Dying for our own Biographies: The Abortion Act 1967

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> I once knew a woman who had a backstreet abortion and died: a married woman, already the mother of three young children, who just could not afford another child. I was absolutely shocked. It was the first time I had come across abortion. I was in my early twenties, working at St Bartholomew's Hospital doing research, and I mentioned it to a group of doctors one lunch time. They looked at me in amazement, and said words to the effect: 'Well, where have you been all your life? Stay behind on Friday.' I discovered that Bart's and all the other London hospitals put wards aside every Friday and Saturday night for women who were brought in as a result of backstreet abortions – Friday being pay day. Bleeding, septic, sometimes dying. This was accepted everywhere (Munday, BPAS, 2007).

'Bleeding, septic, sometimes dying' speaks to the pre-1967 biographies of many women who sought to induce their own miscarriages or seek the help of others to gain reproductive 'control'. Many women lost their lives. Others, and more typically untrained abortionists, lost their liberty. The Abortion Act 1967 transformed a procedure performed clandestinely and at huge physical risk to women, into one that would be lawful when performed by the medical profession. The 1967 Act provides for abortion if two registered medical practitioners are of the opinion, formed in good faith, that to continue the pregnancy would 'endanger the physical or mental health of the pregnant woman or any existing children of her family', or 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'.

The significance of the Abortion Act 1967 as a 'Women's Legal Landmark' then, seems largely self-explanatory. It constitutes a significant step forward for women's rights in providing a secure legislative footing explicitly for abortion. Given the legal uncertainties prior to the 1967 Act, where abortion stood as 'a dirty and potentially lethal secret' (Piercy, 1994), the Act's existence affords women and abortion providers with clarity as to when abortion will be lawful. The 1967 Act, at least to some extent, went some way towards countering the notion of abortion as an illegitimate medical procedure. As such, its importance is not that abortion happens (for it happens irrespective of the law), but it transforms the conditions of how abortions happen, who performs them and remedies some of the hypocrisy inherent in pre-1967 law.

This landmark has had a transformative role on our biographies as women. This is not something to be taken for granted. While we celebrate the Abortion Act 1967, we note here the continued presence of winners and losers. For some in the UK, most notably Northern Irish women, this landmark remains largely out of sight.[1] Akin to any physical landmark, the 1967 Act is fragile, incomplete and is often contested. We need to be prepared to defend its existence, as well as to fight for others to enjoy the same *basic* liberties the 1967 Act provides. As such, the authors' project consists of looking back to appreciate the emergence of this landmark, those that suffered in its absence, those that fought for it, the translation of the 1967 Act over time, and how it has changed women's biographical horizons. Nevertheless, while a landmark in our journey, it is not the endpoint; where our aspiration is to gain the freedom to determine when and if we reproduce and to have identities untied to our reproductivity, this landmark reminds us of an 'unfinished revolution'.

[1] By contrast with Northern Ireland, where the 1967 Act does not apply, the rest of the UK enjoys greater biographical and geographic fortune. Reference to Marie Fox' landmark.

Context
With the exception of Scotland, the governance of abortion in the UK prior to the 1967 Act consisted of the Offences Against the Person Act 1861, section 58 which made abortion an offence, carrying a maximum penalty of 'penal servitude for life'.[2] The only exception to this was via the Infant Life (Preservation) Act 1929 which made it lawful for a doctor to perform a termination in order to save the woman's *life*. While the judiciary played a role in broadening the circumstances by which a termination could be performed in *R v Bourne* (1938),[3] the law seemed both fragile and ambiguous.[4] By virtue of the chilling effect of the criminal law[5] and a 'strong tradition against the operation within their profession', Hindell and Simms (1971: 14) note that few doctors were willing to terminate openly in the NHS on *Bourne* grounds. As such, 'the spirit of the old law still had a wide deterrent effect. Tens of thousands of women who wanted their abortions either could not get them or dared not ask their doctors for them' (1971: 16).

As Barbara Brooke explains, while a woman's issue, women 'were on the periphery of the medical and legal debates on abortion which shaped governmental policy from the early nineteenth century'. 'Women's choice' or 'reproductive control', are relatively modern concepts. Instead, abortion continued to be typified as the 'illegal operation' in being the 'only operation specifically prohibited by law' (Brookes, 1990). The effect of law was to bar the way to most women who wanted *lawful and safe* abortions and to leave women dependent upon a clandestine industry which responded to women's need for reproductive control. From stories of women, commonly among the working classes, sharing information and assisting each other in procuring abortion, a range of techniques emerged as a private network of interventions to address 'female irregularities'. Termination by use of 'slippery elm' (a bark that expanded with moisture), applying hot douches, consuming abortifacients intended for domestic animals, use of hat pins, knitting needles or skewers to use of pills and potions advertised by a rising industry of medical manufacturing 'to 'restore regularity' or to 'remove obstructions', the effect of the law was not to prevent such interventions. Rather its effect was to withhold the opportunity for care, safety and expertise in respect of procedures that were commonly performed with results that were 'generally undesirable and often appalling' (Hindell & Simms, 1990, p. 25).

