Three Years' Experience of the Abortion Act

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My choice of subject was to some extent occassioned by the fact that this meeting happens to fall within a week of the third anniversary of the coming into effect of the Abortion Act, and, as this Act affects to a greater or lesser degree everyone working in the maternity services of this country, it seemed an appropriate time to assess the impact which it has had.

So much has already been written and spoken on the matter, yet it is vital to keep it under constant review, because there are few subjects in medicine as profound or so complex as this problem of termination of pregnancy. It is also depressing because so many unhappy people are involved. I cannot hope to even touch on the religious, philosophical and ethical questions involved, nor to compare the various methods presently available or which may become available. I propose to do three things briefly :

1. To outline my own personal experience of the problem as I have met it here in Stirling and the surrounding district.
2. To sound a warning note on the seldom publicised dangers and complications of the operation.
3. To try to enlist your sympathetic support for your obstetrician colleagues, who have been landed with the job of trying to work this social reform—if reform it is—to the best of their ability.

When the Abortion Act came into force at the end of April 1968, gynaecologists throughout Britain found themselves overnight with a new and rapidly expanding problem. The wording of the Act made it possible to legally terminate pregnancy under a very wide variety of circumstances hitherto forbidden, and how to interpret the Act became the first difficulty.

My own personal views on the moral side of it had to undergo change. Previous indoctrination, and the serious view taken by the law, made one instinctively and automatically view abortion as unequivocally wicked, the murder of the innocent and only to be done in the most extreme circumstances. However, the harrowing experience of these unhappy patients relating their predicaments has made me over the years become more liberal in my outlook. It is an almost intolerable responsibility which has been placed on doctors, and gynaecologists in particular, to sit in judgement as to which patient shall have her request granted and which not.

The following are my own personal figures for the past three years and, as will be seen, the number of referrals has steadily increased.

In the first eight months 29 patients were referred, of which 19 were terminated, nine were refused and one was not pregnant.

In 1969, 79 patients were referred, of which 64 were terminated, 11 were refused, one was not pregnant and three did not wish the operation after the matter had been fully discussed.

In 1970, I interviewed 108 patients, 82 of which were terminated, 14 were refused, five were not pregnant ; three patients decided not to pursue the matter after discussion, three changed their minds prior to an agreed admission and one was referred elsewhere as she worked on the staff.

In the first four months of this year, I have seen 39 patients, of whom 33 were terminated, two were refused and the rest were either not pregnant or changed their minds.

Thus, in 1968 there was a 70% acceptance rate, which rose to 84% in 1969, fell slightly to 82% in 1970. and seems to have risen to 91% in the first four months of this year.

As far as the increasing number of patients referred is concerned, it looks to me as if the peak has possibly just about been reached and I sincerely hope so, as this added burden has seriously strained the resources of the Department, to such an extent that there is now an eight months waiting list for major gynaecological operations of a non-urgent nature, whereas in April, 1968, there was virtually no waiting list at all.

It is hoped that the increasing use of sterilisation and better contraceptive advice for the community will diminish the numbers in future. No one can feel satisfied with the present situation.

The patients seem to fall into several well defined groups. A few of the terminations are done on purely medical grounds, such as severe cardiac disease, and a few are done on account of possible fatal deformity. The "psychiatrically-disturbed" constitute another important but relatively small group. These are patients suffering from a mental illness as opposed to patients who are temporarily psychologically disturbed by the worry of the unwanted pregnancy. The advice of the psychiatrist is essential for the former, but is not generally necessary for the latter.

The great majority of the patients, however, do not fall into these categories, and are less easily defined as being within the social category. On analysing this somewhat amorphous group, I find that three distinct categories emerge. The largest group concerns married women, aged between 30 and 40, with families. I find this very significant. One tends to think that somehow it is all to do with the permissive society and long hair and drugs and such things, but this is not borne out by the facts. Single girls account for only about one quarter of the referrals, and they constitute the

second group—the separated, the divorced and the widow.

Each patient tells her own unhappy tale, generally calmy and without histrionics, but tears are seldom far away. A source of disquiet is the fact that, in a so-called affluent society, there should still be so many families badly housed and inadequately provided for in terms of the money now needed to feed and clothe a family. All too commonly there is a story of the husband being on short pay or unemployed, making it essential for the mother to work to augment the family income in order to keep up any reasonable standard of living. All seems reasonable well until the unplanned pregnancy occurs and apparent disaster threatens the family.

Among the unmarried group one is dismayed by the number of betrayals by seemingly devoted young lovers who disappear when told there is a pregnancy, leaving the disillusioned and desperate women to face the future alone. Not infrequently the patient will state that, if she cannot have the pregnancy terminated legally, she will take other steps irrespective of the dangers involved in a back street abortion. I know of at least two patients in this series who were refused by me, because I felt that their grounds were insufficient, who went to London and had the operation carried out at great expense.

These are but a few examples of the kind of problems which have to be faced. The decision is never an easy one. To make it even more difficult for the doctor, is the increasing awareness of the possible dangers and long-term after effects, such as sterility, which have to be weighed up against the patient's present predicament. I feel that the dangers of this controversial operation and the remote complications have been sadly understated in both the press and on television, so that the public have been led to believe that abortion is more or less without risk to life or health, and this simply is not the case.

