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"A Fifth Freedom" or "Hideous Atheistic Expediency"? The Medical Community and Abortion Law Reform in Scotland, *c*.1960–1975

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Introduction

The purpose of the Medical Termination of Pregnancy Bill, published on 15 June 1966, was to amend and clarify the law relating to termination of pregnancy by a registered medical practitioner. When David Steel, a young Liberal MP from the Scottish Borders, put this bill forward, some suggested that a Scottish politician had no need to introduce abortion reform since Scots law was already satisfactory in this regard. Certainly, abortion law in Scotland was more flexible than its English counterpart, and the number of prosecutions few. The line between criminal and non-criminal abortion was, however, just as indistinct, with great medical uncertainty in this area. On becoming law, the 1967 Abortion Act was the first piece of abortion-related legislation to cover Scotland, England and Wales collectively.[1] None the less, for a variety of legal and moral reasons, abortion policy and practice continued to differ on either side of the Border.

The sexual politics surrounding abortion law reform has, in recent years, attracted increasing attention from historians, sociologists and political scientists. Several broad strands of interpretation may be detected within the literature. Early writing on the history of abortion and the 1967 Abortion Act generally subscribed to an "heroic" interpretation of events. It was largely produced by abortion law reform activists and sympathizers to stress the significant advantages accruing from an end to surreptitious and expensive criminal abortions, and to praise the importance of the Abortion Law Reform Association (hereafter ALRA) within the process of legal reform.[2] Thereafter, a range of more nuanced approaches have been advanced. For example, historians of sexuality have interpreted abortion law reform as part of a whole raft of legislation in the 1960s, including homosexual law reform and the revision of divorce law, which redefined the relationship of the State and the law to the moral domain of the private

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[1] Full details of the act can be found at *Public General Statutes, Elizabeth II, CH. 87*.

[2] See, especially, K Hindell and M Simms, *Abortion law reformed*, London, Peter Owen, 1971.

citizen.[3] Other commentators have focused on the political manoeuvring surrounding the 1967 Abortion Act, often as a case study in the role of pressure groups in shaping sexual politics.[4] In addition, a body of literature has investigated the role of the medical profession within abortion law reform, and the degree to which the law has influenced, and been interpreted within, medical practice.[5] In particular, feminist analysis, some drawing heavily upon the work of Foucault, has been brought to bear on the implications of the "medicalization" of abortion law reform for the reproductive rights of women.[6] Such writing tends to exhibit pronounced ambivalence towards the medical monopoly of abortion provision through the 1967 act.[7] In many respects, this literature feeds into other areas of research centring on the impact and penetration of biomedical perspectives within individual, social and political life.[8]

However, while the history of abortion policy and provision in Britain has received extensive attention by scholars, such studies have mainly centred on the social politics surrounding the issue at Whitehall and Westminster. There have been no substantial corresponding studies of Scotland to date, despite the fact that, to a significant extent, Scotland possessed its own system of law, local government and medical practice, as well as arguably a distinctive civic and sexual culture. In the case of abortion law reform this is particularly surprising given that the 1967 act was to be substantially modelled on the Scottish experience.

Using a range of legal, medical and governmental files, supplemented by oral testimony, this article seeks in part to rectify these omissions by examining such regional differences as they informed abortion law reform. First, it surveys abortion law as it existed in Scotland prior to the 1967 act, contrasting it with English statute law and law enforcement on the subject. Secondly, the article examines Scottish medical practice relating to abortion before the 1967 act, highlighting the work of the gynaecologist, Dugald Baird, and the influence of his liberal ideology and clinical practice in Aberdeen at a time when uncertainty and misunderstanding of abortion law prevailed elsewhere in Scotland. Thirdly, it explores the input of Scottish medicine to the politics surrounding the 1967 act, focusing on the two key medical figures of Dugald Baird and Ian Donald. Residual doubts over the

[3] See, for example, Hera Cook, *The long sexual revolution: English women, sex, and contraception 1800–1975*, Oxford University Press, 2004; L A Hall, *Sex, gender and social change in Britain since 1880*, Basingstoke, Macmillan, 2000; J Weeks, *Sex, politics and society: the regulation of sexuality since 1800*, 2nd ed., London, Longman, 1989.

[4] See, for example, M Durham, *Sex and politics: the family and morality in the Thatcher years*, Basingstoke, Macmillan Education, 1991; B Brookes, *Abortion in England, 1900–1967*, London, Croom Helm, 1988; L J F Smith, 'The abortion controversy, 1936–77: a case study in "emergence of law"', PhD thesis, University of Edinburgh, 1980.

[5] See, for example, J Keown, *Abortion, doctors and the law: some aspects of the legal regulation of abortion in England from 1803 to 1982*, Cambridge University Press, 1988; S MacIntyre, 'The medical profession and the 1967 Abortion Act in Britain', *Soc. Sci. & Med.*, 1973, **7:** 121–34.

[6] See, especially, L Hoggart, *Feminist campaigns for birth control and abortion rights in Britain*, Lewiston and Lampeter, Edwin Mellen Press, 2003; M Latham, *Regulating reproduction: a century of conflict in Britain and France*, Manchester and New York, Manchester University Press, 2002; S Sheldon, *Beyond control: medical power and abortion law*, London, Pluto Press, 1997.

[7] As Sheldon sums up: "Medicalisation has been the greatest strength of the British abortion law and its greatest weakness. It has simultaneously depoliticised the extension of women's access to abortion services, defused political conflict and left women dependent on the vagaries of medical discretion and good will". See Ibid., p. 168.

[8] For an historiographical introduction to the concept of "medicalization", see R Nye, 'The evolution of the concept of medicalization in the late twentieth century', *J. Hist. Behav. Sci.*, 2003, **39:** 115–29.

inclusion of Scotland in abortion legislation and continuing anomalies between English and Scots Law after the passing of the act are then discussed. Finally, the impact of the act north of the Border is charted using Scottish evidence to the Lane Committee (1971–74), and an evaluation made of how far abortion procedures were in fact medicalized in the following decade.

The article concludes by characterizing the attitude of the Scottish medical community to abortion in the 1960s as one of "reluctant medicalization", an attitude which current historiography has generally failed to take account of when critiquing the process of "medicalization". Many Scottish doctors, and even more Scottish nurses, strongly questioned intervention in this field both in terms of ethics and propriety. Moreover, whereas the conventional historiography largely stereotypes the response of the medical community towards abortion, this article will suggest the need for a more nuanced approach which captures the diversity and ambiguities that characterized the medical community's response to the "medicalization"—or enforced medical monopoly—of abortion at this time.

Scottish Abortion Law before 1967

Prior to the 1967 Abortion Act, English abortion legislation dated from Section 58 of the Offences Against the Person Act, 1861, which made the procurement of a miscarriage a crime. This was subsequently modified by the Infant Life (Preservation) Act, 1929, which exempted those cases where abortion was necessary to save the life of the mother, and by a 1938 judicial ruling—the Bourne case—which interpreted the 1929 act as permitting abortion where the woman's mental health was at risk. North of the Border, however, abortion law followed a somewhat different course. Neither of the aforementioned acts applied, nor did the Bourne case. In Scotland, abortion was a common law offence without strictly defined limits. Thus, it was possible to interpret it more elastically than English statute law. Scottish legal textbooks recorded that abortion was illegal but that it could be legally carried out when certain medical criteria relating to the life and health of the mother were satisfied.[9] In short, it was possible for a medical practitioner, acting in good faith in the interests of the health or welfare of his patient, to terminate a pregnancy after a careful study of all the circumstances of the case, and after due consultation with appropriate medical specialists. Thus, abortion was only a crime in Scotland if criminal intent could be proved, a doctor having freedom to practise medicine in this type of case, as in all others, according to his clinical judgement.

As well as separate legislation, there were peculiarities in abortion law enforcement. In English law, due to the terms of the 1861 Offences against the Person Act, an individual other than the mother might be guilty of the offence whether the woman "be or be not with child".[10] The crime here was not the abortion itself but the doing of an act with intent to procure abortion; the doing of an act not requiring a victim before it could be held unlawful. In contrast, north of the Border, conviction for attempted abortion could be obtained only if it was proved that the woman was actually pregnant, the reason for the necessity of

[9] See, for example, G Gordon, *The criminal law of Scotland*, Edinburgh, W Green & Son, 1967.

