alan continued as treasurer until 1981). At that time, Malcolm was the London-based Medical Director of the International Planned Parenthood Federation. Peter Huntingford became a member in 1974 and was chairman from 1977-81. Peter had just returned from a WHO attachment in India and Indonesia and was now Professor of Obstetrics and Gynaecology at the London Hospital Medical School where he had organised an NHS day-care abortion unit.

Led by Malcolm Potts, PAS approached the Department of Health with evidence that day-care was safe for first trimester abortion, and that the assurance that an approved place must have overnight beds and a fully equipped operating theatre was unnecessary and doubled the cost of the abortion; permission to start a day-care unit at Fairfield was refused. PAS continued to campaign for day-care in the first trimester by holding a one-day meeting at the Royal Society of Medicine at which Malcolm Potts and NHS gynaecologists presented the data to an audience of health professionals. PAS also supported a study of menstrual extraction (when a period was up to 14 days overdue) at three London teaching hospitals⁴⁹. The Department finally allowed day-care in 1976, but only with assurances that the woman should have a journey to the clinic of no more than an hour and after a letter from her general practitioner that guaranteed medical cover at home for the first 24 hours. It was some years before these conditions were lifted and day-care was possible in premises in Central London that had no inpatient accommodation.

The late 1970s were a time of crisis for PAS: the leases on Margaret St and Fitzroy Square and the agreement with Fairfield were all due for renewal. It was decided that the increasing case-load required a larger clinic that would be entirely controlled by PAS. After much searching, Barbara Chandler and her team found a suitable registered nursing home in Rosslyn Rd, Richmond. This was bought by taking on a large mortgage with a variable rate of interest which, at that time, was

⁴⁹Stringer J, Anderson M, Beard RW, Fairweather DVI, et al. Very early termination of pregnancy (menstrual extraction). *British Medical Journal* 1975; 263: 7-9.

reasonably low. Rosslyn Clinic was already in use as a registered nursing home and had had been adapted from a large Victorian house. There was a modern operating suite, and enough space for the development of a day-care unit and an assessment bureau to serve local women. The agreement with Fairfield was cancelled in anticipation that the Department of Health would grant approval as an abortion clinic and that women could be admitted almost immediately.

Unfortunately, approval was delayed for five months because the Minister, Patrick Jenkin, believed a newspaper report that PAS had been advertising its services in Spain – this was when Parliament, and the media were considering the restrictions on abortion proposed in the Corrie Bill, discussed in a later chapter. It took five months to convince the Department that the report was completely untrue. PAS's financial reserves were strained to the limit; there was no income from fees but the mortgage had to be paid, as did the several Rosslyn staff who had been retained. In the meantime women had to be referred to private gynaecologists for their terminations, with increased costs for the women and for PAS. Once fully open, Rosslyn was able to provide all PAS abortions. The smooth running of Rosslyn and the high morale of its staff was due to Doreen Lloyd, the manager from 1981 to 1997.

Margaret Street and Fitzroy Square were replaced by leasing premises at 13 Charlotte St, a short walk from Oxford St and from the tube at Tottenham Court Rd. There was much more space: waiting areas for the women were much improved and there were rooms for counselling, consulting suites for the doctors and areas for urine testing and for taking samples of blood. The walk-in pregnancy testing unit that had been opened in Margaret Street was re-established in the basement, and reached by exterior stairs from the street. The women seeking abortion entered the front door of at street level. A year or so later, a donor insemination service with a laboratory for the cold storage of semen was set up on the third floor. Charlotte Street enabled PAS to provide care for more women each day and a much improved environment for staff.

A major change was the increasing involvement of the staff in the management. From the mid-1970s, the departmental managers attended the Management Committee but only as spectators. Peter Huntingford, who took over as chairman in 1977, was strongly in favour of more staff participation. He believed the staff should have a right to be heard, and that this would result in a service more responsive to the needs of women. A review, made jointly by an independent advisor and Cathy Johnson, a senior member of staff, recommended management changes that would result in full engagement of the workers in decisions at all levels. After a year of consultation within PAS, the Directors of the company (the trustees of the charity) decided to change the articles of association so that the workers (the employees) would be members of the company and entitled to elect the Directors annually (who would also be the trustees of the charity).

The positive result of becoming a collective was a marked improvement in the morale of the workers and the emotional support they provided for the clients. Doreen Lloyd was keen that all personnel in contact with the clients should have basic counselling skills. She felt this was particularly important at Rosslyn when women found they were ambivalent about their decision to

have an abortion, or when they were sure their decision was right but acutely distressed that they should be in this situation.

The negative effect of the collective was that it did not provide effective governance. Difficult decisions were made slowly or postponed and cost-efficiency had low priority – it was easy for staff to recommend improvements in their working environment and the appointment of additional workers, and almost impossible to consider a need to reduce their numbers. Financially, PAS was only just achieving an annual surplus and had virtually no reserves. In 1987, the spectre of insolvency loomed and the trustees decided to replace the collective with three small management teams. The post of general manager was advertised and Joan Hutchinson was appointed. She led a small team, selected by the trustees that included the existing officers in charge of finance, marketing and personnel, and the senior gynaecologist. The senior staff members that had been running Charlotte Street and Rosslyn were made managers with defined responsibilities. The elected committees of workers were retained but with only advisory powers.

Between 1981 and 1986, PAS failed to expand: the collective focused on better services at Charlotte St and Rosslyn. But improved commercial pregnancy testing kits had made the walk-in pregnancy unit redundant and donor insemination, although less expensive than at the commercial services, did no more than cover its costs. In the meantime, the other charitable providers, BPAS and the recently founded Marie Stopes International (MSI), were becoming efficient national networks.

In 1981, the Department of Health introduced agency arrangements that allowed NHS trusts to provide legal abortion through contracts with independent providers. BPAS made the first agency arrangement in 1981, followed closely by MSI. It was 1984 before PAS, in competition with MSI, won a contract to provide a second trimester abortion service for Brent, extended subsequently to earlier gestations; other contracts were made with several other London health authorities but at a price that only just covered the cost of provision. These contracts kept Rosslyn busy but made Charlotte Street a liability rather than an asset – fewer women now needed to pay PAS for their terminations as agency arrangements improved NHS provision. BPAS and MSI, with their several centres scattered all over England, obtained an increasing proportion of their income from agency contracts while PAS lacked the resources to expand. The terms of the lease of Charlotte Street did not allow PAS to sublet and the facilities could not meet Department of Health requirements for a day-care unit.

By 1995, drastic measures were necessary. In 1996, the trustees were forced to act as PAS was almost insolvent. PAS merged with BPAS, and Catherine Spurling and I joined the board of BPAS for the next seven years.

Marie Stopes International (MSI)

The Marie Stopes organisation began to provide family planning services in 1976, eight years after legal abortion became legal. Women were still having difficulty in getting help they could afford – the NHS was providing only 49 per cent of all abortions for women living in England and Wales.

PAS and BPAS had expanded sufficiently to compete effectively with the private gynaecologists, who were finding it necessary to reduce their fees. But women had easy access to the independent charitable services only in the London and Birmingham regions. There was plenty of scope for a third not-for-profit provider.

The organisation was the creation of Tim Black and his wife Jean. Tim Black's postgraduate experience had been in general medicine rather than gynaecology. In 1966, as a young doctor in charge of a hospital in Papua New Guinea, he had become acutely aware of the severe hardship inflicted on women who lack easy access to effective fertility control – he realised “that preventing a birth could be as important as saving a life”. On his return from New Guinea in 1968, he obtained the diploma of the Liverpool School of Tropical Medicine and Hygiene and, in 1970, fellowships from the Population Council and the Ford Foundation to study for a master's degree in population dynamics at the University of North Carolina, USA.

While on the course, Tim Black and a co-student, Phil Harvey, set up an organisation that sold condoms by post. Tim Black moved to Kenya in 1972 to organise and run Contraceptive Social Marketing; Phil Harvey remained in the USA where he used his considerable entrepreneurial skills to make contraceptive devices available online. Their joint activities resulted in their contributing a chapter on the commercial distribution of contraceptives in a book co-edited by Malcolm Potts⁵⁰.

Tim Black and his wife Jean returned to England in 1974, where they founded Population Services Family Planning Programmes Limited with the intention of making contraceptive devices easier to buy in Britain. In 1976, the clinic in central London that had been opened by Marie Stopes in 1925 went into liquidation. Tim Black seized the moment and, with help from Phil Harvey, bought the lease of the historic premises at 108 Whitfield St, London W1 as a base for their company. The services provided in Whitfield Street for people living or working in Central London were similar to those that had been provided by the previous leaseholder but was soon expanded by a network of vasectomy centres in many parts of England. These produced enough surplus income to initiate fertility control services outside in other countries, beginning with The Well Woman Centre in Dublin and followed by similar initiatives in India, Sri Lanka and Kenya – abortion is offered only in countries where this is legal.

The services in developing countries attracted support from the Government and international donors. This expansion of Family Planning Services Ltd evolved into Marie Stopes International. MSI kick-starts the overseas services, and may help by negotiating financial support from major donors, but are intended to be run by local staff and financed from fees the local people can afford. MSI acquired its first abortion clinic in England in 1980 and, like BPAS, has bought private clinics throughout the country that were in danger of closure because of falling admissions for private general surgery and terminations; the result of competition from newly-built, more luxurious, private hospitals and the charitable abortion services.

⁵⁰ *New Concepts in Contraception*, Eds. Malcolm Potts and Clive Wood. Kluwer Academic Publishers (Oct 1972).

NHS provision in Scotland

The NHS gynaecologists in most parts of Scotland were much more willing to provide legal abortions than those in England. The women referred by their general practitioner for NHS abortions used the same outpatient clinics and wards as did women receiving other types of gynaecological care. Access was so adequate that the women who had private abortions were usually from the small well-to-do minority who paid for all their medical care. Women with strong social reasons for concealing their pregnancies probably travelled to London to obtain help.

The gynaecologists of Aberdeen, Dundee and Edinburgh had been influenced by the teaching and practice of Professor Dugald Baird who had prepared the ground for a liberal interpretation of the Abortion Act. This liberal tradition was maintained by his successors in the Aberdeen chair. Ian MacGillivray, appointed in 1965, supported a large study of the long-term social and psychological outcome when Aberdeen women either had their request for abortion approved or refused by the NHS consultants⁵¹. His successor, Alan Templeton, not only provide a local service but was also a leader in the development of early medical abortion – the research published from his unit influenced abortion practice all over the world.

The provision of abortion in western Scotland in the first half of the 1970s was poor to non-existent. Most of the consultant gynaecologists in that region followed the lead of Ian Donald, Regius Professor at Glasgow University, a staunch protestant; he taught that abortion is immoral unless the woman's life is in danger. An additional factor was that some gynaecologists were Roman Catholics, a reflection of the high prevalence of Catholicism in the local population. Women who could afford to pay travelled to London for private care and, by the mid-1970s, to Liverpool or Manchester to use the newly established not-for-profit services. The situation in Glasgow slowly improved after 1970 when Malcolm Macnaughton was appointed Muirhead Professor; he had been a lecturer in Aberdeen and, motivated by Dugald Baird, set an example for Glasgow gynaecologists by establishing an NHS abortion service within his professorial unit.

⁵¹ Horobin G (ed). *Experience with abortion*. 1973, Cambridge University Press: Cambridge.

Chapter 6. Birth Control Campaign and Birth Control Trust

In 1970, the members of the ALRA executive, led by Vera Houghton and Alastair Service, decided that having achieved its immediate aims, a new organisation was necessary to make the case in Parliament that it was anomalous, now that legal abortion was provided free of charge by the NHS, that there should still be a need to pay for contraception. In 1972 most family planning clinics were run by the Family Planning Association, a charity that charged a fee to cover costs and restricted its services to married women, or those about to marry. It was argued that advice and supplies should be made available through the NHS, regardless of marital state.

