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Conflict and Compromise: Abortion Law Reform in Britain, Canada, and Spain, 1960s-1980s

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Abstract

Between the 1960s and 1980s, a wave of abortion law reforms swept through various Western nations. The reforms aimed to clarify extant laws, protect doctors from criminal prosecution, and curtail the toll of backstreet abortions on women's bodies and lives. They emerged out of a series of conflicts and compromises evident in the design and implementation of new abortion laws which, on the one hand, expanded the parameters for legal abortion, but on the other, criminalized abortions that did not fall within them. Despite divergent historical, political and medical contexts, a transnational comparative analysis of abortion law reform efforts in Britain, Canada, and Spain in this period highlights the conflicts and compromises each experienced, the similarities and dissimilarities in legislation, and the impact of that legislation on medical professionals, abortion providers, and women seeking legal abortion services.

Keywords: abortion law reform; abortion services; Britain; Canada; Spain

Introduction

Studying abortion law reform in a transnational comparative framework is a useful endeavour for historians of health. The flux of global abortion law reform stretches back to 1920, when abortion on demand was first made available legally in the Soviet Union. What followed was a complex timeline of measures

to restrict or liberalise access to abortion that can be traced across the globe in the twentieth century. We can locate the peak of Western efforts to reform abortion laws in the three decades since 1960. Reforms aimed variously to update extant legislation, curtail the toll of 'back-street' abortions on women's health, and protect doctors from criminal prosecution.[1] What follows is an attempt to trace abortion law reform efforts and their impact on abortion provision in three Western countries –Britain, Canada, and Spain – in this period. Crucially, despite divergent historical, political and medical contexts, their policies to 'liberalise' abortion laws did not necessarily mean decriminalising abortion, but rather expanding the parameters for legal abortion while retaining abortion within a criminal code. In each example, abortion law reform was based upon a series of conflicts and compromises that medicalised oversight mechanisms, decentred women's experiences of unwanted pregnancy, and caused dissension among medical professionals, resulting in unequal access to abortion services for women.

Britain: The Abortion Act, 1967

British abortion law reform can be considered part of a raft of legislation – including reforms to contraceptive, homosexual, and divorce laws – introduced by a Labour government that redefined the relationship of the state and the law to the moral domain of the private citizen. Despite the appearance of

liberalisation, Britain's 1967 Abortion Act was not particularly permissive. It legalised abortion where the risk to the life of a pregnant woman, or injury to her physical or mental health, or to that of her existing children, was greater than the risk from abortion, or where there was a substantial possibility of serious foetal anomaly. In order to eradicate backstreet abortions by unqualified persons, two registered doctors had to certify any one of these indications for abortion, and the operation had to be performed in a National Health Service (NHS) hospital or another officially approved location.[2] By placing abortion firmly under medical control, the Act left women 'dependent on the vagaries of medical discretion and good will'.[3] It also fell short of what pro-choice activist groups, notably the Abortion Law Reform Association (ALRA), had been campaigning for since 1936.[4]

The purpose of the Abortion Act, which came into operation in April 1968, was to amend and clarify the law relating to termination of pregnancy. In England, the Offences Against the Person Act of 1861 had made it unlawful to procure a miscarriage, although the 1929 Infant Life (Preservation) Act qualified this stipulation by exempting cases where an abortion was deemed necessary to preserve the life of the pregnant woman. With the 1938 judicial ruling, *Rex v. Bourne*, that abortion should be permitted where pregnancy made the woman 'a physical or mental wreck', it seemed possible that medical practitioners could take a wider interpretation of risk to a woman's health, but the exceptional nature of the Bourne case (involving the rape of a fourteen-year-old girl by a group of soldiers) left deep uncertainty over the legalities of abortion. Most doctors in Britain thus believed abortion was a crime unless the pregnant

woman's life was in imminent danger.[5] Consequently, the services of illegal abortion providers were utilised in the years preceding the 1967 Act. Indeed, some doctors positively valued competent and affordable local backstreet abortionists willing to help desperate women.[6]