[10] Wellcome Library, Archives and Manuscripts (hereafter Wellcome), SA/ALR/C.119, R Ireland, 'Scottish section of the historical and international appendix' (undated).

pregnancy being that abortion was "held to be criminal because its successful accomplishment result[ed] in the destruction of potential human life".[11] The victim of the crime of abortion or attempted abortion in Scots law was the potential child, so that if there was no potential child there was no crime.[12]

Furthermore, the high standard of proof called for in Scottish criminal prosecutions made it difficult to obtain sufficient evidence for a prosecution for illegal abortion, since the operator, pregnant woman and her family would usually have a joint interest in concealment. A doctor who carried out an abortion in Scotland could not be charged with any crime unless a definite complaint was made. Even then the matter would be investigated by doctors nominated by the Crown Office, and if they were satisfied that the operation had been carried out in good faith and in a proper manner the case would be closed. Such investigations and decisions took place in private within this centralized system, the press and public knowing nothing of them. By contrast, in England, all such matters were brought before either a magistrate's court to decide whether there was a *prima facie* case, or a coroner's court in the case of death from the operation. Moreover, in England, a prosecution could be instituted by any of the innumerable local police forces—who might differ in their policies—even if all proper professional procedures had been followed and there were clear medical grounds for the termination. A police investigation of this kind, conducted in the hospital with an interrogation of the medical men concerned, could seriously disrupt the hospital environment.[13]

In July 1966, the Secretary of State for Scotland was asked whether any prosecution had been instituted against a registered medical practitioner in Scotland since 1945 for procuring an abortion where the defence had argued that the abortion was in the interests of the life or health of the mother. William Ross replied that enquiries had not revealed a single case of this description.[14] Although a trawl of Scottish High Court records for the decades before 1966 does reveal a number of cases for the crime of procuring abortion, prosecutions were usually in cases where an "amateur" person was making a trade of abortion for private gain, or where there had been a risk to health by use of improper methods, with a medical element usually lacking.

The story of a highly unusual case in 1967, when Dr Roderick Sutherland Ross, a general practitioner, was tried at the High Court in Edinburgh on two charges of procuring abortion, merely serves to reinforce this picture.[15] The principal distinguishing feature of this high-profile case was the fact that the defendant was medically qualified; his counsel, Mr A Bell, QC, describing the case as "unique in these courts" since his client was the first doctor in modern times to stand before a Scottish court on such charges. This doctor, Bell continued, was "no fumbling, unqualified, back-street quack", but a qualified, skilled and experienced medical practitioner who had built up a large practice, both private and National Health, in the previous nineteen years. In both cases, it was claimed, the girls had

[11] K McKnorrie, 'Abortion in Great Britain: one act, two laws', *Criminal Law Review*, 1985: 475–88, p. 483.

[12] This was founded on a ruling by a single judge in Glasgow (*HM Advocate* v *Anderson*, 1928), proceeding on the assertion that "to attempt to do what is physically impossible can never . . . be a crime". The ruling was approved by three High Court judges in 1937, the law thereafter being regarded as settled.

[13] *Observer*, 6 Feb. 1966.

[14] National Archives of Scotland (hereafter NAS), AD63/759/1, House of Commons question, 19 July 1966.

[15] NAS, JC26/1967/117, High Court of Edinburgh trial papers, 24 Jan. 1967.

come to Ross in a state of "complete agitation and desperation". The doctor had consulted a professional colleague before proceeding, and the operation had been a success, with no unfortunate sequellae.[16]

In response, the Crown Agent stated: "The main point is surely that Ross pled Guilty to criminal abortion. Obviously had the operations he performed been on, or even near the borderline, between the criminal and the necessary or therapeutic, he would never have pled guilty, and might very well never have been charged".[17] Ross was stated to have been "well known among the young of Edinburgh" as an abortionist, offering to perform the procedure for £100. It was alleged that, with little or no preliminary examination, other than to confirm the fact and duration of pregnancy, Ross simply gave these girls the injections "very much after the manner of the back street abortionist", sent them home, and told them that if anything cropped up they should get in touch with him. According to the Prosecution, it was "inherent in the whole argument . . . that the girls aborted when at home with no one there to give any kind of medical advice or help". These injections were given, not in a clinical setting, but in a "little bedsitting room acquired by the accused ostensibly for bagpipe practice".[18] Everything was thus said to point to these having been nothing but commercial abortions rather than being performed in good faith for therapeutic reasons. As such, the Court found Ross guilty and sentenced him to four years' imprisonment. Yet, the fact that this legal case provoked such a storm of controversy and media coverage was precisely because its medical element was so exceptional in Scots law.

Dugald Baird and the Practice of Abortion

A key but, as we shall see, somewhat atypical medical figure in the history of Scottish abortion practice and law reform, was Sir Dugald Baird (1899–1986). Born in Greenock and educated in Glasgow, Baird spent several years in junior hospital positions in Glasgow before working as a gynaecology registrar at Glasgow Royal Infirmary under the renowned Munro Kerr. It was in Glasgow during the Depression that Baird grew to recognize the various influences that social and economic factors could have upon maternal health and women's physiology. He was shocked by the high maternal mortality amongst mothers due primarily to the effect of excessive childbearing, to the lack of advice on family planning, and to the lack of access to abortion.[19] Baird's experience in the city would lead to his long-lasting involvement with social research into reproductive health.

In 1936, Baird was appointed to the Regius Chair of Midwifery at the University of Aberdeen. On arrival in 1937, he found social conditions very similar to those prevailing in Glasgow.[20] However, he accepted the Aberdeen appointment for various reasons, above all believing the city to be ideal for the research he considered necessary to establish the factors needed for efficient childbearing.[21] The city was of appropriate size for epidemio-

[16] NAS, HH41/1820, John Hobson, MP, to Bruce Millan, Scottish Office, 20 Feb. 1967.

[17] NAS, AD63/759/2, Note by Crown Agent, Feb. 1967. It is unclear from the legal records why Ross pleaded guilty.

[18] Ibid.

[19] Wellcome, SA/ALR/C.115, Note by Sir Dugald Baird (undated).

[20] Although Glasgow was much the larger of the two, both cities were plagued by poverty and severe employment and housing shortages at this time.

[21] S MacIntyre and L MacAulay (eds), *Thirty years and still going strong: papers presented at the 30th anniversary of the MRC Medical Sociology Unit, University of Glasgow*, Occasional Paper no.1, MRC Medical Sociology Unit, Glasgow, 1996, p. 1.

logical research, the settled population enabling the effective follow-up of women and their families, and the centralized medical service facilitating studies of a total population.[22] The Medical Officer of Health during the 1950s and 1960s—Dr Ian MacQueen—was also instrumental in helping Baird to construct his maternal care policies for the city, and ensured the backing of local health authorities; while Baird's wife, May, was a councillor who became Chairman of the Health Board.[23] Finally, the Aberdonian community exhibited "liberal" political attitudes and religious diversity in the post-war era, providing an accepting environment for Baird's policies. As such, Aberdeen was able to offer financial, medical and popular support to Baird.

