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Medical Aspects of the Danish Legislation on Abortions

Henrik Hoffmeyer, M.D.

With many American groups requesting amendments to existing abortion laws, it becomes important to examine the more liberal European laws. The Danish Pregnancy Act was amended in 1956 to give the Danish Mothers Aid Centers the authority to grant permission for abortions. Dr. Hoffmeyer presents the medical aspects of the administration of the law, discussing in detail the various types of medical indications which are considered in evaluating applications for abortions. He explains that the Mothers Aid Centers also have an after-care program, consisting of family therapy and in some cases sterilizations, for women who have terminated their pregnancy. The author includes a discussion of recent European studies most of which support the Danish practices. Dr. Hoffmeyer expresses the hope that the present system will be continued and that more funds will be made available for the sociomedical and support portions of the Mothers Aid Centers.

IN 1956, the Danish legislature amended the Pregnancy Act of 1937[1] and established a system, still in effect, whereby the legal indications for an abortion were to be decided by a three-member sociomedical board attached to the Mothers Aid Centers.[2] This amendment was a departure from the 1937 act which provided that two doctors — one being the patient's private doctor and the other, the surgeon who was to eventually perform the operation — had to decide whether an abortion was indicated. The purpose, here, is to examine some of the medical problems connected with the administration of the amended Danish abortion law.

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I. REASONS FOR THE ADOPTION OF THE 1956 AMENDMENT

The Pregnancy Act of 1937[3] required that a woman must have

[1] Act Concerning Provisions Relating to Pregnancy, Act No. 163 of May 18, 1937, as amended by Act No. 89 of March 15, 1939 [hereinafter cited as 1937 PREGNANCY ACT].

[2] Act Concerning Provisions Relating to Pregnancy, Act No. 177 of June 23, 1956 [hereinafter cited as 1956 PREGNANCY ACT] reprinted in Appendix to Skalts & Nørgaard, *Abortion Legislation in Denmark*, 17 W. RES. L. REV. 498, 522 (1965) [hereinafter cited as Appendix p].

[3] 1937 PREGNANCY ACT § 2(1).

applied to a Mothers Aid Office for help before permission for an abortion would be granted.

In the years following the adoption of the 1937 act, more and more women applied to Mothers Aid, most of them being sent by their private doctors for the purpose of having the Centers decide upon the need or desirability of an abortion. The reasons for the increased numbers of women applying for abortion are many: (1) the general practitioners preferred not to be involved in the decisions on indications; (2) the individual doctors often had limited experience and sometimes were pressured by their patients; (3) the surgeons who were to perform the abortions did not feel inclined to follow an indication from the general practitioner without having another examination by an expert; (4) the psychiatric wards, most often responsible for expert examinations, were overcrowded and therefore inclined to recommend that examinations be done by the Mothers Aid consultant; and (5) the Mothers Aid Centers, because of the nature of their organization, with its facilities for giving social advice and financial support, were better fit for giving advice on abortions than were hospitals.

About eighty per cent of all recommendations for abortions were made through Mothers Aid Centers which, because of this demand, had to enlarge their medical departments.[4] Because of this increase in the use and popularity of the Centers and because of the Centers' facilities for ruling on indications for abortions, the legislature in 1956 changed the procedure for deciding on abortions, giving the power to make that decision to the three-member medicosocial boards of Mothers Aid.[5]

II. PRE-ABORTION PROCEDURE UNDER THE PRESENT DANISH ABORTION LAW

The primary goal of the abortion legislation is to persuade women to carry through with their pregnancies whenever possible. The performance of an abortion is only a secondary goal when all other help-measures fail. This goal is demonstrated by the fact that pregnancy legislation[6] and the Mothers Aid legislation are not simply exceptions to the penal code but are, rather, separate and specific

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[4] From the files of the Mothers Aid Institute.

[5] 1956 PREGNANCY ACT § 3(3), Appendix p. 524. For a discussion of how decisions were made before the 1956 amendments, see Skalts & Nørgaard, *supra* note 2, at 503 n. 29.

[6] 1937 PREGNANCY ACT; see Skalts & Nørgaard, *supra* note 2, at 498-500, 502-05.

laws providing for the support of pregnant women and mothers.

A. *Medical, Psychiatric, and Social Investigations*

The Danish statute provides specific procedures which are to be followed when a woman applies for a legal abortion.[7] The woman, whether or not she is sent by her doctor, first sees the social worker who writes a detailed case history. On one of the following days, she submits to a gynecological examination including laboratory tests. After her examination, she will see one of Mothers Aid's psychiatrists; if necessary, she is asked to return later for a further psychiatric interview. The social worker then conducts an investigation which includes visiting the husband, or the alleged father, and other relatives, and collecting information from other institutions which the woman might have visited.

The medical department of Mothers Aid also conducts an investigation, checking with any hospitals and practitioners that might have treated the patient. If the woman's medical condition so warrants, she may be referred to the Institute for Human Genetics.

B. *Conference of Medicosocial Boards*

After all the investigations are completed, a team conference is conducted among the doctors, social workers, and lawyers connected with the case. At each of these conferences the board members discuss the possibility of having the patient carry through with her pregnancy. In some cases further examinations are deemed necessary and often admittance to a hospital for observation is indicated. Generally, however, it is preferable to observe the woman during a stay at one of the more "home-like" sub-institutions of the Mothers Aid instead of sending the patient to a hospital. In many cases the patient will change her mind during this stay.

C. *Report of Findings and Board Decision*

When all of these examinations are completed, a "Discussion and Summary" is written by the psychiatrist and the social worker. This report is written in an objective manner, and sets forth the recommendation as to whether the pregnancy should be interrupted or carried through. Copies of all reports are sent to the members of the board. It should be mentioned that these reports sometimes run up to twenty pages, represent a heavy strain on office personnel,

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[7] 1956 PREGNANCY ACT § 3(3), Appendix p. 524.

and require a large number of working hours for the many staffs involved.