The Abortion Act did not decriminalise abortion but carved out a series of 'therapeutic' exceptions that made abortion lawful where the pregnancy was terminated by a registered medical practitioner, once two registered medical practitioners had agreed 'in good faith' that the pregnant woman's circumstances satisfied one of the indications laid down in the Act. Where termination was believed 'immediately necessary to save the life or to prevent grave permanent injury' to the pregnant woman, the judgement of one medical practitioner would suffice. For campaigners such as Diane Munday – who went on to work for the ALRA, and then the British Pregnancy Advisory Service (BPAS) – the 1967 Act was a sizeable compromise. She deemed it 'absolutely iniquitous to have that two doctor [*sic*] clause in. How could, or should, somebody who's probably never seen the woman before, and is never going to see her afterwards, make such an important decision for that woman's life and future?'[7]

Importantly, neither should it be assumed that the legislation found favour with the medical profession. Many believed there to be a fundamental clash between the established role of doctors to save and preserve life and the more destructive implications of abortion.[8] Even stronger resistance came from nurses and midwives, reported to remain 'almost unthinkingly pronatalist' through the 1960s and 1970s.[9] The exercise of the conscientious objection

clause written into the Act (except in an emergency) was the ultimate opt-out for medical staff. There were complaints of friction with other team members due to the Act's impact on staff resourcing, and allegations that a 'recognized unwillingness' to carry out abortions impaired career progression for both doctors and nurses.[10] Thus, it is not straightforward to suggest that the Abortion Act served medical interests.

Yet, deference to medical authority was a persistent leitmotif. Doctors were judged uniquely qualified to determine risks to the pregnant woman, her existing children, and the foetus. Medical opinion embraced 'all shades of attitude' on this emotive and notoriously divisive issue,[11] with medical definitions of risk ranging from the extreme stance that only the endangerment of a woman's life justified an abortion, to a broader concept of well-being and quality of life that took a wider range of social and environmental factors into consideration. For a select group of doctors, abortion appears to have constituted neither a medical nor social decision, but a personal one, which the woman herself should make, with the doctor assuming the role of advisor or facilitator.[12] Many others appear to have accepted the need for social as well as medical reasons for abortion, but distanced themselves from the concept of 'abortion on demand', which gave too much decision-making power to the pregnant woman.[13] The remainder adopted the narrowest interpretation of the Act by refusing to terminate a pregnancy unless there were serious foetal anomalies or the pregnant woman's life was in grave danger.

Crucially, as the ultimate deference to medical authority, the Act was built on a premise of non-interference with clinical freedom.[14] Thus, medical

gatekeepers were free to translate their own widely varying attitudes into clinical decisions based on their own value judgements. While women seeking abortion services were visiting their doctors' surgeries in rapidly increasing numbers, doctors appear to have been more willing to terminate the pregnancies of older married women who had a family than younger women with putatively objectionable standards of sexual behaviour, and more likely to favour better-educated, middle-class girls, acknowledging the damage of illegitimacy to their career prospects and parental reputation.[15] Some doctors openly opposed the availability of abortion, reflecting concern that they were being asked to defend the institutions of marriage and the family, and perform 'the role of guardian of the public morality'.[16] In addition to moral reservations, there were more practical impediments. Young women, often constrained by fear, parental disapproval, or denial, were more likely to present at a later stage of their pregnancy, with a higher risk of medical complications in addition to heightened moral anxiety.[17]

In a controversial but widely cited article, the Scottish psychiatrist, I.M. Ingram, examined how doctors responded to the 'doubt and conflict' that the Act engendered.[18] By applying 'transactional game analysis' as employed by the Canadian-born psychiatrist Eric Berne,[19] to abortion decision-making, Ingram depicted a series of strategies that helped doctors to minimise their personal responsibility for the decisions they made. ~~The~~ General practitioners might refuse to refer the patient to a local hospital or refer them, but write a neutral letter which committed ~~himself or herself~~ themselves to no decision, thereby evading responsibility for whatever followed, or covertly disapprove but avoid a

confrontation by apparently agreeing to the patient's request but referring her instead to someone known to be antagonistic to abortion. As gatekeeper to hospital services provided under the NHS, family doctors had a great deal of discretion as to how the Abortion Act was interpreted. They could effectively harness knowledge of the attitudes of local gynaecologists, enabling a referral to the consultant whose decision coincided best with their own views, whether sympathetic or hostile.