Diane Munday, while supporting this view, argued that a significant minority of MPs were strongly opposed to the permissive wording of the Act. She pointed out that, as long as the anti-abortion lobby remained active, ALRA would continue to have an important role. It was decided the ALRA should continue, with Diane as general secretary, and that a new pressure group, Birth Control Campaign, should be established.

Birth Control Campaign (BCC)

Alastair Service agreed to be chairman and Dilys Cossey became the general secretary. The primary object of BCC was to promote a free and comprehensive birth control service in the NHS. The Family Planning Act 1967 had enabled local authorities to provide, either directly or through voluntary organisations, contraceptive pills and appliances to any person who needed them but had suggested that a charge should usually be made for the cost of the materials and left some uncertainty as to whether “person” included men and women who were not married. The NHS (Family Planning) Amendment Act 1972 added vasectomy to the local authority list of services – tubal ligation was already available at the discretion of NHS hospital gynaecologists.

BCC was launched on 21 April 1970 at a well-attended evening meeting in a committee room at Westminster with Lord Gardiner in the chair and Malcolm Potts, newly appointed as Medical Director of the International Planned Parenthood Federation, as the speaker. A press conference was held the following day. This attracted a paying membership and local groups were formed in Liverpool and Southampton, and in several other centres. A regular newsletter was circulated to MPs and members. Income was also obtained from subscriptions to *Parliamentary Questions and Population References (PQPR)*, a weekly abstract of relevant topics compiled from Hansard.

In 1972-73, the consultations that preceded the passing of the National Health Service (Reorganisation) Act 1973 created an opportunity to include a section on the provision of contraception. This was achieved after several months of interviews with the media, letter writing to the press and very effective lobbying of parliamentarians by key MPs and peers, such as Rt Hon Douglas Houghton MP, Sir George Sinclair MP, Dr Tom Stuttaford MP, Chris Price MP, Lord Vernon, Baroness Gaitskell, as well as by Alastair Service and Dilys Cossey. The result was Section 4 of Act.

This reads:

It shall be the duty of the Secretary of State to make arrangements to meet all reasonable requirements in England and Wales, for the giving of advice on contraception, the medical examination of all persons seeking advice on contraception, the treatment of such persons and the supply of contraceptive substances and appliances...

This made contraception available in the NHS, to anyone, free of charge, and whether single or married. This became effective in April 1974. Implementation for female methods was immediate in family planning clinics. General practitioners were more reluctant but, in February 1975, agreed an annual item-of-service payment of £3.50 for pill and cap and £10 for fitting an IUD⁵². Free condoms were rarely issued to or requested by men in person but were sometimes given to women for their male partners. The change in the law resulted in a major expansion of the national provision of contraception and led the Family Planning Association (fpa) to transfer almost all of its clinics to the NHS so that it could concentrate on training health professionals and educating the public.

The growing threat to the Abortion Act from a succession private members' Bills resulted in BCC remaining active in Parliament after its primary objective had been achieved. The leading members of the Executive Committee had developed a small but effective pro-choice lobby and, with a modest income from subscribing members, saw themselves as the Westminster arm of ALRA. This renewed activity was driven by the continuing public and political debate on the morality of abortion and the causes of unwanted pregnancy and was informed by the tabloid press, the Society for the Preservation of the Unborn Child (SPUC), and the Roman Catholic Church – whose greatest achievement had to persuade the public that the foetus is an unborn child; with the implication that the moral status of the foetus is equal to that of people who had been born and that abortion is murder.

A further concern was that some general practitioners and gynaecologists were being judgemental in their consultations with women requesting abortion, limiting access to treatment in the NHS, and showing a lack of understanding of the causes of unplanned pregnancies and the difficulty of using contraception effectively. The BCC executive decided there was scope for a new charity that could help women with unwanted pregnancies with advice on obtaining legal abortion and these women, politicians, the media and the public, accurate information about methods and complication, and the need for improved sex education.

Birth Control Trust (BCT)

Birth Control Trust was set up in June 1972 as a registered charity with the following objects:

- To advance medical and sociological research in contraception, sterilisation and lawful termination of pregnancy and their demographic effects and to publish the results of such research;

⁵² *The Fight for Family Planning*, Audrey Leathard, Macmillan 1980 p. 203.

- To educate the public in the field of procreation and contraception with particular reference to personal responsibility in sexual relationships;
- To preserve and protect the good health both mental and physical of parents, young people and children and to prevent the poverty, hardship and distress caused by unwanted pregnancy;
- To provide advice and assistance for women who are suffering from any physical or mental distress as a result of unwanted pregnancy or the risk of unwanted pregnancy.

BCT was conceived by Vera Houghton, Alastair Service and Madeleine Simms. I became a trustee together with Lady Monckton, Donn Casey, Clarice Ellison, Caroline Woodroffe, Lord Vernon and Lord Winterbottom, all of whom became members of the executive committee (the titled members usually attended only for the AGM). Caroline Woodroffe was the first chairman, followed by Vera Houghton when Caroline replaced Lady Brook as chief executive of Brook Advisory Centres. I took over from Vera in 1981 and remained in post until 1998.

BCT received regular donations from several charitable trusts. Chief among them was the Cadbury Trust, a generous and consistent funder; others included the Ajahma Trust, the Pamela Sheridan Trust and the Simon Population Trust. This income enabled BCT to employ a full-time secretary, some part-time assistance and to rent office space in central London. BCC was based in the BCT office and used its facilities but had a separate executive committee and accounting systems.

In the late 1970s, funds were given by the UN Population Fund (UNFPA) to support an All-Party Parliamentary Group (APPG) on Population, Development and Reproductive Health with a desk in the Palace of Westminster. The founding parliamentarians were Rt Hon Lord Houghton of Sowerby and Sir George Sinclair; Dilys Cossey was its first secretary. BCT benefited greatly from a succession of secretaries including Joanna Chambers, Jane Roe, Cerys Williams, and Madeleine Tearse. Its most productive years began in 1992, when Dilys Cossey became Director and Ann Furedi her Assistant Director. Ann succeeded Dilys and was the Director from 1995-98.

BCT commissioned and published a long series of booklets, of which the most successful were:

- *The Pill Off Prescription*, by Michael Smith and Penny Kane (1974)
- *Report on Non-medical Abortion Counselling*, by Madeleine Simms (1973, reprinted 1977)
- *Advertising and Contraceptives*, by Suzie Hayman (1977)
- *Teenage Pregnancy in Britain*, by Judith Bury (1984, reprinted 1988).

Most of the publications in the 1980s and 90s were based on the proceedings of all-day meetings with invited speakers and fee-paying audiences of health professionals, politicians and journalists. In the 1990s, I wrote most of the introductions and edited the text, sometimes writing up a talk from a speaker's notes. The booklets included:

- *Day Care Abortion and the NHS* (1980)
- *Sterilisation and the NHS* (1981)
- *Sterilisation: Services Organisation Procedures* (1983)
- *The Abortion Pill* (1990)
- *Running an Early Medical Abortion Service* (1993)
- *Abortion Services in England & Wales* (jointly with PAS, 1994)
- *Purchasing Abortion Services: a Guide for Fundholders* by Birth Control Trust (1996)
- *Antenatal Screening and Abortion for Foetal Abnormality* (1997)
- *Twenty Questions About Emergency Contraception Answered*, by David Paintin (1998)
- *Twenty Questions About Legal Abortion Answered*, by David Paintin (1997).

BCT also published *A Model Specification for Abortion Services* (1991) that was widely adopted as the outline for many of the contracts between NHS Trusts and the independent providers BPAS, PAS and Marie Stopes. I wrote this, with considerable help from Sheila Adams with the details of the NHS commissioning process and the style preferred in such documents by the Department of Health.

Apart from a telephone service to provide advice about abortion for women, BCT became a leading source of information on reproductive health for journalists and politicians. Working with the All-Party Group on Population, Development and Reproductive Health and other informal groupings of MPs and peers, many meetings were arranged at Westminster to provide background facts during the frequent attempts to amend or restrict the Abortion Act or when some aspect of reproductive health was in the news. I prepared briefs on the alleged associations of induced abortion with psychiatric illness and breast cancer; the inability of the foetus to feel pain at less than at 24 weeks; the safety of day-care abortion; why abortion should be an option following the antenatal diagnosis of Down's syndrome; the safety of oral contraception; the value of emergency contraception; screening for infection with chlamydia, and others. BCT occupied a significant part of my time until 1998.

The fpa and BCT were closely associated. Alastair Service was chairman of the fpa from 1975 to 79, and the general secretary 1980 to 89. Dilys Cossey was fpa chairman 1987-1993. BCT rented a room in the BPAS headquarters in Mortimer St, moving across the road when the fpa moved to new premises in Islington. There was some overlap between BCT and the fpa as the lead source for the media when a reproductive health topic became a news story. In the 1970s, BCT focused on termination of pregnancy and the fpa on sexual behaviour and contraception.

But in the 1980s and 90s, BCT was approached increasingly for comments on contraception and had the advantage of being able to provide a prompt medical opinion, and an expert immediately available for interview on radio or television. In the 1990s, the fpa became concerned that their

expert role was being challenged but BCT felt journalists should be free to select their sources and that there was room for both organisations. The matter was resolved in 1998 when BCT was wound up, leaving the fpa free to give more priority to the role of legal abortion in reproductive health. The fpa took over unsold copies of BCT publications and some of the BCT library. The Wellcome Trust holds selected historically significant papers for preservation in its archives.

Chapter 7. Parliamentary reaction to the effects of the Abortion Act

Criticism of the operation of the Abortion Act began as soon as notification data became available. This was based on the rapid and sustained increase in notifications and, particularly, on the provision of abortion by private clinics for women living outside Britain. These data were regarded by the anti-abortion lobby as clear evidence that the law was being interpreted much too permissively. There were also two or three reports of abortions at 20 or more weeks that had resulted in the expulsion of living foetuses that had been allowed to die rather than registered as a live birth and given proper neonatal care.

The need to provide coordinated opposition to the anti-abortion activity in Parliament led to the formation of the Co-ordinating Committee in Defence of the 1967 Abortion Act (CO-ORD). This was an ALRA/BCC/BCT initiative and brought together the many pro-choice pressure groups – ALRA/BCC, National Abortion Campaign (NAC), Labour Abortion Rights Action Group (LARC), National Council for Civil Liberties, Brook Advisory Centres, Marie Stopes Clinics, BPAS and PAS. From a group of 16 organisations at its inception, by 1980 it had 56 member-organisations. In 1978 a CO-ORD Lawyers' Group was set up by Bill Birtles⁵³ to provide *pro bono* advice and help, particularly with drafting amendments to legislation.

My involvement in the Parliamentary pro-choice lobby during the period 1969 to 1980 was focused on attending meetings of CO-ORD and writing briefs when there was a need to inform MPs and the media. During this decade, I was fully occupied by clinical work, undergraduate teaching and the need to adjust to the major reorganisation of the Department at St Mary's resulting from the replacement of Professor Peter Huntingford by Richard Beard. The definitive description of the attempts to restrict the Abortion Act during these years is *Abortion Politics* by David Marsh and Joanna Chambers (Junction Books, London, 1981) – I have used their work (and *Hansard*) to expand the gaps in my memory.

Problems with provision by private clinics 1968-71

Investigative journalists reported that some women were being charged disproportionately large fees and that one or two clinics were commissioning taxi drivers at London Heathrow to bring them women asking at the airport about abortion services in London. More seriously, some private clinics were not providing safe medical care. NHS gynaecologists in central London were reporting the emergency transfer to their units of an unacceptable number of women with severe intra-operative complications. I managed two such patients at the Samaritan Hospital: both had uterine perforations and required blood transfusion and urgent abdominal surgery – one woman had been operated upon by a GP with minimal gynaecological experience and had a uterus so badly damaged that hysterectomy was necessary. Such clinics had been opened by entrepreneurial doctors keen to exploit a new market and under the misapprehension that termination of pregnancy did not require special training.