Another important element which must be considered is that most of the women who come to the Centers are under a great deal of emotional stress which is not lessened by the procedure and examinations of Mothers Aid. The board knows that those who have a strong desire for an abortion, or who do not consider their chance for legal abortion to be very great, may resort to having it performed illegally in order to avoid the stress combined with the legal procedure. For these reasons the boards may take abbreviated measures when they are needed.

The boards meet once a week. At times they will ask for further examination or even turn to the central board for advice.[8] When the board has made its decision, a detailed letter is sent to the woman's private doctor giving the reasons for the decision and suggestions for further treatment and help.

III. INDICATIONS FOR ABORTION UNDER THE ACT

A. *The Medical Indication*

The main criterion under the law is "the grave danger to the woman's life or health."[9] This provision states that the conditions of life which the woman has to endure must be taken into consideration.[10] However, this does not imply that there is any social indication for abortion. It is only a reflection of a generally adopted medical principle that the assessment of the health-state of a patient and the indications for therapeutic measures always have to be matched to the conditions of life. The provision, moreover, provides that threatening "states of weakness" have to be considered.[11] Then, at least theoretically, it should not be necessary to prove any present illness or weakness — only that the threat of carrying through with the pregnancy and of having another child will seriously threaten the life or health of the pregnant woman.

Since the medical indication is the one most commonly used, it is important to examine it in detail. The type of cases which come under this provision include convention conflicts, stress syndromes, and stress syndromes of housewives.

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[8] See Skalts & Nørgaard, *supra* note 2, at 510 n.58 and accompanying text.

[9] 1956 PREGNANCY ACT § 1(1)(1), Appendix p. 522.

[10] See Skalts & Nørgaard, *supra* note 2, at 508.

[11] 1956 PREGNANCY ACT § 1(1)(1), Appendix p. 522.

(1) *Convention Conflicts.*—Quite a large proportion of women applying for legal abortions are experiencing what is called a "convention conflict." The pregnancy itself or the expected child provokes a conflict between the woman and the conventions of the social group to which she belongs.

Such conflicts can appear in many different variations. Typical situations can be found in very young teen-age girls, young unwed women, married women who have had extra-marital relations, married women more than thirty-five or forty years of age who are ashamed of showing that they are still sexually active, separated or divorced women, and widows. Some of these situations are apt to produce "reactive depressive states." However, contrary to what was originally believed, these depressions are rarely very deep. Most often the reaction could better be characterized as a "panic-reaction" created by the fear of not being able to cope with the demands and the responsibility of a future motherhood. These reactions are often dramatic and can come close to psychotic states. However, most often these women can be made to look after their daily jobs, thereby diverting their attention, and to speak about other matters than the pregnancy. When an application for legal abortion has been finally rejected, and the pregnancy advances to the fourth or fifth month, the panic normally declines. A realistic adjustment to the situation takes place when the woman begins to prepare for the baby's arrival by picking out baby clothes and the like. At times, suicidal threats or superficial suicidal acts are made, but most often these are a part of the appeal for a legal abortion. The degree of appeal, dramatic or hysterical traits, as well as other characteristics of the reaction depend upon the specific personality-type of the individual woman. In some rare occasions more severe psychotic reactions of a depressive nature can occur. Here the suicidal danger is much more typical; but during the years it has been observed that these women, owing to the psychotic inhibition and their lack of reality-adjustment, seldom seek the aid of a doctor or the Mothers Aid Center. When they do seek aid, they are most often brought by a relative or friend who realizes the seriousness of the situation.

During the years, it has been found with increasing frequency that the background of the "panic-reaction" could be characterized as a "conflict of ambivalence." The more pronounced panic-reactions are found in women who have passed their adolescence, women who under other circumstances certainly would have been enjoying a pregnancy, and women who have well-developed and mature,

maternal feelings. The panic arises as a consequence of the conflict between the positive (*e.g.*, ethical) feelings toward the conservation of the pregnancy and the realistic assessment of the heavy burden which the continuation of the pregnancy will bring about. The instructive and ethical impulses toward the continuation of the pregnancy are experienced as terrible dangers confronting the women with all the fears of reality. As a defense, she is apt to completely repress the factors favoring the continuation of the pregnancy in order to be able to carry through her strong, one-sided advocacy for legal abortion.

Seen against this background it is quite clear that the strength of the indication for legal abortion could not be determined by the strength of the emotional reaction. Danish doctors and psychiatrists, perhaps, cannot completely acquit themselves for not doing so. But in discussions with surgeons, who traditionally — and this is well understandable — are more resistant to interruption of pregnancy, it was indicated that the strong emotional reactions and the suicidal threats could make an impression sufficient to convince them to perform the operation. However severe the depressive reaction might be, there is always the possibility that contraindicating factors might be of such an importance that an abortion ought not to be performed. Only a thorough psychiatric examination can clear this up. To the extent that the "ambivalence conflict" plays a role, the strength of the emotional reaction will more likely be inversely proportional to the strength of the indication for legal abortion, since it reflects the strength of the motivations for preserving the pregnancy.

In addition to the women presenting the pronounced affective reactions, there is another group of women in similar "convention conflicts" in whom the pregnancy-conserving motives are so strong that there is no doubt about their wish to continue the pregnancy. They apply to the Mothers Aid late in their pregnancy to have practical and legal advice and help. Finally, another (and perhaps much larger) group exists in whom the motive for abortion is absolute and other motives so weak that there is no doubt about the decision that the pregnancy must be interrupted. They do not want to talk to any authority and consider medical and social preliminary investigations as red tape. They, therefore, immediately turn to illegal methods. They also acknowledge that case workers and doctors might activate their repressed counter-conceptions and postpone the

decision until the pregnancy has progressed to a point where the emotional balance is normally changed in favor of the baby.

