The Physical and Psycho-Social effects of Abortion on Women

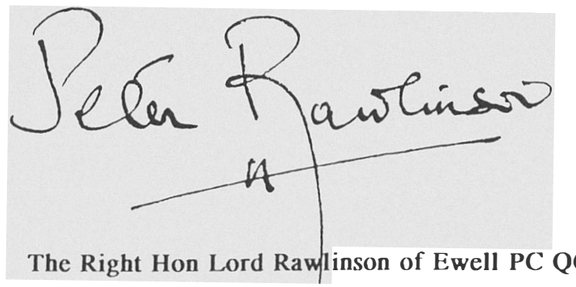
A Report by the Commission of Inquiry into the Operation and Consequences of The Abortion Act

JUNE 1994

CONTENTS

Abortion is an important issue that generates much debate and discussion and touches the lives, either directly or indirectly, of many thousands of people. This first Report of the private Commission of Inquiry, which I have had the privilege of chairing, has not set out to look at, or make a statement on, the ethics of abortion itself, but instead to investigate the effects of abortion on those directly involved - the women. Thus the Commission has invited written and oral evidence on this subject from a wide range of experts who have differing views and experiences of the abortion debate. This report is the summary of our findings from the past two years research. I very much hope that it will also highlight the urgent need for further comprehensive, balanced and long-term research to be carried out into this particular aspect of abortion.

It has been a great privilege to Chair this Commission and to work alongside those who have served on it. My thanks and appreciation goes to each one for giving so generously of their time, wisdom and resources. I would also like to thank the Secretariat of the Commission, without whose hard work the report could neither have been researched or written. I am particularly grateful to Dr Stephanie Smith (nee Lewis) who began as Secretary and who spent nearly a year organising the hearing and collecting of evidence, and also to Mrs Philippa Taylor who continued with this research and organisation throughout the following year.



The Right Hon Lord Rawlinson of Ewell PC QC

INTRODUCTION

1. The 1967 Abortion Act decriminalised abortion for a number of specified medical grounds. In the 27 years since then there have been over four million abortions performed in Great Britain on these grounds. Thus there has been ample opportunity to acquire data on the effects of abortion on the lives of individuals and on society as a whole.

2. A number of individuals including MPs, gynaecologists, general practitioners and others, have been concerned to ensure that this evidence is not neglected and that areas where research might provide information that is lacking should be highlighted. Accordingly, a private Commission was established in November 1992 under the chairmanship of Lord Rawlinson of Ewell to inquire into the operation and consequences of the Abortion Act.

3. A list of the members of this Commission is given in Annex 1.

4. The Commission's remit is to act in a manner similar to a Parliamentary Select Committee. Specifically, to investigate various aspects of abortion by soliciting evidence, written and oral, from experts representing a wide spectrum of opinion. Reports, of which this is the first, will be produced for each aspect considered.

5. The Commission chose as its initial task to investigate the incidence of physical and psycho-social effects of abortion on women. This report does not look at the ethics of abortion itself, but limits itself to the effects of abortion felt directly by women.

6. A number of experts and organisations were invited to give written and/or oral evidence. These are listed in Annex 2, together with those who actually attended. The oral evidence was transcribed verbatim. Each expert witness has had an opportunity to see the transcript of his/her evidence in order to confirm its accuracy and/or to make corrections and additional comments. A number of the witnesses also submitted written evidence and/or references to published materials. These references are listed in Annex 3.

7. The Commission invited any women who had had an abortion to write to the Commission.[1] They were then offered the opportunity to complete a questionnaire (see Annex 4) and/or to give oral evidence. In all nearly 200 women responded, requesting a questionnaire and/or sending information. 136 women completed the questionnaire with 87 being willing to give oral evidence. The summarised responses from the questionnaires are contained in Annex 5. Nine women were invited to give oral evidence of their experiences to a sub-group of the Commission and their responses are contained in Annex 6. The Commission wished to ensure that the evidence it received included as wide a range of experience as possible, both good and bad. Thus it deliberately avoided wording the invitation in a way that might encourage only women who had had a bad experience or alternatively only those who had had a good experience from responding.

8. However, the group of women responding were inevitably self-selected and therefore are more likely to have had an experience significant enough to share it, whether good or bad. Compared with similar self-selected surveys the numbers responding were high, particularly given the sensitivity of the subject. The profile of respondents is similar to that of the abortion population (for example, in terms of age, marital status, period of gestation, NHS and private abortions) showing no more than a 10% difference from the equivalent OPCS legal abortion figures for 1992. While this is not a fully representative sample of all women who undergo abortion, the anecdotal evidence obtained is of value since it is the actual experience of this group of women.

9. After hearing from the majority of witnesses the Commission also wrote to the Department of Health. While the Department of Health did not feel it appropriate to give oral evidence it did agree to respond to specific questions which had arisen as a result of the expert evidence to that point.

[1] An advert was placed in two women's magazines in general circulation (SHE and Good Housekeeping) stating that Lord Rawlinson was chairing a private Commission of Inquiry to look at the impact of abortion on individual women. The advert invited anyone who had had an abortion, and was willing to share their experience on a confidential basis, to contact the Secretary of the Commission.

OVERVIEW

10. There is a growing divergence of opinion in the medical profession about the occurrence and incidence of adverse effects following abortion. Many gynaecologists, psychiatrists, and other experts assert that there is no evidence to support the idea that there is widespread suffering – either physically or mentally – following abortion.[2] However, other research has yielded evidence of both physical and psychological adverse affects.[3]

PHYSICAL CONSEQUENCES OF ABORTION

11. Mortality rates for women from abortion and post-delivery are both small – 1/100,000 and 3/100,000 respectively, according to Dr Alan Rogers.[4] Avoiding a potential maternal death is, however, rarely the reason for performing an abortion. In his paper[5], Dr Michael Jarmulowicz stated that of all the abortions which have been performed in the UK since the introduction of the 1967 Abortion Act, only 151 (0.004%) of these were done in order to save the life of the mother.

12. Dr Rogers suggested that in the last twenty years the ability of the profession to offer safe abortions has improved greatly and that unsafe abortion is a thing of the past. He quoted from an interim report by the Royal College of Obstetricians and Gynaecologists in 1984 (see para 21) which stated that even late abortions could be considered safe as far as major hazards to life of the mother were concerned.

13. Apart from life threatening circumstances, various post-abortion physical complications are possible which may have effects upon a woman's life that could be far-reaching and even permanent in some cases. Early complications may include perforation of the uterus, cervical laceration, haemorrhage and intrauterine sepsis and retained placenta in second trimester abortions. Complications which may manifest later include post-abortion tubal blockage or salpingitis, cervical incompetence, rhesus isoimmunization, endometriosis, choriocarcinoma and menstrual disturbances.[6]

14. Dr Rogers claimed that post-abortion physical complications were extremely rare. None of the patients for whom he had done repeat abortions had suffered from cervical incompetence or uterus damage as a result of the previous abortion(s). It must be noted, however, that Dr Rogers was unaware of the continuing reproductive history of most of the patients on whom he performed abortions (see para below, para 41 and para 79).

15. However, Mr Robert Balfour described a number of recent cases which he had treated in which he had been required to attempt to repair damage to the uterus or cervix caused by the abortion procedure. It is evident that complications do still occur as a result of surgical errors.

16. Mr Balfour stated that the majority of complications which he had seen had occurred more than 7 days after the abortion. Seven days is the time given for returning information on complications using the statutory 'yellow' abortion notification form. Additionally, a woman may have an abortion at a clinic outside her home area and so will have returned home by the time a complication occurs unless it is very immediate. If she is seen by her local GP and referred to the local hospital the abortion clinic may not be notified and so will not know of any complication. Thus it is likely that the complication rate is under-reported. Mr Balfour suggested that there might be up to 10% more cases which are recognised but go un-reported.

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[2] eg. BREWER, C. 1977 Incidence of post-abortion psychosis: a prospective study *British Medical Journal 1 476–7*; ROMANS-CLARKSON, S. E. 1989 Psychological sequelae of induced abortion *Australian and New Zealand Journal of Psychiatry 23 555–65*; Clinical Reviews – Psychiatry: Mental health after abortion *Medical Monitor (12 June 1992) 44–45,47*

[3] JARMULOWICZ, M. 1992 Physical and psychological effects of abortion: A review of the medical literature *(Written submission to the Commission)*; McCALL, K. & WILSON, W. P. 1987 Ritual mourning for unresolved grief after abortion *Southern Medical Journal 80 (7) 817–21*; NEY, P.G. & WICKETT, A.D. 1989 Mental health and abortion: Review and analysis *Psychiatric Journal of the University of Ottawa 14 (4) 506–16*

[4] We note actual figures of a total maternal mortality rate of 8/100,000 in the UK *(Guardian Fact File 23rd September 1993)*.

[5] JARMULOWICZ, M. 1992 Physical and psychological effects of abortion: A review of the medical literature *(Written submission to the Commission)*

[6] BRUDENELL, M 1980 Gynaecological sequelae of induced abortion *The Practitioner 224 893–8*

17. The Department of Health, in its response to the Commission, stated that after 7 days only 51% of notification forms were returned and even after 28 days the return rate was only 92%. This introduces another possible source of under-reporting of complications. The Department stated that it will be investigating the poor return rate.

18. It is also unlikely that women who have experienced complications will return to the clinic at which they had the abortion. Dr Blacker reported that the raw data from a very recent study that he had performed showed that the women in this study did not attend their GP in the follow-up period. He told the Commission that the results of this and Dr Gabriella Zolese's[7] recent study (not yet published) suggest that most women stay away from medical services after abortion. Consequently, even if there were more complications than Dr Rogers believes, it is unlikely that he, and others in a similar position will see them. Studies such as Dr Blacker's and Dr Zolese's are called prospective studies. Women are recruited to the study before the abortion and followed up after it. Thus the results are collected as they occur. Many previous studies have been retrospective, that is, women are recruited after the abortion and asked to recall the emotional and physical consequences of it. As academic research, these studies are less reliable as they depend on the memories of the experience, which may be subjective, rather than recording the experiences as they occur.