Baird took advantage of these circumstances to implement the sort of system he could not have obtained in Glasgow. Abortion was a notoriously unpopular procedure among Glaswegian doctors, due primarily to the relatively high proportion of Roman Catholics there, whereas Baird felt it to be a reliable medical practice applicable in many different situations. He was aware of the tenuous legal standing of abortion when he arrived in Aberdeen. Indeed, in the late 1930s he sought the advice of Thomas Smith, Professor of Law at the University, for clarification on the issue. According to Baird, Smith explained that there was little likelihood of the Lord Advocate or Procurator-fiscal initiating prosecutions against Baird for terminating a pregnancy unless they were convinced of "criminal intent".[24] Given such assurances, Baird and his colleagues subsequently adopted an active policy of therapeutic abortion, recognizing "social" indications,[25] and terminating about two out of every hundred pregnancies in the Aberdeen area long before abortion practice had been liberalized in any other part of Scotland, and decades before the 1967 act.[26] Moreover, this was with the full support of the local police. As Chief Constable William Smith of the Aberdeen City Police explained: "What we are concerned about is the procuring of abortion with criminal intention. We have no connection with what the doctors do in the hospitals".[27]

Not only was Baird's clinical practice unusual at this time. He was also unusual for his willingness to publicize this work and to become increasingly involved in the politics surrounding abortion. During the 1960s, Baird began to dedicate himself to helping women achieve what he referred to in his classic lecture as a "Fifth Freedom"—"freedom from the tyranny of excessive fertility".[28] This lecture heralded a more politicized Baird,

[22] Baird later reflected that, in the largest area of Scotland—the western—the organization of maternity services was complicated by the many large obstetric hospitals; whereas the north-east and eastern regions had only one main teaching hospital each, which had many advantages, such as a common administrative policy, and agreement on methods of investigation and treatment. See D Baird, 'An area maternity service', *Lancet*, 1969, **i:** 515–19, p. 516.

[23] The ultimate combination of Chairman of the Board and Professor of Obstetrics was a powerful one, adding greatly to Baird's power to influence policy and appointments.

[24] G Bhatia, 'Social obstetrics, maternal health care policies and reproductive rights: the role of Dugald Baird in Great Britain, 1937–65', MPhil thesis, University of Oxford, 1996, p. 59.

[25] However, it should be noted that Hugh McLaren, who was Baird's first registrar in Aberdeen, and who subsequently became a leading critic of abortion as Professor of Obstetrics and Gynaecology in Birmingham, later questioned the extent to which social abortions had been conducted in Aberdeen prior to the Second World War. See *Scotsman*, 22 Dec. 1966.

[26] Hindell and Simms, op. cit., note 2 above, p. 54. However, most patients were married women of high parity, worn down by years of childbearing. Terminations in unmarried women were still rare at this time, and abortion "on request" viewed as unacceptable.

[27] *Turiff and District Advertiser*, 11 Feb. 1966.

[28] D Baird, 'A fifth freedom?', *Br. med. J.*, 1965, **ii:** 1141–8, p. 1141.

who began explicitly to discuss female rights within reproductive medicine. Through free and effective contraception and abortion provision, women could achieve autonomy over their bodies, as well as having the satisfaction, alongside men, of becoming educated "to their maximum potential ability" and having "the opportunity to exercise their skills in a wider sphere than the immediate family".[29]

Baird's stance should be contextualized within Scottish medicine at this time. When the Liberal MP, David Steel, introduced his Medical Termination of Pregnancy Bill in 1966, many observers considered that the measure was superfluous given the state of existing Scottish abortion law. Certainly, the number of prosecutions for abortion in Scotland was minimal—only twenty in the previous five years, of which hardly any involved a doctor. Yet the line between criminal and non-criminal abortion was just as indistinct as in England. Although in north-east Scotland, gynaecologists like Baird had for many years been terminating pregnancies in good faith, and without fear of prosecution, in other areas of the country the legal right to terminate pregnancy was not being utilized, nor were the differences between English and Scots law in this regard made clear to medical students.[30] As a result, graduates generally believed that procuring an abortion was a crime unless the woman's life was in imminent danger.

Aberdeen was thus one of the few cities in Scotland to exploit the ambiguities of the law relating to abortion. Equally, while Baird trained a generation of gynaecologists—including Malcolm Macnaughton, David Paintin, Alexander Turnbull and James Walker—who were to command the heights of obstetrics in Britain, and uphold Aberdeen's liberal policies, Baird himself remained until the mid-1960s an exception within the ranks of Scottish medicine. Elsewhere in Scotland, gynaecologists remained wary of terminating pregnancies except in cases of pronounced "medical" need.[31] In fact, Baird felt a sense of frustration that the law had to be changed at all, and that his fellow doctors were not following his lead, explaining:

> What I have done is to act as a spearhead for those who are not so strongly placed. A Scottish professor has considerable status and the security which that brings ... One hears talk about modernising the abortion laws. Certainly the law should be clarified and spelt out in words of one syllable. But the work has been done for 20 years, it has all been documented, and I haven't gone outside the law.[32]

Scottish Medical Input to the 1966 Bill

The thalidomide tragedies of the early 1960s are generally believed to have contributed to the climate of public and medical sympathy for women seeking abortion. Soon after the

[29] Ibid., p. 1148.

[30] However, this is not surprising, given that textbooks such as J Glaister and E Rentoul, *Medical jurisprudence and toxicology*—the "medico-legal bible" for generations of doctors in Scotland—failed to differentiate England and Scotland in this regard. See 12th ed., Edinburgh and London, E & S Livingstone, 1966, pp. 363–6.

[31] Oral testimony suggests that indications other than of an emergency medical nature were little used, most doctors believing social and psychological grounds to be illegal. Transcripts of a series of interviews with retired general practitioners, gynaecologists and psychiatrists, Apr. 2003 to Apr. 2004, are held by Gayle Davis. These were granted on condition of anonymity and confidentiality and are not available for consultation.

[32] *Observer*, 30 Jan. 1966.

publicizing of British cases, a *Daily Mail* national opinion poll showed 73 per cent of the British public to be in favour of abortion where a child might be born deformed.[33] While publicity surrounding this tragedy undoubtedly generated sympathy for the idea of permitting abortion in certain circumstances, a number of abortion bills presented in Parliament during the 1960s met with failure. However, there was a rising tide of public opinion, which the ALRA was helping to orchestrate by publicity and the political lobbying of MPs and parliamentary candidates.[34] It was in this way that David Steel became involved in the abortion issue. After consultation with the ALRA, and having recently read Alice Jenkins' *Law for the rich*,[35] he found himself "convinced that this was a substantial issue, well worth doing",[36] and introduced his Private Members' Bill on the issue, having come third in the ballot.

During 1966, Steel was subjected to advice and pressure from many sources whilst drafting the bill—from the ALRA, religious groups, and government ministers, among others. However, it was a doctor who was to prove one of the most important influences on Steel. Dugald Baird was not only busy implementing an active abortion programme in Aberdeen but also taking an active interest in policy-making at the national level. He began to meet with politicians and publicly supported both the NHS provision of contraception and abortion law reform in his writings and lectures. In November 1966, Baird, together with Malcolm Millar, Professor of Mental Health in Aberdeen, lunched with Steel in Scotland. Baird was interested in incorporating some kind of "social" clause into the bill but also urged the MP not to separate social from medical factors as he did not view such a separation as good medical practice.[37] Steel himself recognized the importance of this discussion, later claiming: "I was greatly influenced by . . . Baird, who persuaded me to accept amendments creating a single socio-medical clause rather than a series of individual categories".[38]

Pressure groups also made use of Baird. To promote the passage of the bill and to counteract anti-abortionist writings, the ALRA publicized the support of such medical practitioners. Baird was also asked to persuade other gynaecologists to deliver statements to the local and national press in order to "counteract [negative] publicity" engendered by opponents of reform.[39] He responded generously to the ALRA's requests, making himself visible at fertility control forums and writing to newspapers and medical periodicals in

[33] *Daily Mail*, 25 July 1962.

[34] The ALRA was the most notable of the women's campaign groups involved in this issue. In 1936, this group of articulate middle-class women, active in sex reform and socialist politics, was formed to bring women in from the periphery of the abortion discussion. See Brookes, op. cit., note 4 above.

[35] A Jenkins, *Law for the rich*, London, Victor Gollancz, 1960, highlighted the social inequalities that existed in abortion practice with regard to both income and geography.