At the specialist level there were more numerous and complicated games. Those in positions of authority could impose on their staff an extreme policy for or against abortion, enforced in an authoritarian way. The general practitioner would soon know the consultant's views and refer or divert patients accordingly, while neighbouring consultants might see more patients as a result and engage in a corresponding defensive game. Gynaecologists might force the patient to wait many months for an appointment, perhaps until it was too late, or require the pregnant woman to agree to a simultaneous sterilisation and abortion. Psychiatrists might take the stance that there were no psychiatric indications for abortion, based on evidence that the major psychoses were not worsened by pregnancy and suicide rare during pregnancy, or take an opposite reading of the Act's wording and interpret mental health in the widest possible sense.[20]

These strategic games, and the power of certain senior individuals to control abortion policy in their region, explain in large part the regional variations in NHS abortion provision.[21] Significantly, NHS provision rates can be neatly mapped onto the opinion of a city's most senior obstetrician. As founding

members of the leading anti-abortion organisation, the Society for the Protection of Unborn Children, Professors Hugh McLaren in Birmingham and Ian Donald in Glasgow had been particularly vociferous in opposing abortion law reform, and often prevented doctors working under them from performing abortions. Concerns about women residing in areas controlled by anti-abortion doctors, particularly the city of Birmingham, led ALRA members to create the Birmingham Pregnancy Advisory Service (BPAS) and the London Pregnancy Advisory Service.[22] Women denied an NHS abortion and unable to pay the hefty fees charged by private clinics (£150–600[23]) could now look to such non-profit providers as BPAS, which charged up to £65 and waived charges altogether in the neediest cases.[24] BPAS established a network of clinics across Britain and, in 1972, accordingly, changed its name to the 'British' Pregnancy Advisory Service.

A major review of the Act led to the publication of a three-volume *Report of the Committee on the Working of the Abortion Act* in 1974.[25] It acknowledged geographic variability in NHS abortion services for resident women as a major concern, for the reasons discussed above. However, English critics were more concerned by the role of the private sector, the advertising of British abortion services abroad, and the fact that many thousands of women travelled to Britain to access services.[26] The perceived availability of abortion services and the high reputation of British medicine attracted a rapidly increasing number of non-resident women to England in search of a legal abortion. NHS residency requirements worked to deny them a free abortion, but private clinics were eager to attract these visitors, charging them even more than resident women.

The influx of women from other countries peaked in 1973 at over 56,000, coming predominantly from France (35,293) and West Germany (11,326).[27] At this time, women referred by doctors in France formed around forty percent of the clients seen at the BPAS clinic in Brighton, where they could see a French-speaking counsellor but would only be accepted for treatment if capacity remained once resident women had been accommodated.[28] The number of Spanish women coming to Britain for an abortion (1,763 in 1973) peaked at 22,000 in 1983, but dropped rapidly thereafter, likely due to an increase in availability of abortion services in clandestine Spanish clinics.[29]

The international media ran lurid stories of these women's experiences of travel and exploitation for commercial gain, with 'package holiday' deals to attract foreign women to have their abortions in Britain. They bore the high costs of the operation, travel and accommodation. London was a particular focus of sensationalised news stories portraying it as the 'abortion capital of the world'.[30] The number of non-resident women declined rapidly as other Western countries' abortion laws were liberalised.[31] This decline made the number of women travelling from the island of Ireland appear more prominent: from 1,007 women from Northern Ireland and 1,193 from the Irish Republic in 1973 to – by 1989 – 24,000 and 50,000 respectively.[32]

Canada: The Making of the 1969 Abortion Law

The influence of British jurisprudence in Canada, a former British colony and Commonwealth member, has long been apparent. However, when the federal government decided to modernise the Criminal Code, the resultant 1969 abortion law departed from Britain's 1967 Abortion Act.[33] Concern over backstreet abortion, the birth of children affected by rubella and thalidomide, and the medical profession's confusion over contradictory legal language – all concerns shared by the British – led to calls to liberalise laws that penalised abortion providers and women who procured abortions.[34] The medical profession had long been careful to distinguish between criminal abortion, referring to abortions that contravened the law, and therapeutic abortion, interpreted as medically necessary to save the pregnant woman's life,[35] and, after the Bourne ruling, to preserve her mental or physical health, although the ruling's applicability to Canada was subject to debate.[36]