19. Dr Jarmulowicz quoted a number of publications in which the incidence of early and long term complications was reported. Perforation of the uterus was considered the most likely early complication with figures of 0.1–0.3% to 2% being quoted, with later abortions having the highest rates. Long term complications for which figures were quoted included effects on subsequent pregnancy such as an increased risk of miscarriage – 4% of the women in a UK study reported at a Ciba Foundation Symposium (1985)[8] were likely to miscarry as a result of the effects of a previous abortion.[9] Evidence was also received of post-abortion chlamydia associated pelvic inflammatory disease which leads to a further risk of spontaneous miscarriage, ectopic pregnancy, endometriosis, hysterectomy and other fertility related disorders.[10]

20. Professor Wendy Savage reported that at the clinic which she runs women are informed before the abortion of the complications which are possible. After the abortion they are told to return to their GP for a follow-up visit in 2 weeks time – although, it seems, a woman's GP will not be informed by the clinic of any complications or infections. Professor Savage remarked that follow-up visits were often missed. The Commission sought clarification of this subsequent to Professor Savage giving oral evidence and in reply she suggested that, in an area such as the one in which she works, many of the women are poor and do not have access to travel facilities, etc. and may have considerable difficulty in being able to get to the doctor or clinic. If they are feeling well they may not see any need to return for a follow-up visit.

21. It was clear from a number of witnesses[11] and from the published surveys that follow-up rates are always low. Even in the Royal College of General Practitioners (RCGP)/Royal College of Obstetricians and Gynaecologists (RCOG) survey[12] which Dr Peter Frank reported on to the Commission, more than 60% of all the women surveyed were lost to follow-up.[13] This may

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Dr Zolese (MRCPsych) is a lecturer and honorary Senior Registrar in the Department of Psychological Medicine at St Bartholomews Hospital in London

[8] Ciba Foundation Symposium 1985 115: Pitman, London

[9] Oral evidence and submitted paper JARMULOWICZ, M. 1992 Physical and psychological effects of abortion: A review of the medical literature *(Written submission to the Commission)*

[10] BUCHAN, H., VESSEY, M., GOLDACRE, M. & FAIRWEATHER, J. 1993 Morbidity following pelvic inflammatory disease *British Journal of Obstetrics and Gynaecology* 100 558–62; BLACKWELL, A.L., THOMAS, P.D., WAREHAM, K. & EMERY, S.J. 1993 Health gains from screening for infection of the lower genital tract in women attending for termination of pregnancy *The Lancet* 342 206–10

[11] Dr Jarmulowicz, Mr Balfour, Dr Blacker

[12] The Manchester Research Unit of the Royal College of General Practitioners has co-ordinated a large, long-term, joint study with the Royal College of Obstetricians and Gynaecologists, on the effects of induced abortion on women's health. The study was carried out between 1976 – 1987 and a number of papers have been published on the findings (see Annex 3).

[13] There are a number of other concerns about the representative nature of the RCGP/RCOG survey (see para 29).

indicate that there is a more universal cause than poverty or lack of suitable facilities to ease return visits since by no means all women who have abortions have low incomes or live in areas with poor public facilities.

22. Professor Robert Winston, an experienced expert in infertility treatment, stated that tubal damage was one of the main causes of ectopic pregnancy. His own practice is heavily biased towards tubally damaged patients. He admitted that in the past he had considered that abortion played a significant part in the pathology of infertility caused by tubal damage. However, from other published data he now feels less certain that abortion *does* cause any greater incidence of infertility than giving birth which also carries a risk of intrauterine damage and infection. Professor Winston did not provide the Commission with any data, for which he was asked a number of times, on the rate of patients who receive infertility treatment following induced abortion as opposed to post-natal care. The recently published results of the RCGP/RCOG prospective study on abortion also failed to find that a previous abortion significantly inhibited fertility.[14]

23. However, not all cases of infertility resulting from abortion may be reported. Dr Jarmulowicz related the story of a woman he knew who, despite having for many years suffered pain and being infertile following an abortion, would not attend an infertility clinic. Thus the incidence of infertility following a previous abortion may be under-reported if women suffering in this way fail to attend an infertility clinic due to psychological or emotional reasons.

24. It was clear from the evidence received by the Commission that chlamydia associated tubal infections can be caused by abortions – especially where a low-grade infection from chlamydia was present previously.[15] When an abortion results in tubal infections that would otherwise not have occurred there must, by implication, be an increased risk of infertility. This connection was also made by the authors of a number of published clinical studies.[16] This will be significant for the individual women concerned even if the surveys of large numbers of women, as quoted by Professor Winston, indicate that for the population of women seeking infertility treatment as a whole, abortion is not a significant factor.

25. There have been a number of recent surveys in which the occurrence of chlamydia infection prior to an abortion is clearly linked to subsequent pelvic inflammatory disease. The authors' conclusions in each case was that screening and/or prophylactic treatment for chlamydia infection should be administered prior to an abortion in order to reduce the incidence of chlamydia associated pelvic inflammatory disease and such serious gynaecological consequences as ectopic pregnancies and infertility.[17] In one study[18] potential short term cost savings were calculated to be £6.50 per patient if chlamydia screening and prophylaxis were introduced, which would both reduce the costs of treating an incident of pelvic inflammatory disease and, consequently, the cost of abortion to the NHS.[19]

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[14] FRANK, P., McNAMEE, R., HANNAFORD, P.C., KAY, C.R. and HIRSCH, S. 1993 The effect of induced abortion on subsequent fertility *British Journal of Obstetrics and Gynaecology 100 575–80*

[15] JARMULOWICZ, M. 1992 Physical and psychological effects of abortion: A review of the medical literature *(Written submission to the Commission)*

[16] SOUTHGATE,L., TREHARNE, J. & WILLIAMS R. 1989 Detection, treatment and follow up of women with Chlamydia trachomatis infection seeking abortion in inner city general practices *British Medical Journal 299 1137–8*; WOOD, S.M. & MUSCAT, I. 1989 Screening and treatment to prevent post-abortion chlamydial pelvic infection *The Lancet 928*; COHN, M. & STEWART, M. 1989 Post-abortion chlamydial pelvic infection *The Lancet 1219*; CATES, W, ROLFS, R.T. & ARAL, S.O. 1990 Sexually transmitted diseases, pelvic inflammatory disease, and infertility: an epidemiologic update *Epidemiological Review* 12 199–220; BLACKWELL, A.L., THOMAS, P.D., WAREHAM, K. & EMERY, S.J. 1993 Health gains from screening for infection of the lower genital tract in women attending for termination of pregnancy *The Lancet* 342 206-10

[17] DUTHIE, S.J., HOBSON, D., TAIT, I.A., PRATT, B.C., LOWE, N., SEQUEIRA, P.J.L. & HARGREAVES,C. 1987 Morbidity after termination of pregnancy in first trimester *Genitourinary Medicine* 63 182–7; BUCHAN, H., VESSEY, M., GOLDACRE, M. & FAIRWEATHER, J. 1993 Morbidity following pelvic inflammatory disease *British Journal of Obstetrics and Gynaecology* 100 558–62; BLACKWELL, A.L., THOMAS, P.D., WAREHAM, K. & EMERY, S.J. 1993 Health gains from screening for infection of the lower genital tract in women attending for termination of pregnancy *The Lancet* 342 206–10

[18] BLACKWELL, A.L., THOMAS, P.D., WAREHAM, K. & EMERY, S.J. 1993 Health gains from screening for infection of the lower genital tract in women attending for termination of pregnancy *The Lancet* 342 206–10

[19] Another recent report estimated that genital and associated chlamydial infections and their sequelae cost Britain at least £50 million a year for diagnosis and management. TAYLOR-ROBINSON, Prof. David 1994 Chlamydia trachomatis and sexually transmitted disease *British Medical Journal* 308 150–1

26. Professor Wendy Savage agreed with a question from the Commission that it is good clinical practice to screen women for chlamydial infections and treat them prior to abortion – especially in the case of younger women. She stated that she thought screening of young women prior to abortion should be required by the Department of Health as part of a good quality service.

PSYCHOLOGICAL CONSEQUENCES OF ABORTION

27. There is a divergence of opinion amongst the medical profession about the incidence and severity of any psychological effects of abortion. The popular consensus seems to be that abortions have few adverse psychological consequences.[20] However, there is conflicting evidence from a number of surveys and from anecdotal accounts of individual women's experience that adverse effects do occur for at least some women.[21]

28. This divergence of opinion may be the result of, or at least compounded by, deficiencies in methodology, insufficient length of follow-up of clinical studies[22] and bias in non-systematic literature reviews.[23]

29. In the UK, the recent RCGP/RCOG prospective study was probably the largest of this kind. However, there are a number of limitations to it which are likely to have affected the results obtained. The most significant limitation is that it only included those women who had obtained an abortion by GP referral. The other 30% of women in the UK who go directly to private clinics without referral were not part of the study. The effect of this was that, for a number of factors, the women in the study were not representative of all women who have abortions. For instance, 73% of the women in the survey had an NHS abortion compared to 46% of all women who had an abortion[24]; 18.4% of the women in the study, 9.9% of the controls and 15.2% of all aborting women were over 35 years old[25]; 47.4% of women in the study, 32.3% of controls were single compared to the national figure for all aborting women of 50.4%.[26] Thus it is unlikely that the results of this survey accurately reflect the situation for all women who have an abortion. On questioning, Dr Frank, from the RCGP, agreed that the experiences of women who went directly to clinics might have significantly altered the results of the study. In addition, a very limited number of parameters were monitored in this survey. Other physical consequences of abortion which have been reported elsewhere include the incidence of ectopic pregnancies, miscarriages, hysterectomies and maternal deaths. These were not studied. Neither were a number of psychological effects such as anger, child abuse and insomnia which have also been reported as a result of abortion. A further limitation of this study was the high drop-out rate (see para 47).