[36] M D Kandiah and G Staerck (eds), *The Abortion Act, 1967*, London, Institute of Contemporary British History, 2002, p. 25. Abortion was not Steel's first choice. The "touchy" subjects of homosexual and abortion law reform were suggested to him, for both of which private members' bills had already been passed in the House of Lords and awaited a champion in the Commons. Steel plumped for abortion because Scottish opinion was seen to be adamantly opposed to homosexual law reform. See T Newburn, *Permission and regulation: law and morals in post-war Britain*, London, Routledge, 1992, p. 142; R Davidson and G Davis, '"A field for private members": the Wolfenden Committee and Scottish homosexual law reform, 1950–1967', *Twentieth Century Br. Hist.*, 2004, **15:** 174–201.

[37] Kandiah and Staerck (eds), op. cit., note 36 above, p. 47.

[38] D Steel, *Against Goliath: David Steel's story*, London, Weidenfield and Nicolson, 1989, p. 53.

[39] Wellcome, SA/ALR/A.6/1, V Houghton to D Baird, 4 Nov. 1966.

justification of his actions. Baird further recognized that it was important to involve the new generation of medical practitioners, especially consultants, in the campaign. In private correspondence to the ALRA, Baird explained that it would be politically constructive for "younger men, like [Baird's successor, Professor Ian] MacGillivray, [to] come out into the open on the matter". He felt that it could easily be put about that his views were "very exceptional in clinical circles" or that he was "senile".[40] In addition, the ability of the ALRA to cite Aberdeen as an example of a city with a successful, active abortion policy was significant for the political campaign.

Glasgow provides a very fitting comparison with Aberdeen in this regard, for it lay at the other extreme in terms of Scottish abortion provision. Glasgow had the lowest abortion rate of any Scottish city, due, according to Baird, partly to the existence of a large Roman Catholic minority, but more so to the anti-abortion views of several of its leading obstetricians.[41] As with Aberdeen, an individual seems to have exerted considerable influence within the obstetrical community. Ian Donald (1910–87) was born in Cornwall, and educated in Scotland and South Africa. Service in the RAF stimulated his interest in gadgetry, where he became familiar with radar and sonar, an expertise he was later to apply to medical diagnostics by developing obstetric ultrasound.[42] In 1954, Donald moved to Glasgow to accept the Regius Chair of Midwifery. An active member of the Scottish Episcopal Church, he was to become a committed opponent of termination of pregnancy for social reasons, a leading campaigner against the 1967 Abortion Act, and Dugald Baird's most outspoken critic. Throughout his career, Donald refused to terminate a pregnancy unless the foetus was grossly deformed or the mother's life in serious danger, seeing even therapeutic abortion—that is, termination of pregnancy for medical reasons—as "fundamentally destructive".[43] He considered issues such as inadequate housing, financial debt, and marital breakdown as inadequate reasons for "killing a baby", pointing to the "huge social services" available to help people to cope in such circumstances.[44] Baird's "Fifth Freedom" was dismissed as a "doctrine of hideous atheistic expediency".[45] Instead, Donald discussed abortion within the context of the holocaust, likening abortion for social reasons to the Nazi campaign of "destroying the socially unacceptable Jews".[46] In practical terms, Donald claimed that one pregnancy in fifty was terminated in Aberdeen, compared to one in 3,750 in Glasgow.[47]

Donald employed his new ultrasound technology as a powerful anti-abortion resource. In Glasgow's Queen Mother Maternity Hospital, oral testimony suggests that Donald would show ultrasound images to women seeking an abortion in a deliberate attempt to deter them from their chosen course of action.[48] At public meetings, he used a similar

[40] Wellcome, SA/ALR/A.6/1, D Baird to V Houghton, 8 Nov. 1966.

[41] D Baird, 'Induced abortion: epidemiological aspects', *J. Med. Ethics*, 1975, **1:** 122–6, p. 124.

[42] During the Second World War, echoes from high-frequency sound waves were used to detect submarines. In 1950s Glasgow, Donald led a team of clinicians and engineers who modified this technology to provide clinically useful images and to measure the foetus in the amniotic fluid.

[43] I Donald, 'Abortion and the obstetrician', *Lancet*, 1971, **i:** 1233.

[44] *Scottish Daily Record*, 1 Feb. 1967.

[45] *Scotsman*, 31 Dec. 1966.

[46] *Scotsman*, 26 Dec. 1966.

[47] *Scotsman*, 23 Dec. 1966.

[48] This was at a time when ultrasound was not used routinely in the management of pregnancy. These scans were, it seems, specially organized to persuade women to continue with their pregnancies. See M Nicolson, 'Ian Donald—diagnostician and moralist', pp. 1–26, pp. 21–2 (section 4). http://www.rcpe.ac.uk/library/history/donald/donald1.php.

technique, showing slides of premature babies accompanied by tape recordings of the beating heart of a six-week foetus, as a powerful accompaniment to his anti-abortion speech.[49] As he explained, "there was a popular idea that in early pregnancy there was a sort of inanimate jelly which could be scooped out", whereas ultrasound revealed the foetus at twenty-eight days to be "recognizable, with head, eyes, fingers and toes".[50] Through its depiction of the foetus's characteristics, ultrasound arguably endowed the foetus with an identifiable individuality.[51]

Donald's ideology did not feed into policy debates as Baird's did, but his views were widely exploited by the Catholic Church and anti-abortion organizations in the later 1960s and beyond. In fact, mirroring Baird's involvement with the ALRA, Donald became a founder member of the Society for the Protection of the Unborn Child (hereafter SPUC), set up in January 1967 in opposition to Steel's bill and the ALRA. This voluntary organization was to prove one of the leading anti-abortion forces, Steel admitting retrospectively that the SPUC could be "a real menace", particularly in view of the involvement of several major medical figures with its activities.[52] However, the SPUC lacked the political skill and well-placed connections of the ALRA, and arguably was formed too late to have a significant impact on the immediate campaign surrounding the 1967 act. Rather, its role was to sustain in the longer term a more protracted struggle to reverse the impact of the act on access to abortion.

Glasgow and Aberdeen provide a stark contrast in terms of the abortion ideology of their main obstetricians. As Sally MacIntyre discusses, the 1967 act raised an issue increasingly facing medicine and society; namely the boundary of the profession's sphere of competence and authority.[53] During the passage of Steel's bill in the Commons, one group argued for the sanctity of life and the doctor's duty to preserve it; while another argued that the doctor's prime duty was to the health of his patient. On the former side were doctors like Donald, whose philosophy was based on the argument that, if destroying the foetus for any other reason than immediate danger to the woman's life were to be permitted, the profession would utilize its expertise to destroy life in other situations. Donald summarized this argument in referring to abortion as: "the thin end of the wedge that leads to Belsen, euthanasia of the old, infirm and imbecile, and a brave new 1984 world of test tube babies in artificial wombs".[54] Those who took the latter view tended to focus on the mother, arguing that they were being true to their vocation by preventing ill-health. According to Baird and MacGillivray in Aberdeen, in considering abortion, the well-being of the mother was the prime factor. The preservation of life at all costs was, they argued, "surely not the point". Rather, they believed that doctors should be concerned with "the relief of human

[49] Wellcome, SA/ALR/H.58, Note on a Public Meeting, 6 Dec. 1966.

[50] *The Times*, 12 Jan. 1967.

[51] New reproductive technologies have subsequently been used more widely to strengthen pro-life arguments. The pseudo-scientific film, *The silent scream*, became the *pièce de résistance* of this genre. See Sheldon, op. cit., note 6 above, pp. 151–2. See, also, P Treichler, L Cartwright and C Penley (eds), *The visible woman: imaging technologies, gender, and science*, New York and London, New York University Press, 1998, chs. 5 and 6; R Petchesky, 'Foetal images: the power of visual culture in the politics of reproduction', in M Stanworth (ed.), *Reproductive technologies: gender, motherhood and medicine*, Cambridge, Polity Press in association with Blackwell, 1987, pp. 57–80.

[52] Kandiah and Staerck (eds), op. cit., note 36 above, p. 42. In this sense, both pressure groups were in agreement, finding that it was medical rhetoric which had the greatest potential in fighting their cause.

[53] MacIntyre, op. cit., note 5 above, p. 121.

[54] *Daily Sketch*, 12 Jan. 1967.

suffering''.[55] Those supporting Steel's bill thereby espoused a broader concept of health and, by extension, of their own functions and expertise.