The Landmark
A range of professional bodies and critical figures were crucial in bringing this legislation into being including the members of the Abortion Law Reform Association (ALRA), parliamentary sponsors, most notably David Steel MP, and key alliances formed between Steel, ALRA and major doctors' associations, including the British Medical Association (BMA) and Royal College of Obstetrics and Gynaecology (RCOG). ALRA, instituted in 1936, placed abortion into the public realm for debate. Constituted by an initially small group of middle-class women active in feminism and politically mobile in matters of birth control and sex reform, ALRA centralised issues of maternity mortality by virtue of illegally performed abortions, and as was

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[2] It provides that the pregnant woman herself, as well as those performing abortions, could be held guilty of the offence.
[3] *R v Bourne* [1938] 3 All ER 615. See landmark by XXX.
[4] Note that in Scotland the situation was different; the Offences Against the Person Act, Infant Life (Preservation) Act and the *Bourne* judgment did not apply. Abortion was a common law offence but as Hindell and Simms note (1971: 14), 'its limits were not strictly defined' or it would appear frequently enforced. Some within the Scottish medical profession regarded the Abortion Act 1967 as a reform affording England and Wales some of the freedoms that Scottish doctors had thus far enjoyed in this field.
[5] Despite the fact that doctors were rarely arrested (by contrast with lay women abortionists), and in practice there were few convictions for unlawfully procured abortions (see Gleeson, 2007).

fashionable at the time, eugenic concerns. Whilst WWII was raging, the 1950s marked a point for taking a direct approach to law reform. ALRA lobbied Parliament for legislation that would provide lawful access to termination of pregnancy on therapeutic grounds, where pregnancy was the result of sexual offences, for women with too many children and in respect of 'abnormal' foetuses. The 'eugenic clause' proved quite central to ALRA's lobbying efforts, and also helped to strongly align ALRA with the BMA, which had long advocated law reform for eugenic terminations.

Noted as being the first systematic attempt to 'lobby' support, ALRA convinced a number of Parliamentarians whose names had been drawn in the annual Private Members' Ballot, to sponsor an Abortion Bill. While failing to gain traction on Bills introduced to Parliament in 1954 and 1960, as Gleeson highlights (2007:30), and Madelaine Simms notes as central to her involvement in ALRA, the Thalidomide tragedy provided a dramatic new lobbying platform. The Thalidomide tragedy, which resulted in hundreds of babies being born with congenital disabilities as a result of their mothers consuming a pill for morning sickness, gripped the public imagination. The international rubella epidemic in the mid-60s, also helped to freshly reinvigorate ALRA. With the BMA concerned about legal ambiguity in respect of criminal liability for providing abortions for women that had contracted rubella, a fresh agenda for law reform was set. ALRA is well known to have courted the medical profession, to legitimate its position and help convince politicians and the public at large, of its cause. In the meantime, the BMA was asserting its authority on the matter of abortion and formed a special committee to direct reform in 1965. For the BMA and ALRA, the styling of abortion reform was not in the name of 'abortion on demand'. The BMA sought the full medicalisation of abortion, and explicitly sought to 'protect clinical autonomy and discretion of doctors on abortion' discerning rather different motivations from ALRA.

In May 1966, ALRA's latest sponsor, Liberal Party MP David Steel, introduced the Medical Termination of Pregnancy Bill that after a series of amendments became the Abortion Act 1967. This included the 'foetal abnormality' clause, which he highlighted for him stood as 'ethically the most difficult of all parts of the Bill'.[6] In course of the passage of the Bill, David Steel strategically manoeuvred between parliamentarians and the BMA and RCOG, making a considerable number of compromises, by which to encourage the greatest support for the Bill.

What happened next?

The Abortion Act 1967 came into operation on 27 April 1968. Described as having a greater immediate impact than anticipated, NHS hospitals saw a dramatic increase in the number of abortions performed. Women who had once turned to backstreet abortionists or sought clandestine terminations from doctors in private, now consulted their GPs and were referred to gynaecologists. In 1967, less than ten thousand NHS abortions were carried out officially. A year after the Act came into effect that number increased to 22,000, and by 1970, just under 50,000 (Hindell and Simms, 1971: 214). In the year following reform, some disparities in provision appeared between 'the liberal and the illiberal regions' with patients seeking treatment by liberal providers. In response to an even sharper rise in demand some hospitals refused to treat patients outside of their catchment areas. Meeting this demand, Pregnancy Advisory Services emerged with the British Pregnancy Advisory Service opening up when the 1967 Act came into operation. The growth of this sector, comprised of non-profit making organisations and commercial organisations, spurred a backlash, fuelled by concerns that women were not accessing abortions as had been envisaged (through the NHS) and of the potential for the abuse of women. In 1970, David Steel MP joined a working party to consider