30. According to a prospective study carried out by Dr Colin Brewer in 1975 the incidence of serious mental disturbance, necessitating hospitalisation, was low either

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[20] eg. BREWER, C. 1977 Incidence of post-abortion psychosis: a prospective study *British Medical Journal 1 476–7*; GIBBONS, M. 1984 Psychiatric sequelae of induced abortion *Journal of the Royal College of General Practitioners 34 146–50*; ROMANS-CLARKSON, S.E. 1989 Psychological sequelae of induced abortion *Australian and New Zealand Journal of Psychiatry 23 555–565*; ROSENFELD, J. 1992 Emotional responses to therapeutic abortion *American Family Physician 45 (1) 137–40*

[21] eg. McALL, K. & WILSON, W.P. 1987 Ritual mourning for unresolved grief after abortion *Southern Medical Journal 80 (7) 817–21*; NEY, P.G. & WICKETT, A. 1989 Mental health and abortion: review and analysis *Psychiatric Journal of the University of Ottawa 14 506–16*; SPECKHARD, A.C. & RUE, V.M. 1992 Post-abortion syndrome: An emerging public health concern *Journal of Social Issues 48 (3) 95–119*; JARMULOWICZ, M. 1992 Physical and psychological effects of abortion: A review of the medical literature *(Written submission to the Commission)*; REARDON, D.C. 1987 Aborted Women – Silent no more *Westchester, Illinois; Crossways Books*

[22] GIBBONS, M. 1984 Psychiatric sequelae of induced abortion *Journal of the Royal College of General Practitioners 34 146–50*; ZOLESE, G. & BLACKER, C.V.R. The psychological complications of therapeutic abortion *British Journal of Psychiatry 162 742–49*

[23] LARIMORE, W.L., LARSON, D.B. & SHERRILL, K.A. 1992 Interpreting literature on abortion *American Family Physician 46 (3) 666–7*

[24] CRAFT, I., EVANS, D. & YOVICH, J. 1979 Consequences of induced abortion *The Lancet* 437

[25] KAY, C.R.& FRANK, P.I. 1981 Characteristics of women recruited to a long-term study of the sequelae of induced abortion *Journal of the Royal College of General Practitioners* 31 473–77

[26] KAY, C.R.& FRANK, P.I. 1981 Characteristics of women recruited to a long-term study of the sequelae of induced abortion *Journal of the Royal College of General Practitioners* 31 473–77

Table 1 First psychiatric admissions and admission rates among aborting and delivering women in Denmark within three months after abortion or delivery in 1975 and among all Danish women for three months during 1974/75 by age groups

Age groups	Aborting women			Delivering women			Other women aged 15 to 49[a]		
	Total no.	Psychiatric admissions	Rate per 10000	Total no.	Psychiatric admissions	Rate per 10000	Total[b] no.	Psychiatric admissions	Rate per 10000
–19	4375	5	11.4	4812	3	6.2	180465	354	4.9
20–24	5820	11	18.9	24808	26	10.5	184911	503	6.8
25–29	6303	13	20.6	27150	31	11.4	207885	585	7.0
30–34	5504	14	25.4	11452	19	16.6	166970	601	9.0
35–39	3532	6	17.0	2675	7	26.2	145618	549	9.4
40–44	1565	–	–	460	–	–	138338	414	7.5
45–49	135	1	74.1	21	–	–	145632	487	8.4
Total	27234	50	18.4	71378	86	12.0	1169819	3493	7.5

[a] Same age groups except none under age 15.
[b] By 1 January 1975 (Sundhedsstyrelsen 1978).
[c] Total annual admissions adjusted for three-month period.

DAVID, H.P. 1985 Post-abortion and post-partum psychiatric hospitalization *Abortion: Medical Progress and Social Implications* Pitman, London (Ciba Foundation Symposium 115) 150–64

post-abortion (0.3/1000) or post-delivery (1.7/1000).[27] The results of a Danish study performed over the same time period of three months, although also showing a low incidence of hospitalisation, differed in that hospitalisation was higher post-abortion (1.84/1000) than post-delivery (1.2/1000).[28]

31. Dr Brewer's study was the first of its kind in the UK to attempt to study prospectively the effects of abortion on a large sample of women. However, there were severe limitations to the design of the study; eg. only 25% of the consultants in the region were included, and some of the consultants' catchment areas overlapped so that the population covered could only be estimated and the number of abortions performed was not accurately recorded but was calculated from the estimated figure for the population covered and by reference to the regional rate at the time.[29] The design of the Danish study was able to eliminate these difficulties and looked at a much larger sample – the total female population of Denmark. Since all women who underwent abortions were included, all bias, intentional and unintentional, was eliminated. Thus the results of the Danish study may be considered more reliable than those of the UK survey.

32. Both surveys indicate that the rate of hospitalisation within three months for mental disorder is low. However this should not obscure the fact that, given the rate of abortion in the UK at about 180,000 per year there will be a predicted 45 – 325 (dependent on which set of figures are used to estimate the incidence) new cases of post-abortion psychosis per year.

33. Other psychological effects of abortion, although significant, may not be severe enough to necessitate hospitalisation. Dr Blacker reported an incidence of short to medium term psychiatric effects of approximately 10% both from his literature review[30] and from the raw data of a recently completed prospective study (see para 18).

34. It would appear that the most common initial reaction to an abortion is one of relief. The finding that high rates of distress at presentation were followed by a rapid improvement once abortion takes place was described by Dr Blacker as common to a number of previous studies as well as his own. This was also reported by Dr Margaret Oates. Dr Blacker told the Commission, however, that in the recent prospective

[27] BREWER, C. 1977 Incidence of post-abortion psychosis: a prospective study *British Medical Journal 1 476–7*

[28] DAVID, H.P. 1985 Post-abortion and post-partum psychiatric hospitalization *Abortion: Medical Progress and Social Implications* Pitman, London (Ciba Foundation Symposium 115) 150–64

[29] BISHOP, S.1992 A study of post abortion syndrome in the light of recent research to consider how social work might better respond to this area of need *Dissertation for Master of Social Work, University of York*

[30] ZOLESE, G. & BLACKER, C.V.R. 1992 The psychological complications of therapeutic abortion *British Journal of Psychiatry 160 742–9*

study by Dr Zolese and himself (see para 18), at 4 weeks after the abortion, of the 18% of women who were psychiatrically unwell 25% were new cases. In addition, Dr Blacker told the Commission that anecdotal evidence from clinical practice points towards long-term adverse psychological sequelae following abortion developing some time after the abortion rather than straight away. Thus, the appearance of these new cases may be evidence of long-term sequelae developing.

35. Ms Joanna Thompson, an experienced post-abortion counsellor from CCFL (Christians Caring For Life) stated that relief is often the predominant emotion following an abortion until the time when the baby should have been born. At this time regret, depression, guilt, etc. may occur. Dr Blacker reported that in the prospective study conducted by Dr Zolese and himself (see para 18) the original intention was to follow-up at the time the birth would have occurred. However, the attrition rate was so high that the study was not continued longer than 6 months after the abortion. Thus, the incidence of adverse psychological effects at the time at which the baby would have been born was not assessed.

36. Dr Rogers told the Commission that it was his opinion that the sadness that some women experience following abortion is natural but that he saw psychological complications following abortion very rarely. He attributes the majority of distress seen following abortion as being caused by society's attitude to abortion and by the social circumstances the woman is in, which may have been the reason she had an abortion in the first place.

37. Both Dr Rogers and Dr Brewer suggested that offering post-abortion counselling may create problems for women by implying that they *should* be experiencing some adverse emotional or psychological effects.

38. However, amongst the case histories collected from individual women there were a number who were performing normally within society prior to having an abortion and had no expectation of experiencing adverse consequences. Indeed, a number described their distress at not having been warned that adverse effects such as depression, etc. might occur. In addition, in some of the cases no difficulty was experienced until years after the abortion, when some event triggered a significant adverse reaction.[31] For them it was not an offer of counselling that created or precipitated their problems.

39. Although it is clear that the women who responded to the Commission are not necessarily a representative sample of all women who have undergone an abortion (see para 7 and 8), it was evident that at least some women do experience long-term adverse emotional consequences. An analysis of the questionnaires showed that 87% of the women experienced long-term emotional consequences, and 20 women actually requested counselling.

40. The Commission were surprised by Dr Rogers' claim that in the twenty years in which he had been carrying out abortions, during which time he has carried out in excess of 100,000 abortions, he had never seen a woman who had suffered ill-effects.

41. He acknowledged, however, that there is little follow-up of patients from his clinic thus it seems unlikely that the clinic staff would see any adverse effects other than those which were very immediate. Dr Rogers stated that it is expected that women will inform their own GP of their abortion. Indeed, a pre-requisite for performing abortions on a day-care basis is that the women's GPs be informed. However, in order to respect the confidentiality of the patient, Dr Rogers' clinic has no formal connection with a woman's GP. Thus there is no way of ensuring that the woman contacts her GP before or after the abortion.

42. A number of the witnesses, including Dr Blacker and those representing CCFL and BVA (British Victims of Abortion), stated that it was very unlikely that women who had experienced adverse psychological effects from abortion would return to the clinic where they had had the abortion or to the GP that referred them. Indeed both Dr Brewer and Dr Rogers also agreed that this would not be surprising. In the RCGP/RCOG study a larger number of women having abortions, 66%, dropped out of the study than of those continuing to term, 58%.[32] This was attributed to the group having abortions being more mobile. Dr Frank agreed that it would not be surprising if those women experiencing

[31] eg Summary of written and oral evidence from *Alice* (Annex 6)

[32] FRANK, P., McNAMEE, R., HANNAFORD, P.C., KAY, C.R. and HIRSCH, S. 1991 The effect of induced abortion on subsequent pregnancy outcome *British Journal of Obstetrics and Gynaecology 98 1015–24*

adverse effects after an abortion would change their GP in order to avoid returning to the GP who referred them. Furthermore, we note that Dr Roger's clinic, in common with other Marie Stopes clinics, currently charges £25 for post-abortion counselling, after the first session. It is also possible that a woman may go to her GP for a variety of unrelated minor illnesses and/or depression, which may have been precipitated by the abortion, but not realise the link.[33]

43. Dr Blacker reported that the results of his recent study and of Dr Zolese's recent prospective study suggest that most women stay away from medical services after abortion (see para 18). Thus the approximately 17,000 new cases of psychiatric disturbances which might be expected per year from the conservative estimate of an incidence of 10%, given by Dr Brewer, must either resolve spontaneously, or through independent counselling, or the women must suffer in silence. In her evidence, Ms Jane Airey from BVA stated that many of the women counselled by that organisation are indeed suffering in silence because no-one has recognised that they are suffering as a result of a previous abortion. She stated that there is a classic pattern of symptoms which is seen in many women suffering following abortion.