Some hospitals established informal 'therapeutic abortion committees' (TACs) permitting doctors to consult one another before performing a few abortions annually that TACs classified as therapeutic. However, the prospect of criminal charges and antipathy toward abortion meant that only a minority of doctors provided abortions, even in a hospital setting.[37] Overall, doctors' inaction, complained one journalist in 1962, meant that every year an estimated 75,000 women

> don't get the conscientious care of an antiseptic hospital or concerned doctors. These women get their abortions on kitchen tables, bathroom floors and beds laid out with plastic sheets. They

> usually don't know who their abortionists are, or even if they are skilled enough to avoid killing a client.[38]

In the late 1960s the federal government, led by the Liberal Party of Canada, appointed a Standing Committee on Health and Welfare to examine three abortion law reform bills. Each sought to clarify or expand indications for therapeutic abortion, but disagreements soon arose among committee members and witnesses.[39] Representing the Canadian Medical Association (CMA), General Secretary D.M. Aitken informed the committee of a contentious resolution that the organisation's General Council passed in 1967. It supported three indications for therapeutic abortion: when a pregnant woman's life or health was endangered, there was a 'substantial risk' of birthing a physically or mentally disabled child, and there were 'reasonable grounds to believe' a pregnancy had resulted from rape. Only after a TAC in an accredited hospital supported one or more of these indications could a doctor perform an abortion. Aitken allowed that the resolution had not been accepted unanimously, emphasising his profession's 'distaste' for abortion services and the lack of consensus around indications for a therapeutic abortion.[40]

The expansion of indications for abortion was contested fiercely, presaging the emergence of a 'pro-life' movement.[41] Representatives from Catholic organisations took little comfort in TACs as medical gatekeepers, telling the committee that liberalisation might lead to state-sanctioned destruction of the unborn. Although expressing sympathy for women facing an unwanted pregnancy, Catholic clergy were keen to protect foetal life, and both

Catholic and non-Catholic doctors testified to its significance from conception onward. The Emergency Organization for the Defence of Unborn Children claimed no religious affiliation but told the committee that abortion denied a foetus its humanity, likening it to racism against Canada's Indigenous peoples. Foetal anomaly was the most disputed indication for a therapeutic abortion, with representatives from many organisations avowing that all human life was of equal value, regardless of the prospect of disability.[42]

Standing Committee discussions inevitably pitted a foetal right to life against a woman's right to an abortion. Dr Henry Morgentaler of the Montreal Humanist Association, and representatives from Toronto Women's Liberation (TWL), one of the earliest second-wave feminist groups in the country, warned against implicating TACs in any abortion law reform efforts. Morgentaler supported abortion on demand in the first trimester of pregnancy. Thereafter, abortion required medical consultation because it became more complicated surgically. Barring rare exemptions, abortion would not be permitted once the foetus could survive *ex utero*. He likened TACs, which were composed mainly of male doctors, to an 'authoritarian inquisition by the state'.[43] TWL representatives blasted the three abortion law reform bills before the committee, arguing they were rooted in the sexist assumption 'that the function of women in society is to bear children'.[44] No such bill, they asserted, could encapsulate all the reasons why a woman might wish to terminate a pregnancy, and no male-dominated TAC could possibly render a verdict untainted by male chauvinism.

Undeterred by criticism of TACs, in 1969 the federal government amended the Criminal Code (Section 251) as part of an omnibus bill

encompassing reforms to homosexuality, divorce, and contraception that had also been enacted in Britain.[45] While the British Abortion Act required two doctors to approve an abortion on the basis of codified medical or non-medical indications, by contrast, the Canadian legislation permitted a legal abortion only after a doctor's referral to a TAC in an approved or accredited hospital. Composed of at least three doctors, TACs determined, on a case-by-case basis, whether the pregnancy risked the 'life or health' of the pregnant women. TAC authorisation meant that 'established medical practices' in some hospitals were formalised as abortion law reform.[46]

Importantly, the law provided no definition of 'health', leaving it open to interpretation. Neither the referring doctor nor a doctor serving on a TAC could perform the authorised abortion. No hospital was obliged to establish a TAC; Catholic hospitals refused to participate in abortion provision, and – although the law contained no conscientious objection clause – no doctor was required to serve on a TAC or perform an abortion. In sum, the federal government 'ensured limited access to abortion but without explicit policy' because of its central compromise: 'give public symbolic support to the [abortion law] reformers, while also giving quiet reassurance to the pro-life movement.'[47] In so doing, the law subordinated 'questions of women's rights and equity…to the legal rights and moral scruples of doctors and hospitals, to whom the state had delegated responsibility'.[48]