⁵³ Bill Birtles, then a young barrister, was a trustee and chairman of the board of PAS from 1981-84. He retired in 2014 as His Honour Judge William Birtles.

The only successful prosecution was of a doctor who maintained that he had acted in good faith to protect mental health of a single woman aged 19 when he terminated her pregnancy in April 1970⁵⁴. There was convincing evidence that the assessment had been perfunctory and the surgery incompetent. The late production of the scanty case notes and Certificate A suggested these might have been written in retrospect; the operation note stated that miscarriage was already in progress although the woman stated she had no bleeding before or after the surgery and that she aborted at home two days later. The fee of £150 (about £1,900 in 2005) was demanded on arrival at the nursing home, where the manager was found guilty of making a false entry in the register. The judge said that only the jury could decide if the doctor had acted in good faith. The verdict was guilty and was upheld in the Court of Appeal. The case rested solely on the convincing evidence of malpractice and provides no guidance on how to assess “a threat to physical or mental health”.

Norman St John Stevas MP sought to take advantage of this atmosphere of criticism by introducing the first of many attempts by to amend the Act restrictively through a private member's Bill. He was supported strongly by the Society for the Protection of the Unborn Child (SPUC) and the Roman Catholic Church, and by right-wing newspapers such as the *Telegraph*, *Daily Mail* and *Daily Express*.

Abortion (Amendment) Bill (15/7/69). Ten-Minute Rule Bill: Norman St John Stevas⁵⁵

This had the intention of restricting the availability of legal abortion by requiring that one of the two certifying doctors should be “...a consultant gynaecologist in the NHS or a doctor of similar status approved for this purpose by the Minister of State”. St John Stevas argued that the rapid increase in private abortions must mean that private doctors were not interpreting the law responsibly and were “making huge fortunes” – he claimed that in the first three months of 1969 there had been 52 abortions in the NHS but 5,000 in the private clinics.

In response, David Steel said that the Act was achieving its object of reducing criminal abortions: admissions via the Emergency Bed Service for incomplete abortion in the first quarter of 1966 had been 1363 but had fallen to 870 in same period in 1969. There were only about 600 NHS consultant gynaecologists in the country, and insisting on consultant involvement in every case would seriously limit provision and force women back into illegal abortion.

The Bill was defeated but by only 11 votes: Ayes 199: Noes 210. There was a further attempt with a similar objective the following February.

Abortion (Amendment) Bill (13/2/70). Private Member's Bill: Bryant Godwin Irvine⁵⁶

Closely similar to the St John Stevas Bill, this was “...designed to limit the more blatantly commercial exploitation of the new law that is largely carried out in London”. David Steel summed up his opposition with the following quotation from the current issue of *The Lancet*:

Mr Irvine's Bill is out of place. What difference can it make? Few abusing doctors will be excluded from the market by legislation that requires a Government department to

⁵⁴ *Regina v Smith* 19 July 1973 1 WLR 1510.

⁵⁵ HC Deb 15 July 1969 vol 787 cc411-24

⁵⁶ HC Deb 13 February 1970 vol 795 cc1653-703

pronounce that they are not of equivalent status. Perhaps, under the cover of this device, some supporters of the Bill are reviving long-rooted opposition to the reform.

The Bill was talked out: Douglas Houghton was still speaking at 4 pm, the scheduled end of the debate.

The Lane Committee, 1971 – 1974

By 1970, it was evident that the original criteria for approving clinics had been inadequate. With little or no publicity, the Department of Health strengthened the requirements for the approval of private clinics: more stringent inspections were introduced; two or three private clinics in London were closed and the medical owner of one of them was found guilty by the General Medical Council of advertising for patients in a German newspaper but was then reprieved on technical grounds by the Privy Council.

The Conservative government of Edward Heath came under increasing pressure from parliamentary questions and articles in the tabloid press. The result was that the Secretary of State for Health, Sir Keith Joseph, convened the Committee on the Working of the Abortion Act, chaired by The Hon Mrs Justice Lane. This was appointed in June 1971 and reported in April 1974. The terms of reference were “To review the operation of the Abortion Act ... on the basis that section 1 of the Act remains unamended, and to make recommendations”, and implied that the Government supported the principles of the Act.

This inference that was confirmed when it became apparent that none of the 15 members of the Committee were known opponents of the Act. These were the two pro-choice gynaecologists, Miss Josephine Barnes, and Professor AC Turnbull (a protégé of Sir Dugald Baird); sociologists Miss Judith Cheetam and Mrs Eva Lerner, who were both known to support women’s choice; Dr Rosemary Rue, Medical Officer for Oxford Regional Health Authority with a particular interest in equal employment for women; two Queen’s Counsels and senior representatives from the Royal College of Nursing (RCN), Royal College of Midwives (RCM), and British Medical Association (BMA). Dr Doreen Rothman was the medical secretary. There were 55 days of deliberations, some away from London; many witnesses were called and several surveys commissioned.

The Lane Committee’s three-volume report was published in April 1974 and provides a detailed account of abortion provision at that time⁵⁷. The findings were summarised by the statement: “... we are unanimous in supporting the Act and its provisions. We have no doubts that the gains facilitated have much out-weighted any disadvantages for which it has been criticised.” The only major change proposed was a reduction in the gestational limit for abortions from 28 to 24 weeks. The provision of abortion services for non-resident [foreign] women was not criticised but it was stated some restriction might be necessary if abuses connected with their treatment persisted.

The most important recommendations were:

⁵⁷ *Report of the Committee on the Working of the Abortion Act, 1974*; Cmnd. 55793, vol 1, pp 288. Her Majesty’s Stationery Office: London.

- the NHS should be the main provider of legal abortion, through existing gynaecological services rather than in specialist units;
- as far as possible, all abortions should be before 12 weeks;
- day care should be encouraged both in the public and private sectors;
- NHS contraceptive services should be adequate and acceptable;
- contraceptive advice and prescription should be offered to all maternity and abortion patients;
- health professionals should have improved training in the problems associated with abortion;
- education on human and sexual relations, including contraception, should be provided in schools.

The Labour Government of Harold Wilson (in office from March 1974) did not respond immediately to the report of the Lane Committee. This may have been because the Prime Minister was personally uncomfortable about abortion or because the Lane conclusions supported the Act and did not validate the vehement criticism of the Act by Conservative MPs and the tabloid press. The Government may have been hoping that a further private member's Bill would be introduced that would take the issue out of party politics.

A particularly egregious but influential example of anti-abortion propaganda appeared two months before the Lane Report was published. The *News of the World* on 29 February 1974 and for the following three weeks carried a series of articles by Michael Litchfield and Susan Kentish under the headline "Phantom Babies". The authors had posed as a couple with an unwanted pregnancy. Susan Kentish, although not pregnant, had her urine tests reported as positive by seven pregnancy testing services and, when referred on to abortion providers, was informed that both the pregnancy tests and examinations confirmed that she was pregnant. She was always offered an abortion because she and her partner indicated that the pregnancy was unwanted, even though the reasons behind their request were "trivial".

The journalists claimed, on the basis of this very limited research, that the abortion law was widely abused. This material was the basis of their book *Babies for Burning* published in December 1974 (reviewed in the *BMJ* by Richard Beard and myself.⁵⁸). In this, they claimed that among the doctors who arranged and performed legal abortions were some with debased moral values, who admired fascism, and cared only for money. They also said they had been told of a foetus being thrown alive into an incinerator, and that foetuses had been sold to cosmetic firms for the value of their body fat.

Litchfield and Kentish had no direct evidence that their claims about foetal disposal were true and appeared unaware that the immature foetus has negligible stores of body fat. Their research into their experience of abortion providers proved difficult to substantiate but was sufficient to create uncertainty about the integrity of some private clinics. The book, although obviously flawed, was regarded as likely to be true by many anti-abortion parliamentarians. Litchfield and Kentish were

⁵⁸ *BMJ* 1975;1doi: 10.1136/*BMJ*.1.5953.340

successfully sued for libel by one of the gynaecologists, Dr Bloom, in 1977, and by BPAS in 1978 for a dishonest and damaging account of a clinic visit. The court ordered that that the book should be withdrawn and existing stock destroyed.

The intensity of the anti-abortion campaign led to a sequence of private members' Bills that the anti-abortion MPs hoped would achieve their aim of amending the Act. The first of these was the Abortion (Amendment) Bill sponsored by James White, discussed below. It was on 7 February 1975, during the Second Reading of that Bill, that Dr David Owen, Minister of State for Health, gave the Government's first response to the Report of the Lane Committee (10 months after it had been published). He made the following points:

- The Lane Committee concluded that by facilitating a greatly increased number of abortions the 1967 Act has relieved a vast amount of individual suffering.
- The Committee has rightly drawn attention to the strain imposed on the National Health Service by the increased number of women seeking legal abortion since the passing of the Act and the marked inequalities over the country in the provision of services.
- The Committee acknowledges that the private sector has enabled many patients to have treatment in privacy and with the amenities they want and has compensated to a considerable extent for deficiencies in the provision of services by the NHS.
- At the same time it points out that the private sector has contributed to the inequalities of which many responsible people complain:
 - a small number of doctors and their financial backers have used the Act to make large sums of money;
 - there have been instances of gross irresponsibility in private medical practice;
 - in some parts of the commercial private sector the provisions of the Act have been flouted and abortion on request has been provided.

Dr Owen went on to say that since taking office in March 1974, action had been taken to tighten up on abuses in the private sector:

- the 28 private clinics with more than 6 beds have been registered only until 31 March pending their response to a letter asking about facilities, fees charged, relationships with referral agencies and the intake of foreign patients;
- 70 referral agencies have been asked to comment on a proposed conditions for them to practice and those that fail to reply ("more than half") will not be approved;
- the Government was consulting on the appropriate level for medical fees and considering requiring private clinics to quote a fixed comprehensive fee.

Abortion (Amendment) Bill 1975. Private Member's Bill: James White⁵⁹

James White presented his Bill as necessary to control the exploitation of non-resident women

⁵⁹HC Deb 07 February 1975 vol 885 cc1757-868

seeking help in London from private abortion providers but his main purpose was to remove the wide discretion the Abortion Act allows doctors when assessing whether a woman's health was at risk because of a pregnancy: essentially, to allow only those terminations necessary because of serious physical or mental illness.

The proposed amendments were to:

- increase the threat to the life to “grave” and to health as “serious”;
- remove the requirement that the risk of continuing the pregnancy should be “greater than if the pregnancy was terminated”;
- specify that the two certifying doctors “should not normally be in practice together” and that one should have “a minimum of five years’ experience”;
- require approved nursing homes to have on their staff a consultant medical advisor to superintend clinical procedures, medical staff appointments and the use of the home by doctors;
- require foreign women to have been resident in the UK for 20 weeks;
- reduce the gestational limit to 20 weeks;
- prohibit the charging of fees for referring a woman for abortion.

The Second Reading was on 7 February 1975. James White introduced the Bill by saying: “I insist that abortion must be available to all women with problems... What concerns people is the abuses that have come about because of the Act. This is now a public scandal...” He went on to say that he was delighted the Government had offered to set up a Select Committee and that he wanted an assurance from the Minister that this would be reappointed if unable to complete its work before the end of the session. He said:

The abuses which cause so much public concern operate largely in the private sector. But there were profound misgivings in the wider community ... that relate to late abortions ... There is concern about the growing number of foreign women who are lured into Britain... [by commercial operators] ...in the knowledge that for cash a group of doctors will perform illegal abortions on request, totally ignoring the criteria of the Act... ; ... in 1971 the notified number of foreign women coming here in 1971 was 30,000; in 1972 it was 49,000 and in 1973 it was 56,000. We are not concerned only with foreign women. We want a tighter control on [all] clinics, to ensure that skilled and ethical medical staff work in them. We must also consider the position of the live foetus or potentially live foetus and how it is disposed of, whether for research or even perhaps for commercial purposes.