44. It may be that women are more likely to attend an independent counselling organisation such as LIFE, BVA or CCFL which would not be seen as associated with the medical profession. LIFE received many thousands of requests for help in 1992 – including situations where pregnancy was the result of rape, incest or abuse; where the child might have been handicapped and where girls who were under 16 were pregnant. It was clear from the evidence that Ms Thompson gave to the Commission that CCFL see an increasing number of clients in this position. Although the numbers they and BVA see in a year for post abortion counselling are still small compared to the predicted number of cases, they are increasing.[34]

45. In contrast to Dr Rogers' experience, at the beginning of March 1976, a symposium was held at Westminster Hospital on investigations into 1,000 attempted suicides which had occurred in the hospital attachment area during 12 months, mainly amongst young people.[35] The researchers reported that the only common factor they found was that "...seven times as many women who attempted suicide had had abortions as there were in the control group..." and the figure rose to nine times as many women as in the general population. In the survey, not one women who attempted suicide was pregnant. Although these figures are small the Commission was concerned to learn from Dr Kumar, who was representing the Royal College of Psychiatrists, that it would not be routine or even likely that someone being treated for attempted suicide would be asked about any history of previous abortion. Furthermore, no further investigations into this link have been instigated by the psychiatric profession.

46. Long-term psychiatric sequelae seem to be less well understood than short-term. This is, in the most part, because of the very high attrition rate in studies after more than a few months. Thus, any estimates of the incidence of sequelae must be made on the evidence of the few women that remain in the study. However, this is a self-selecting group. Those who are experiencing adverse affects are likely to drop out of the study since when these occur women will probably wish to avoid anything which would remind them of the abortion. Thus the complication rate may be underestimated. Additionally, the Commission heard from several witnesses[36] that women may use 'denial' (ie. denying, even to themselves, that they have experienced any adverse effects) as a means of coping with the effects of the abortion. Whether or not this is considered to be a 'good' or 'bad' adaptive mechanism – it clearly will dispose the woman to avoid any reminder of the event such as follow-up questionnaires, interviews, etc.

47. Thus in most cases the evidence of long-term sequelae appears to be anecdotal with little indication of incidence. Evidence submitted by BVA indicated that women may not experience any effects until several years later. For example, there has even been a case of a client recently referred to BVA by The Samaritans who had had an abortion 35 years ago. Ms Thompson of CCFL reported that they had counselled women who had had an abortion up to seven years earlier. Some of the

[33] e.g. Summary of written and oral evidence from *Beth* and *Alice* (annex 6)

[34] Oral evidence from Ms Margaret Cuthill and written evidence from Ms Joanna Thompson.

[35] FARMER Dr & O'BRIAN S, 1975 Evidence submitted to the Select Committee of the House of Commons on Abortion

[36] Dr Blacker, Dr Brewer, Ms Joanna Thompson, Ms Margaret Cuthill

individual women who corresponded with the Commission had experienced adverse effects more than twelve years after the abortion. Only the RCGP/RCOG study has attempted to do long-term follow-up after abortion. In this study women were followed up for 11 years, by which time more than 60% had dropped out.[37]

48. Although the rate of incidence of long-term adverse psychological effects may not be known the Commission received evidence that such effects do occur. One witness, Dr McAll, gave evidence of his personal experience in a private psychiatric practice. Many of his patients who had had a previous abortion suffered from apparently unrelated physical and psychological disorders, eg. arthritis, gastrointestinal problems, alcoholism, anorexia nervosa and bulimia, etc. As many as 74% of his cases resolve when treatment directed at resolving the emotional trauma of abortion is received (see para 44).

49. We note that an RCOG/RCGP Study on abortion and self-harm has not yet been published, although a report on it detailed that women who obtained an abortion had a 10 per cent increased chance of non-psychotic problems compared with other groups. The report suggested that GPs should warn patients considering an abortion that it was associated with non-psychotic events like anxiety and neurosis.[38]

50. The Commission received evidence indicating that there are a number of factors that will predispose an individual woman to suffer psychologically and emotionally following an abortion.

These may include:

- the age of the woman – younger women are more likely to suffer [39] [40]
- if there have been previous pregnancies [41]
- a previous history of depressive or psychiatric illness (see para 51) [42] [43]
- ambivalence toward abortion [44] [45]
- if the abortion was done for fetal handicap or genetic reasons [46] [47] [48]
- socio-cultural disapproval and/or a religious background [49] [50]

51. The results of the RCGP/RCOG study failed to show that a history of previous depressive or psychiatric illness increased the risk of adverse psychological and

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[37] FRANK, P., McNAMEE, R., HANNAFORD, P.C., KAY, C.R. and HIRSCH, S. 1991 The effect of induced abortion on subsequent pregnancy outcome *British Journal of Obstetrics and Gynaecology 98 1015–24*

[38] Self-harm follows abortion request. *Pulse, Nov 1990.*

[39] SPECKHARD A.C. & RUE, V.M. 1992 Postabortion Syndrome: An emerging public health concern *Journal of Social Issues 48 (3) 95–119*

[40] Oral evidence from *Alex*, one of the women who gave evidence to the Commission and who had experienced an abortion at 13 years of age (See Annex 6).

[41] BISHOP, S.1992 A study of post abortion syndrome in the light of recent research to consider how social work might better respond to this area of need *Dissertation for Master of Social Work, University of York*; ZOLESE, G. & BLACKER, C.V.R. The psychological complications of therapeutic abortion *British Journal of Psychiatry 160 742–9*; Mental health after abortion *Medical Monitor, Clinical Reviews (12/6/92)*

[42] Oral evidence from Dr Oates

[43] Mental health after abortion *Medical Monitor; Clinical reviews (12/6/92)*

[44] Oral evidence from Dr Brewer and Dr Oates

[45] Oral evidence from a number of the women who had undergone an abortion and gave evidence to the Commission (See Annex 6)

[46] Oral evidence from Dr Brewer and Dr Oates

[47] Written evidence submitted by Dr Blacker; also ZOLESE, G. & BLACKER, C.V.R. 1992 The Psychological complications of therapeutic abortions *British Journal of Psychiatry 160 742–9*; Mental health after abortion *Medical Monitor:Clinical Reviews (12/6/92)*

[48] Support for women undergoing abortion for such reasons is essential. The organisation Support After Termination for Foetal Abnormality (SATFA) exists to try and support such women.

[49] Oral evidence from Dr Casey, Dr Blacker, Ms Thompson

[50] See footnote 47

emotional consequences after the abortion.[1] However, this was contradicted by the evidence given to the Commission by the Royal College of Psychiatrists, who clearly stated that experience had shown that previous psychiatric disorders predisposed individuals to similar problems after the abortion. This may be an indication that the RCOG/RCGP study was not truly representative of the majority of women who undergo abortion (see para 29).

52. The Commission heard evidence that further research into the predisposing factors was necessary if women were to be adequately informed of the potential consequences of an abortion. The Commission urges the Department of Health to fund much needed independent research as well as research into the consequences of abortion for women who attend private clinics without GP referral, since this substantial group of women (30% of abortions in the UK) have been neglected in previous studies.

PSYCHOLOGICAL CONSEQUENCES OF PREGNANCY

53. Some witnesses suggested that the Commission should look at the related problem of adverse psychological consequences as a result of continued pregnancy. For instance, Dr Brewer referred to his own study (see para 30) which showed that abortion results in less risk of psychological consequences than does pregnancy; Dr Rogers claimed that in his experience very few, if any, women suffered serious emotional or psychological consequences; and Dr Oates, in her evidence, stated that she considered childbirth to be the biggest risk to the mental health of a woman and that psychological problems resulting from abortion were few in comparison.

54. However, Dr Oates provided little published evidence to support her opinion and Dr Brewer's study was flawed in a number of ways which make the results less reliable than might at first be apparent (see para 31). A Danish study carried out at the same time which can be considered more reliable (see para 31) showed the opposite effect, with more cases of psychosis following abortion than childbirth (see para 30).

55. Dr Rogers told the Commission that there was little follow-up of patients from his clinic (see para 41). It is not surprising therefore that he encounters few women who have experienced adverse psychological consequences since these are unlikely to be apparent immediately after the abortion.

56. Dr Oates agreed during questioning that there has been no adequate research into the long-term sequelae of induced abortion since there are major methodological difficulties in following up women who have had abortions. This difficulty in long-term follow-up was mentioned a number of times by different witnesses (see para 18, 21, 35 and 46).

57. Thus there must clearly be considerable doubt about the validity of any claims, based on such limited and flawed evidence, that pregnancy results in more psychological distress than does abortion. Since long-term studies have not been very successful at following-up women after abortion (see above) it is not possible to know if the pattern of development of psychological problems following delivery and abortion are the same. Extrapolation from short-term studies may be unreliable. A number of alternative hypotheses can be proposed which also fit the limited evidence available.

58. For instance, it may be that, following delivery, the majority of psychological problems occur shortly after the event with a subsequent tailing off whereas for abortion there may be fewer problems occurring in the short term with more occurring over the long term. Since psychological problems following pregnancy are more socially recognised than post-abortion problems, the denial mechanisms described earlier (see para 46) may promote delayed post-abortion responses. The anecdotal evidence received from individual women revealed that a number of women make the connection between feelings of depression and the abortion experience only after some years. Dr McAll reported instances where adverse affects were only recognised as being linked to a previous abortion many years later.

59. Alternatively, it may be that more acute psychological problems occur following delivery, which thus are more likely to come to the attention of a medical practitioner. Following abortion there may be fewer acute problems but a larger number of chronic

[1] FRANK, P.I., KAY, C.R., SCOTT, L.M., HANNAFORD, P.C. and HARAN, D. 1987 Pregnancy following induced abortion: maternal morbidity, congenital abnormalities and neonatal death *British Journal of Obstetrics and Gynaecology 94 836–42*

problems which significantly change the character and behaviour of individual women without necessarily ever coming to the attention of a doctor and therefore never receiving proper treatment and attention. The anecdotal evidence from some of the case histories of women and many of the letters received by the Commission indicated that this does reflect at least some women's experience.

60. Clearly, any conclusions that are drawn from the scanty evidence must be treated as theories, none of which has yet been proven. There is obviously more than one way of interpreting this information and there is no evidence to say that post-delivery effects are more frequent than post-abortion effects – even although they may appear more quickly and debatably are more acute.

61. Given the lack of concrete evidence that a continued pregnancy poses a greater risk to the mental health of a woman than does an abortion (see above) the Commission were very concerned by some of the evidence given by Dr Oates and Dr Kumar, representing the Royal College of Psychiatrists. They stated that although most abortions are carried out on the grounds of danger to the mother's mental health[52], it is their expert opinion as psychiatrists that there is, in fact, *no* psychiatric justification for abortion.