The law was a federal matter but implemented by provincial and territorial healthcare systems. Its uneven regional application roused women's liberation groups to champion abortion law repeal. Morgentaler became a

pivotal figure, performing vacuum aspiration abortions by electric pump in his Montreal clinic. He endured lengthy court battles for flouting a law that had centralised hospital-based TAC authorisation for legal abortion.[49] Women unable to afford the costs of a legal abortion abroad exposed not just regional disparities, but also class inequality and punitive treatment at home. When a 1970 'Abortion Caravan' led by the Vancouver Women's Caucus gathered supporters on Parliament Hill in Ottawa to protest the abortion law, a pregnant poverty rights activist, Doris Powers, told the assembled that a Toronto TAC had rejected her abortion referral because she refused to be sterilised:

> We, the poor of Canada, are the dirt shoved under the rug of a vicious economy. In obtaining abortions, we pay a price second to none*, our lives*. We can't afford to fly off to England for a safe, legal abortion. We have to seek out the back street butchers [*sic*].[50]

In 1970, a few American states liberalised their abortion laws *sans* residency requirements. Canadian women crossed the border for abortion services and did so in their thousands after the US Supreme Court 1973 decision, *Roe v. Wade*.[51]

Facing turmoil in its ranks over abortion provision, in 1971 the General Council of the CMA advised justifying non-medical indications for abortion, hinting at socio-economic considerations. It also suggested removing references to TACs in the Criminal Code, performing abortions in accredited

hospitals after a consultation between one doctor and the pregnant woman only. Aware of the split between liberal and conservative interpretations of the law, D.A. Geekie, CMA Director of Communications, positioned the CMA as a wise arbiter. Reviewing its policies and positions, Geekie denied that the CMA supported abortion on demand or abortion law repeal. It rejected performing abortions in settings outside accredited hospitals but insisted that at least one hospital in every region make abortion and sterilisation available. It agreed that doctors opposed to abortions did not have to perform them but should inform patients of their views. Finally, Geekie confirmed that the CMA had made no official statement 'of when, if not at conception, does the fetus become a human being', but repudiated abortion after foetal viability, a timeline Morgentaler had earlier suggested to the Standing Committee on Health and Welfare.[52]

The CMA's contortions were embarrassingly ineffective. Just how was made apparent in 1977 in the federal government-commissioned *Report of the Committee on the Operation of the Abortion Law*, a document reminiscent of its British 1974 counterpart. It showed that after the passage of the 1969 abortion law, doctors were overwhelmed by the unexpectedly large number of requests for abortion referrals. In 1971, 30,000 legal abortions were recorded, but – as in Britain – gross regional disparities surfaced. Some TACs rubber stamped all abortion referrals while others rejected them because of varying definitions of health. Most doctors surveyed were men. Almost half of all doctors surveyed said that abortion devalued human life. At the same time, there was limited support for TACs; in many communities, there were not enough doctors to serve on TACs, and two thirds of hospitals eligible to establish TACs had not

done so for religious or ethical reasons. Given the difficulties of accessing a timely legal abortion, there was an average eight-week wait between a woman's first contact with a doctor and her abortion, meaning that one in five patients had abortions after 16 weeks gestation. It concluded: 'obtaining therapeutic abortion is in practice illusory for many Canadian women.'[53]

Rather than risk inordinate delays for such a time-sensitive procedure, an estimated 50,000 Canadian women went to American hospitals and clinics between 1970 and 1975 for abortion services. Those who stayed in Canada had illegal abortions in their own homes or in the offices, basements, or apartments of illegal abortionists, paying $200 or more for the service. Some who took the legal abortion route found that doctors who served on TACs could be disrespectful, intrusive, and intimidating. The TAC approval process varied from a simple matter to a complicated affair involving medical tests, questionnaires, interviews, and gynaecological examinations.[54] Sometimes TAC approval depended upon consent to sterilisation, a concern Powers raised in her Abortion Caravan speech. Women between the ages of 20 to 35 with low educational attainment levels were the most likely to be sterilised, a finding suggestive of patient vulnerability and pressure from doctors. One third of all doctors surveyed were likely to recommend sterilisation for women with two or more children born outside marriage, while half would do the same for women who had two or more abortions.[55]