The Minister of State for Health, David Owen, in the latter part of his speech on the Lane Report emphasised the Government's support for the unamended Act. He said:

We are unanimous in supporting the Act and its provisions. We have no doubt that the gains facilitated by the Act have much outweighed any disadvantages for which it has been criticised. The problems which we have identified in its working, and they are admittedly considerable, are problems for which solutions should be sought by administrative and professional action, and by better education of the public. They are not, we believe, indications that the grounds set out in the Act should be amended in a restrictive way. To do so when the number of unwanted pregnancies is increasing and before comprehensive services are available to all who need them would be to increase the sum of human suffering and ill-health, and probably drive more women to seek the squalid and dangerous help of the back-street abortionist. The Committee was unanimous in its conclusion that there should be no restrictive amendment to the grounds for abortion set out in the Act.

David Steel welcomed the opportunity for a debate on the working of the Abortion Act. His speech contains the fullest description he ever gave to the Commons of the purpose of the Act⁶⁰:

I want to remind the House that one of the main reasons why Parliament passed the 1967 Act was that we were determined as a House to stamp out from this country the scourge of criminal abortion. We can look back over the official figures of deaths of women in this country from abortion. We can see that they have been falling steadily from the high point of 62 in 1960, before the Act, to the very small figure of 12 deaths last year from abortion, of which only six were from criminal abortion.

There is ample evidence from the medical profession that criminal abortion has been virtually eliminated from Britain. Some Members who met members of the medical profession in a room downstairs earlier this week were told of a renal dialysis unit which was set up in a hospital in London just before the 1967 Act specially to deal with the after-effects on women who had taken drugs in an attempt to abort themselves. Happily, that unit is now closed through lack of patients.

We were told of the eye consultant who finds that in his practice he no longer has to deal with the effects on women who have either partially lost or in some cases wholly lost their sight through overdoses of quinine. Such cases no longer come to him. We were told by a general practitioner in North London that in the course of his ordinary practice he used to have four or five patients a year who were tragic cases of sterility or were suffering from severe physical damage as a result of criminal abortion. He no longer has such cases.

The official Home Office records show that there has been a drastic reduction in the number of criminal prosecutions each year for abortion offences. All of this is on the good side. It is necessary for the House to take a balanced view of the good and the bad in the working of the 1967 Act.

He added that although annual numbers of legal abortions had increased to 163,000 in 1974, this

⁶⁰HC Deb 07 February 1975 vol 885 cc1764-67

was within the estimate of from 100 to 200,000 illegal abortions each year before the Act, and that the rate of 154/1000 live births for England and Wales was modest by European standards. David Steel agreed with the Lane Committee that:

Much of the adverse criticism is justified: in consequence of the Abortion Act, a situation has arisen in which a very small number, of perhaps about 20 or 30 members, of the medical profession and those associated with them have brought considerable reproach on this country, both at home and abroad. It was never the intention of the House when we passed the Act that we should have a situation in which commercial referral agencies would establish themselves in association with private clinics, and in which doctors on a moneymaking basis could advertise abroad, bringing people here and paying back-handers to taxi drivers, in order to make as much money as possible.

He went on to point out that: "While it is the responsibility of the House to decide the ethical basis on which the law should rest, in my view it is the responsibility of the Government, once Parliament decides the ethical basis of the law, to ensure that the law is administered fairly and competently and without abuse", and continued:

The requirements that the risk has to be serious and the injury to health grave in Clause 1(1)(a) are capable of causing considerable difficulties in practice and may mean that terminations carried out on certain medical indications which are accepted under current medical practice would become questionable in future.

Many members spoke: the debate began at 11:08 am and continued almost to the time limit of 4 pm. The Second Reading was passed: Ayes 203, Noes 88. The House then agreed that the Bill should be committed to a Select Committee.

The Select Committee(s) on the Abortion (Amendment) Bill 1975-76

The Select Committee met 22 times between March and November 1975 and produced four special reports (a majority of the Committee were of James White's point of view; the MPs supporting the Act were David Steel, Betty Boothroyd, Joyce Butler, Helene Hayman, Dr M. S. Miller, and Sir George Sinclair). The time taken by the Select Committee was due to a series of blocking amendments drawn up by CO-ORD and the MPs on the Committee who opposed the Bill. This involved BCC/BCT in many early-evening planning meetings at Westminster, which I attended if clinical duties permitted. We were assisted in the drafting process by several young women barristers.

In the next parliamentary session, the Commons voted to re-appoint the Select Committee but this time it consisted only of the MPs opposing the Act. David Steel and his supporters declined to attend: it was clear to them that the intention of the Committee was destructive rather than constructive. The reduced Committee met 28 times between February and November 1976 and produced two further reports. In effect, the text of the 1967 Act was examined in detail, together

with the findings of the Lane Committee and oral and written evidence invited from wide range of individuals and organisations.

The report of the Select Committee supported the restrictive aims of the original White Bill and recommended some further restrictions. It was presented to the Commons in July 1976. The Government responded by reiterating what had been said about the report of the Lane Committee: in effect that abortion provision was now more strictly regulated and, by implication, that further action was unnecessary.

Barbara Castle, Secretary of State for Health, report on measures already taken to control abuse of the Abortion Act

Barbara Castle spoke on 10 October during a meeting of the Select Committee. She reported on progress made by her Department in controlling abortion provision by private clinics. Among other things, she had:

- received assurances on the total fees charged and on financial arrangements between referral agencies and nursing homes;
- ruled that only private clinics with adequate facilities would be approved for abortions after 20 weeks and that such clinics must have equipment for resuscitating any foetus born alive;
- required clinics to make quarterly returns on the number of foreign patients;
- drafted a revision of the Abortion Regulations 1968 that would:
 - permit the Chief Medical Officer to disclose information about particular notification to the Chairman of the General Medical Council when there was evidence of medical misconduct;
 - add “Have/have not* seen” and “Have/have not* examined”, for each certifying doctor to “*delete as appropriate”, for the both certifying doctor to mark before adding their signatures. Similar wording was inserted in the buff notification form.

The revised Regulations were laid before Parliament in February 1976 and became law on 1 March. The green form (HSA1) now offered the doctors the option of indicating that they had seen but not examined the woman. It appears that, for the Chief Medical Officer, it was sufficient that two doctors gave their opinion and that they could be trusted to adjust their assessment process to the circumstances of each case.

Abortion (Amendment) Bill 1977. Private Member’s Bill: William Benyon MP⁶¹

This Bill was similar to that of James White, and was introduced because the restrictive recommendations of the subsequent Select Committee had not been adopted by the Government. The Second Reading was passed by 170 to 132 on 25 February and was referred to a Standing Committee. The proceedings were prolonged by amendments drafted mainly by CO-ORD and BCC/BCT, and the Bill ultimately failed for lack of parliamentary time.

⁶¹ HC Deb 25 February 1977 vol 926 cc1783-895

Abortion (Amendment) Bill 1977. Ten-Minute Rule Bill: Sir Bernard Braine MP⁶²

The First Reading was on 21 Feb 1978. Sir Bernard said that the Select Committee's report on the White Bill had been ignored by the Government and the purpose of his Bill was to introduce of the three changes that had been recommended:

- the time limit for abortion should be reduced from 28 to 20 weeks;
- the provisions for conscientious objection to abortion by medical and nursing staff should be strengthened;
- pregnancy advisory bureaux should not be allowed to have any financial connection with abortion clinics.

The Commons voted in favour by 181 to 175 but, as with almost all Ten-Minute Rule Bills, no further parliamentary time was allocated and the Bill did not progress.

Abortion (Amendment) Bill 1979. Private Member's Bill: Mr John Corrie MP⁶³

John Corrie drew first in the private members' ballot when Parliament was reconvened after the general election in 1979 when the Conservatives, led by Margaret Thatcher, replaced Labour, led by James Callaghan. The anti-abortion lobby – SPUC, Life and the Roman Catholic Church – had been very active during the election campaign, focusing on the humanity of the foetus and the need to make the grounds for legal abortion more stringent; in particular, to prevent the Act being interpreted by some doctors as allowing abortion on request as always being safer than continuing the pregnancy to term.

The Corrie Bill was supported by many Conservatives: Mrs Thatcher and several of her ministers were known to support restriction of legal abortion and, of the 60 new Conservative MPs, 59 were to vote in favour of anti-abortion legislation. John Corrie took two or three weeks to come to a firm decision to make abortion law reform the subject of his Bill – he had not been prominent among the anti-abortion MPs in the previous session. He consulted widely not only with SPUC and Life but also with the Department of Health, the BMA, the RCOG, and Doctors in Defence of the Abortion Act. When the Bill was published, only two or three days before the Second Reading, it had eleven lengthy clauses and was clearly intended to remove all aspects of the Abortion Act that allow doctors to provide the abortions that women had, previously, obtained illegally.

Among the many amendments the most important were as follows:

- the risk to life to be “grave”, to health “serious” and “substantially” greater than if the pregnancy was terminated, such opinion having been formed on the basis of individual examination alone [i.e. not only from reading the notes made by the first doctor];
- the gestational limit to be less than 20 weeks – by amending the Infant Life (Preservation) Act (ILPA) 1929;
- the conscience clause to be expanded to include objection on “religious, ethical or other

⁶²HC Deb 21 February 1978 vol 944 cc1213-24

⁶³HC Deb 13 July 1979 vol 970 cc891-983

grounds” and to remove the burden of proof from the person claiming objection to the prosecutor.

- separation of private referral agencies from abortion providing clinics, with more stringent licensing and inspection by the Department of Health.

The Second Reading of the Corrie Bill took place on 13 July 1979. John Corrie set the tone of the debate when he said:

At the end of the 1967 debate the Right Hon. Member for Roxburgh, Selkirk and Peebles said that it was not the intention of the promoters of the Bill to leave a wide open door for abortion on request. Sadly, that is exactly what happened. Members who supported the 1967 Act are now deeply and sincerely worried about its effects. Now we must decide whether we continue to support that Act. ... As far back as 21 July 1971 Professor Peter Huntingford first stated in *The Daily Telegraph* that he was practising abortion on request. He said: “I have no qualms about this at all, and I am quite certain that it does not contravene the Abortion Act”. He added that the Act allowed abortion when the risk of permitting the pregnancy to continue was greater than the risk of the abortion. The simple fact is that when an abortion is carried out in the first 12 weeks of pregnancy it is safer than allowing the pregnancy to go to full term.

Imposing more stringent requirements for assessing the risk to health, and the deletion of the definition of “risk” that supported the “statistical argument” for abortion on request used by Peter Huntingford, were principal aims of the Bill but of equal importance was a reduction in the gestational limit to less than 28 weeks. The latter concern was shared by the pro-choice MPs who could have agreed on 24 weeks – in line with the Lane Committee – but who opposed the lower limits preferred by the anti-abortion members.

Seven speakers supported, and five opposed the Bill, and there were numerous interventions from the floor of the House. The Second Reading was approved: Ayes 242: Noes 98. It was clear that the Bill was a major threat to the pro-choice cause.

At Committee Stage, John Corrie and nine of his supporters, including Michael Ancrum, William Benyon, Sir Bernard Braine, Jill Knight, James Dunn and James White, were opposed by Jo Richardson, Oonagh McLeod, Ian Mikardo, William Hamilton and Stan Thorne – all selected because of their knowledge of abortion politics and their experience of parliamentary procedure. The Minister of Health, Gerard Vaughan, known to support at least some of the aims of the Bill, was present to provide information but did not vote. There were 17 sittings between 25 July and 18 December – a record for a private member’s Bill.