62. The Commission urges caution in any assumption that the comparison of adverse post-abortion and post-delivery psychological problems is truly comparing like events. Pregnancy and subsequent delivery, wanted or otherwise, is the natural result of unprotected sexual intercourse whereas abortion is a surgical or medical intervention to terminate prematurely a state which would otherwise naturally result in the birth of a baby. Thus abortion and pregnancy are clearly not identical events – even if both are related to the conception and development of a fetus in the womb.

INFORMED CONSENT

63. A necessary requirement of good medical practice is adequate information about the possible consequences of medical treatment prior to commencing that treatment in order to allow the patient to make an informed decision when consenting to it. The importance of counselling was noted in the Lane Committee report and Department of Health circular HC(77)26, which state that women "should be told of the nature of the operation and the likelihood of complete recovery from it or the possible resultant morbidity". Responding to written questions the Department of Health stated that information given prior to any medical treatment should be sufficient for a balanced judgement to be made. However, the Department does not consider it necessary to make the giving of any particular information mandatory but are content to leave it to the discretion of the attending doctor. Information on alternative options need not be given although the Department of Health guidelines on counselling suggest that it be given at the time of counselling which is voluntary.

64. Professor Savage described the information given to the women who came to her clinic prior to abortion. This included rates of bleeding, infection, uterine damage and the frequency with which this is serious enough to need surgical repair. In addition they are informed of the possibility of experiencing 'mixed feelings' in the short or long term.[53]

65. We were unable to establish how much information is actually given to the women at Dr Rogers' clinic prior to abortion. Dr Rogers told the Commission that he was confident that he could 'tell' from experience when a women is ready for an abortion and understands the consequences and could recognise when she had made the right decision. However, Dr Rogers is only a signatory to 15% of the patients at his clinic. Thus he must rely on the other doctors at his clinic to be equally sensitive to the patient's awareness and preparedness.

66. It was clear from evidence submitted by LIFE, BVA and CCFL and from the case histories of individual women that at least for some women there is inadequate information given to permit an informed decision and, as a result, they experienced regret afterwards at having made what they subsequently considered was a wrong decision. In fact, the evidence from the case histories of women suggests that many did not receive counselling that met the suggested Department of Health guidelines.

67. In particular it seems that information about the

[52] For example, 163,360 of the 179,522 abortions carried out in 1991 were done on the grounds of mental health. *Office of Population Censuses and Surveys. Medical series AB No.18, Table 27*

[53] See Annex 7 for guidance list for counsellors at the Tower Hamlets Pregnancy Counselling and Abortion Service

stage of fetal development is omitted as is the actual procedure by which the operation will be performed. The Commission heard from the BVA representatives that it is often only during a second wanted pregnancy that a woman inadvertently receives information which causes her to realise the stage of development that the aborted fetus was at when the pregnancy was terminated. This was clearly the case for one of the women who had had an abortion and gave oral evidence to the Commission (see Annex 6).[54]

68. In order to ensure that women receive sufficient information prior to the abortion the Commission urges the Department of Health to require abortion providers to give essential information as to the risk of physical and emotional consequences and the stages of fetal development.

69. Most countries in Europe recognise that there needs to be a waiting period between consultation for an abortion and the operation. During this time counselling may be given, which must include information about alternatives and the services available to the woman to help her keep her child. Furthermore, an ultrasound scan to confirm pregnancy and gestation may be offered, including the opportunity for the pregnant woman to see the scan. Ms Thompson from CCFL told the Commission that a waiting period would be beneficial since the time pressure to make a decision would be relieved and the woman would be able to investigate further all of the options available to her and to consider their consequences. A number of the women who gave oral evidence to the Commission of their own experiences of abortion also stated that there was too much time pressure on them to make a rapid decision.

70. Dr Brewer concurred that, in principle, it might be wise to have such a waiting period but expressed concern for women who discovered that they were pregnant only at a later stage of the pregnancy. However, Dr Brewer himself indicated that in his experience women who aborted later pregnancies, especially after they had felt fetal movement, were more likely to experience ambivalence and distress. It is all the more necessary in those cases to allow adequate time for decision making.

71. The response of the DOH to the question of whether such a waiting period should be considered in the UK was to state that during none of the Parliamentary debates about reform of the abortion law had such a waiting period been considered.

72. Given the irreversibility of the decision to abort a pregnancy and the potential to experience permanent consequences as a result of it, the Commission believes that a waiting period of at least one week before an abortion can be performed is essential and recommends that it be made statutory along with a requirement to give advice on alternatives and services such as social security benefits, housing, information on adoption agencies etc.

COUNSELLING

73. The DOH stated that an opportunity for counselling must be given and guidelines exist for such counselling (Health Circular HC(77)26). However, there is no mandatory requirement for counselling.

74. Both Dr Rogers and Professor Savage indicated that counselling is offered prior to an abortion. Professor Savage's Tower Hamlets Service has a "Counselling Form" a copy of which was sent to the Commission (see Annex 7). It was not clear, however, from Dr Rogers evidence that all the women that came to his clinic had been counselled before the operation since some did not receive counselling at the clinic if they reported that they had been counselled elsewhere.

75. In her evidence Dr Oates stated that a psychiatric assessment before an abortion as well as subsequent psychological help and counselling after it, was clearly indicated in the following circumstances –

- all mid-trimester abortions;
- all women with a history, or current experience, of psychiatric illness;
- women who felt coerced or were ambivalent about the decision to abort.

The Commission were unable to establish whether this actually happens in practice, and how widespread it is.

76. Evidence from the RCGP/RCOG study suggested that women who requested abortion were often emotionally unstable.[55] The Commission believe this is all the more reason why counselling should be given to

[54] eg. Summary of written and oral evidence from *Alice*

[55] Oral evidence from Dr Frank

these women before an abortion and should be available to them after the operation.

77. Dr Blacker told the Commission that, in his opinion, there was evidence that better pre-abortion counselling makes abortion less traumatic. However, a sample telephone survey of 14 private clinics which he had conducted indicated that only 3 of these actually offered pre-abortion counselling.

78. From the case histories of women who had experienced abortion it was clear that at least some women do not receive pre-abortion counselling and feel resentful subsequently that they were not adequately prepared for the potential consequences. There appears to be little advertising about post-abortion counselling. Women may hear about it by accident or in discussion with other women.[56]

79. Dr Rogers indicated that post-abortion counselling is offered at his clinic but only very rarely is that offer taken up by women. However, he also told the Commission that women leave his clinic shortly after the abortion, often within 1–3 hours and after 2 days at the longest. At this stage they will probably still be in the period where most women experience immediate relief (see para 34). The Commission received other evidence (see para 42) that women who equate the experience of an abortion with current emotional problems were unlikely to return to the clinic where they had the abortion if they subsequently feel they need help. Thus it is hardly surprising that Dr Rogers does not see many women returning to the clinic for post-abortion counselling. A number of the women giving oral evidence to the Commission described the staff at the clinic where they had their abortions as particularly unhelpful once the abortion was over.

80. Professor Savage attributed the poor follow-up rates in her area to low income, poor home conditions, difficulty with travel and thus a reluctance to return for follow-up visits especially if the woman is not experiencing any adverse effects. Professor Savage had been asked by the Commission to address the physical consequences of abortion and so her comments on the follow-up rates did not specifically mention adverse psychological consequences. However, for some women the reluctance to return to the clinic for *any* follow-up may be a result of experiencing adverse emotional effects.

81. In support of this interpretation for the lack of demand for post-abortion counselling services from clinics, the Commission received information from organisations such as LIFE, BVA and CCFL that they were seeing an increasing number of women who needed such counselling (see para 44).

82. It was also clear from the case histories of women who had undergone abortion that there were many who had not found that post-abortion counselling was adequately made available to them and who, in many cases, felt abandoned.

83. The Commission would like to see the issue of both pre- and post-abortion counselling urgently addressed in order to minimise the distress experienced by women who have undergone abortion without adequate opportunity to address the emotional turmoil they are often experiencing.

[56] eg. Summary of written and oral evidence from *Beth* and *Lucy*

CONCLUSIONS

84. The Commission concludes from the evidence received that adverse physical consequences of abortion do occur. In particular, tubal infection may result from abortion and tubal infection is the most common cause of infertility. Statistically the frequency with which a previous abortion is a factor in the pathology of infertility is uncertain. However, it would be prudent, as a matter of course, to screen and give prophylactic treatment for all pelvic infections and in particular chlamydia, which is notoriously difficult to diagnose, prior to an abortion in order to reduce the risk of postoperative pelvic inflammatory disease and consequent infertility. In addition, this would decrease the per patient cost to the NHS by reducing the necessity for hospitalisation and treatment of postoperative pelvic inflammatory disease, as well as any long-term effects such as ectopic pregnancy or infertility.

85. Psychological effects may be short-term or long-term. Acute short-term effects requiring hospitalisation are low but, given the large numbers of abortions carried out annually, do result in significant numbers of new cases every year. Less acute effects are underestimated due to very high attrition rates in surveys attempting to investigate the effects of abortion at periods of longer than a few months after the event.

86. Relief appears to be the over-riding emotion experienced immediately following the abortion. However, the Commission received evidence that feelings of regret can occur later, such as at the time the child should have been born or at a later event such as a subsequent pregnancy, the birth of a child to another member of the family or to a friend or even at menopause.[57] An accurate assessment of the incidence of long-term psychological effects is difficult to estimate due to the high attrition rates of surveys. Also, psychological effects have been reported many years after the abortion and no surveys have attempted to follow-up women this long after the event. However, the case histories of women who have undergone an abortion which were submitted to the Commission demonstrated that such effects do indeed occur for some women and may have a significant adverse effect on the lives and relationships of the individual women suffering in this way. Unless this is better recognised such women may never receive the treatment they need.

87. The Commission heard that certain factors are believed to increase the possibility that a woman will experience adverse emotional effects following an abortion, such as the age of the woman, previous pregnancies, ambivalence towards abortion, fetal handicap or previous history of depressive or psychiatric illness. These 'at-risk' women should be advised of this prior to the abortion so that this knowledge may inform the decision they make. The Commission received evidence that this did not happen for all such women, which may be partly because General Practitioners are not aware of these factors.

88. Pregnancy itself may result in adverse physical and psychological consequences. There is conflicting evidence as to whether induced abortion or normal delivery results in a greater incidence of acute psychiatric disorder although the results of the Danish study (see para 30) indicate that hospitalisation is greater following abortion than following delivery. However, the evidence received by the Commission indicates that the validity of comparing the effects of delivery and abortion must be questioned. The comparison is not of two like events and there is insufficient evidence to conclude that the general pattern of effects is similar.

