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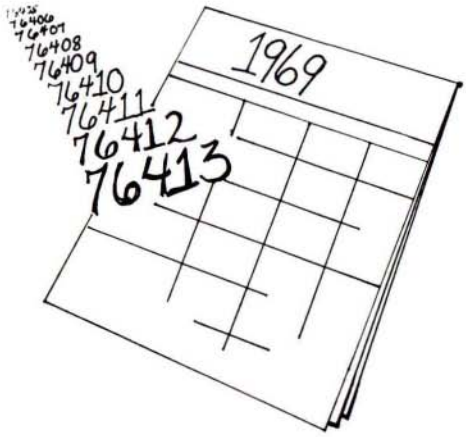
Dr. O'Sullivan traces the process leading to the passage of the 1968 British Abortion Act and the consequences of that act with a view to helping the American medical profession learn from the British experience.



The Effects of Legalized Abortion in England

J. Vincent O'Sullivan, MD, FRCS, FRCOG

This article discusses the effect that legalized abortion has had upon the people, and particularly the physicians, in England. Although New York State, among others, has now legalized abortion, it has not had sufficient experience with it to adequately assess its effects. But the English have had sufficient experience with it, and its effects there indicate that attempts to legalize abortion demand close watching.

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Abortion may be defined as the expulsion of the fetus before it is viable, that is, before it is capable of independent life. Prior to the legalization of abortion in England, no specific laws existed permitting abortion, but the operation was performed openly in government hospitals when certain medical conditions indicated it was necessary. These medical conditions included: Maternal heart failure; nephritis; carcinoma of breasts, uterus, or cervix; psychiatric disease; etc.

During the last decade, public sentiment in England began to demand a change in the abortion law for several social and medical reasons. First, proponents of abortion pointed to the social and economic ordeal that the unmarried mother has to endure. Until quite recently, she was regarded as a social outcast in most circles. More-

over, she has the responsibility not only of caring for her child, but also of finding time to work in order to support him. In addition, the children of unmarried mothers often present problems in later life. These children are reared without the discipline that a father would normally provide, and they must spend many hours without the direction of either father or mother, since the mother has to work. Moreover, many of these children are reared in a poor environment. These conditions greatly increase the probability of such children becoming juvenile delinquents.

Second, abortion proponents argued that, in the face of a population explosion, there is little sense in adding unwanted children to the growing number of wanted children, especially since there is an increased chance that unwanted children may require state aid at a later date.

Third, they argued that legalized abortion would abolish the practice of criminal abortions, which was reported to be rife. Pro-abortionists suggested that 100,000 to 500,000 criminal abortions were performed each year. The Royal College of Obstetricians and Gynaecologists (RCOG) stated that an estimate of 14,000 was nearer the truth.

Fourth, those in favor of abortion argued that a suitably timed and carefully performed abortion could reduce the medical risks involved in carrying and delivering a full-term, unwanted child.

These were the principal arguments advanced by the pro-abortionists in support of their position. They were countered by arguments against legalized abortion presented by those who opposed it. First, anti-abortionists pointed out that abortions were being performed legally when specified medical conditions indicated that such operations were necessary to maintain the health or life of the mother. They argued that if the medical indications for abortion were broadened, moral and medical dangers would follow.

Abortion opponents argued that the fetus has immediate individual rights from the time of conception and that the violation of these rights would

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destroy the basis for rational argument against such things as euthanasia and lead to the loss of respect for human life and to consequent moral collapse.

They pointed out that the Minister for Health and Social Security, in stating that over 5,000 abortions had been performed without a single death, failed to mention the 5,000 fetuses that were aborted, 80 per cent of whom would have reached adult life if they had not been killed by abortion. In addition, they noted that improved medical knowledge, techniques and facilities have raised the question of how valid the previously accepted definition of fetal viability (28 weeks) is. As science discovers ways of keeping alive fetuses delivered earlier than 28 weeks, the problem of determining viability will become more acute. Physicians who perform abortions may hold infants in their hands who they know could live if confined for a period of time in modern premature units.