Although Baird and Donald reveal the sheer diversity of medical responses to the suggested medicalization of termination of pregnancy, their highly visible involvement in the politics of abortion was, in fact, extremely unusual within Scottish medicine at this time. Few individuals were willing to stand up and be counted as these men were. While the major London-based medical bodies, in particular the British Medical Association (hereafter BMA) and Royal College of Obstetricians and Gynaecologists (hereafter RCOG) did play a significant part in shaping the 1967 act, neither the Scottish Council of the BMA nor the Scottish Standing Committee of the RCOG articulated a specifically Scottish view on the issue. Although Scottish medical opinion was said to ''embrace all shades of attitude'',[56] such evidence as is available would suggest that much of the medical community and the majority of practitioners were broadly opposed to the bill, either on ethical or professional grounds. For example, the Scottish Council of the Royal College of Midwives registered firm opposition to the bill on ethical grounds.[57] The attitude of general practitioners is more difficult to identify, but appears also to have been hostile. For example, one family doctor likened abortion to ''euthanasia and possibly even murder''.[58] He doubted whether nurses and medical students could be ''injected properly with the principles of medicine'' if they saw one doctor saving life and another taking it away at the will of prospective parents. On somewhat different grounds, another doctor aired his concerns to the Secretary of State for Scotland that the bill would enable abortion to be obtained on demand by any woman, leaving the doctor in no position to refuse her request.[59] This concern over the impact of the act on professional autonomy, and the widely held view that existing abortion law in Scotland was perfectly satisfactory, were also echoed in the correspondence of an Edinburgh gynaecologist to the *Scotsman*.[60]

Such ethical and professional concerns reflected the two key issues engaging public and professional debate over abortion law reform in the United Kingdom: the issue of how far abortion should be controlled solely by medical practitioners, and the issue of how far ''social'' criteria might appropriately be considered. On the issue of eliminating competing medical services by unqualified persons, or so-called ''kitchen table'' abortions,[61] Baird and Donald were in fact in agreement. Although in general Baird preferred the law to ''interfere as little as possible with clinical practice'', he did recognize that ''one [had] to legislate for the unscrupulous, especially where large fees [were] possible''.[62] Similarly, Donald supported legislation to retain medical control of abortion and to exclude the

[55] MacIntyre, op. cit., note 5 above, p. 125.

[56] NAS, HH41/1820, D Cowperthwaite to J Hogarth, SHHD, 28 Nov. 1966.

[57] 'Abortion law reform Bill', *Midwives Chron.*, 1967, **80:** 69–70, p. 70. This is in contrast to the UK Royal College of Nursing, which refused to formulate a policy statement on abortion while the bill was before Parliament, on the grounds that the abortion decision-making process was a medical one and so outside their remit. See, for example, Royal College of Nursing Archives, RCN/4/1972/5, Proceedings of the Lane Committee (hereafter PLC), Submission of Royal College of Nursing, Feb. 1972.

[58] *Scotsman*, 31 Dec. 1966.

[59] NAS, HH41/1820, A Orcharton, Ayrshire, to Rt Hon W Ross, House of Commons, 3 May 1967.

[60] *Scotsman*, 23 Dec. 1966.

[61] *Glasgow Herald*, 2 Mar. 1966. Indeed, the eradication of dangerous back-street abortions was David Steel's stated primary aim.

[62] Wellcome, SA/ALR/A.6/1, D Baird to V Houghton, 12 Mar. 1967.

"racketeer who has brought such discredit upon our profession".[63] It seems likely that such views, underpinned by a strong Scottish tradition of professional autonomy in this area, strongly influenced David Steel in his drafting of the bill. Thus, he opted, subject to certain administrative formalities, to give doctors complete control in the decision-making process surrounding abortion.

On the issue relating to the desirability of social criteria for abortion, it is Baird's views that seem to have had a decisive influence. While the ALRA felt strongly that the bill should contain a "social clause" allowing abortion after rape, when a patient was under sixteen, or lacked the capacity to be a mother, David Steel was acutely aware of the opposition of the medical establishment to such a clause, which in the view of the BMA and RCOG required doctors to sanction and perform a medical operation on non-medical grounds, outside their realm of expertise.[64] To try to pacify medical opposition, Steel duly amended his bill in December 1966. On advice from Baird, he deliberately widened the definition of "social", dropping the words "serious" (risk to life) and "grave" (injury to health), and instead adopting the idea of the mother's "well being" and that of her existing children.[65] As a result, in line with Baird's long-standing belief that social factors were inseparable from medical considerations, the act subsequently buried the social clause in the general grounds for termination.

Attempts to Exclude Scotland

According to a senior official of the Scottish Home and Health Department (hereafter SHHD), there was still, in 1966, considerable doubt in the minds of Scottish politicians and administrators over the desirability of Scotland's inclusion in the Medical Termination of Pregnancy Bill.[66] While acknowledging that the existing law of abortion in Scotland was "difficult to defend in theory", the Lord Advocate's Department was persuaded that there was "no specific demand" for reform of Scots law in this area.[67] Similarly, the Secretary of State for Scotland, William Ross, observed that: "I am bound to say that I personally would have preferred that it did not apply to Scotland, where the law has not given rise to the difficulties in England and Wales which seem to motivate the sponsors".[68]

A range of objections—some general, some more specific—were advanced. First, it was feared that if the grounds for termination were to be further restricted during the Committee stage of the bill—for example, if family circumstances could not be taken into consideration—powers under the existing law in Scotland might ultimately be reduced.[69] This was part of a more general concern within the Scottish political and medical establishment that clinical flexibility, hitherto permissible under Scots law, must be maintained. Secondly, the Scottish Office questioned the wisdom of applying "uniform standards" throughout the country, whether it be Orkney or Harley Street, given the wide variation in

[63] Donald, op. cit., note 43 above, p. 1233.

[64] See Hindell and Simms, op. cit., note 2 above, pp. 166–76.

[65] See file NAS, AD63/759/13.

[66] NAS, AD63/759/1, Note by D Cowperthwaite, SHHD, 5 Dec. 1966.

[67] Ibid.

[68] NAS, HH41/1820, W Ross to A Orcharton, 12 June 1967.

[69] NAS, HH41/1821, D Cowperthwaite to J Brennan, 10 Aug. 1967. Cowperthwaite wished to "record a strong Scottish view" that the words "existing children of her family" remain in the bill, otherwise "the Bill must be allowed to die".

medical facilities and the comparatively small number of registered nursing homes in Scotland.[70] Since in Scotland very few abortions were performed outside NHS facilities, the problem of policing private clinics was not viewed with the same urgency as in England. Another issue involved the appropriateness of a doctor being required to decide whether rape had been committed prior to an abortion procedure, given that such a decision was normally the outcome of High Court proceedings in Scotland.[71] A similar difficulty surrounded the issue of conscientious objection, where doctors were involved in civil proceedings as a result of refusing treatment on grounds of conscience.[72] The Medical Termination of Pregnancy Bill placed the onus of proof solely on the conscientious objector, whereas under Scots law, corroborative evidence was required.[73] As a result, the bill was amended to allow for variance between the two legal systems on this issue.

However, in the event, Dugald Baird was to play a vital role in persuading David Steel to include Scotland in his bill. According to Steel, Baird told him: "Whatever you do, don't let them drop Scotland out of the bill on the spurious grounds that it is easier under the common law; it *is* easier under the common law, but I am the only person doing it".[74] Steel had quickly realized that the situation in Aberdeen was very different from that in Glasgow, Edinburgh and the other medical centres in Scotland, and that consequently there was a need to apply legislation north of the Border.[75] Accordingly, he successfully orchestrated opposition to a series of amendments threatening to delete Scotland from the bill.

Continuing Regional Variations

The provisions of the 1967 Abortion Act came into operation from 27 April 1968. It made termination legal where the risk to the life of a pregnant woman, or of injury to her physical or mental health, or to that of her existing children, was greater than the risks from abortion, or where there was a substantial risk that a baby would be seriously handicapped. Two doctors were required to certify that the indications for abortion existed, except in cases of medical emergency, where one was deemed sufficient; and the operation was only to be performed in an NHS hospital or another officially approved location. No doctor was obliged to administer such treatment if he or she had a conscientious objection, except in cases of emergency.