89. The Commission heard from witnesses representing the Royal College of Psychiatrists who stated that although the majority of abortions are carried out on the grounds of danger to the mother's mental health, there is *no* psychiatric justification for abortion. Thus the Commission believes that to perform abortions on this ground is not only questionable in terms of compliance with the law but also puts women at risk of suffering a psychiatric disturbance after abortion without alleviating any psychiatric problems that already exist.

90. The issue of abortion is often presented as one of a woman's choice even although in legislative terms it is a medical decision which requires doctors to apply certain criteria. The philosophy of choice is, however, flawed where all the options are weighted in favour of abortion. Women who now regret a previous abortion might have taken another option if alternatives, and the necessary support to take one of those alternatives, had been offered. The Commission received evidence from many of the witnesses and from the case histories of individual women indicating that far from being a choice of several alternatives, the decision to have an abortion often appeared to be the only "choice" available

[57] Eg. Summaries of evidence from *Beth*, *Alice* and *Susan* (Annex 6) and evidence from BVA and CCFL

to them. Such a decision does not represent a free choice.

91. From the evidence received the Commission concludes that the amount of information given to women prior to abortion varies greatly. Pre-abortion counselling may be offered at some clinics – but by no means all. Since there is no information that it is mandatory to give, information on alternatives is often not offered or is perfunctorily given. The Commission was very concerned to discover from the case histories of the women who gave evidence that many did not receive counselling that met the Department of Health suggested guidelines. Thus, this irreversible act may be chosen without sufficient knowledge to adequately inform the choice, with minimal or no counselling and with insufficient time to truly consider all the alternatives. The Commission believes that this is particularly relevant with the wider availability of medical abortions through the use of RU486.

92. Independent organisations which offer counselling in crisis pregnancies and post-abortion are seeing an increasing demand for their services by women who are experiencing adverse emotional effects as a result of an abortion which occurred sometimes years earlier. Women may feel less threatened by such organisations – especially as some of the counsellors may themselves have experienced similar circumstances. At least some of the women who have experienced adverse effects appear to be reluctant to return to anyone in the medical service for help.

93. There is some published evidence[58] and the Commission heard evidence from two of the expert witnesses, Dr McAll and Mrs Scarisbrick (representing LIFE) indicating that other individuals, e.g. the father, the woman's parents, other children, medical staff etc, may also suffer adversely. However, the Commission limited itself to the effects felt directly by the women who had had an abortion.

[58] GOLDBERG, J.R. The medical debate: Abortion – regret or relief? *Oregon's Magazine on Women and Health*; NEY, P.G. 1979 Relationship between abortion and child abuse *Canadian Journal of Psychiatry 24 610–20*; NEY, P.G. A consideration of abortion survivors *Child Psychiatry and Human Development 13 (3) 168–77)*

RECOMMENDATIONS

94. In 1976, following the Select Committee on Abortion, the Department of Health introduced a number of provisions and made a number of changes in procedure, without changes in the law. With this in mind, the Commission makes the following recommendations.

95. The Commission recommends that the Department of Health make screening for vaginal infections, including chlamydial infection, and the administration of prophylactic antibiotic treatment prior to an abortion a standard part of the procedure, in order to reduce the incidence of post-abortion chlamydia associated pelvic inflammatory disease and consequent risk of infertility.

96. The Commission recommends the Department of Health should fund urgently needed prospective studies giving serious consideration to reducing the attrition rate and ensuring that they include women who have had their abortions at clinics without GP referral. The Commission agreed with the suggestion from one witness, Dr Blacker, that if follow-up interviews with individuals in the study were seen as part of some ongoing therapeutic offer, the fall-out might be lower. With such divergence in opinion amongst medical professionals, counsellors and others involved in the issue of abortion, the Commission believes that it is essential that further good quality research with a fully representative sample, be carried out to determine the extent of physical and, especially, psychological consequences of abortion.

97. Patients who default at follow-up may be the most distressed. Thus the Commission recommends that special efforts should be made to keep such women in touch with personnel who could proffer appropriate treatment. For instance, abortion centres (both NHS and Private) should be required to initiate *independent* and long-term follow-up on those of their clients considered most at risk of experiencing distress.

98. In the light of evidence from the Psychiatrists representing the Royal College of Psychiatrists, that there are *no psychiatric indications for abortion*, the Commission recommends that the Department of Health should ensure compliance with the Abortion Act (1967) and Human Fertilisation Act (1990) by regular inspections, or spot checks, of the grounds given for abortions, in order to ascertain whether mental health grounds (see para 61) are genuine and can be substantiated, or do not comply with the legislation and should be challenged.

99. The Commission disagrees with the tendency to compare the effects of pregnancy and abortion since these are not two like events. Information on the occurrence of immediate and delayed psychological sequelae following both events is limited (see paras 53–62) and thus comparisons between them are inappropriate at best and likely to be inaccurate.

100. While it is in principle undesirable to conceive children when there is no commitment to accept and rear them, once a child is conceived it is important that practical and financial support should be available to the mother. In the absence of such support it may appear to many women that they have no realistic alternative to abortion.

101. The Commission recommends that women contemplating abortion should be given information about the risk of adverse effects, the stages of fetal development, alternative options and aid available both from public funds and from private organisations such as LIFE, BVA, CCFL, etc. The Commission also recommends that further studies be undertaken which will help clarify the situation with regard to *risk* factors for adverse psychological consequences.

102. The Commission recommends that the Government instructs NHS hospitals to ensure that women have a waiting period of 1 week between the first visit to a doctor at which an abortion is considered and the actual operation. The Government should also make it clear that the same requirement applies to private abortion clinics. Any failure to follow such a policy should result in a clinic losing it's licence. Advice should also be given on alternative options and services available to help the woman to keep her child. Such measures not only provides time to consider all the consequences and alternatives of the proposed action but also alleviates some of the immediate time pressure on the decision. Decisions taken under pressure are notorious for being regretted later when the pressure is removed.

103. The Commission urges the Department of Health to investigate how its guidelines on counselling are actually applied in practice and seek ways to improve compliance, particularly because it seems that many of the clinics fail to offer pre-abortion counselling.

104. In view of the apparent reluctance that women experience to return to the clinic where they had the abortion if they have problems, the Commission urges that clinics be required to make information available about local and national *independent* counsellors and counselling agencies who offer post-abortion counselling.

105. Independent organisations which offer post-abortion counselling appear to attract those women who might not return to medical services. Thus, the Commission recommends that such organisations be encouraged and official grants be provided for training courses to be made available to lay post-abortion counsellors to cope with the increasing demand.

ANNEX 1

LIST OF MEMBERS

The Right Hon Lord Rawlinson of Ewell PC QC (Chairman)
Ms Helen Alford MEng
Mr David Alton MP
Mr David Amess MP
Dr Hartley Booth MP
Mrs Phyllis Bowman
The Baroness Cox
Mr Jonathan Evans MP
Ms Ann Farmer
Ms Catherine Francoise
Mr Luke Gormally LicPhil
Mr Christopher Graffius
Ms Anna Grear LLB
Mr Ken Hargreaves
Dr Joseph Hendron MP FRCGP
The Right Hon The Lord Jakobovits
Miss Mary Langdon-Stokes FRCOG
Dr John McLean
The Hon Christopher Monckton DL
The Hon Mrs Christopher Monckton
Dr Philip R Norris MD FRCOG
Prof John Scarisbrick MA PhD FRFL
Prof Norman Stone MA
Prof Ronald Taylor FRCOG
Dr Margaret White JP MBChB DObst RCOG

Secretariat provided by Mr Nigel Williams, Dr Stephanie Smith Bsc Phd and Ms Philippa Taylor.

ANNEX 2

WITNESSES PROVIDING ORAL EVIDENCE

Ms Jane Airey	Counsellor and psycho-therapist, BVA
Mr Robert Balfour	Consultant Obstetrician and Gynaecologist
Dr Russell Blacker	Consultant Psychiatrist, Cornwall and Isles of Scilly Health Authority
Dr Colin Brewer	Specialist in Psychiatry, Medical Director of The Stapleford Centre
Prof Patricia Casey	Professor of Psychiatry, Mater Misericordiae Hospital, Dublin
Ms Margaret Cuthill	Project Coordinator, British Victims of Abortion (BVA)
Ms Elaine Davis	Counsellor, CCFL
Dr Peter Frank	Deputy Director of the Manchester Research Unit of the RCGP
Mr Peter Garrett	Research Officer, LIFE
Dr Michael Jarmulowicz	Consultant Pathologist, Royal Free Hospital
Mr John Kelly	Clinical Obstetrician and Gynaecologist
Prof Kumar	Professor of Perinatal Psychology at the Institute of Psychology, London
Dr Kenneth McAll	Psychiatrist
Dr Margaret Oates	Consultant Psychiatrist, Queens Medical Centre, Nottingham
Mr Alan Rogers	Consultant Gynaecologist at Marie Stopes Park View Clinic
Dr Wendy Savage	Consultant in Obstetrics and Gynaecology
Mrs Nuala Scarisbrick	Trustee and Hon National Administrator of LIFE
Mrs Joanna Thompson	National Coordinator, Christians Caring for Life (CCFL)
Prof R Winston	Prof of Fertility Studies, Hammersmith Hospital

In addition, a wide range of written papers and articles on the physical and pyscho-social consequences of abortion have been received by the Commission to aid their Inquiry.