A specific group which is subject to these "convention conflicts" is the teen-age girl. It is generally thought today that sexual relations are commonly started at an earlier age, that premarital sexual relations are more common in larger circles of the population, and that social conventions of the youth groups (especially with regard to relations between the sexes) are more liberal. Still, experience shows that girls who become pregnant early in their teen-age years (before the age of seventeen) generally represent a specific group, characterized by emotional isolation and frustration in their parental relations. The different reasons for this fact shall not be discussed here. In addition, very authoritative, as well as liberal and pseudo-modern, attitudes held by the parents produce an environment making the girl feel lost, isolated, and frightened to such a degree that she compensates by engaging in premature sexual relations. More specific psychological disturbances, either in the girl herself (neurotic, pseudo-neurotic, or psychotic states) or in the family-pattern, may also explain why a girl starts to have premature sexual relations. The compensatory or neurotic types of premature sexual relations, however, are generally characterized by starting at an age premature to the rest of the physical and psychological development. Too often the partner is one who is not socially or emotionally able to support the girl when she gets pregnant.

The psychological reactions encounted with this type of girl are very often only superficial. Rather often they look forward to having a baby — a further loneliness-compensation. Psychologically, they are usually reflecting the serious reaction of desperate parents. If the pregnancy is carried through, very often the girl's mother will, for the first few years, also function as the real mother of the child.

The termination of a pregnancy, under the Danish law, on the basis of "convention conflicts"[12] is rarely done. In some cases the difficulty in distinguishing between psychotic depression and "panic-reaction" might be an indication for the interruption of the pregnancy even if the mere diagnosis of psychotic depression does not necessarily indicate the interruption. In some other cases, facts relevant to other provisions of the legislation might supplement medical reasons for interrupting the pregnancy. By and large the attitude toward this type of psychological reaction to an un-

[12] Board of Health Circular, March 25, 1939 (unpublished); Ministry of Justice Ruling, January 23, 1940 (unpublished).

wanted pregnancy has changed during the time the legislation has been effective. A more objective and sober attitude on the part of officials has been adopted as it was realized that suicides and the development of chronic psychopathology were rare in these cases.

(2) *Stress Syndromes.*—The condition which is the primary cause for legal abortions in Denmark has been named the "stress syndrome." This is a more or less chronic condition existing before the unwanted pregnancy, and interruption of the pregnancy can be granted to prevent a further development of the syndrome.

In the discussions, during the first decades of the legislation's existence, between the surgeons and gynecologists on the one hand, and the psychiatrists and social workers, on the other hand, it was realized by the latter that they had to try to re-define the conditions found in a considerable number of women applying for legal abortions. As previously mentioned,[13] there was a tendency to label these conditions as psychotic depressions. In some cases, however, the psychological reaction to the pregnancy was only very slight; in other cases, the reaction represented health conditions which, from a common, general medical point of view, seemed most urgently to demand a legal abortion. By using common medical diagnostic techniques it was difficult to tell what sort of illness these women had, to label them with some "main diagnosis." They seemed to have many separately unimportant illnesses.

Most of the women belonging to this group are married with two, three, or four children, and are living under some form of stress owing to poor housing conditions, economic difficulties, marital problems, illness, or defective or maladjusted children. Very often the core of the problem is represented by the husband who is ill, disabled, a poor breadwinner, or perhaps addicted to alcohol. Obviously, such conditions get progressively worse with each new weight laid on the shoulders of such a woman. Furthermore, in some cases, the mental or physical resistance beforehand may be impaired by hereditary or other factors or as a result of previous illnesses.

Depending upon the resistance in the individual case, symptoms of what has been called "insufficiency" will develop sooner or later. The diffuse word "insufficiency" is used intentionally as this condition does not cover any known clinical notion. This condition occurs as a result of confinement or of some other increase in the stress to which she is subjected. In the milder cases, the "insuffi-

[13] See p. 533 *supra.*

ciency" will disappear in a short time, perhaps as a result of some social or medical provision supporting or relieving her. At this point the Mothers Aid attempts to offer some relief. But if the stress increases or continues, the "insufficiency" will also continue and may change from an intermittent to a chronic type which in severe cases can be disabling.

The "insufficiency" is caused by physical and mental symptoms, and by diseases such as varicose veins, chronic infections in the genital organs and the lungs, and arthritis. Symptoms of a psychosomatic nature are muscular tensions, migraine headaches, and the like. The mental symptoms are typically fatigue, irritability, sleep disturbances, anxiety states, and increased reactivity. If, beforehand, there has been specific neuroses, the symptoms often develop and manifest themselves in an intensified way during such an "insufficiency state." Such women, of course, often show a minor resistance to the constant stress situation. Thus there is no contrast between the sociological and the psychological analyses of the situation since they represent explanations in different, but supplementary, levels.