It soon became apparent that the Corrie supporters did not agree among themselves, particularly the priority to be given to the several objectives of the Bill – making abortion less available by

amending the grounds for abortion, removing the “statistical argument” and limiting the charitable providers, PAS and BPAS. Essentially, the Bill was too complicated and its supporters too determined to gain their own outcomes. Corrie proved to lack the depth of knowledge and the leadership skills necessary to coordinate his group. In contrast, his opponents were united in their aims and had much more experience of parliamentary procedure.

The desire to limit the way the charitable clinics were organised conflicted with the reluctance of the Department of Health and Social Security to impose further restrictions on the private sector, aware that the charities were already inspected closely and, as a matter of principle, believing they should be free to make their own decisions about how best to serve their clients. The Bill that emerged from the Committee had been amended extensively. Many of the original clauses had been replaced by alternative wording, particularly those relating to licensing arrangements for private agencies. But in spite of all these changes the four principal objectives of the Bill had been retained: it was as restrictive as it had been at Second Reading.

The Report Stage was also unusually protracted and occupied four Friday sessions. Intense lobbying began in January: CO-ORD wrote to all MPs and ALRA, BCC, LARC and NAC urged their members to do the same. A meeting of Labour members was organised by CO-ORD at Westminster with several speakers, including myself and Bill Birtles. The anti-abortion groups were similarly active – MPs reported that for the first time in their experience they had received roughly similar numbers of letters from both sides. The Speaker tabled an unusually large number of amendments because the changes in Committee had virtually replaced the original text and, to speed the debates, had grouped some amendments.

The gestational limit and the level of risk to health occupied most of the debating time. The attempt to amend the Infant Life (Preservation) Act was on advice from the Department of Health that it would be almost impossible to redraft precisely and in any case, unlike the Abortion Act did not apply in Scotland. Section 1 of the Act was amended extensively to include a gestational limit of 24 weeks; requirements that the risk to the health of the woman should be “serious” and, of continuing the pregnancy, to be “substantially greater”; and abortion when immediately necessary to save the life of the woman became a new sub-section 1A instead of 1.(4) as in the 1967 Act: the latter being an attempt to remove the “statistical argument” being used to justify abortion on request.

During the third day, it became apparent that the Bill was likely to run out of parliamentary time and Corrie and his supporters withdrew the amendments that would have given the minister statutory powers to reduce the gestational limit; extend the right to conscientious objection; and increase the licensing requirements for private clinics.

At the beginning of the fourth day, Sam Silkin, Attorney General in the previous Labour administration, pointed out that the Bill had been amended such that “we shall be sending to another place a measure that is complete nonsense.” There were two problems; when expanding and re-arranging section 1 of the Act, the original sub-section dealing with abortion immediately

necessary to save life had not been deleted so that this topic was now included in two sub-sections. The other problem was that a risk that was substantially greater would be very difficult to define in court and could be interpreted as giving lower priority to the life of the woman than that of the foetus.

Silkin proposed a complicated amendment that would correct these defects. This was passed (Ayes 157: Noes 122) but only after a further 90 minutes of debate. A premature attempt by William Benyon to propose closure of the Report Stage was rejected by a majority of seven. The debate continued with divisions on several amendments and members were still speaking at 2.30 pm when the debate was scheduled to end. There was an unopposed motion that the Report Stage should continue on the next private members' Friday, but the sponsors realised that they were very unlikely to be given more time and that the Bill had fallen. John Corrie withdrew his Bill on 25 March.

It is my opinion that the Bill would have been passed had it been restricted to lowering the gestational limit to 24 weeks, a change recommended by the Lane Committee and supported by MPs of all persuasions. Many MPs would have voted for 20 weeks. Also, the Conservatives had a majority in the Commons and would have supported less ambitious legislation – very few of their Members had pro-choice views. There would have been considerable support for increasing the risk to the health of the woman to serious – many MPs of both parties considered abortion was too easily available and did not understand that it was the permissive terms of the 1967 Act that had abolished the need for clandestine, dangerous abortion.

The weakness of the Bill was its length and complexity. Its sponsors were divided in their priorities and blinded by the frustration caused by their repeated failures to amend the Act in the previous decade. John Corrie lacked the anti-abortion fervour of Bernard Braine, William Benyon and Jill Knight – their belief that the moral status of the foetus required women to continue unwanted pregnancies unless doing so would result in their death or gravely and permanently damage their health, and that these views were widely supported by voters or doctors.

The failure of the Bill was also due to the strength of the pro-choice lobby, the opposition of some members of the Privy Council, the Royal Colleges and the DHSS, and by the work of CO-ORD, in bringing together the various pro-choice groups and providing information and support daily to the MPs who led the opposition: particularly, Jo Richardson, Oonagh McLeod, Ian Mikardo, William Hamilton and Stan Thorne. A well-supported opposition is essential if reactionary restriction is to be prevented.

Abortion (Amendment) Bill 1980. Ten-Minute Rule Bill: Mr David Alton MP⁶⁴

David Alton proposed that the gestational limit for abortion should be reduced from 28 to 24 weeks. This was rejected without a division.

⁶⁴ HC Deb 22 April 1980 vol 983 cc221-6

⁶⁵ HC Deb 22 January 1988 vol 125 cc1228-96

Abortion (Amendment) Bill 1987 (28 Oct 1987): Mr David Alton MP⁶⁵

This short Bill limited abortion to the first 18 weeks of pregnancy and would have allowed later abortion only when necessary to save the life of the woman, or when immediately necessary to prevent grave permanent injury to her physical health, or if the child was likely to be born dead or with such physical abnormalities so serious that its life cannot be independently sustained. Introduced and printed on 28 November 1987, it passed at Second Reading on 22 January 1988 by 296 to 251 and was committed to a Standing Committee that sat four times. The Report Stage was on 6 May but was not completed: the Speaker stated that further time would not be available. Subsequently, several requests for extra time were refused and the Bill fell.

This Bill was notable for the response of the public, with numerous letters to MPs recommending it should be allowed extra time and some that it should be that it should be allowed to fail. In answer to a parliamentary question, Mrs Thatcher said she had received 15,000 letters. Parliament accepted several large petitions urging that the Bill should be rejected as restricting women's access to abortion. The Government may have been influenced by the strong opposition of the medical establishment: there are few abortions after 18 weeks but a significant proportion of those that were done were to avoid the birth of a child with severe handicap due to conditions that were difficult detect earlier in pregnancy.

Chapter 8. Lord Houghton improves the Abortion Act 1987-90

Opposition to liberal abortion is driven by a fervour that is religious rather than intellectual: a deep belief that the termination of pregnancy is wrong and not open to rational debate. Such belief motivated the repeated parliamentary attempts to restrict the Abortion Act during the 20 years since 1967. In spite of being defeated consistently, these MPs remained convinced that, sub-consciously, most members shared their moral outlook and that a free vote in Parliament would be certain to confirm their views. They claimed that the supporters of the Act had been successful in defeating their attempts at amending the law only through procedural devices, and that Parliament had been prevented from expressing its real opinion.

In 1987, the opponents of abortion unwittingly triggered a sequence of events that would end in a vote that would show majority support for a gestational limit of 24 weeks and that would permit termination at any gestation if the woman's life or health was in grave danger, or when the foetus was seriously abnormal. These events began when the Bishop of Birmingham introduced a Bill in the House of Lords with the "modest aim of making abortion illegal after 24 weeks".

Infant Life (Preservation) Bill 1987 (HL); Second Reading 28 Jan 1987. Private Member's Bill: the Bishop of Birmingham (Hugh Montefiore)⁶⁶

The intention was to amend the Infant Life (Preservation) Act 1929 so that the gestation at which a foetus is presumed to be "a child capable of being born alive" would have been reduced from 28 to 24 weeks. This would have set the limit to 24 weeks because the Abortion Act 1967 cited ILPA 1929 as defining the gestation after which abortion would not be legal.

Introducing the Second Reading of his Bill, the Bishop explained that he had "met with Ministers of State both from the Home Office and the DHSS, and I think it is fair to say that my Bill has gestated as a result of that meeting". He said: "My Bill has one moral presupposition and one only. It is this. It is immoral and wrong to kill a child that is capable of being born alive"; and pointed out the limit of 24 weeks was supported by the BMA and the RCOG and had been recommended by the Lane Committee. The Bishop considered the Abortion Act had been "too widely drawn" but emphasised that his Bill was intended only to protect the life of the foetus.

What he did not say was that the Birmingham-based charity Life had been advised that "... some lawyers argued that the Infant Life (Preservation) Act ... which made it a crime knowingly to kill in the womb a child capable of being born alive, was a powerful weapon lying unused".

Lord Houghton explained that the Bill was inappropriate as ILPA applies only to England and Wales and was intended to fill a theoretical gap in the criminal law that occurred if a child was deliberately killed during the process of birth, when it was protected neither by the law on abortion nor the law

⁶⁶HL Deb 28 January 1987 vol 483 cc1406-51

on murder, and made child destruction a felony with a maximum penalty of life in prison – grossly disproportionate to the penalties specified in the Abortion Act 1967. He also pointed out that the Bill was unnecessary because, in 1985, following the report on *Foetal Viability and Clinical Practice* by the RCOG recommending a limit of 24 weeks, the Department of Health had obtained agreement from the proprietors of approved nursing homes that they would not provide abortion after 24 weeks and that abortions from 20 to 24 weeks should be allowed only in specially-licensed nursing homes that had staff trained and equipped to resuscitate any foetus born alive.

Lord Houghton proposed that the Bill should be committed to a Select Committee but this was rejected by 31 to 41 votes, and the Bill passed its Second Reading without a further division. The Bill was considered again in the Lords on 11 February⁶⁷ when the Bishop himself proposed that the Bill be committed to a Select Committee. He was surprised and disappointed that it had aroused so much opposition and accepted that examination by a Select Committee would “avoid many hours of bitterness and the inconvenience of acrimonious debate night after night”. Committal to a Select Committee was agreed.

Select Committee on the 1929 Infant Life (Preservation) Act, 1987

The Committee was appointed on 5 March 1987 with Lord Brightman in the chair. At that time Lord Brightman knew little about abortion and, realising this, Lord Houghton asked me to meet him and Lord Brightman for an afternoon of discussion at Westminster. We covered most aspects of legal abortion: Lord Brightman was easy to talk to and, as would be expected of a senior judge, quick to understand new topics and to formulate penetrating questions.

The Committee met regularly; written memoranda from 51 persons and organisations and oral evidence from seven individuals had been considered when, in May, its work was cut short by the dissolution of Parliament and the consequent fall of the Bishop’s Bill. The Committee sought a way to continue its work towards deciding how the gestational limit for legal abortion should be defined. To do this, Lord Houghton agreed to reintroduce the Bishop’s Bill under his own name in the new parliamentary session so that the Committee could reconvene and continue its work; this Bill had its Second Reading on 22 July and was immediately recommitted to the Select Committee. There were nine meetings in November and December, at four of which oral evidence was taken. (The four-month delay was largely due to the summer recess.)

I gave oral evidence for about three hours on the afternoon of 16 November. The questions ranged widely but focused on methods of termination, particularly in the second trimester, and the precision with which gestation could be estimated when the gestation was over 20 weeks. Oral evidence was taken on subsequent afternoons from Life, ALRA, the Royal College of Midwives, Wendy Savage, Dr RP Norris and the now ex-Bishop, the Right Reverend Dr Hugh Montefiore. Written evidence was considered from the Department of Health and Social Security, BCT, the Family Planning Association, the Royal College of Psychiatrists, the RCOG Working Party on Foetal Viability and Clinical Practice, the Mothers’ Union and several individuals with strong views for and against legal termination.