WITNESSES INVITED TO PROVIDE ORAL AND/OR WRITTTEN EVIDENCE

Ms Jane Airey (British Victims of Abortion)
Mr Robert Balfour
Mr L S Barron
Dr Russell Blacker
Dr Colin Brewer (British Pregnancy Advisory Service)
Prof Patricia Casey
Ms Margaret Cuthill (BVA)
Ms Elaine Davis (Christians Caring For Life)
Dr Peter Frank (Royal College General Practitioners)
Mr Peter Garrett (LIFE)
Dr Josephine Green (Centre For Family Research)
Dr Michael Jarmulowicz
Mr John Kelly
Prof Kumar (Royal College of Psychiatrists)
Dr Kenneth McAll (Psychiatrist)
Dr Bernard Nathanson (USA)
Dr Philip Ney (USA)
Dr Margaret Oates (RCP)
Mr David Paintin
Mr Alan Rogers (Marie Stopes)
Dr Wendy Savage
Mrs Nuala Scarisbrick (LIFE)
Support After Termination For Abnormality
The Department of Health
The Royal College of General Practitioners
The Royal College of Midwives
The Royal College of Nurses
The Royal College of Obstetricians and Gynaecologists
The Samaritans
Ms Joanna Thompson (CCFL)
Prof R Winston
Women Hurt By Abortion

ANNEX 3

LIST OF REFERENCES PROVIDED BY VARIOUS WITNESSES

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ANNEX 4

QUESTIONNAIRE ISSUED BY THE COMMISSION

As you know, we are carrying out a survey to find out the impact of abortion on the lives of individual women. We would be very grateful if you would fill in the following questionnaire. Do not worry if you are unable to answer all the questions. Answer as many as you can and return the completed form to:

The Secretary to the Commission
53 Romney Street
London
SW1P 3RF by 31st March 1993

All information given will be kept *in the strictest confidence*. Any reference to the results of the survey will not include any details which might lead to the identification of any individual.

Would you be willing to be questioned about your experience by a small group of members of the Commission, who will all be women? Yes/No

(If you have answered "yes", the Commission will be in touch with you in the near future.)

Unless instructed differently, please circle only one answer to each question.

SECTION 1
Details of your situation at the time of the abortion

1. Had you had an abortion before?

   If so, how many? *please specify*

2. When was your (most recent) abortion?

   1993 1992 1991 1990

   Other *please specify*

3. At the time of your abortion, were you:

   Married Single Divorced

   Separated Widowed Living with partner

4. Did you have any children at the time of your abortion? If so, how many?

   0 1 2 3 4 5+

5. Was your physical health good at the time of the abortion?

   Yes No

6. Were you taking any medication at the time of the abortion?

   Yes *If you have circled this, go to question 7*
   No *If you have circled this, go to question 8*

7. What medication were you taking?
   Please write in the space provided _____
   _____
   _____

8. Was your emotional health good?

   Yes No

   If not, and you are able to, please explain why not
   Please write in the space provided _____
   _____
   _____
   _____

9. Were you receiving any social security benefits at the time?

   Yes *please specify* No
   _____
   _____
   _____

10. Into which of the following bands did your income fall into at the time of your abortion?

Up to £5,000 per year
£6,000 – £10,000 per year
£11,000 – £15,000 per year
£16,000 – £20,000 per year
£20,000 – £30,000 per year
Over £30,000

11. Were you working full-time or part-time?

Full-time *If you have circled this, go to question 12*
Part-time *If you have circled this, go to question 12*
Not working *If you have circled this, go to question 13*

12. What was your occupation at the time of your abortion?

Please write in the space provided _____
_____
_____

13. At what stage in your pregnancy did you discover that you were pregnant? *Please write in weeks*

At _____ weeks

14. How long after this discovery did you decide to have the abortion? *Please write in weeks*

At _____ weeks

15. Why did you decide to have the abortion?

Please write in the space provided _____
_____
_____
_____
_____

SECTION 2
Details of counselling/advice received

16. Did anyone else recommend you have an abortion?

Yes No

If yes, please specify who _____
if you have answered yes, please go to question 17
if you have answered no, please go to question 18

17. What reasons did this person/these people give for the recommendation?

Please write in the space provided _____
_____
_____
_____

18. Did you receive *any other* advice or counselling about whether or not to have an abortion?

Yes *If you have circled this, go to question 19*
No *If you have circled this, go to question 23*

19. Who counselled or advised you before your abortion?
Please circle all relevant answers

G.P.
Abortion Counsellor
Other *Please specify* _____

20. Were you given any information on any of the following:
Please circle all relevant answers

The nature of the operation itself?
Yes No
The stage of development of the foetus?
Yes No
Any potential health risks to you?
Yes No

21. How helpful was the information you were given?

Very helpful Quite helpful
Not very helpful Not at all helpful

22. How would you describe your counsellor?

Very strongly in favour of your abortion
Quite strongly in favour of your abortion
Unbiased
Quite opposed to your abortion
Very opposed to your abortion

SECTION 3
Details of the operation

23. Was your abortion

Self referred GP referred

24. At what stage of the pregnancy was the operation performed?

Under 12 weeks 12–15 weeks
16–25 weeks 26–30 weeks
31–32 weeks After 32 weeks

25. Did you have a scan? Yes No

26. Did you have any other tests, eg to find out if the foetus was handicapped?

Yes *Please specify* _____
No

27. Was the operation performed:

Privately On the NHS

28. What method of abortion was employed?

Suction evacuation
Dilation and evacuation
Induced early labour/extra or
intra amniotic prostiglandins
Hysterotomy
Don't know

29. How long did you stay in the hospital/clinic?

Less than 1/2 day Less than 1 day
Overnight More than one night

30. Was the operation more or less painful than you expected?

More painful Less painful
As I expected

31. Were there any physical complications during the operation?

Yes *If you have circled this, go to question 32*
No *If you have circled this, go to question 34*

32. What were these physical complications?
Please write in the space provided
_____
_____
_____
_____
_____

33. What medical treatment have you had for these problems?
Please write in the space provided
If nothing, write 'Nothing done'
_____
_____

34. Did the operation itself have any effect on you emotionally?

Yes *If you have circled this, go to question 35*
No *If you have circled this, go to question 36*

35. What effect(s) did it have?
Please write in the space provided _____
_____
_____

SECTION 4
Details about your experiences following the abortion

36. After your abortion, were you given any of the following?

Immediate bedrest at the place of abortion
Yes No
Advice and/or counselling Yes No
Information on who to contact in an emergency
Yes No

37. If you received advice and/or counselling, from whom did you receive it?
Please write in the space provided _____
_____
_____

38. Were you in any physical pain after the abortion?

Yes *If you have circled this, go to question 39*
No *If you have circled this, go to question 40*

39. For how long after the operation were you in pain?

Up to one hour 1–2 hours 3–8 hours
Other *please specify*

40. Did you suffer any emotional consequences from the abortion?

Yes *If you have circled this, go to question 41*
No *If you have circled this, go to question 42*

41. Have you felt the need to express feelings arising from the abortion?

Yes No

42. Have you actually been able to express your feelings adequately since your abortion?

Yes No

43. Has anyone encouraged you to express your feelings?

Yes No

44. Did the abortion have any effect on your relationship with the father?

Yes *If you have circled this, go to question 45*
No *If you have circled this, go to question 46*

45. What effect has your abortion had on your relationship with the father?
Please write in the space provided _____

46. Did you have any children of your own living with you at the time of your abortion?

Yes *If you have circled this, go to question 47*
No *If you have circled this, go to question 49*

47. Did you tell them about the abortion at any time before or after it?

Yes *If you have circled this, go to question 48*
No *If you have circled this, go to question 49*

48. Did telling them affect your relationship with them in any way?

If no, write 'No', if yes please write in the space provided

49. Did you receive treatment for any emotional consequences of the abortion?

Yes *If you have circled this, go to question 50*
No *If you have circled this, go to question 51*

50. What treatment did you receive?
Please write in the space provided _____

SECTION 5
Details of any longer-term consequences

51. Have you had any children since the abortion?

Yes *If you have circled this, go to question 52*
No *If you have circled this, go to question 54*

52. Was any conception and pregnancy, had since the abortion, trouble-free?

Yes *If you have circled this, go to question 53*
No *If you have circled this, go to question 54*

53. What problems occurred, and why?
Please write in the space provided _____

SECTION 6
Additional personal information

54. What is your present marital status:

Married Single Divorced
Separated Widowed Living with partner

55. If you have one, is your current partner the same as at the time of the abortion?

Yes No

56. If you have one, is your current partner the father of the aborted baby?

Yes No

57. How many children do you now have?

1 2 3 4 5+

58. How many children are living with you?

1 2 3 4 5+

Name _____

Address _____

_____ Postcode _____

Telephone number _____

Date of birth _____ Age _____

Would you like to receive a summary of the results from this survey? Yes No

If you have discovered that dwelling on your abortion experience has left you with any sense of unresolved pain, we can put you in touch with a trained counsellor who would be very pleased to give you confidential support.

Thank you very much for taking the time and trouble to complete this questionnaire.

ANNEX 5

SUMMARY PROFILE OF QUESTIONAIRE RESPONDENTS

Total
In total, 136 women completed and returned their questionnaires. Of these, 87 (64%) were willing to be interviewed orally.

Age of respondents at abortion *
The majority of respondents were between 20–34 years at the time of their abortion (59%). The next largest category was the 35–44 age group (20%), followed by 15% who were between 16–19 years. 5 respondents were under 16 years.

Marital status at abortion *
The most likely group to have a termination were those who were single at the time of their pregnancy – 42% of respondents. Just over a quarter of respondents (27%) were married at the time of their abortion and 19% were living with a partner.

Income at time of abortion
These figures should be treated with a degree of caution as although the majority of women detailed just their own income some included the income of their partner. Also, it should be noted, the wife's income may not be an accurate reflection of the standard of living in the household, as this is more likely to be dictated by her partner's income.

Nearly half the respondents (46%) were in the lowest income band of under £5,000 per annum. The rest of the respondents were split almost equally between £5,000 – £10,000 and over £10,000.

Gestation period
Two-thirds of the respondents had their abortion in the first twelve weeks of pregnancy. 21% had their abortion between 12–15 weeks and 13% between 16–25 weeks of the pregnancy. No-one said they had their abortion after 25 weeks.

NHS/private *
Slightly under half of respondents (43%) had their termination on the NHS. The remainder went to a private clinic.

Number of abortions
Most respondents had only had one abortion (121 women) however this question was misunderstood by some people so the results are not totally accurate and should be taken with care.

Partner
Following the abortion almost half the women who responded were now with a different partner (46%). 40% have remained with the same partner while 13% have no current partner.

Marital status now
As we would expect, more women are now married than at the time of their abortion – 46%, compared to 27% at the time. There is therefore a corresponding drop in the numbers who are now single, from 42% to 21% and in those living with a partner, from 19% to 13%. Again, not surprisingly, there is an increase in the number of women who are divorced, separated or widowed, from 12% to 19%.

FURTHER INFORMATION

Complications arising from abortion
A relatively small number of women suffered from physical complications at the time of the abortion (13%) but of women who have later had children two-thirds (67%) had some sort of physical complications with either conception or pregnancy (in particular, miscarriages).