An investigation of the pathology appearing in women applying for legal abortion shows that the pathology is varied and is in no way only of a psychiatric nature. In an investigation at Mothers Aid counting all possible diagnoses of any importance in 200 randomly selected women applying for legal abortion, 594 diagnoses were counted — 322 psychiatric and 272 somatic (physical) diagnoses.[14] The psychiatric diagnoses were comprised of 55 per cent neurotic and neurasthenic states, 23 per cent behavior disorders or psychopathic states, 10 per cent mental deficiences, and only 8 per cent reactive depressions. The remaining 4 per cent was comprised of different minor groups.[15] The somatic diagnoses were comprised of 28 per cent general diseases, such as emaciation, anemia, obesity, and metabolic disorders; 17 per cent neurological diseases such as headaches, migraines, sequela after earlier concussions, and meningitis; 14 per cent gynecological diseases; 9 per cent varicose veins; and 5 per cent for each of the following: lung diseases, kidney diseases, and ear and eye diseases.[16]

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[14] Hoffmeyer, *The Medical Work in the Mothers Aid Institution*, 119 UGESKRIFT FOR LÆGER 1396-1403 (1957); Hoffmeyer, *Pregnancy Legislation and Mothers Aid Legislation*, 119 UGESKRIFT FOR LÆGER 1528-33 (1957),

[15] *Ibid.*

[16] *Ibid.*

The characteristic property of this complex of symptoms is that it appears uniformly, repeating itself almost identically from case to case both with regard to symptoms and to course, appearing to be a real disease but with features which cut across common clinical notions or concepts. It is understandable only from a holistic point of view. Somatic and mental symptoms, the previous medical and social history, and the social and family background are combined in one unity. It must be understood that the sum total of singly unimportant symptoms or diseases under certain conditions could represent a serious state of health. The patient and her illness must be evaluated on the basis of her history and her social background. The doctor working in a clinic is accustomed to analyzing his cases and to isolating the causes for the disease. In a social-disease field, the doctor has to integrate and synthesize to understand the influence of pathological factors in order to evaluate the ability of the person in question to solve her conflict under the circumstances in which she has to live.

In several cases it has been possible with the means and facilities of Mothers Aid to offer material assistance in the form of a cash grant, domestic help, a rest cure, or medical or psychological treatment in order to prevent a disastrous development. In other cases the view has been taken that, if the pregnancy were continued, these women would run a serious risk that the "insufficiency" would develop into a chronic, irreversible, and disabling condition — a condition which would mean insufficiency to meet the demands made upon them as mothers and housewives. In such cases legal abortion, possibly combined with sterilization, has sometimes been indicated.

(3) *Stress Syndrome of Housewives.*—The "stress syndrome of the housewives" seems to appear in two slightly different types. One type is dominated by social, financial, and housing problems. In these cases physical symptoms in addition to the stress are often predominant. The other type more often appears in middle-class women who are not directly threatened by social destitution due to the pregnancy, but who are motivated to seek an abortion through the fear of a reduction in their standard of living; they are anxious to preserve the level generally accepted for their social class. This area has been a matter of controversy in discussions of the abortion policy since the abortions help people to obtain empty, materialistic goals. Still, it must be remembered that the ambitions of the middle class are responsible also for the many positive material as well as cultural achievements of the modern welfare society. In a coun-

try such as Denmark, families with more than three or four children find it difficult to maintain the generally accepted standard of living for most working and middle-class families. The emotional forces requiring the maintenance of this level of social prestige are of considerable strength and are mobilized when the threat to it becomes realistic. The stress represented by this fear, when in effect for years, seems to be able to produce similar "stress syndromes" as previously described.[17] The physical symptoms in these cases are developed to a minor degree whereas the psychological and emotional symptoms are dominant.

It might be asked why contraceptive measures, in a country with liberal access to information on, instruction in, and purchase of, contraceptives, do not prevent unwanted pregnancies to a larger degree. The answer must be that while contraception certainly prevents the unwanted pregnancies, the "stress syndromes," the fear of pregnancy, and the frigidity in countless numbers of cases, there still remain groups to whom conventional contraceptive methods are not acceptable and who prefer to take the risk of an unwanted pregnancy. Perhaps modern developments in the field of contraception will at least change the picture to some degree.

Several factors have been shown to affect the medical or sociomedical indications for legal abortion. Women applying for legal abortion are brought through an unwanted pregnancy into a social or personal conflict complicated by some sort of mental or physical pathology. The pathology influences the ability of the woman to cope with her conflict. It is most often the total — minor or major — pathology and not the single disease which creates the problems. Therefore, a synthetic and integrating description and evaluation is a prerequisite for a correct estimation of indications and contraindications for legal abortion.

The main criterion for legal abortion is a medical one, *i.e.*, serious danger to life or health. It is, therefore, in no way contrary to the legislation when married women, more often than unmarried ones, have legal abortions performed, even if the latter group encounters greater external difficulties. Sometimes a woman living in good social conditions and with only a few children will obtain an abortion more easily than a poor woman with many children. These simple facts are very often badly misunderstood by critics who forget that the indication is medical and not social.

The assessment of the danger to life or health cannot be based

[17] See p. 536-38 *supra*.

only upon an observation of the present emotional state. The immediate reaction to an unwanted pregnancy is highly dependent upon personality traits influencing sensitivity and reactivity and tells very little about the ability that the woman might have for overcoming her conflict and for coping with the situation in the long run.

Experience has shown that those who most need abortions are women with chronic conditions which very often started years before the present pregnancy appeared. Pregnancy, delivery, and the stress combined with the raising of a further child can severely aggravate the chronic "stress syndrome of the housewives."

When assessing the condition of a woman who is applying for legal abortion, it must be remembered that these women are often repressing their anxiety and what they tell is often a plea in advocacy of their case. Sometimes one has the impression that the more detailed the examinations, the more one-sided and persistent the argument of the woman. Thus, it is necessary that care be taken not to create situations which are too artificial and which thereby bring the patient into a "controversy" or "opponent" position vis-à-vis doctors and advisors.

The after care of women who had applied for legal abortion showed especially that these women very often were more ambivalent than the immediate impression indicated. Therefore, it is of the utmost importance that doctors and social workers engaged in the evaluation of women applying for legal abortion have an opportunity to follow-up their cases.