Left unexplored was a history of coercive sterilisation practices targeting poor women and disabled women that continued into the 1970s in some provinces, including revelations of abortions carried out in a non-accredited

Northern hospital and unnecessary hysterectomies performed on Indigenous women.[56] A decade later, the Canadian Supreme Court struck down the 1969 abortion law in a significant ruling, *R. v. Morgentaler* (1988). It established that the legal restrictions placed on abortion violated women's right to 'life, liberty and security of the person' under Section 7 of the *Canadian Charter of Rights and Freedoms*. However, ongoing regional disparities in abortion access, and an anti-abortion movement that targetted abortion providers and clinics with harassment and violence, roiled this judicial victory.[57]

Spain: Decriminalising Abortion in the 1980s

Unlike Britain and Canada, both stable constitutional monarchies and multi-party parliamentary democracies, Spain underwent seismic political shifts in governance in the twentieth century. The country endured a Civil War between 1936 and 1939, a National-Catholic dictatorship helmed by General Francisco Franco from 1939 to 1975, and a transition to a parliamentary monarchy after his death in 1975. During the civil war, the Catalonia region legislated one of the broadest abortion laws in contemporary Europe for 'therapeutic, eugenic and ethical reasons', but it was barely implemented.[58] In 1941, the Franco regime introduced an abortion ban which, unlike the British and Canadian cases, did not allow any therapeutic exceptions. It was partially lifted only in 1985, a decade after the dictator's death. Public debate about abortion began in Franco's final years. Despite the legal repression of abortion, the practice itself persisted, largely because of the involvement of women's networks enabling access to underground abortion provision.[59] The 1974 report of the Supreme

Court Prosecutor on the court's activity in the previous legal year estimated that approximately 300,000 clandestine abortions took place in a country of almost 35 million.[60] The figure was speculative but it was widely quoted in reference to an abortion underground that provided abortions and, from the late 1960s onwards, referred women abroad to abortion providers.[61]

The transition to democracy initiated a slow but unstoppable dismantlement of Francoist sexual politics. They had developed in accordance with a Catholic-conservative doctrine about family life that promoted strict gender complementarity: femininity meant domesticity and motherhood, preferably with several children, and masculinity, paid employment and financial responsibility for a large family.[62] The dismantling involved decriminalising homosexuality and contraception in 1978 and legalising divorce in 1981,[63] reforms that won social support. However, Spaniards were divided over abortion law reform. Sociological surveys conducted between 1976 and 1983 revealed that more than half the population agreed with legalising therapeutic abortion when a pregnancy endangered the pregnant woman's life or when foetal anomaly was suspected. Between 15 to 25 percent supported abortion on demand, but a similar proportion held that abortion should be criminalised.[64]

Concurrently, abortion travel, especially to England, where Spanish women constituted a substantial proportion of the foreign clientele frequenting private and charitable abortion clinics, became a key theme in the public debate. Travel overseas was facilitated by newly emerging Spanish family planning clinics sponsored by municipal authorities and left-wing political parties, as well as by feminist abortion referral networks.[65] From the late 1970s

onward, feminists intensified their efforts to politicise abortion, exemplified by their response to the 1979 Bilbao criminal trial of a working-class abortion provider, her daughter, several clients, and one man accused of forcing his partner to have an abortion.[66] It led to mass protests in support of the accused women. The trial came to represent women's unequal access to abortion services because the accused did not have the resources to travel abroad.[67] Concurrently, militant abortion groups offering manual vacuum aspiration abortions materialised in Valencia, Seville and Barcelona, and some doctors with leftist sympathies began providing cheap clandestine abortion services in Valencia, Málaga and Madrid. The feminist movement called for free (or publicly funded) abortion on demand provided by doctors and channeled through the public healthcare system; Spain was at this time in the process of adopting its *Sistema Nacional de Salud*, which resembled the NHS.[68]