Anti-abortionists argued that liberalized abortion laws would make it easy to obtain an abortion and, thus, invite sexual freedom. Such freedom, they said, presents a moral danger because it undermines the tradition of marriage, and a medical danger, because it facilitates the spread of venereal disease.

In rebutting the social and economic argument of the pro-abortionists, the anti-abortionists said that the unmarried mother's unenviable position could be improved, both financially and socially (as, indeed, it has been). In addition, they said that extermination of unwanted children is a rather primitive solution to the problems such children are likely to experience or present.

The anti-abortionists answered the argument about the population explosion by pointing out that there is one legal termination for every 16 births in England. They went on to say that in some countries, notably Yugoslavia and Hungary, there are more terminations than births, and Japan has expressed a fear for its future manpower if the incidence of abortion continues at its present rate.

In answering the medical argument, they said that abortion is undoubtedly more dangerous than normal delivery, if all aspects of the patient's condition are considered. Many abortions are followed by hemorrhage, sepsis, or sterility. In addition, some patients experience psychiatric trauma (guilt complex), leading, in a small percentage of cases, to suicide. Moreover, with the increased number of abortion admissions, the quality of care that abortion patients receive from medical attendants decreases. Some patients have actually been admitted in the morning, aborted at noon, and discharged in the afternoon. The later the abortion is performed, the higher the mortality figures. (In 25 per cent of all abortions that have been performed since the passage of the 1968 British Abortion Act, the pregnancies were terminated by hysterotomy. In this operation, some local damage is inevitable, and severe complications, such as rupture of the uterus or intestines, do occur.)

In hospitals where abortions are performed, routine gynecological work is disrupted. Once a patient and physician agree that an abortion can be performed, admission must be regarded as an emergency, particularly since the woman often presents herself to the doctor about the third month of pregnancy. Consequently, routine

gynecological admission, often involving cancer, must be delayed. In some hospitals, as many as 25 per cent of the gynecological beds are occupied by women who are scheduled to have abortions.

Finally, anti-abortionists pointed out that since the National Health Service (NHS) now provides free family planning services to all women, married or single, there should be little need for wholesale abortion – a crude, brutal, and costly form of contraception.

Learn from England

Despite all the arguments advanced by opponents of legalized abortion, a liberalized abortion law was enacted. It is appropriate for those in other countries, who are faced with the possibility of legalized abortion, to examine the method by which a legalized abortion bill was introduced, passed, and enacted into law.

Because the Labor Government in Britain was unwilling to adopt controversial legislation, a liberal party back-bencher, encouraged by the Abortion Law Reform Association, sponsored a Private Member's Bill which was designed to make it easier for women to obtain a legal therapeutic abortion.

Many Unacceptable Clauses

Since the medical profession in Great Britain favored abortion when the mother's life or physical or mental health were endangered, it felt that abortion under such circumstances should be legalized, rather than merely accepted. Consequently, it was content to let a legalized abortion bill be presented to Parliament. Unfortunately, many clauses that were wholly unacceptable to the majority of the medical profession were included in the bill. When it was passed, all of its clauses, including those to which the medical profession objected, became the law of the land.

The extent of the medical profession's opposition to the bill, as it stood, can be estimated by noting that 90 per cent of the members of the RCOG voted against it. In addition, of the 179 Fellows of the Royal College called together in Birmingham, 172 voted against the bill as submitted to Parliament.

The RCOG was consulted about the bill on several occasions. The president and secretary of the RCOG attended two or three meetings of the House of Commons and the RCOG Council submitted a report to Parliament. The RCOG recommended that the bill should include specific provisions about who should perform abortions and where such operations should take place. They recommended that a gynecologist, who had consultant appointment in the NHS, should perform the operation and that it should be done only in an NHS hospital, in order to avoid abuse. These recommendations were ignored. In fact, the bill was amended to require that the chief medical officer at the Department of Health be notified of the details of every legal abortion, only as the result of a special plea from the RCOG. This requirement at least makes it possible to obtain accurate statistics on abortion.