B. *The Ethical Indication*

No specific medical problems are attached to this rarely used provision. For a discussion of this area, see the article in this symposium which deals with Danish abortion laws.[18]

C. *The Eugenic or Hereditary Indications*

This provision provides that serious fetal damage, whether caused by genetic disturbance or by damage to the fetus during its stay in the womb, can be the reason for legal abortion.[19] Among the causes of fetal damage are rubella virus, toxoplasmotic infections, syphilitic infection, Rhesus-negativity, radiation, teratogenic chemical compounds, and genetic factors.

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[18] See Skalts & Nørgaard, *supra* note 2, at 508, 514-15.

[19] 1956 PREGNANCY ACT § 1(1)(3), Appendix p. 522.

(1) *Rubella Virus.*—It is now known that rubella infections[20] in a woman during the first trimester of pregnancy might cause serious physical and mental disturbances to the fetus. There is no reason to go into detail with regard to the many medical complexities involved in this area. It is enough to say that the defects caused by the rubella virus in fetuses might be very disturbing. Although the frequency of such defects has varied in different epidemics, it is estimated to be at least ten to twenty per cent during the first months of pregnancy, with no risk after the fourth month.[21] It is necessary to establish the diagnosis of rubella with as much certainty as possible. Therefore, a careful and unbiased diagnosis from a doctor who examined the patient when she was ill is a necessity in each case.

Legal abortion in case of rubella in the pregnant mother represents only a preventive measure. In such cases it is extremely important to set stringent requirements upon the quality of the indication for legal abortion and also to stress the importance of possible contraindicating risks. During 1957, there were three cases in the Copenhagen Mothers Aid where childless women, because of rubella, had legal abortions performed which, unfortunately, were complicated by such serious secondary genital infections that the women developed sterility. This, of course, represents only a coincidence, but it highlights the urgent demand for convincing evidence when recommending legal abortion as a preventive measure.

(2) *Toxoplasmotic Infections.*—In quite a few cases there is the risk of fetal damage to the brain of the fetus as a consequence of toxoplasmotic infection[22] in the mother. This is still a subject of research, but the danger to the fetus seems only to exist when the mother has recently contracted her infection. Difficulty arises because the disease only causes very slight symptoms in an adult person so the woman is likely to overlook the infection, which is very widespread in the population.

(3) *Syphilitic Infection.*—Syphilitic infection is rarely a reason for legal abortion since preventive treatment can be given during the pregnancy. In Denmark such prophylactic treatment is mandatory for all pregnant women who have ever had a syphilitic infection.

(4) *Rhesus-Negativity.*—The risk of damage to the fetus or the new-born child as a consequence of Rhesus-negativity in the

20 Commonly known as German measles.

21 From the files of the Mothers Aid Institute.

22 The disease caused by infection with the protozoan.

blood type of the mother is of decreasing importance as a reason for legal abortion. In all cases of Rhesus-negativity in a pregnant woman the titers of antibodies in her blood are measured at regular intervals during her pregnancy. Only in cases where antibodies are increasing to a very high level are legal abortions permitted, and then only after it is shown that previous miscarriages and post-natal deaths have undermined the psychological resistance of the woman in question. Otherwise, these women are admitted to deliver in clinics specially equipped for performing replacement transfusions after the child has been born and where they can stay without charge.

(5) *Radiation.*—In some cases radiation damage to the fetus has been the reason why a woman has applied for legal abortion. It has been argued in a very few cases that the risk of genetic disturbances in one of the parents caused by radiation exposure of the sex glands at an earlier date should be grounds for legal abortion. In most of these cases the source of radiation has been an X-ray apparatus. In such cases the amount of radiation is carefully evaluated through a detailed analysis of the procedures during exposure. Some quantitative limits have been established, and exposure surpassing these limits has sometimes been accepted as grounds for legal abortion. In order to avoid occurrences of this kind, there have recently been established in all hospitals regulations aimed at preventing, as far as possible, exposure of the reproductive organs to radiation, especially in women who have just ovulated.

(6) *Teratogenic Chemical Compounds.*[23]—Last among the teratogenic noxes sometimes indicating legal abortions are the teratogenic chemical compounds. The thalidomide catastrophe did not affect the Scandinavian countries to any considerable degree. In a few cases an attempt was made, through cautious X-ray examinations, to estimate the development of the fetus before considering the possible indication for legal abortion. As long as thalidomide was still obtainable, it was rather easy for a woman attempting to deceive the board to insist that she had used the drug. The general conclusion from the thalidomide catastrophe in Denmark has been to warn doctors, as well as the public, against any use of drugs dur-

[23] Some reports seem to indicate that viruses other than the rubella virus can also have a teratogenic effect on the fetus. There is no reason to go into detail regarding these still not completely established relations other than to say that the most common and widespread types of viruses like the common cold virus, the influenza viruses, and others do not seem to have any notable teratogenic effect. It is, of course, of the utmost importance that experts acquainted with the results of modern research are always heard in doubtful cases and in fields where research is rapidly progressing.

ing the first trimester of pregnancy unless such use is urgently needed.

(7) *Genetic Reasons.*—As to the genetic reasons for legal abortion, what has been said generally concerning the teratogenic noxes also holds true. In follow-up investigations the number of women who regret an earlier legal abortion is highest where the abortion was motivated by hereditary reasons.[24] As mental defectives and psychopaths are especially prominent in this group, these reactions should perhaps not be of too much importance. Still, it must be emphasized that the hereditary prognosis must be as well established as possible before performing a legal abortion. In the field of psychiatry, human genetics has not developed to the extent necessary to make it possible to establish any certain prognosis in many cases of neurotic or behavioral disorders. Unfortunately, these are the most common conditions appearing in the families of women applying for legal abortion. More objective reasons for legal abortion could be obtained if hereditary factors were considered together with the social factors responsible for the circumstances under which the expected child will have to grow up. Here again an integration of biological and social factors is necessary.