Following the height of social mobilisation for legal abortion, the social-democratic Spanish Socialist Workers' Party (PSOE) used the parliamentary majority it won in the 1982 federal elections to introduce limited abortion law reform. It was somewhat inspired by the British Abortion Act, but without its explicit recognition of socio-economic indications. As in Britain and Canada, Spanish abortion law reform privileged doctors in the abortion decision-making process. Instead of passing a specific abortion law, the PSOE proposed including abortion law reform in the broader adaptation of the Francoist Penal Code to the new democratic reality. In 1983, the Spanish Parliament approved adding an article to the Penal Code that permitted three indications for legal abortion: a pregnancy that resulted from rape, a suspected foetal anomaly, and

a pregnancy that endangered the woman's life or health. All three were familiar to the British Abortion Act, while the third mirrored Canada's abortion law. The PSOE promoted this limited decriminalisation as one that most Spaniards could accept, denying feminist claims for abortion on demand.

The parliamentary opposition, led by the conservative *Alianza Popular* (AP), protested abortion law reform on the grounds of unconstitutionality, and built its objections around the idea that life begins at conception, naming the foetus a 'child', or a *nasciturus*, meaning a foetus able to survive *ex utero.* Likewise, it evoked the anti-abortion positions of local medical and pharmaceutical associations as well as several religious faiths, perhaps to reinforce the perception of a plurality of opposition to abortion. Finally, the appeal quoted European and American pro-life organisations as examples of international social opposition to liberalised abortion laws.

The AP's appeal to unconstitutionality suspended the inclusion of abortion law reform in the Penal Code. Yet, the public debate about abortion flourished, energised by both ongoing feminist pro-abortion mobilisations and organised anti-abortion activism that drew heavily upon the familiar Francoist conservative-Catholic doctrine, which framed abortion as a threat to family life.[69] Rendering its decision in April 1985, the Constitutional Court recognised that human life was a process that began in the womb, but did not consider any of the indications for legal abortion defined in the 1983 Spanish abortion law as unconstitutional. Importantly, the court also broached the subject of conscientious objection which, unlike the British Abortion Act, was never written into Spanish law. Instead, the court noted that medical professionals had a right

to object to providing abortion services as derived from the fundamental rights to religious and ideological freedoms that the 1978 Spanish Constitution guaranteed. Parliament's approval of the law – known as 9/1985 – in early July signified the formal beginning of legal abortion in Spain.

In its early months the implementation of the law was governed by an executive order published by the Ministry of Health on 31 July, which prompted a series of fixes to strengthen constitutional protections for foetal life, as well as defend women who requested abortion services. It set demanding requirements for abortion providers. These included a blood bank and a nursing unit on the premises, and, for a time, the establishment of an Evaluation Commission composed of doctors, nurses, psychologists, and social workers whose aim was to collect information on the implementation of the abortion law.[70] Unlike Canadian TACs, the regulation did not assign these commissions a decisive role in evaluating women's abortion requests. Rather, they acted as institutional watchdogs to ensure a narrow interpretation of the law.[71]

These requirements ended up restricting abortion provision to hospitals alone, and most doctors employed in public hospitals declared their conscientious objection. They refused to participate in terminations, seriously limiting abortion access. The lack of explicit regulation of conscientious objection solidified the idea that a doctor's conscience could be mobilised only to oppose but not provide abortion services.[72] Most medical professionals engaged in family planning activism were comfortable with providing abortion referrals, but just a handful of doctors – most with leftist leanings and a commitment to public healthcare – engaged with the surgical provision of

abortion in hospitals, facing hostility, ostracism, and even persecution.[73] The aversion to abortion was further encouraged by a budding Spanish pro-life movement that stigmatised abortion providers.[74]

During the late 1970s and early 1980s, the Spanish medical profession underwent profound changes, graduating more women and working-class students than ever before. This younger generation of doctors was more likely to exhibit leftist sympathies and support public healthcare and family planning initiatives than the older medical elites, who expressed more conservative views. This generational divide was visible around abortion. A 1981 survey revealed that over forty percent of doctors aged under forty supported legalising abortion and approximately twenty percent rejected it. For doctors aged over forty, the proportion was inverse.[75] Professional medical organisations, usually managed by conservative members, supported the 1983 constitutional appeal and actively lobbied against legalising abortion.