⁶⁷HL Deb 11 February 1987 vol 484 cc710-6

The Select Committee published its report on 15 February 1988. The 16 pages are a clear and accurate summary of the provision of legal abortion in Great Britain and an analysis of why the Infant Life (Preservation) Act 1929 should not be used to define the gestational limit for legal abortion. These were: it does not apply in Scotland; it was drafted in the late 1920s to fill a theoretical gap in the criminal law; the phrase “a child capable of being born alive” is difficult to interpret. The presumption in 1929 that the foetus is always viable after 28 weeks was not appropriate in 1987 – advances in neonatal care have made survival possible after 24 weeks.

The Select Committee recommended:

- a) the Infant Life (Preservation) Bill [HL] should not proceed [i.e. the Bishop of Birmingham’s Bill];
- b) repeal of sub-section 5(i) of the Abortion Act that defines the gestational limit by reference to the Infant Life (Preservation) Act 1929;
- c) the exemption of doctors providing legal abortion from being prosecuted under the Infant Life (Preservation) Act 1929 (i.e. the moral discretion of the doctors should control the gestational limit);
- d) that a pregnancy should not be terminated after 24 weeks unless two doctors certify that this is essential to the physical or mental health of the woman and not when there is only a risk to her health or that of any existing children of her family;
- e) that if Parliament does not accept (b) and wishes to impose a statutory maximum gestational age this should be by specific provision in the Abortion Act and not be by cross reference to the Infant Life (Preservation) Act 1929.

The report was presented to the House of Lords on 25 March 1988 and accepted – but only after a long, somewhat angry, debate generated by the supporters of the Bishop’s Bill.

Abortion (Amendment) Bill (2) [HL]. Private Member’s Bill: Lord Houghton⁶⁸

This was drafted with the intention of amending the Abortion Act as had been advised by the Select Committee: the clauses were recommendations (b) to (e) listed above. The First and Second Readings in the Lords were on 3 May and 22 November 1989; there were no amendments in Committee. The Bill passed Third Reading and was sent to the Commons on 7 March 1990. Lord Houghton expected his Bill would be supported in the Commons and would result in a positive revision of the Abortion Act.

There was a problem: the parliamentary calendar was full and the Bill would be unlikely to complete its process by the end of the session. But there was another possibility: a clause to amend the Abortion Act 1967 could be inserted into the Human Fertilisation and Embryology Bill (HEFB) that had passed its Second Reading in the Commons was about to be debated by a Committee of the Whole House. (The HEFB had been introduced in the Lords where it had been read a second time on 7 December 1989). This use of the HEFB as a vehicle for amending the Abortion Act was suggested by the Government and welcomed by Lord Houghton.

⁶⁸HL Deb 22 November 1989 vol 513 c22

The amendments that became “New Clause 4” of the HFEB were planned, I was told many years later, when Sir Geoffrey Howe and Kenneth Clarke met at Lord Houghton’s home in Surrey⁶⁹. The opportunity was taken to include not only the recommendations of the Select Committee on ILPA that had been in Lord Houghton’s Bill but also to allow the Commons to review the gestational limits for all the grounds for legal abortion; to simplify the arrangement of the sections of the original Act; and to include new sections allowing foetal reduction in multiple pregnancy and the special approval of premises for the provision of medical abortion.

This resulted in a daunting list of 18 amendments, organised so that MPs who either supported or opposed legal abortion had an opportunity to vote on the details of the Abortion Act – something that the hard-core of members who wished to restrict the law believed had been denied to them for twenty years.

The pro-choice lobby became active: CO-ORD circulated an analysis of the effects of the amendments to MPs, and its member organisation encouraged their members to write letters to their own Members and to the media. I drafted the following letter that was also signed by Richard Beard, and six other professors of obstetrics and gynaecology who had been trained by Dugald Baird. This was published in *The Times* on 23 April and sent to selected MPs, and read:

The gestation limit for legal abortion

As senior consultant gynaecologists we support the provisions of the Abortion Act 1967. We consider that gynaecologists should be able to provide legal termination of pregnancy up to 24 weeks when this is necessary to protect physical or mental health and, in exceptional circumstances, beyond that limit when either the fetus is gravely abnormal or when the life of the woman is threatened by the continuation of the pregnancy. Late abortions are always performed after the most careful consideration of all the circumstances and with great reluctance. This is shown by the fact that in 1989 less than 2% of all abortions were performed after the 20th week and only 22 (of an annual total of 180,000) after the 24th week. Gynaecologists need to retain the discretion they currently have to perform late abortions on the relatively few occasions when this is necessary. A gestation limit of less than 24 weeks would force some women to continue a pregnancy in the face of a serious threat to their health or in spite of grave abnormality in the fetus.

The crucial debate was in a Committee of the Whole House on 24 April⁷⁰. Sir Geoffrey Howe, as Leader of the House, introduced the New Clause 4, which read:

(1) For paragraphs (a) and (b) of section 1(1) of the Abortion Act 1967 (grounds for medical termination of pregnancy) there is substituted —

- (a) —that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman**

⁶⁹ Personal communication from Madeleine Simms.

⁷⁰ HC Deb 24 April 1990 vol 171 cc166-304

or any existing children of her family; or

- (b) —that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or**
- (c) —that the pregnancy has not exceeded its twenty-eighth week and that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.**

2) In section 1(4) of that Act, for “to save the life” to the end there is substituted

- (a) —to save the life of the pregnant woman, or**
- (b) —to prevent grave permanent injury to her physical or mental health, and, in the latter case, that the pregnancy has not exceeded its twenty-fourth week.**

The first speaker was Virginia Bottomley (Minister of Health). She explained why the Government had become involved in a topic previously considered to be private members’ business, saying:

The Government have an inescapable role in administering what Parliament has decided to enact. With it comes the role of advising Parliament if a legislative proposal seems confusing, or difficult to operate in practice, or inconsistent with some other provision. With it also comes the further role of advising Parliament of ways in which changes over time and the recent developments in medical and scientific practices may have affected the existing legislation in ways in which Parliament should take account. It is in that context that the Government have considered the question of abortion time limits.

She then gave a commendably clear account of the contents of New Clause 4 and the changes to the Act that each amendment would have if it was passed, an explanation that was repeated by Kenneth Clark, at the end of the debate and before the divisions were taken. Subsequently, several anti-abortion MPs claimed that the order paper had been deliberately confusing – but perhaps they were not in the Chamber when either Mrs Bottomley or Kenneth Clarke spoke.

Seven hours of debate followed, the supporters and opponents of the amendment reiterating familiar arguments. The House was full: between 11 pm and 1.17 am from 464 to 536 members passed through the lobbies at each of the twelve divisions. These are listed below.

- **The gestational limit when there is a risk to physical or mental health.**

This was relatively uncontroversial: 24 weeks had been recommended as the limit for abortions to protect the woman’s physical or mental health by the Lane Committee in 1974 and by recent statements from the BMA and RCOG, and would include 99 per cent of all legal abortions. Studies of the survival of very premature babies had established that survival was possible from 23 to 24 weeks and that intensive neonatal care had improved the proportion at surviving at 24 to 26 weeks but was not successful when birth was earlier in pregnancy – the limiting factor being the biological immaturity of the foetal lungs. The five divisions are shown below; 24 weeks was convincingly

confirmed by the rejection of limits ranging from 18 to 28 weeks.

Proposed amendment for 24 weeks substitute	Weeks	Ayes	Noes	Total votes
	18	165	355	520
	28	141	382	523
	20	189	358	547
	26	156	372	528
	22	255	301	556

- **No gestational limit when there is a substantial risk of serious foetal abnormality**

Initially, this appalled many MPs, but most became reconciled when they realised that less than 2 per cent of abortions were done for this reason, that almost all of these were at less than 24 weeks, and that those done later were for very severe abnormality, in some cases not detectable earlier in pregnancy. The actual amendment — to leave out “that the pregnancy has not exceeded 28 weeks” — was accepted: Ayes 277, Noes 210.

- **No limit when the woman was at risk of death or grave permanent injury to health.**

There was more general support for this amendment when members realised that very few abortions were done after 24 weeks and that when the woman was seriously ill, the pregnancy was usually managed not by abortion but by caesarean section — the intention being to maximise the survival of both the woman and her child. This was agreed: Ayes 337, Noes 146.

- **The exclusion of the Infant Life (Preservation) Act 1929**

The attempt in January 1987 by the Bishop of Birmingham, to amend ILPA to prevent abortion after 24 weeks, had initiated the sequence of parliamentary events that led to the House of Commons debate on 24 April 1990. As gestational limits had now been agreed for all grounds for legal abortion, ILPA was no longer necessary for this purpose and would conflict with the Abortion Act on the occasions when termination was necessary after 24 weeks and the foetus could be considered “a child capable of being born alive” — making the doctor guilty of felony. To deal with this conflict, it was proposed that:

For section 5(1) of that Act (effect on Infant Life (Preservation) Act 1929) there is substituted—(1) No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act.

This was agreed: Ayes 308, Noes 149.

- **New Clause 4 to be added to the Human Fertilisation and Embryology Bill.**

This was the last division of the debate on 24 April and was agreed: Ayes 335, Noes 149.

CO-ORD continued its lobby in preparation for the next Commons debate. I wrote to the President of the RCOG (Sir George Pinker) on 28 May, suggesting that the majority of Fellows and Members would regret any reversal of the decisions made by the Commons on 24 April and suggesting wording that would be suitable⁷¹. He agreed and the following statement was published:

The Royal College of Obstetricians and Gynaecologists welcomes the clarification of the abortion law incorporated in the amendments made on 24th April to the Human Fertilisation and Embryology Bill. These support the view of the College that abortion to avoid risk to the physical or mental health of the pregnant woman should not be performed after the 24th week of pregnancy. The College accepts that grave fetal abnormality or a risk to the life of the pregnant woman can justify termination at any gestation but point out that, in the latter circumstances, every effort is made to maximise the survival of both the ill woman and her normal fetus. The exclusion of the Infant Life (Preservation) Act from the interpretation of the Abortion Act removes the legal uncertainty that currently adds to the difficulties faced by the woman and her doctors when termination has to be considered at a time in pregnancy when there could be debate as to whether the fetus is "A child capable of being born alive.

The amendment of the Abortion Act within the Human Fertilisation and Embryology Bill⁷²

The second day of the two-day debate on the Report Stage of the HFE Bill was reserved for consideration of the amendments to the Abortion Act 1967. This opened at 4.15 pm on 21 June 1990, and closure was set for 11pm. The debate began with three unsuccessful attempts to make legal abortion more easily available – the first two were proposed by Harriet Harman and supported by CO-ORD.

- **To allow abortion up to 12 weeks after certification by only one doctor.**

This had been an aim of the pro-choice lobbies – the intention was to make abortion more accessible in the first trimester and to reduce bureaucracy. This would have been a first step towards abortion on request in the first trimester – a freedom that was already available in several European countries and in the USA. There were two divisions, the first to amend the Abortion Act directly and the second to add a further amendment to the HFE Bill. Both were defeated: Ayes 159, Noes 200, and 228, 264, respectively.

- **To restrict the use of the conscience clause to doctors who had registered their objection in advance with the Chief Medical Officer at the Department of Health**

There was some evidence from surveys of trainee gynaecologists that a substantial proportion were claiming conscientious objection, not because of moral conviction but because it would excuse

⁷¹ The Paintin papers.

⁷² HC Deb 21 June 1990 vol 174 cc1136-69

them from involvement in abortion provision, which they regarded as a distasteful chore rather than as an important service for women. This was proving a problem in many NHS hospitals where abortion provision was through the routine gynaecological services.