The Institute of Human Genetics at the University of Copenhagen maintains a central registry where all criminal cases, as well as admittances to psychiatric institutions, are listed. The Institute also maintains a registry of most Danish families with the more pronounced hereditary diseases. In cases where hereditary indications might be present, a thorough report on the hereditary background is given by the Institute to the Mothers Aid.

The possible contraindications also have to be emphasized. In one case, a woman was very frightened by the fear of developing schizophrenia since some distant relations had this disease. Quite different hereditary factors among her closer relatives made a hereditary indication for legal abortion possible. However, it was necessary to refrain from using this to prevent her from feeling that her suspicions had been confirmed.

D. *The Defect Indication*

While the indications based upon this provision are described in another article in this symposium,[25] it should be emphasized that this provision theoretically concerns what could be called "social" indi-

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[24] From the files of the Mothers Aid Institute.

[25] See Skalts & Nørgaard, *supra* note 2, at 509, 514-15.

cations. A legal abortion based upon this provision is not intended to cure or protect the woman herself, but is for the benefit of her child for whom she is supposedly not able to care. This makes an abortion based upon this provision somewhat humiliating to the woman in question. Most often, however, the woman does not recognize what provision the board used in deciding upon the indication. In a few cases, relatives or social authorities have persuaded a woman, poorly equipped both physically and mentally, to apply for abortion under this defect provision. However, each case has to be assessed on the basis of its own, particular facts.

IV. TIME LIMITS FOR ABORTION UNDER THE PREGNANCY LEGISLATION

The pregnancy act provides that a legal abortion should be performed before the sixteenth week of pregnancy when the abortion is based upon the provisions concerning ethical, hereditary, and defect indications.[26] However, there is no limit with regard to the medical or sociomedical indications. In urgent medical cases involving a vital danger to the pregnant woman, an abortion is possible at any time during the pregnancy. In practice, however, abortions are very rarely performed later than the eighteenth to twentieth week of pregnancy.

Originally the government proposed to set the limit at the twentieth week. The Mothers Aid would then have had more time to persuade the woman to continue with her pregnancy. Moreover, it was realistically thought that many women would change their minds since the pregnancy would be so far advanced that they might feel the baby moving in their womb. A lobby of gynecologists opposed such a late limit, and the government changed its mind, fixing the limit at the sixteenth week. Today it might be argued that the limit ought to be as early as the twelfth week. Recent statistics have shown that the frequency of complications and the mortality rate are considerably increased when operations have been performed after the twelfth to the fourteenth week of pregnancy. Of special interest were the figures published by Dr. C. Tietze comparing mortality rates in Hungary and Scandinavia.[27] Hungary has unlimited legal abortions, but the operation has to be performed before the twelfth week of pregnancy. Mortality rates

[26] 1956 PREGNANCY ACT § 1(2), Appendix p. 523.

[27] See Tietze & Lehfeldt, *Legal Abortion in Eastern Europe,* 175 A.M.A.J. 1149 (1961).

in connection with legal abortion operations in Hungary are considerably lower than the same rates in the well-equipped Scandinavian hospitals.[28]

It was found in Denmark that when applying for legal abortions 60 per cent of the applicants applied before the tenth week, 17 per cent between the tenth and twelfth week, 15 per cent between the twelfth and sixteenth week, and 6 per cent after the sixteenth week.[29]

V. After-Care Program

A. *Contraception and Sterilization*

The decision of the board granting an abortion is the starting point for the after-care program. Much emphasis has been placed upon the prevention of unwanted pregnancies. Thus, after termination of the pregnancy by abortion or birth, the woman is always urgently invited to utilize the contraception service of the gynecological clinic of the Mothers Aid Centers. Due regard is paid to the many psychological and ethical facets involved in contraception.

The gynecological clinic of the Copenhagen Mothers Aid Center has been engaged in comprehensive research programs on oral contraceptive methods and intra-uterine devices in collaboration with the New York Population Council. Where contraceptive measures are deemed not suitable for physical, psychological, or social reasons, a voluntary sterilization might, in some urgent cases, be the necessary consequence. In fact, about thirty per cent of all legal abortions[30] are followed immediately by sterilization since the two operations are so often similar. Sometimes, however, the sterilization will be postponed until a later date — for those who go to term with their pregnancy, to the puerperal period. In a few cases the husband will have a vasectomy performed either because he is carrying the hereditary burden or as a substitute for the wife who is too weak to be operated upon.

It is surprising that a considerable number of women have applied for voluntary sterilization. It is commonly supposed that this reflects a widespread and strong motivation for effective and narrow, family size-limitation and simultaneously a general distrust of conventional contraceptive methods which are deemed inadequate

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[28] *Ibid.*

[29] From the files of the Mothers Aid Institute.

[30] *Ibid.*

and psychologically disturbing. It is hoped that the modern contraceptive methods now under development will better fit the needs and thus be a substitute for some of the sterilizations. Sterilization in Denmark can be obtained in four different ways: (1) where a surgeon's approval, based on medical indications (health reasons), is given without any formal procedures, provided that the operation is medically indicated as a prophylactic or therapeutic measure;[31] (2) where social and eugenic factors are the main reasons for sterilization and application to the Ministry of Justice is made and accepted;[32] (3) where an application is made to the Ministry of Social Affairs on the basis of feeble-mindedness;[33] and (4) where the woman wants it after she has had her pregnancy legally terminated because of her hereditary status.[34]

Eighty per cent of the sterilizations are performed without formal procedures based on medical indications.[35] Most cases have been investigated and assessed by the Mothers Aid Centers and the abortion boards, even if they do not have any legal basis for expressing their opinion. However, this procedure is generally accepted and is approved in a committee proposal to a new comprehensive sterilization law now in preparation.