Given that the 1967 act was to apply to England, Wales and Scotland collectively, one might assume that the law of abortion, for all practical purposes, became the same throughout mainland Britain. Certainly, most of the rules laid down in the act were of equal applicability to all three countries. The medical opinions to be obtained, the places where induced abortions might be carried out, and the circumstances in which an induced abortion

[70] NAS, HH41/1820, W Robertson to M MacDonald, 2 Mar. 1967.

[71] *Glasgow Herald*, 3 June 1967.

[72] The conscience clause stipulated that no doctor or nurse be required to participate in abortion work—except in emergency circumstances—should it contradict their own personal beliefs, and was intended to protect the professional standing of medical and nursing staff who chose not to take part in terminations.

[73] NAS, HH41/1821, R Lawrie, St Andrew's House, to G Mitchell, Lord Advocate's Chambers, 22 July 1967.

[74] Kandiah and Staerck (eds), op. cit., note 36 above, p. 47.

[75] This was also a concern voiced by the Church of Scotland in its General Assembly reports of 1966 and 1967, which lamented this very "evident divergence, both of interpretation and practice, in different parts of Scotland". See Church of Scotland, *Report to the General Assembly* (1967), p. 511.

was legal, were identical in all jurisdictions. However, in practice, there still remained significant legal anomalies. Indeed, D Cowperthwaite, Assistant Secretary of the SHHD, protested at the "quite unnecessary Scottish presentational and political difficulties because of the unwillingness of English departments and draftsmen to budge from drafts which [met] English needs on purely English considerations but cause[d] difficulty for the Scots".[76]

The most significant of these anomalies was the time limit. As the time limit in Steel's bill was based upon the provisions of the 1929 Infant Life (Preservation) Act, in effect it set a limit of twenty-eight weeks for abortions. However, as the 1929 act was not applicable to Scotland, in theory at least, the 1967 act could be interpreted much more liberally north of the Border, so as to allow terminations up to the moment of birth, so long as two medical practitioners certified in good faith that certain conditions were satisfied. A second important anomaly related to the different criteria for abortion as specified on medical documentation in England and Scotland. David Steel objected to the classification "non-medical" used on the English form as, in his view, admitting a distinct and separate "social" category of reasons, which his legislation had consciously tried to avoid.[77] The Scottish form differed in this respect, deliberately employing instead the term "medico-social" in order to avoid such a distinction, and to encapsulate "the spirit of a medical judgement in a social context".[78]

Generally speaking, the Abortion Act arguably made little difference to the freedom already existing in Scotland, apart from the requirement to notify all terminations of pregnancy to the Chief Medical Officer of the SHHD and to register nursing homes carrying out such operations. In fact, as *Medical News* reported, "The new Abortion Act [was] largely ignored by many Scottish doctors, who [had] been practising abortion under their own Common Law for years".[79] Similarly, as the Crown Office subsequently claimed, while English law had been brought "more or less into line with the practice in Scotland", in theory, Scottish practice had been, if anything, restricted by the new law.[80]

Evidence to the Lane Committee

Criticism of the way the 1967 act was working began almost as soon as the legislation came into force. On the basis of considerable parliamentary and other pressure for an enquiry, the Secretary of State for Social Services, Sir Keith Joseph, announced in 1970 the Government's decision to appoint a committee to review the operation of the act.[81] The SHHD was invited to participate in giving evidence to this enquiry. However, Scottish policy-makers were initially dubious about the need for this investigation to cover Scotland; the general feeling being that the act was working satisfactorily.[82]

[76] NAS, AD63/759/2, D Cowperthwaite to R Lawrie, 2 Oct. 1967.

[77] NAS, HH102/971, W McCulloch to J Burnett, 15 May 1968.

[78] NAS, HH102/971, 'Abortion (Scotland) Regulations, 1968', May 1968.

[79] Wellcome, SA/FPA/A17/129, 'Aberdeen shows way on abortion', *Med. News*, 18 July 1969. This publication was, it should be noted, heavily biased towards an Aberdeen perspective.

[80] NAS, AD101/13, P Layden to Lord Advocate, 17 July 1978.

[81] NAS, HH61/1315, Draft Memo by the Secretary of State for Social Services, 1970. Significantly, the terms of reference did not cover any review of the wording or principles of the existing act. See Report of the Committee on the Working of the Abortion Act, PP 1974, XVI (Cmnd. 5579), volume 1, p. 1.

[82] NAS, HH61/1315, R Johnson to E Taylor, 21 Oct. 1970.

In particular, the fact that the issue of private abortion clinics was far "less acute" north of the Border served to reinforce this feeling.[83] However, on balance, it was felt that it was advisable for any enquiry to cover the whole of Great Britain, with the SHHD prepared to go along with any legislative changes proposed for the sake of "uniformity in the law rather than any current clamant problem in Scotland".[84]

Under the chairmanship of Justice Elizabeth Lane, the fifteen-member Committee on the Working of the Abortion Act (Lane Committee) was assembled, consisting of senior members of the medical, legal and nursing professions, and leading representatives from the fields of social science, education and welfare.[85] The Committee began to take evidence from a variety of organizations and private individuals in August 1971, asking them to submit their criticisms of the act and suggestions for improvement.[86] The Committee sat for two-and-a-half years before publishing its three-volume report in April 1974, in which it suggested a variety of administrative measures to tighten the regulations and improve the act's effectiveness, including regulation of abortion in the private sector, improved counselling of patients, the prevention of pregnancy and abortion through education and contraception, and the lowering of the upper limit for termination from twenty-eight weeks to twenty-four. However, most significantly, the Committee unexpectedly and unanimously expressed confidence in the act and its provisions.[87]

Scottish evidence submitted to the Committee and reaction to the final report reveals that the dichotomy in medical opinion on abortion, epitomized by Baird and Donald prior to the act, was still very much in evidence. As Professor E McGirr, Dean of the Faculty of Medicine at the University of Glasgow, observed:

> There is a wide spectrum of opinion on the subject amongst medical teachers. It varies from the view that the implied assumption of the utter disposability of life must entitle the Report to the distinction of being one of the most pagan in British parliamentary history to full agreement with the views expressed by the Committee.[88]

In general, the report was well received by those Scottish medical bodies to which it was circulated. The Royal College of Physicians, Edinburgh, commented that the recommendations were almost entirely consistent with their own submission to the Lane Committee, while for the Borders Health Board it was "a most excellent account of the situation".[89] However, not all were so positive. Borders Health Board's Nursing and Midwifery Advisory Committee recorded that their own discussions "quite often

[83] NAS, HH61/1315, R Bell to J Walker, 31 Mar. 1970. In 1970, only 1.5 per cent of abortions in Scotland were performed outside NHS hospitals, and these few cases were performed in a reputable nursing home, the main function of which was not the provision of abortion. See NAS, HH61/1315, Hector Monro, Scottish Office, to Tam Dalyell, House of Commons, 18 Apr. 1972.

[84] NAS, HH61/1315, W Miller to R Bell, 4 Nov. 1970; W Miller, SHHD, to R Hughes, DHSS, 16 Nov. 1970.

[85] Two were Scottish—Ivor Batchelor, a professor of psychiatry at the University of Dundee, and A M Johnston, a QC and member of the Scottish Law Commission.

[86] Replies were received from some thirty medical bodies in Scotland, including the twelve Health Boards, the Royal Colleges, medical and nursing organizations, and four university medical faculties.

[87] For a discussion on how this consensus was reached, see A Wivel, 'Abortion policy and politics on the Lane Committee of Enquiry, 1971–1974', *Soc. Hist. Med.*, 1998, **11:** 109–35.

[88] NAS, HH102/1232, Professor E McGirr, University of Glasgow, to Miss M Macdonald, SHHD, 1974.