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[6] Cited in Gleeson (2007: 35), who also notes that 'the 'handicapped clause' promoted by both the BMA and supported by ALRA secured law reform in an era dominated by panic over Thalidomide' (2007: 36).

the operation of the Act in the private sector and recommended a system of notification by providers to the Department of Health of key statistics, as well as the signatures from the two doctors confirming they had examined the patient and formed their opinion in good faith. At the same time, Hindell and Simms describe the variety of unsuccessful attempts to 'destroy the Abortion Act before it had time to prove itself'. These attacks, they highlight 'came thick and fast', including numerous attempts in the House of Commons to 'curtail and restrict the new legislation' (1971: 219). But one year later, such attempts to unravel the Abortion Act looked less likely to command support. MPs were impressed by figures pointing to the reduction in abortion-related deaths and emergencies, and were aware of the strong support the 1967 Act commanded within the medical profession.

Since its enactment, there have been few revisions to the 1967 Act's central terms. One exception is section 37 of the Human Fertilisation and Embryology Act 1990 which revised the 1967 Act, imposing a time limit of 24 weeks except where there was a serious risk to the pregnant woman's life or health or a substantial risk of foetal handicap. Nevertheless, with the exception of the latter which stands for around 1 per cent of terminations performed each year, these changes were largely cosmetic, reflecting existing law and clinical practice.

A wide-scale review of the Abortion Act 1967 in terms of reducing access to abortion, looks unlikely. In large measure, the 1967 Act is working well, with an abortion rate that corresponds with other Western countries, with low mortality rates and the majority of terminations taking place early in pregnancy. As Sheldon notes, 'In sum, since 1967, abortion has become entrenched as a normal part of routine healthcare, with the AA offering a platform for the provision of safe, high quality, state-funded services, typically provided in the first trimester of pregnancy' (Sheldon, 2016).

Significance

> No choice has a more profound impact on a woman's life than her decision whether or not to become a mother. Bound up with sexuality and gender identity, choices about childbearing and motherhood are emotionally gripping and socially pivotal. They affect one's attitude towards oneself – self-esteem may be enhanced, or it may suffer… (Meyers, 2001: 735).

The Abortion Act 1967 provided the medical profession and women with greater certainty around when, and under what circumstances termination of pregnancy would be legally permissible, something that should unequivocally be valued. It has also formed the bedrock for the emergence of clinical technologies associated with 'reproductive choice', such as prenatal screening, and other diagnostic technologies. But when evaluating the broader social significance of the Act to *women*, much more needs to be said.

Intriguingly, for an Act that has become so crucial for women, the various legislative architects had never advocated affording women the freedom to determine what happens to their bodies. Instead, for the large medical associations, that was the specific fear. The BMA and RCOG were resistant to any provision that was fashioned by reference to 'non-medical criteria' that could lead patients 'to believe that abortions would be carried out automatically'. In this respect, the language of the debate leading up to the 1967 Act, stands at odds with a feminist agenda. Reflecting on the passage of the 1967 Act, Sheldon notes how terminating women were characterised: as a 'marginal and deviant figure who stands against a wider norm of women who neither need nor desire abortion'. The decision to terminate, rather than an acceptable choice that any woman could make at some time in her life is instead portrayed as

'an option which may be justified only in certain cases by the individual circumstances (or inadequacies) of individual women, in the opinion of two doctors' (1997: 42).

Critically however, the 1967 Act is a living instrument. The language of the 1960s does not define the meaning of abortion provision today. While strict on its face and affording women no right to demand an abortion, in practice doctors interpret the Act liberally, beyond what reformers had originally intended. And that attitudinal shift is significant. The symbolic effect of the Abortion Act 1967 lies in the growing acceptance that a woman's identity *can* be separate from her reproductivity. The impact of the 1967 Act reaches beyond the creation of a space where abortion is represented as both 'lawful' and 'legitimate', to a broader transformation of the politics of women's identities. As with the availability of lawful contraception, abortion is implicated as one part of women becoming the authors of their own lives and identities, rather than these being defined by others.

Conclusion

The inclusion of the Abortion Act 1967 as a Women's Legal Landmark has assumed some level of obviousness about why it is a landmark. It is a women's issue, a public health issue, and a social need. It remains a deeply contested and politicised landmark, but one without which our biographies as women would look very different indeed. While a number of authors point to problems in its current operation and the need to modernise the law (McGuinness, 2015; Sheldon, 2016), it remains the case that the 1967 Act is to be valued for there is much to be lost without it: our bodies, our lives, our biographies.

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