This difficulty has been lessened since 1990 by the provision of many NHS abortions through contracts with the large independent charitable providers, PAS, BPAS and Marie Stopes International. But it had resulted in a new problem: the marked fall in the numbers of abortions in NHS gynaecological units has reduced opportunities for training junior gynaecologists, so that some young consultants had no abortion providing skills – a serious deficiency when women with rare but serious abortion complications in the independent centres are transferred urgently to the local NHS gynaecology unit, or when abortion is necessary for women with life-threatening illnesses that require the immediate availability of intensive care and the support of expert physicians.

The amendment failed: Ayes 115, Noes 228.

The third amendment was introduced by Sir David Steel. This was:

- **To make the Abortion Act 1967 apply in Northern Ireland**

Sir David said:

I cannot remember exactly why the 1967 Act was not extended to Northern Ireland, but I suspect that one reason was that in those days Stormont still existed. We had only a small coterie of Northern Ireland Members in the House. Again, we are entitled to examine the practice of the law since 1967. Ireland – both the north and the south – is now the only country in Europe where abortion has not been legalised.

Sir David pointed out that it was unjust that, each year, a minimum of 1500 women feel obliged to travel to England for termination of pregnancy. He was supported strongly by Maria Fyfe who was motivated by her knowledge of the plight of women in Glasgow (where, at that time, most of the gynaecologists followed the lead of Professor Ian Donald, a vehement opponent of abortion law reform).

There was strong opposition from members from Northern Ireland, supported by David Alton and Patrick Duffy who pointed out that there were political and legislative reasons why the amendment was unwise and impracticable. David Alton said:

In 1984 – the last time this was considered – the Northern Ireland Assembly voted 20 to one against an extension to Northern Ireland. Every political party apart from Sinn Fein – even it recently modified its policy to one of neutrality – opposes the extension of the legislation. Eighteen councils are against extension and none is in favour. A poll of doctors in 1987 showed that 90 per cent were against extension and a Gallup poll in 1982 found

that 83 per cent of people expressing an opinion were opposed to social abortions. So the people of Northern Ireland oppose an extension of the legislation and their views should be heard.

Patrick Duffy said:

Health in Northern Ireland was covered by transferred powers to the old Stormont Parliament and to the power-sharing executive. It has certainly been Opposition policy, although this is not a party political matter, to interfere as little as possible in matters that should properly be devolved to a legislative Assembly in Northern Ireland. Specifically and directly health is one matter that would be transferred to a devolved Assembly.

The Government agreed with both speakers. The Minister of Health, Virginia Bottomley, said:

... The 1967 Act, which legalised abortion under certain circumstances, does not extend to Northern Ireland. The provisions of that Act were not originally introduced in Northern Ireland because the Government considered that the reform of social law in the Province was a matter for the Northern Ireland Government. It has been the policy of successive Governments throughout direct rule that Northern Ireland's unique position makes it desirable to re-establish a devolved Administration there.

The Northern Ireland Constitution Act 1973 provides for a Northern Ireland Assembly to determine its own policy and pass its own legislation on certain matters. The amendment falls clearly within that legislation. Parliament may of course legislate in such matters, but we have always been at pains to tailor such legislation to the particular circumstances of Northern Ireland, especially in social legislation, where the values of the people of Northern Ireland may differ from those of people living in England, Wales and Scotland.

To the best of my knowledge, no Northern Ireland Member of Parliament has ever called for changes in the Northern Ireland abortion laws. Similarly, all the soundings of opinion have made it very clear that there is no will in Northern Ireland for such a change. I am informed that my noble Friend Lord Skelmersdale and my right hon. Friend the Secretary of State for Northern Ireland have received more than 2,000 letters on the subject, urging them robustly to resist such a new clause. I strongly urge the House to reject new clause 7, which would be offensive to the overwhelming majority of people in the Province. ... it is for hon. Members to weigh up the merits of the new clauses and amendments and to exercise their judgment on behalf of their constituents.

However, many members spoke in favour of the amendment and it was passed: Ayes 267, Noes 131.

The supporters of the amendment were disappointed when it was deleted without discussion when the HFEB returned to the Lords for final approval on 18 October. The Lord Chancellor (Lord MacKay of Clashfern) said:

As the Bill stands, this means that the new clause, which amends the Abortion Act 1967, will also extend to Northern Ireland. However, as that Act does not itself extend to Northern Ireland it is not possible for an amendment to it to extend to Northern Ireland⁷³.

The greater part of the debate that day was filled by the discussion of the following restrictive amendments:

- **To re-impose the limit of 24 weeks for terminations to protect the health of the woman when foetal abnormality was the reason for the termination, and of 28 weeks when the foetus was seriously abnormal.**
- **To require much more detailed notification of the foetal abnormality and the probable resulting handicap to the Department of Health.**

These were strongly supported by Michael Alison, Ann Widdecombe, David Alton, Ann Winterton, Dame Elaine Kellet Bowman, Sir Bernard Braine and Patrick Cormack. They were ably opposed by Kenneth Clark, Sir David Steel, Jo Richardson, Harriet Harman and Peter Thurnham.

Kenneth Clarke pointed out that the first of these amendments would reverse decisions that had been supported by a majority of MPs on 24 April and that the speakers were repeating the arguments used then. Sir David Steel said that the President of the RCOG, Sir George Pinker, supported the amendments passed on 24 April and in a letter to him had said: "We would not like to see the Infant Life (Preservation) Act insinuated into the provisions of the Abortion Act". Sir David Steel brought this part of the debate to a close by saying:

I shall end by quoting from Mr David Paintin, reader in obstetrics and gynaecology at St. Mary's Hospital. He was one of the original medical advisers on my team in 1967. He now says about the proposal that is before us:

"There are few circumstances in which abortion is necessary after the 24th week; there were only 23 cases notified in this country in 1988. Most such abortions are performed because the foetus has been shown to have an abnormality that would prevent sustained life after birth or that would result in gross handicap. A small number of such abortions are induced because the woman is gravely ill and her health would be permanently harmed or she might die if the pregnancy continued. In these cases the foetus is so immature or so affected by the illness in the woman that it would not survive. If the foetus is mature enough to have a reasonable chance of survival with modern intensive care, all possible steps are taken to optimise the survival of both mother and foetus; delivery is normally by caesarean section."

He concludes: "A proper ethical attitude to abortion must take into account the potential humanity of the foetus."

⁷³ Colthart G. Abortion law, House of Commons Library (Standard Note: SN/SES/4309), 2009.

That was the basic principle of the 1967 Act – but we must also consider the humanity of the woman and the circumstances which, in her view and her doctors' view, make continuation of the pregnancy inadvisable. I believe that it is wrong to force the woman to continue the pregnancy to the serious detriment of her health or to force her to carry a foetus that is severely abnormal. The sensible decisions taken by Parliament in April clarify and improve the law. In my experience, women and doctors agree that abortion after the 24th week should be performed only in the most exceptional circumstances.

I believe that the House should rest by the decision that we have taken.

Both restrictive amendments were very narrowly defeated, the first by only 14 votes (Ayes 215, Noes 229) and the second by the chairman's casting vote (Ayes 197, Noes 197). There were fewer members in the Chamber than on 24 April, and it is likely that those who opposed abortion on principle were more motivated to attend.

The two amendments that extended the Act received surprisingly little discussion; the arguments against them made in the course of the debate reflected the deep feeling of the opponents of legal abortion that the protection of the foetus should have priority over the benefit to women. The first amendment was:

- **To give the Secretary of State power to approve places where abortion could be provided by medical methods:**

(2A) After section 1(3) of that Act there is inserted – (3A) The power under subsection (3) of this section to approve a place includes power, in relation to treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places.

This amendment, proposed by Robert Key and supported by Kenneth Clarke, had originated in the Department of Health and been prepared by the parliamentary draftsmen. It was designed to anticipate the use of medication rather than vacuum aspiration for first trimester terminations.

By 1990, there was considerable evidence that abortion could be induced safely and by a single oral dose of mifepristone (RU486), an anti-progesterone drug developed by the French pharmaceutical firm Roussel Uclaf, and that the abortion process could be made swifter and more effective by the administration of a prostaglandin 24 to 48 hours later – for most women the experience was similar to having a painful heavy menstrual period. The treatment could be given safely without admission to a hospital bed, did not require the existence on-site of a fully equipped operating theatre and had the potential to be used by outpatients. Large-scale clinical research was in process but the method promised to provide early abortion in a way that was acceptable to women and relatively inexpensive. (This would prove to be true: in 2012, 61% of abortions under 9 weeks were medical abortions.) Existing regulations had been drafted when only methods were surgical and did not

provide the Secretary of State with the discretion to allow abortion in places that did not have full operating facilities and overnight accommodation.

The amendment was approved: Ayes 233, Noes 141.

The second and final amendment was:

To allow selective reduction in multiple pregnancies

(4) In section 5(2) of that Act, for the words from “the miscarriage” to the end there is substituted “a woman’s miscarriage (or, in the case of a woman carrying more than one foetus, her miscarriage of any foetus) is unlawfully done unless authorised by section 1 of this Act and, in the case of a woman carrying more than one foetus, anything done with intent to procure her miscarriage of any foetus is authorised by that section if—

(a) the ground for termination of the pregnancy specified in subsection (1)(d) of that section applies in relation to any foetus and the thing is done for the purpose of procuring the miscarriage of that foetus, or

(b) any of the other grounds for termination of the pregnancy specified in that section applies.

Developments in the treatment of infertility had resulted in a marked increase in multiple pregnancies. The outcome for the woman and the foetuses were acceptable for twins but the risks increased considerably when there were triplets or quads. There was evidence that the results could be improved by selective reduction – making a lethal injection into the heart of each unwanted foetus (the small dead foetus shrivels but remains in the uterus and is expelled when the woman is delivered).

There was uncertainty whether selective reduction was an abortion and was within the grounds of the Act. To clarify the situation, the amendment allowed selective foeticide but only when this would be within the existing grounds for legal abortion; i.e. to protect the woman’s health or when the foetus was severely abnormal. This was approved: Ayes 236, Noes 166.

The Third Reading of the Human Embryology and Fertilisation Bill was completed by a division at 11 pm: Ayes 303, Noes 65.

The final debate in the Lords did not happen until the autumn. There was a risk that the Peers might oppose the abortion amendments. Once again, we became active in writing to Peers who had been sympathetic to our cause in previous debates. On 8 October, Lord Houghton sent a long memorandum to his supporters in the Lords and to CO-ORD⁷⁴. He pointed out that The Society for the Protection of the Unborn Child had published a circular with the misleading statement that “The Commons have inserted a new clause that allows abortion up to birth on a series of grounds”. After summarising the effects of the amendments. He said the abortion law was useful in the earlier stages of pregnancy but, after 24 weeks was less enforceable. He concluded by writing:

⁷⁴The Paintin papers.

The Select Committee of the Lords did their best to find a way which would satisfy reasonable opinion. That way was unanimously agreed on the Select Committee. It was in the Abortion (Amendment) Bill passed by the House and is now in Clause 36 of the Human Fertilisation and Embryology Bill (HL). The Commons have twice decided to stand firmly behind the House of Lords in this matter. It would be shameful for this House to turn its back on a difficult and heart-searching job well done.

This stimulated a flood of letters and memoranda to the Members of the Lords. These were from CO-ORD, Birth Control Trust, Birth Control Campaign and Support After Termination for Foetal Abnormality (SATFA) — most were dated 15 October. Richard Beard and I sent our own letter of support. We were very concerned to learn from Lord Houghton that Lord Brightman, who had helped to draft the recommendations of the Select Committee, had written, in a letter dated 15 October: “I have looked at the amendments. I do not think any of them is suitable”. He had great influence in the Lords – we were in suspense until the debate itself when, to our relief, Lord Brightman cast his vote in our favour.