[89] NAS, HH102/1232, C Henderson to L Cunning, 10 Dec. 1974.

led [them] back to the question as to whether or not the Abortion Act should ever have been introduced''.[90] Meanwhile, Redlands Hospital for Women wished to put across ''the state of bafflement tinged with resentment felt by many of the older gynaecologists when faced with the working of what was not a very well thought-out Act''.[91]

English critics of the act focused particularly on three issues: the role of the private sector, access by foreign women to British abortion services, and the advertising of British abortion services abroad;[92] none of which were crucial issues in Scotland. However, there were areas of joint concern, expressed by the Scottish medical community in both their evidence to the Committee and their responses to the final report. These included, in particular, the pressure on gynaecological services imposed by abortion work, the impact on staff resourcing of the conscience clause and of professional differences over the appropriateness of abortion procedures within normal maternity care, geographical variations in the interpretation of the act, and issues surrounding the statutory time limit for terminations.

A *leitmotiv* of the Scottish evidence was the impact of the rising number of abortions on existing hospital facilities. The Scottish Association of Executive Councils deplored the fact that the act had led to an increase in the waiting list for normal gynaecological operations, taking the view ''that if a choice ha[d] to be made between more terminations and a reduction in the gynaecological waiting list they would unreservedly choose the latter''.[93] Nursing staff voiced similar concerns. For example, the Matron of Bellshill Maternity Hospital complained that:

> this problem has been foisted upon us without the necessary resources of space, theatre time and personnel to deal with it. . . . [O]ur commitments to our ordinary patients are barely met, standards of nursing care are falling, and yet we have to spread our professional skills still further to cope with this additional category of patient.[94]

While several leading gynaecologists, including Ian MacGillivray, stressed the need for termination procedures to be largely under medical control,[95] there were other groups of medical staff—particularly nurses and midwives—who considered that it was entirely inappropriate for such cases to be dealt with within an ordinary obstetric setting.[96] As the Principal Nursing Officer for the Aberdeen Special Hospitals reported, there was a ''general feeling that a maternity hospital [was] not the best place for a termination of preg-

[90] NAS, HH102/1232, A Welstead, Secretary of Borders Health Board, to Miss M Macdonald, SHHD, 1 Aug. 1974.

[91] Wellcome, SA/ALR/C.27, PLC, Submission of Glasgow Maternity and Women's Hospitals Board of Management, 9 Dec. 1971.

[92] Wivel, op. cit., note 87 above, p. 122.

[93] Wellcome, SA/ALR/C.27, PLC, Submission of A W Smith, Scottish Association of Executive Councils, 20 Dec. 1971.

[94] Wellcome, SA/ALR/C.22, PLC, Submission of Board of Management for Coatbridge, Airdrie and District Hospitals, 1972.

[95] Ibid.; *Scottish Daily Record*, 16 May 1973.

[96] In this respect, Glasgow Royal Infirmary was exceptional in stressing the co-operation of its nursing staff with abortion work, both in the ward and in the theatre. See Wellcome, SA/ALR/C.35, PLC, Submission of Board of Management for Glasgow Royal Infirmary and Associated Hospitals, Dec. 1971. Oral testimony suggests that nursing objections were not solely due to personal distaste, but also because nurses were not involved in the decision-making process around termination and therefore had difficulty sympathizing with the patients. This Infirmary was relatively unusual in ''positively involving'' its nurses in abortion-related decision-making, which may be the reason why there was less staff dissent there. Interviews with retired gynaecologist and family planning doctor, 12 Jan. 2004 and 5 Mar. 2004, held by Gayle Davis under the same conditions as those cited in note 31 above.

nancy, and that midwifery staff whose interests [lay] in the care of mothers and babies, and who [chose] to work in a maternity hospital, [did] not expect to be involved in this type of work".[97] Similarly, in the experience of one Matron, nurses—not all of whom had religious affiliations—"frankly resent[ed] the use of their skills and their professional time in this way, particularly as many of them [did] not feel that they [met] their commitments to the patients for whom they [felt] they owe[d] a nursing duty".[98] Indeed, there was considerable evidence that the issue in some institutions was seriously impairing the relationship between doctors and nursing staff.[99]

Moreover, the issue of "conscience" also had implications for recruitment, especially of Catholic doctors. Some witnesses registered their concern that the act might be deterring "good young doctors from entering the specialty of gynaecology", particularly as their career development might be damaged if they refused to perform terminations.[100] Clearly, the need to balance the right of the individual doctor to conscientious objection with the broader obligation within the NHS to provide an abortion service proved highly problematic for senior clinicians seeking to staff their departments.

Geographical variations in abortion provision within Scotland was an additional concern expressed both in the media and in evidence to the Lane Committee. The *Scottish Daily Record* deplored the fact that obtaining an NHS abortion depended on where you happened to live, as revealed quite clearly by SHHD statistics.[101] It was claimed that a female resident in North-East Scotland was more than twice as likely to get an abortion as a woman living in the West; Glasgow having "diehard pro and anti-abortion forces . . . battling it out in the various theatres of war". In Edinburgh, abortions "seem[ed] to be left pretty much to the consciences of individual doctors". Meanwhile, in Dundee, it was estimated that more than 700 abortions were being carried out yearly, the highest rate per head of population in Scotland.[102] As one of the city's senior gynaecologists observed: "It has reached the stage where we carry out abortions almost on request. Though we don't shout it from the rooftops". Elsewhere, Aberdeen was said to be "still among the leaders", although only women living in the hospitals' catchment areas were considered. Thus, as the *Scottish Daily Record* concluded: "The working of the Abortion Act [was] a giant lottery and if your number [came] up you [could] thank lady luck for the privilege".[103] Due partly to this geographical inequality, significant numbers of women normally resident in Scotland were reported to be obtaining abortions in England and Wales—the vast majority in non-NHS premises. To place this in context, from 1972, about 7,500 abortions were carried out each year in Scotland, while as many as 1,000 women travelled south for an abortion.[104] In fact, the Glasgow-Liverpool train was nicknamed "the Abortion Express", in recognition of this

[97] Grampian Regional Health Board Archive, B14/2, Principal Nursing Officer, Board of Management for the Aberdeen Special Hospitals, to Chief Nursing Officer, Aberdeen Royal Infirmary, 16 Sep. 1971.

[98] Wellcome, SA/ALR/C.22, PLC, Submission of Board of Management for Coatbridge, Airdrie and District Hospitals, 1972.

[99] See, for example, Wellcome, SA/ALR/C.27, PLC, Submission of Glasgow Maternity and Women's Hospitals Board of Management, 9 Dec. 1971.

[100] NAS, HH102/1232, Professor E McGirr, University of Glasgow, to Miss M Macdonald, SHHD, 1974.

[101] *Scottish Daily Record*, 16 May 1973.

[102] Almost half of these were single girls.

[103] *Scottish Daily Record*, 16 May 1973.

[104] H Homans (ed.), *The sexual politics of reproduction*, Aldershot, Gower, 1985, pp. 84–5. In relation to abortion, statistics must, of course, be regarded with suspicion since an unknown proportion of women might either give a false address or none at all.

traffic south by women forced to pay for the operation because a free NHS abortion had been denied them.[105]

Similar evidence was presented to the Lane Committee. The Scottish General Medical Services Committee claimed that facilities for termination were "sporadic and unevenly distributed throughout the country, due to the individual attitude of some doctors".[106] As the Scottish Association of Executive Councils noted: "Variation in the application of the Act . . . sometimes result[ed] in 'shopping around' to find a gynaecologist whose interpretation of the criteria [was] liberal and who [was] prepared to agree to termination of a pregnancy".[107] Indeed, the Board of Management for Glasgow Royal Infirmary made clear that it was this very "shopping around" that was responsible for their greatly increased gynaecological waiting list.[108] However, in response, the SHHD commented that, although they were "fully aware that the individual attitudes of some obstetricians and gynaecologists in certain areas to abortion may have tended to create an unevenness of service in Scotland", the decision whether or not to terminate a pregnancy was "a medical one and the Department would not wish to interfere with the judgment of any doctor".[109] Thus the pre-1967 pattern persisted, with policy-makers deflecting responsibility onto the medical profession, which continued to interpret policy according to individual clinical judgements.