Despite medical opposition and a rather stormy passage through the various legislative stages, the bill finally became law on April 27, 1968. It is helpful to examine a precis of the 1968 British Abortion Act.

Essentially, the Act states that an abortion can be performed by a registered medical practitioner (type not specified), if two medical practitioners (also unspecified) are of the opinion that continuation of the pregnancy would involve greater risk to the life of the pregnant woman, to her physical or mental health, or to the physical or mental health of her children than would termination. It also specifies that an abortion can be performed if there is a substantial risk that the unborn child would suffer from physical or mental abnormalities.

The Act permits abortion to be performed in an NHS hospital or in a place approved by the Minister of State, providing that notification of termination is supplied within seven days of the operation. This "notification" amounts to nothing more than circling the appropriate indication on a form and sending the form, together with the signatures of two physicians, to the Minister of State. Anyone who refuses to participate in an abortion operation may be required to prove in a court of law that his reasons for refusing are legally acceptable.

What effects has this legislation had in England? The language of the Act allowed such loose interpretation that virtually no legal contraindication to abortion exists any longer. Any woman or her physician can make her condition "fit" the medical indications for abortion identified in the Act. **Figs. 1-5** illustrate the effect that this complete freedom has had upon the incidence of legal abortions in England. The figures indicate the size of the problem that the Act has created.

What people are included in this huge abortion statistic? Sixty per cent of the women who received abortions were between the ages of 20 and 34. Fifty-five per cent were single, that is, unmarried, widowed, or divorced. Only 6 per cent came from abroad. In more than 60 per cent of the cases, the abortion was performed in London.

FIGURE 1: No. of Abortions Reported in England and Wales in 1968 and 1969

	No.
1968	
2nd quarter	4,412
3rd quarter	7,939
4th quarter	9,905
1969	
1st quarter	11,342
2nd quarter	13,116
3rd quarter	13,871
4th quarter	15,828
Total	76,413

FIGURE 2: No. of Abortions Reported in England and Wales in 1968 and 1969, According to Medical Indication

Medical Indication	No.
Risk of injury to woman's physical or mental health	58,441
Risk of injury to woman's physical or mental health, with other grounds	11,678
Risk to life of woman	3,008
Substantial risk of child being born abnormal:	
Alone	1,990
With other grounds	1,213
In emergency, to save woman's life or prevent grave permanent injury	83
Total	76,413

FIGURE 3: No. of Abortions Reported in England and Wales in 1968 and 1969, According to Place

Place	No.	Per Cent
NHS hospitals	46,759	61
Approved private institutions	29,464*	39
Others	190	
Total	76,413	100

*Of this number, 26,954 were performed in the northwest metropolitan London area.

FIGURE 4: No. of Abortions Reported in England and Wales in 1968 and 1969, Performed for Women from Abroad

Country of Origin	No.
West Germany	1,076
USA	481
Canada	236
France	138
Holland	86
Others	248
Total	2,265

FIGURE 5: Percentage of Total Number of Abortions Reported in England and Wales in 1968 and 1969 Performed for Women from Abroad

All abortions	6%
Abortions performed in private institutions	15%

How can a woman go about getting an abortion? There are a number of ways. First, she may go to her family doctor and request an abortion. He gives her a supporting letter and refers her to a consultant gynecologist in his outpatient clinic at an NHS hospital. If the consultant agrees to perform the abortion, he adds the woman's name to his waiting list for urgent admission. Thus, the two doctors required by the Act to certify the need for an abortion are the woman's family doctor and the consultant gynecologist. Occasionally, they may seek further advice, usually from a psychiatrist. If the woman's family doctor, who sets the whole process in motion, is unsympathetic, she can always change doctors.

Second, a woman's family doctor can refer her to a hospital consultant in his private office. This consultant can then arrange to have the woman admitted to a general or private hospital.

Third, in London and Birmingham, a woman may go to a pregnancy advisory service, which is usually staffed by doctors who have liberal attitudes toward abortion. For a fee, they will tell her the best way to obtain a legal abortion and, if necessary, give her a supporting letter. Ninety-seven per cent of the women referred from the Birmingham clinic in the first year of the Act had their pregnancies terminated privately. Recently, a 20-bed nursing home has been opened in Birmingham for the sole purpose of performing abortions privately.