The final debate in the House of Lords: 18 October 1990⁷⁵

The Lord Chancellor (Lord Mackay of Clashfern) moved that New Clause 4 should form part of the HFE Bill [HL] (this became clause 34 in the Act because other new clauses had been added by the House of Commons). He explained the changes to the Abortion Act with exemplary clarity. During the lengthy debate on 18 October, the critics of clause 34 focused their attention on the immorality of terminating pregnancies when the foetus could be considered to be “a child capable of being born alive”.

The proposers of the two hostile amendments, Baroness Cox, Baroness Elles, Lord Ashbourne, Viscount Tonypany, Lord Rawlinson, Lord McCol, and Lord Robertson of Oakridge were supported by the Archbishop of York, the Bishop of Gloucester, the Bishop of London and the Duke of Norfolk. They were effectively opposed by Lord Brightman, Lord Walton, Lord Houghton, Lord Ennals and Baroness Warnock. Baroness Lockwood, Viscount Craigavon and Lord Rea, several of whom referred to a statement from the RCOG and briefs they had received from CO-ORD and BCT. Particularly important was the emphasis we had placed on the very small number of abortions each year at more than 24 weeks (22 of about 180,000 in 1989).

Both amendments were defeated: Contents 89: Not content 133; and Contents 53 and Not content 101. A further amendment to delete the clause that excluded the ILPA from terminations provided by the Abortion Act was withdrawn.

The Commons’ amendments and the addition of the amendment of the Abortion Act to the Human Fertilisation and Embryology Bill were then agreed without a further division. The Human Fertilisation and Embryology Act obtained Royal Assent twelve days later, on 1 November 1990.

The triumph of Lord Houghton and the defeat of Life and SPUC

The amended Abortion Act emerged from the debates of 1987 to 1990 more permissive rather than more restrictive. Particularly, the gestational limit had been clarified for all the grounds for legal abortion and the anxiety of being accused of the felony of child destruction when a termination was necessary after 24 weeks because the woman's life was in danger or when there was severe foetal abnormality had been removed by the exclusion of the Infant Life (Preservation) Act. The limit of 24 weeks when there was a risk to physical or mental health had been the de facto situation for some years and gave clinicians welcome protection from attempts at prosecution by anti-abortion organisations. Selective reduction in multiple pregnancies had been given legal status.

The parliamentary vote supporting abortion up to 24 weeks was a major defeat for the anti-abortion lobby. During the 20 years since 1967, a succession of attempts by private members to restrict the gestational limit to 24 weeks or less had been defeated because the Bills had run out of parliamentary time (largely as a result of the many blocking amendments tabled with the help of the pro-choice lobby). The anti-abortion lobby claimed that Parliament, if allowed to vote, would be certain to support a lower limit than 24 weeks: the voting on 24 April proved the opposite – to their considerable disappointment. Lord Houghton rubbed this in during the final debate in the Lords on 18 October, saying:

When the pro-life people finally realised what had happened on 21st June – disaster in Parliament, tendentious stuff in what Parliament had done – what did the national president of the LIFE organisation [Professor Scarisbrick] have to say? Presumably he is a superior officer to the noble Duke, the Duke of Norfolk, if he is still chairman of the All-Party Pro-Life Group. The national chairman stated: “We must honestly admit that we have suffered a numbing political defeat. We are bitterly disappointed. We had all worked so hard. We don't know what else we could have done”. However, here comes the clue to the situation. Referring to the advice they received on the policy of this organisation, the statement continues: Others insisted that we should not do any statute-tinkering. We should instead get the existing law enforced. In particular, some lawyers argued that the Infant Life (Preservation) Act which made it a crime knowingly to kill in the womb a child capable of being born alive was a powerful weapon lying unused”. “Go to it”, the lawyers said. “Every abortion after 12 weeks contravened the law, so get that Act enforced”. That is what they said.

What did that organisation do to try to achieve that? It said, “We tried it”. It set its nurses' spy network to work. There is an organisation called Nurses for Life which was to watch the doctors, see what they were doing and report any suspicious actions. It acted on a spy network of other sources of information and set in motion cases against half a dozen individual doctors who were named in their hospitals and the evidence was given to us. The cases were all thrown out. No doctor has yet been convicted under the Infant Life (Preservation) Act – none. When it comes to the point, whatever the doctor does in good

faith and in his belief that he is discharging his duty to his patient, applying his clinical judgment to the situation, no jury will convict him.

Then said Mr Scarisbrick, “This is a broken reed”. So the 1929 Act was a broken reed. It always has been. We have proved that there is nothing to enforce and much effort and time have been wasted. Money was not mentioned. This organisation spent £46,500 on a campaign that lasted six months. It is now appealing for money. The SPUC organisation, the Society for the Protection of Unborn Children, must have spent well over £500,000 on all the items it has sent round: plastic foetuses, videos from America called *The Silent Scream*, blown-up photographs which the *Sunday Times* newspaper says are very expensive indeed.

In 1990, Lord Houghton was the initiator of the events that strengthened the Abortion Act but he was greatly helped by Lord Brightman’s Select Committee: by the clear proof of the inappropriateness of using ILPA to define the gestational limits for the various grounds for abortion. It was fortunate that the Conservative cabinet ministers Sir Geoffrey Howe, Kenneth Clark and Virginia Bottomley supported the provision of legal abortion and saw the clarification of existing legislation as a reason why the Government should facilitate constructive revision of the Abortion Act rather than leaving it to the uncertainties of private members’ legislation. David Steel made decisive contributions during the debates – as he had done consistently since 1967 whenever abortion had been discussed by the Commons.

The pro-choice organisations had an important supporting role. As chairman of BCT and unofficial advisor on legal abortion to the President of the RCOG, Sir George Pinker, and a long-time advisor of Lord Houghton, I briefed Lord Brightman and then gave written and oral evidence to the House of Lords Select Committee that he chaired. I do not know whether it was Lord Houghton, Sir Geoffrey Howe or Kenneth Clarke who suggested the HFEB as a vehicle for amending the Abortion Act. The suggestion is likely to have come from Sir Geoffrey, as Leader of the House and to have been welcomed by Lord Houghton: every Government since 1967 had been plagued by the attempts of the small number of anti-abortion MPs to restrict the abortion law – many hours of Commons’ committee time had been used to no effect.

Once it was known the abortion was to be debated in the Commons. BCT and CO-ORD sprang into action. Briefs were prepared and sent to members of the Lords, letters were written to the press and BCT/BCC provided information for journalists, and interviewees for radio and television. Relatively little lobbying preceded the debate on 24 April – the insertion of an amendment to the Abortion Act within the HFEB came as a surprise. Activity intensified in preparation for the 21 June and the final debate in the Lords on 18 October – there was anxiety that the gestational limits established on 24 April might be revised downwards as a result of renewed pressure on MPs and Peers from the anti-abortion lobby; an anxiety that was reinforced by the allegation that some MPs had been confused about what they were voting for during the sequence of divisions at the end of the debate.

In the event, there has been no effective challenge to the decisions taken on 14 April. All the

statutory certificates, and the notification form, were revised to take into account the changes in the Act. These came into force on 1 April 1991. The revised Abortion Act is still in effect in 2015.

The 1967 Abortion Act as amended by the 1990 Human Fertilisation and Embryology Act

Medical termination of pregnancy.

1. (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith:

- (a) that the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or
- (b) that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
- (c) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
- (d) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

1. (2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) or (b) of subsection (1) of this section, account may be taken of the pregnant woman's actual; or reasonably foreseeable environment.

1. (3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.

1. (3A) The power under subsection (3) of this section to approve a place includes power, in relation to the treatment consisting primarily in the use of such medicines as may be specified in the approval and carried out in such manner as may be so specified, to approve a class of places.

1. (4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Notification.

2. (1) The Minister of Health in respect of England and Wales, and the Secretary of State in respect of Scotland, shall by statutory instrument make regulations to provide -

(a) for requiring any such opinion as is referred to in section 1 of this Act to be certified by the practitioners or practitioner concerned in such form and at such time as may be prescribed by the regulations, and for requiring the preservation and disposal of certificates made for the purposes of the regulations;

(b) for requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination and such other information relating to the termination as may be so prescribed;

(c) for prohibiting the disclosure, except to such persons or for such purposes as may be so prescribed, of notices given or information furnished pursuant to the regulations.

2. (2) The information furnished in pursuance of regulations made by virtue of paragraph (b) of subsection (1) of this section shall be notified solely to the Chief Medical Officers of the Ministry of Health and the Scottish Home and Health Department respectively.

2. (3) Any person who wilfully contravenes or wilfully fails to comply with the requirements of regulations under subsection (1) of this section shall be liable on summary conviction to a fine not exceeding one hundred pounds.

2. (4) Any statutory instrument made by virtue of this section shall be subject to annulment in pursuance of a resolution of either House of Parliament.

Application of Act to visiting forces etc.

3. (1) In relation to the termination of a pregnancy in a case where the following conditions are satisfied, that is to say:

(a) the treatment for termination of the pregnancy was carried out in a hospital controlled by the proper authorities of a body to which this section applies; and

(b) the pregnant woman had at the time of the treatment a relevant association with that body; and

(c) the treatment was carried out by a registered medical practitioner or a person who at the time of the treatment was a member of that body appointed as a medical practitioner for that body by the proper authorities of that body, this Act shall have effect as if any reference in section 1 to a registered medical practitioner and to a hospital vested in a Minister under the National Health Service Acts included respectively a reference to such a person as is mentioned in paragraph (c) of this subsection and to a hospital controlled as aforesaid, and as if section 2 were omitted.

3. (2) The bodies to which this section applies are any force which is a visiting force within the meaning of any of the provisions of Part I of the Visiting Forces Act 1952 and any headquarters within the meaning of the Schedule to the International Headquarters and Defence Organisations Act 1964; and for the purposes of this section-

(a) a woman shall be treated as having a relevant association at any time with a body to which this section applies if at that time-

(i) in the case of such a force as aforesaid, she had a relevant association within the meaning of the said Part I with the force; and

- (ii) in the case of such a headquarters as aforesaid, she was a member of the headquarters or a dependant within the meaning of the Schedule aforesaid of such a member; and
- (b) any reference to a member of a body to which this section applies shall be construed—
 - (i) in the case of such a force as aforesaid, as a reference to a member of or of a civilian component of that force within the meaning of the said Part I; and
 - (ii) in the case of such a headquarters as aforesaid, as a reference to a member of that headquarters within the meaning of the Schedule aforesaid.

Conscientious objection to participation in treatment.

4. (1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

4. (2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

4. (3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.

5. (1) No offence under the Infant Life (Preservation) Act 1929 shall be committed by a registered medical practitioner who terminates a pregnancy in accordance with the provisions of this Act.

5. (2) For the purposes of the law relating to abortion, anything done with intent to procure a woman's miscarriage (or, in the case of a woman carrying more than one foetus, her miscarriage of any foetus) is unlawfully done unless authorised by section 1 of this Act and, in the case of a woman carrying more than one foetus, anything done with intent to procure her miscarriage of any foetus is authorised by that section if:

- (a) the ground for termination of the pregnancy specified in subsection (1)(d) of that section applies in relation to any foetus and the thing is done for the purpose of procuring the miscarriage of the foetus, or
 - (b) any of the other grounds for termination of the pregnancy specified in that section applies.
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Interpretation.

6. In this Act, the following expressions have meanings hereby assigned to them: “the law relating to abortion” means sections 58 and 59 of the Offences against the Person Act 1861, and any rule of law relating to the procurement of abortion; “the National Health Service Acts” means the National Health Service Act 1946 to 1966 or the National Health Service (Scotland) Acts 1947 to 1966.

Short title, commencement and extent.

7. (1) This Act may be cited as the Abortion Act 1967.

(2) This Act shall come into force on the expiration of the period of six months beginning with the date on which it is passed.

(3) This Act does not extend to Northern Ireland.





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