The official statistics must inevitably be misleading. The reason for this statement is that the notification of an abortion must be made to the appropriate authority within seven days of the operation. Only complications arising during that time would therefore be notified. It must be particularly misleading in relation to the thousands of abortions which are carried out in London nursing homes, where the patient is generally discharged within a few hours of the operation. The statutory form will record no complications, even though the woman may have had to be admitted to a hospital elsewhere. Likewise, there is no means of obtaining accurate statistics regarding long-term complications, which may only arise months, or even the years, later.

In my own personal series, undertaken with all due care and attention, the number of complications is not significant. It includes two uterine perforations, requiring laparotomy and abdominal hysterotomy ; three failed intra-amniotic-saline injections necessitating hysterotomy ; one case of severe haemorrhage requiring hysterectomy (but this was of less moment, as she was to be sterilised in any case) ; and in one case of implantation endometriosis. Blood transfusion was necessary in seven cases because of haemorrhage and uterus had to be re-evacuated on seven occasions.

The other early complications which can occur, but which have fortunately not occured here, are death, visceral damage, acute infection of the pelvic organs and anuria. As it happens, the complications which we have had were all dealt with satisfactorily and the patients are little the worse physically for the experience, but they might not have been so fortunate.

And what of the long-term after-effects ? What of subsequent sterility, recurrent infection, menorrhagia, recurrent abortion, etc., all of which are known to occur ? Only time will tell how high the incidence of acquired sterility is going to be, but what could be more tragic than this result of a youthful indiscretion ? All these things must be borne in mind when making a decision and in helping the patient also to make her decision. Further evidence of how difficult it can be to reach the right decision is afforded by the fact that in this series four women, for whom abortion was agreed, changed their minds in the few days before they were admitted.

Abortion like "having a tooth out"

Abortion was regarded by many unmarried teenaged girls seeking it as being physically and morally no more serious than having a tooth out, a doctor told a nursing conference recently.

Dr. H.M. White of Bromsgrove, Worcestershire, was addressing a Royal College of Nursing Conference at Birmingham on such questions of conscience as abortion, euthansia and resuscitation.

"We cannot subscribe to this view and I prefer to allow these girls adequate time off work afterwards under a proper medical certificate," he said.

Finally, what is the midwife's place in all this ? What is her role, if any ? What is to be her attitude ?

It must of course, be a personal decision, just as it is for the doctor. It is natural and understandable that midwives should tend to feel that termination of pregnancy is not their business. It is, after all, the complete negation of what a midwife is trained for and wants to do, that is to care for pregnant women through normal and abnormal pregnancy and to deliver them of a healthy infant at the end of it. Also, there is no getting away from the fact that the very operation is a most distasteful one to have to perform or to have to witness. This cannot be denied. I suggest, however, that it is the job of the midwife to have concern for all pregnant women, more or less from the earliest weeks, and this will inevitably include women with unwanted pregnancies.

Obstetricians and midwives work in symbiosis and most amicably in all other fields, so I venture to suggest that they must accept that they are needed to help and support their obstetrician colleagues in this particularly difficult matter. For those, of course, with strongly and sincerely held religious and moral objections, there can be no question of compulsion.

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This situation is clearly recognised in a statement by the Defence Union, which reads as follows :

> Neither the anaesthetist nor an assistant to the surgeon need concern himself with the legality of the operation and the terms of the certificate on which the decision has been made. The responsibility for that rests upon the surgeon, but like any other member of the theatre team, he may object to being a party to an abortion on the grounds of conscience. It is to be expected that such conscientious objection will be given in advance to the surgeon and that he will arrange for a substitute, who has no similar objection. A nurse, too, is entitled to hold conscientious objections and doubtless those objections will become known to the surgeon, or to his theatre sister, if she has made them known through the usual channels of her profession.

May I conclude with a few generalisations ? One is aware that there are marked regional differences in the interpretation of this Abortion Act. Personal and religious views must inevitably lead to a situation whereby it is easier to have a termination carried out if one lives in one part of the country as opposed to another. This inequality has led to a most regrettable proliferation of private clinics in London, where anyone can have a so-called legal termination done if they have sufficient cash.

It would seem that, from this point of view, the Act is being worked much more satisfactorily in Scotland than in England. Quoting the Scottish Home and Health Department figures for 1969, out of 3,544 terminations in Scotland only 69 were dealt with in the private sector ; whereas in England and Wales, out of 54,013 terminations 20,863 were dealt with in the private sector.

One of my main criticisms of the whole affair is the fact that no extra provision has been made within the Health Service to cope with this very significant increase in the work load, and all over the country gynaecological waiting lists are steadily becoming longer. I suspect that a breaking point may soon be reached if nothing is done about it.

As far as the follow-up of these patients is concerned, they are all seen approximately six weeks after the operation. They are all asked if they still feel that the right decision was made. Out of the 197 terminations done in this series only one patient expressed strong regret—she was a single girl who had been referred with a strong psychiatric recommendation, and she announced to us that she was going straight off to get pregnant again. The rest expressed the view that they still felt it had been the right decision.

Much importance is attached to the question of future contraception for these patients. Sterilisation was combined with the operation in 47 cases, all the others were offered advice and practical help where required. Two of the patients were referred back for a second termination within the three-year period, an incidence of one per cent. Both had failed to take the advice offered.

As to the future, it can only be hoped that through better sex education, and even more freely available contraceptive advice, the numbers of these unhappy situations will diminish. We have the means available of preventing much of this unhappiness, if only it were properly used. It behoves us as nurses and doctors to take an active part in promoting these ideals, for, as in all branches of medicine, "Prevention is better than cure." *(Courtesy—Midwives Chronicle)*