Fourth, a woman may go to a doctor who has a reputation of performing abortions for money. He requires a cash payment of 150 or 200 pounds before the operation. He arranges to have the termination certificate signed by a colleague (who also probably receives a cash payment) and to have the woman admitted to an approved private nursing home.

Fifth, a woman may go to an unqualified practitioner and have a criminal abortion.

Conscience Clause

Many non-Catholic, as well as Catholic, doctors avoid performing abortions "on demand," both in NHS hospitals and privately. The Act contains a conscience clause, but, as previously noted, those who have conscientious objections to abortion may have to prove that their objections are valid under the law. They may even be required to prove this in a court of law, despite the fact that abortion is in direct opposition to their medical training and to the principles of the Hippocratic Oath.

The conscience clause gave all Catholic doctors and other kinds of health care personnel a perfect opportunity to refuse to participate in or aid an abortion operation in any way. Unfortunately, many Catholics have attempted to cooperate "so far and no further," and this has led to all sorts of moral discussions which, in many cases, have complicated the conscience clause. In effect, the law says that if a Catholic doctor (or any Catholic health care personnel) performs or participates in one abortion, he can no longer invoke the conscience clause.

It should not be assumed that the abortion dilemma involves only obstetricians and gynecologists. General practitioners, anesthetists, and, indeed, most members of the health care profession are also involved. For example, an anesthetist may take the

view that he does not actively participate in an abortion and that he is present at the operation only to relieve the pain that results from the surgery. Thus, he reasons, he can participate. Of course, this argument is fallacious; very few abortions would be performed if there was no anesthetist to relieve the pain caused by the operation. In addition, an anesthetist frequently gives an injection of Ergot I.V., which helps to expel the fetus. He also frequently sets up I.V. blood transfusions to treat hemorrhage. To a less degree, the theatre nursing staff also helps in the abortion operation. Thus, the anesthetist, theatre nursing staff, surgeon, and his assistants are all integral parts of the surgical team performing the abortion.

Young doctors in England, particularly obstetricians, who refuse to assist at abortions, have found that their refusal severely affects their career prospects. Doctors who do perform abortions find that they are not allowed to exercise clinical or selective judgment, that they are forced to perform operations – often, late, and dangerous – for which there are no medical grounds. In some places, hysterotomy makes up almost 25 per cent of doctors' cases.

Because the Act did not specify that the surgeon performing the abortion had to be an NHS consultant and that the surgery had to be performed in an NHS hospital, it opened the way for racketeering. With the pregnant woman eager for complete anonymity and a brief stay in the hospital, not to mention the number of foreign women who want an abortion but who are not eligible for NHS services, there is no shortage of demand. The racketeering that has resulted, while freeing the mass of doctors from the painful decisions raised by abortion on demand, is bringing the entire medical profession into increasing disrepute.

Of the 76,413 abortions performed last year, 40 per cent were done in private hospitals, clinics, or nursing homes. Over 90 per cent of the abortions that were performed were done in the northwest metropolitan area of London, primarily around Harley Street. The fortunes being made by those doctors busily involved in the abortion market, most of whom have no specialist training, are immense.

These, then, are the effects that the 1968 British Abortion Act has had on the people and physicians of England. Any country that is contemplating changing its current abortion laws should carefully study the British law's omissions and mistakes.

In conclusion, I would like to quote Professor Ian Morris of St. Mary's Hospital for Woman and Children, Manchester. Together with many other responsible non-Catholic obstetricians, he is utterly opposed to abortion on demand. He says:

> "The whole operation is a horrible distasteful duty. If I were beginning my medical career knowing what I know now about abortions, I would never choose gynecology.
>
> "I detest the operation. It is a complete reversal of all my medical training. The whole aim is to save life, not perform this particular form of homicide.
>
> "I can never look at the tissues I have removed during the termination of a pregnancy without revulsion. It may be a jelly, but it is, after all, a human life that I am destroying."