Nevertheless, in autumn 1986, the government decided to liberalise the abortion marketplace, especially for first-trimester abortions, by lowering the staff and equipment requirements for health establishments and enabling all abortion clinics fulfilling the updated legal requirements to operate legally and in the open. Abortion clinics that mushroomed after 1986 interpreted the mental health indication for termination broadly, making it possible to expand abortion access. In practice, these clinics offered abortion on demand, whereas public hospitals tended to provide legal abortions when there was a risk to the woman’s physical health or suspected foetal anomaly. Public hospitals found

these kinds of abortions more acceptable, but even so, it was common for abortion providers employed there to face stigma and isolation.

The number of centres (public hospitals and private clinics) providing abortion services grew, but public healthcare continued to provide a very small proportion of abortion services. The geographical distribution of abortion clinics that provided most of the abortion services was also unequal: fewer than twenty percent of Spanish provinces had a dedicated abortion clinic in 1988.[76] Unequal geographies of abortion provision meant that during the initial implementation of the 1985 law, many women continued to travel for abortion services, in Spain and abroad. For instance, the public Family Orientation Centre (COF) in Ourense, Galicia, north-east Spain, referred over half of the 440 abortion requests it received in 1985 to clinics in neighboring Portugal. Toward the end of the decade the short-distance, cross-border travel of the COF's patients was replaced by short- and long-distance interprovincial and interregional journeys to private clinics in Galicia, Asturias and Madrid.[77]

Conclusion

Despite their divergent historical, political and medical contexts, Britain, Canada, and Spain undertook a vexing process of abortion law reform from the 1960s to 1980s alongside legislative revisions to other controversial matters. Generally, the aims of abortion law reform were to modernise criminal codes, improve women's health, and protect doctors from criminal prosecution, with the latter taking precedence to reconcile competing interests and devolve responsibility from politicians on this emotive and notoriously divisive subject.

However, the liberalisation of abortion laws was based upon tenuous compromises that engendered conflicts.

Abortion law reform in this period neither decriminalised abortion nor codified it as a woman's right. It maintained the medical profession's control over the procedure but unleashed tensions over abortion provision itself. It placed doctors in hospitals and clinics on the front lines, stirring discontent, with many refusing to perform abortions while others pushed for more liberal interpretations of indications for legal abortion. Antipathy toward abortion hampered the operation of abortion law reform projects, leading to regional disparities in access to abortion services and the exacerbation of socio-economic inequities among women seeking abortion. Charitable organisations and feminist-driven abortion referral networks enabled women to undertake intra- and inter-regional travel for abortion services, an expensive and stressful endeavour, but constituting a major resource for thousands of women.[78] Not to be overlooked was the growth of a pro-life movement that rejected abortion because of moral qualms over the destruction of the foetus, an issue that no legal compromise has yet been able to manage.

Following the period under investigation, the number of abortion clinics in Spain increased, but the uneven implementation of the 1985 abortion law remained a factor into the 2000s. The region of Andalucía introduced abortion referral into primary healthcare and implemented public funding protocols for abortion services in private clinics. Other regions like Catalonia offered financial support for abortions on an individual basis.[79] The 2010 abortion law reform, which defined abortion during the first 14 weeks of pregnancy as a woman's

right to be funded through the Spanish NHS, eased financial inequalities in abortion access, but the persistent unequal distribution of providers did not entirely end intra- and inter-regional abortion travel.[80]

In Canada, no federal government has succeeded in reinstating a country-wide abortion law since the 1988 *Morgentaler* decision, making it one of the few countries in the world without an abortion law at the federal level. Abortion is legal and available in public and private hospitals and clinics and funded via the Canada Health Act and provincial and territorial health care systems. However, regional disparity in abortion access – especially in Northern, rural, and Eastern Canada – remains a key feature, sometimes necessitating intra-regional travel to urban centres for abortion services. It is also evident in the transition to medical abortion (administered through drugs, as opposed to surgery), which occurred much later in Canada and Spain in comparison to Britain and other Western countries. Opposition to abortion remains an element of political life with private members' bills, albeit ineffectual, supporting foetal personhood.[81]

Similarly in Britain, where the 1967 Act's nebulous wording and deference to medical authority allowed doctors to interpret and implement the law variably as they determined which abortions were socially acceptable as well as medically necessary, wide regional variations in abortion provision persisted. Doctors working within the British framework have, however, tended towards a more liberal interpretation of the legislation over time, with scholars documenting a shift from medical paternalism towards patient autonomy as the legislation reached its milestone fiftieth anniversary.[82]

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