Finally, there was the question of the appropriate time limit for termination. The Lane Committee's recommendation that abortion should be unlawful above twenty-four weeks gestation received more Scottish comment than any other. The Committee's reasoning was said to be based mainly on the wish not to prejudice the use of diagnostic amniocentesis, as in some circumstances the final outcome of this procedure might not be available until the twenty-second week of gestation. The SHHD highlighted the "general feeling" that the existing limit of twenty-eight weeks was "probably too high nowadays in view of the sophistication of modern support systems", although there were pronounced differences of opinion as to what the new lower level should be.[110] The Royal College of Physicians and Surgeons of Glasgow, along with the Lanarkshire and Borders Health Boards, favoured the twenty-four week limit proposed, although bodies like Dumfries and Galloway Health Board made a point of stressing that any limit should not be absolute as obstetricians should have the right to intervene if the mother's life was in danger. There was, however, a very strong measure of support for an upper limit of twenty weeks from nursing and non-medical organizations, including the Scottish Association of Nurse Administrators, the Royal College of Midwives, and the Church of Scotland Moral Welfare Committee. In fact, the Royal College of Midwives noted that several bodies had expressed the opinion that abortion should not be performed after the twelfth week of pregnancy, particularly since morbidity rates were lower at this time.[111] Again,

[105] To a lesser extent, some women based in the west of Scotland also visited the more "liberal" Scottish cities—particularly Aberdeen and Edinburgh—when unsuccessful in obtaining a termination in Glasgow.

[106] NAS, HH102/1232, Notes of Meeting between SHHD and Representatives of the Scottish General Medical Services Committee, 24 Sep. 1974.

[107] Wellcome, SA/ALR/C.27, PLC, Submission of A W Smith, Scottish Association of Executive Councils, 20 Dec. 1971.

[108] Wellcome, SA/ALR/C.35, PLC, Submission of Board of Management for Glasgow Royal Infirmary and Associated Hospitals, Dec. 1971.

[109] NAS, HH102/1232, Notes of Meeting between SHHD and Representatives of the Scottish General Medical Services Committee, 24 Sep. 1974.

[110] NAS, HH60/665, R Fraser to G Monro and Secretary of State for Scotland, 8 Dec. 1973.

[111] NAS, HH102/1232, PLC, Submission of Royal College of Midwives (Scottish Council), 30 July 1974.

nurses and midwives were the most conservative members of the Scottish medical community submitting evidence.[112]

Conclusion

It is clear that, prior to 1967, abortion law in Scotland could be interpreted more flexibly than could statutory provisions south of the Border. Thus, abortion could be legally carried out by a medical practitioner acting in good faith in the interests of the health or welfare of his patient. However, a review of the practice of abortion reveals that most Scottish doctors were not in fact aware of their legal right to terminate a pregnancy, and were not taking advantage of it. Aberdeen was the only city in Scotland systematically to exploit this greater flexibility of Scottish abortion law, principally through the influence of the gynaecologist, Dugald Baird, whose pioneering abortion work in Aberdeen, and willingness to publicize it, were to prove crucial to British abortion law reform. To an extent, there seems to have been a curious tension between, on the one hand, the apparent progressiveness of Scots law and local practice in Aberdeenshire, and, on the other, the very real conservatism of opinion present more generally in Scottish medicine and civic society.

In many respects, this tension continued to inform the Scottish medical input to the politics surrounding the 1967 act; best illustrated by the contrasting ideologies and influence of Dugald Baird and Ian Donald. Baird is seen to have been one of the most influential figures in shaping the agenda of David Steel, promoter of the Medical Termination of Pregnancy Bill, particularly in persuading him to create a socio-medical clause and to disregard pressures to exclude Scotland from the bill. In addition, pro-abortion pressure groups clearly capitalized on Baird's medical reputation to promote abortion law reform, highlighting the success of Aberdeen's "positive" abortion policy as a template for their campaign. By contrast, a powerful anti-abortion culture elsewhere within the Scottish medical community, and pre-eminently in Glasgow, is seen to have been articulated by Donald, one of Baird's most vehement critics. His ideology and restrictive clinical practice did not, however, feed into policy debates as Baird's did, although subsequently his views were to be widely exploited by both the Catholic Church and anti-abortion organizations. Moreover, evidence suggests that the highly visible involvement of Baird and Donald in the politics of abortion was extremely unusual within Scottish medicine at this time, with few individual doctors willing to publicize their views, and even the Royal Colleges in Scotland preferring to stay tight-lipped on the subject.

Furthermore, medical evidence submitted to the Lane Committee in the 1970s reveals that, although the major English concerns were not voiced north of the Border, Scottish medical opinion continued to exhibit pronounced ambivalence and hostility towards abortion. While the Committee's three-volume endorsement of the 1967 Abortion Act was generally well received by Scottish medical authorities, a range of anxieties were aired by the wider medical community of nurses and practitioners, relating in particular to the pressures on existing gynaecological services, to the impact of the conscience clause on

[112] Generally speaking, this conservatism appears to have been less apparent south of the Border where, according to Potts, Diggory and Peel, nursing responses to the act shadowed those of doctors, in that a few protested bitterly but most in fact accepted or even welcomed the legislation. See M Potts, P Diggory and J Peel, *Abortion*, Cambridge University Press, 1977, p. 310.

staff resourcing, to professional differences over the appropriateness of abortion procedures within normal maternity care, to geographical variations in the interpretation of the act, and to the statutory time limit for terminations.

More generally, this article would suggest that the conventional historiography surrounding the medicalization of abortion needs to be modified. Of all the areas of sexual health, the history of abortion has been the one most dominated by concepts of "medicalization". Some feminist writers have been particularly critical of this process, implying that doctors have sought to "colonize" women's reproductive health.[113] This article serves in part to question that historiographical implication. Admittedly, it was largely a small group of male doctors and politicians that shaped and defined this abortion legislation, and in that respect, feminist criticisms remain valid. None the less, this article demonstrates that, so far as the medical community was concerned, a diversity of views existed, with in fact a significant degree of resistance exhibited towards the reframing of abortion as a medical responsibility.

The attitude of the Scottish medical community to abortion in the 1960s can be characterized at best as one of "reluctant medicalization". Dugald Baird established a bridgehead of medical interventionism in sexual health far in advance of the main body of the medical establishment, who continued to question the wisdom of such intervention both in terms of medical ethics and professional propriety. Arguably, the impetus for medicalization did not come from doctors, many of whom resisted the 1966 bill, particularly its explicit "social" element. Rather, it was the State that in many respects imposed medicalization, causing noticeable resentment within the medical community. As one family doctor stated: "There are many doubts in the minds of many doctors [as to induced abortion] and when professionals are in doubt then amateurs would do well to stand aside".[114] Even for those individuals embracing the terms of the bill, it could be argued that it was less about a desire to extend patriarchal control of reproductive health than a desire to sustain professional autonomy while widening access to limited existing facilities.

By the early 1970s, the medical profession in Scotland had clearly begun to come to terms with the provisions of the 1967 act, and there is substantial evidence of senior consultants, in particular, stressing the need for medical control of the abortion procedure. Yet, it is also clear that this remained largely motivated by traditional concerns over professional status rather than any new-found ambition to dominate women's reproductive strategies. Moreover, a substantial body of the medical community in Scotland—particularly nursing staff—continued to voice serious concerns over logistical and ethical issues arising out of abortion; concerns that were to occupy public and professional debate for many years to come.[115]

[113] See, for example, E Lee (ed.), *Abortion law and politics today*, Basingstoke, Macmillan, 1998; Sheldon, op. cit., note 6 above.

[114] *Scotsman*, 31 Dec. 1966.

[115] For an exploration of the impact of the 1967 Abortion Act on Scottish medical practice, see G Davis and R Davidson, '"Big white chief", "Pontius Pilate" and the "plumber": the impact of the 1967 Abortion Act on the Scottish medical community, *c*.1967–80', *Soc. Hist. Med.*, 2005, **18**: 283–306.