B. Family Therapy

Another important field of after-care is family therapy. Acknowledging the fact that the troubles of the individual woman very often depend upon some kind of family problem, it was recognized that real assistance should also involve an offer to help to solve the family situation. In many cases a team comprised of case workers, psychologists, psychiatrists, and lawyers invite the whole family of the woman who applied for abortion — whether or not the application was turned down — to come in for counselling, guidance, or therapeutic sessions. The type of treatment depends upon the kind of family problems. While budget problems are the most typical problems, some families are also faced with neurotic

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31 Report on Sterilization and Castration submitted by a committee established by the Ministry of Justice on December 30, 1958 No. 353 (1964).

32 Act on Sterilization and Castration, Act No. 176 of May 11, 1935.

33 Act on Feeble-Minded Persons, Act No. 171 of May 16, 1934, amended by Act on Care for Feeble-Minded and Other Persons Especially Deficient in Intelligence, Act No. 192 of June 5, 1959. While the earlier act was replaced by the 1959 act, the latter specifies that §§ 6-9 of the 1934 act are still valid.

34 1956 PREGNANCY ACT § 1(4), Appendix p. 523.

35 From the files of the Mothers Aid Institute.

family interaction. Most often the family members are seen individually. Sometimes the work will go on for several years, and disappointments are not too rare in this complicated field. However, a follow-up study has shown that about sixty per cent of the cases definitely improved.[36] In some cases a new pregnancy had appeared in the follow-up period and had been welcomed by the family, thereby supposedly avoiding applications for legal abortions. Because of a lack of staff and appropriations in this area, this type of after-care has developed only to a limited degree and most of the after-care is done according to more conventional methods of social work. The family-centered work, however, seems to attack the abortion problem closer to its roots, and it is hoped that Mothers Aid can develop this program further.

VI. RESEARCH

It is not possible, even briefly, to report upon the whole field of research covering legal abortions. However, an attempt will be made to give a concentrated report of some of the more important research results and of some rather unknown communications.

A. The Clientele of an Illegal Abortionist

Some years ago, an illegal abortionist was arrested in Copenhagen. His mode of operation consisted of having women write to his post office box asking him to come and see them. After his arrest, the police collected well over one hundred such requests and appeared with a social worker from the Mothers Aid who offered such women support and advice. A detailed investigation showed that in about twenty per cent of the cases the women were able to obtain a legal abortion.[37] These women were badly informed or were too pessimistic to believe that they could be helped. Forty per cent of the women decided willingly to continue their pregnancies when supported by the Mothers Aid. The most surprising result was that ten per cent of the women were not pregnant. The quack most likely would not have registered this and would have performed his operation.

In another study,[38] the number of illegal abortions in Denmark

[36] HOFFMEYER, FAMILIEN OG SAMFUNDET (1964).

[37] HOFFMEYER, TIDSSKRIFT FOR PRAKT. LÆGERNING OG SOC. MEDIC. NO. 9 (1965).

[38] Hoffmeyer & Nørgaard, *Incidence of Conception and the Course of Pregnancy*, 126 UGESKRIFT FOR LÆGER 355-71 (1964).

was estimated to be between 12,000 and 15,000 with the number of births being about 80,000, and the number of legal abortions being close to 4,000 a year.

B. Comparison Between Children of Those Turned Down on Abortion Requests and Those Who Made No Applications

In a study by Forssman and Thuwe[39] from Gothenburgen, Sweden, two groups of children were compared at the age of twenty. The one group was comprised of children born of mothers whose application for legal abortion twenty years earlier had been turned down. The other group was comparable to the first but their mothers had not applied for legal abortion. The study was retrospective and indirect, as the children were not seen by the investigators. All kinds of retrospective materials were collected from social, educational, and medical institutions. The incidence of social and psychological maladjustment during childhood and adolescence and of several other negative factors was considerably higher in the first group.

This result shows that the destiny and interests of the child are best provided for in the legislation. As mentioned previously,[40] this is only done in the provision covering "defect" or handicapped pregnant women. And as was also mentioned, an indication based upon such considerations is more of a "social" indication.

C. Follow-up Investigations

One might expect that follow-up studies would be able to highlight the effects of legal abortions. Especially in Sweden, where the regulations concerning legal abortion are nearly the same as in Denmark, quite a number of such studies have been published. However, the results are difficult to interpret. Groups of women who had legal abortions are barely comparable to the groups whose applications were turned down. Furthermore, the pregnancy of many years ago disappears in the memories of the studied women along with later happenings and later pregnancies making it often very difficult to isolate the effect of the topical pregnancy. Rather often, the woman forgets that she applied for an abortion five or ten years previously.

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[39] Forssman & Thuwe, *A Social-Psychiatric Follow-Up Study on 120 Children Born After an Application for Legal Abortion Was Refused*, 14 NORDISK PSYKIATRISK TIDSSKRIFT 265-79 (1960).

[40] See note 25 *supra* and accompanying text.

In a follow-up study at Mothers Aid in Copenhagen,[41] 427 consecutive cases were studied. After five years, 180 women, who had had their applications for abortion turned down, were asked their opinion as to what effect the denial had on them. Those who were absolutely happy numbered 31; those who were only moderate in their satisfaction due to serious troubles in managing the child numbered 40; and another 40 were only moderately satisfied due to difficulties during the pregnancy. Only 29 were not able to make up their minds because their children had been placed in adoptive homes, nursing homes, or similar organizations. The number of mothers who affirmatively stated that they did not care for their babies and did not feel anything for them was only 13. Most of these women were psychopathic or mentally defective.

The study also included 126 women who had had a legal abortion performed. Five years later, 112 were absolutely happy, and 5 regretted the action. Nine had a more complicated point of view. Of 21 admitted illegal abortions, after five years, 16 were absolutely satisfied and 3 regretted the abortion. One had a more complicated point of view.

The conclusion was that about 80 per cent are satisfied in all groups, and around 20 per cent are dissatisfied. Those who were turned down, however, seemed to make certain reservations. It must be remembered also that the natural attachment to the child, even though unwanted originally, may overshadow later complications. Höök,[42] in Sweden, made a follow-up study seven and one-half to twelve years after 249 women had had their applications for legal abortions turned down. Twelve per cent had had an illegal abortion performed while 69 per cent stayed with their child and 40 per cent were pregnant again within three years. At the follow-up interview, 73 per cent were satisfied, while 27 per cent maintained that the pregnancy ought to have been interrupted. Only 22 per cent found that the refusal had been the right way out. Höök found more satisfied women among the psychologically normal women than among the psychologically deviating women. In 24 per cent of the cases, symptoms of mental insufficiency developed. It was concluded that women with neurotic conflicts generally ran a greater risk of developing "insufficiency-states" in connection with unwanted pregnancy than normal women.

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41 See HOFFMEYER, *supra* note 37.

42 Höök, *Refused Abortion: A Follow-Up Study of 249 Women Whose Applications Were Refused by the National Board of Health in Sweden*, ACTA PSYCHIATRICA SCANDINAVICA SUPPLEMENTUM NO. 168 (1963).

Ekblad[43] made a follow-up study in Stockholm consisting of 479 women who had an abortion legally performed. At the follow-up date 64 per cent were absolutely satisfied, 10 per cent had found the procedure and operation disagreeable, 14 per cent had had slight self-reproaches, and 11 per cent had had severe self-reproaches. Only 1 per cent developed psychic insufficiency inhibiting their working capacity slightly. Many of the women contracted a new pregnancy very soon thereafter.

Much discussion has been brought about by a study by Amark and Arén[44] from Sweden. They examined 162 women who had a baby after having had an application for legal abortion accepted. The abortion had, for different reasons, not been performed — some were too long in their pregnancy, some withdrew their applications, and in some cases the surgeon refused to operate. Of this group, 142 kept their babies, with 21 per cent of these developing poor psychic health, and 37 per cent improving their psychic health at the follow-up date as compared to its state when they applied for the legal abortion. This study has been considered a convincing argument against the current abortion policy. It could, however, be doubted if this material is not comprised of women who are especially ambiguous in their wish for an abortion.

VII. CONCLUSION

The Danish abortion legislation is part and parcel of a general social legislation for the support of families, mothers, and their children. It has always been emphasized that abortion, first and foremost, was to be controlled by means of general, positive social and family policies. So far some goals have been reached, but there is still considerable work to be done with regard to the development of the Mothers Aid staff, especially in the area of the more complicated and time-consuming family services, family treatment, and the like.

It has been argued that society is willing to spend quite a large amount of money on staff to sort into "yes" or "no" groups the women applying for legal abortion. Society feels its conscience cleared when this is done as equitably as possible. However, it seems much more difficult to obtain government funds for monetary support of

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[43] Ekblad, *Induced Abortions on Psychiatric Grounds*, ACTA PSYCHIATRICA ET NEUROLOGICA SCANDINAVICA SUPPLEMENTUM 99 (1955).

[44] Arén & Amark, *The Prognosis of Granted But Not Performed Legal Abortions*, 54 SVENSKA LÄKARETIDNINGEN 3709 (1957).

the families and for staff for therapeutic and counselling activities. Thus, the administrative work seems to take precedence over the more constructive work.

The still high number of illegal abortions, the difficulties in interpretation of results from follow-up studies, and the results from the Forssman and Thuwe[45] study showing a preponderance of maladjusted children born by women whose applications for legal abortion were turned down, all point out the unreasonableness of preserving regulations which distinguish between positive and negative indications for legal abortions. Is it possible to realistically assess vaguely defined sociomedical "insufficiency-states" and to differentiate between cases with a serious and a light prognosis? Could one not operate a clear "social" or "welfare" provision as well? Or would it be possible to have no limitation at all? These questions are not easily answered. Experience has shown that it is possible to differentiate on medical grounds between sociomedical cases with a bad and a good prognosis. But the cost of performing this differentiation is high because of the time necessary to prepare the cases thoroughly.

"Social" and "welfare" provisions are often proposed. They could be based upon clearly defined criteria (*e.g.*, size of income, housing conditions, number of children). Such automatic limitations would never do justice to real-life situations; however, using more general definitions, such as "welfare," would make it necessary again to establish some committee or board with the authority to make decisions.

The problem with the use of social criteria is that doctors are not especially qualified to apply them and would certainly refrain from participating. The doctors prefer the sociomedical principles described above, since it is on medical grounds that doctors are able to make estimates. Furthermore, it is felt that unlimited abortions, or abortions on "social" grounds, would expose some women to a danger, namely, that they could be subjected to pressure from the husband, the fiancé, or other relatives. Moreover, the common, temporary mental depression of the first months of pregnancy certainly would induce some women to apply for an abortion which they later would regret.

Important also is the fact that as long as the indication for legal abortion is medically motivated, the collaboration of the whole medical profession can be preserved. If we leave the medical con-

[45] See note 39 *supra*.

text, many surgeons and gynecologists certainly would refrain from performing the operations.

In Denmark there is, for the time being, no tendency to change the current provisions. However, a very vivid discussion is occurring and large circles of the population are arguing that the granting of legal abortion ought to be more liberal. Research projects have been started and will soon be published. The government has established a broad committee studying the whole field of sex education in schools and for adults. It is hoped that better sex information, improved contraceptive instruction, new developments in contraceptive methods, and last, but not least, further development in social and family policy will reduce the need for more liberal abortion legislation.