Three-quarters of women who replied said they experienced emotional consequences arising from the abortion (103 women, 76%). This figure includes approximately 12 women who stated relief was the consequence of the termination. There is a higher number of women, however, who say they have had *long-term* emotional problems following the abortion (114 women, 87%). For some women this has lasted for years (up to 12 or more in a few cases), and for some it is still unresolved. Approximately 20 women requested counselling. (These figures only include the affirmatives

* The percentages here show a difference of less than 10% from the equivalent figures in OPCS Monitor AB 94/1, which details all Legal Abortions for 1992.

at Q40 which has therefore excluded a small proportion of women who say 'No' here but who in the following question say they *have* felt the need to express feelings arising from the abortion).

When decided on the abortion
Half of the respondents decided on having an abortion either immediately or within the first week of discovering their pregnancy, followed by 24% deciding in the second week, 12% in the third week and 16% deciding after the third week.

Reasons for the abortion
The most common reason listed, and mentioned by nearly half (45%) of women, was either partner pressure or an unstable relationship with the partner. 26% of women mentioned their financial problems or situation as the cause, or one of the causes, while family pressures/ situation, career/ studies and age were each mentioned by 15% of respondents. 40% gave some other reason for their abortion which included the following (in approximate order of priority):

Unplanned/did not want children
Emotionally unstable
Health reasons/illness/previous problems with pregnancy
Seemed no alternative
Lack of counselling
Deformed/mongol baby
On drugs/taken 'morning after' pill/rape

Relationship
88 women (65%) said that their relationship with the father of the aborted baby had been affected in some way. For the majority the relationship was adversely affected, and in some cases resulted in a break-up, however 7 women said their relationship had actually been strengthened as a result. 35% said the abortion had had no affect on their relationship with the father.

ANNEX 6

SUMMARY OF WRITTEN AND ORAL EVIDENCE – SUSAN

1. Background

Susan is 30 years old and is married to the father of the aborted baby. She now has a baby of 6 months. Her abortion was in 1990 at a private clinic when she was 26 years old and working as a Community Occupational Therapist.

2. Events leading to the abortion

Susan had been on the pill but stopped when she began getting headaches. She then became pregnant which shocked her enormously. She went to her GP who was "helpful" and "sensible" and asked her if she would be able to really love the child in the light of all her circumstances. He told her he would not write it on her notes in case she had a Catholic GP in the future, so in her second pregnancy no-one knew about her abortion.

As she was trying to buy a flat at the time, she was living with her father and did not think that her relationship with her boyfriend would survive having a child, and it was unfair for him to support a child as well as her. He said it was her decision.

At the time she had been very concerned she would not be allowed to have an abortion as it was just for "convenience" and so not a good enough reason – she later says she was just ignorant.

3. The abortion

This took place under 12 weeks into the pregnancy. "I was shocked by the hardness I felt as I went up to the clinic but I was determined to do it". After it, Susan's boyfriend picked her up and took her home. She remembers feeling very angry because he wanted to watch a film on TV and not talk with her. She returned to work soon after because she did not want anyone to know about it.

4. After the abortion

Susan had a check-up several months later because her periods did not return, which she saw as punishment at first. She adds: "And then imagine how I felt when I miscarried later. But I did try very hard not to get stuck into the 'see how I've been punished' mode". Her miscarriage was at 12 weeks. She says: "I explained to the Doctor that I'd had an abortion and I was upset because I thought I would be judged for it. He told me not to worry, but I felt ashamed and felt 'how can he think I want this baby when I aborted a baby?'...(cries here)...I was trying to face losing a child that I'd really wanted, with dignity, and I really cried a lot about everything at that point. I went to pieces after the miscarriage and took three weeks off work and lapped up all the sympathy I'd wanted the first time...(cries here)...I wasn't given the chance to grieve after the abortion".

"I don't regret the abortion but I wish it had never happened". "I couldn't say the word 'abortion' for a year after I'd had it."

"I felt very much that I had to get married after the abortion – it was incredibly important". However Susan later said the two of them have never really been able ro talk about it properly and she finds this a stumbling block, because she is unable to talk about it without crying. She does not get on with her sister-in-law at all, which began with her sister-in-law's pregnancy. Susan admits it is an irrational anger and puts it down to "a transfer or projection of the anger I feel inside about my abortion."

Susan constantly swings from day to day and in her conversation between two conflicting feelings, which she struggles to reconcile. For instance, at the beginning she says "I don't regret my decision" and later says "Why I get so cross and defensive and sensitive about the abortion is because I thought I took the most socially responsible decision." However she writes "I have been terrified of what else I could do. A sense of self loathing has been hard to overcome." and in conversation she talks about "killing her baby".

5. Counselling

She has used the questionnaire and speaking to the Commission to her own ends and to think things through herself, and move on from it, as she has never had the opportunity to do so before. At the clinic Susan was offered counselling but said, speaking as a medically trained person, that "the lady there obviously had no training, and all she wanted to ascertain was that I wasn't being *forced* into it". Neither did Susan have counselling afterwards nor was she told of possible psychological problems: "It didn't even occur to me. I think if I'd have known how much I think about it now I might have

prepared myself better in the first place". "Counselling at the time would have made this process a lot easier".

6. Conclusion

"I talk about it all now and I'm fine. I can see it was the sensible way because I would have ended up as a single mother. That's on a practical, sensible, responsible level, and then I think 'how *could* you? How could you have done that?' It sounds exactly like a convenience, because it doesn't suit you to have a child at that point...(cries here)...How could you have got rid of a child because...(cries)...you felt it wasn't right timing – how could I? I don't ever manage to resolve it."

"I hear myself talking and saying 'Oh yes, it was right – but that's all very well if you're talking about money, but this is a *life*...(cries)...and then my argument swings again and I think about my life and I wouldn't be able to manage a child in a responsible way because it is hard work. Then I *know* it was the right thing. But then again – I *killed* my baby."

"The ability to choose is very important, but I can't argue logically and this is where I'm stuck. I get stuck all the time. What can I do, where can I go? Most of the time it's all right, but...this is ridiculous, I'm still stuck in the grieving process after three and a half years. I'm crying all the time now, even with a husband and child. But what's still important is that I was able to have one. I *do* have a right to have it. Yet it's three and a half years later and I haven't been able to brush it under the carpet."

SUMMARY OF WRITTEN AND ORAL EVIDENCE – BETH

1. Background

Beth is 33 years old, married to the husband of the aborted baby and has three children. She had the abortion when she was 19 and working as an animal technician. The pregnancy was an accident, resulting from "mucking around with the pill".

2. Events leading to the abortion

Beth visited the doctor once she began feeling different but says the doctor was convinced she was not pregnant and so did not do the test properly. As a result Beth put it out of her mind, convincing herself she wasn't. Only after a visit to another doctor at about 20 weeks was the pregnancy confirmed.

She went straight off on a pre-booked holiday to Amsterdam with her boyfriend. While there she visited a counsellor whose number had been given to her on a leaflet at the airport. The counsellor was very helpful and although appeared to be against Beth having an abortion, as she was at 23 weeks, she said there was a doctor in London who would do it for her. "That was the first time I'd been told I could have a termination. Up until then I thought I was going to have the baby...It then seemed the easy option – the other side seemed to have so many problems.".

"It seemed so unreal...I can't explain...I was in an unreal state. There were times for example...when I was so excited and I wanted everyone to know I was pregnant...but we were both on our own in the middle of a crisis and none of us was sane. We just wanted to get out of this mess".

3. The abortion

Beth went to a London private clinic but remembers little about the abortion itself. She does remember feeling euphoria after it for a while "...thank goodness for that – no more problems".

She was not given any information at the clinic about possible consequences, even the producing of milk afterwards – about which she was very worried at the time.

4. After the abortion

"I don't remember when, maybe a few months, depression then set in. I started going to the doctor quite frequently for silly things". She began to smoke and drink more and recalls telling her doctor that she was really upset about her abortion, however he did not help in any way, telling her to 'buck up'.

She says she realises now that she's counselled and never goes to the doctor any more that the visits were due to the abortion: "I was going so frequently, with this wrong, and that wrong and, looking back, they weren't tangible, they were just made up and I was crying for help that there was something wrong".

When asked about her relationship with her husband she says: "It was very rocky. Afterwards I became frigid

and I think that actually went into my marriage. It was very difficult and I don't think most people would have been able to stay together, but once I latch on I don't let go! We went through really hard times." She writes "I could not understand why he carried on as normal, and my life was shattered".

5. Counselling
When asked what she would have liked most in the way of help during her depression she said: "Someone to tell me I was wrong I think…everyone kept telling me I could not have done anything else and I did what was right…but it wasn't what I felt".

Talking about counselling before the abortion Beth says: "I can't say this in blame, but if there had been counselling when someone could have come to my mother with me, to tell her, or had given me the confidence and said 'look you *can* do this'" then it might have been different. "If someone had said 'don't rush' because everyone said you've only got 24 hours to think about it…Morally it wouldn't make much difference whether the baby was 6 or 10 weeks". Beth said she wanted someone to let her think about it for longer, to suggest other options or offer a home, and to help in telling her mother.

"It is a hard decision, but you don't have to do it – there is another option and actually, life without my baby…(she cries here)…is worse than with".

"People I have spoken to since seem to have as much trauma even at six weeks – they still feel they have lost their baby".

When asked what she would want to say to another girl on her way to Amsterdam in the same situation Beth replied: "I'd like to take her to counsellors – I couldn't help on my own but I'd like to take her to somewhere where professional people could counsel – not just verbally but maybe physically help, i.e. meet the parents, talk to the boyfriend etc".

Beth eventually found help from a church that she started going to. They counselled her for a while, and then she went to *Care in Crisis* for further counselling.

6. Conclusion
Of her husband, who has not been counselled, Beth says: "He can't talk about it, so it's not only me that's been affected", adding later that "He can never cope with me being pregnant or when the children have been very young".

Beth is now a Christian and says of her feelings: "I have handed the baby over to the Lord now, but there is still pain obviously. I have been forgiven. I can actually say I did wrong. It was wrong".

SUMMARY OF WRITTEN AND ORAL EVIDENCE – FIONA

1. Background
Fiona is 28 years old and is married to the father of the aborted baby. She has had one child since the abortion.

Her abortion took place in 1988, at a private clinic, when she was 23 years old. She was single at the time, but in a relationship with her now husband, who was married to someone else but initiating divorce. She worked as a Fraud Investigator for the Employment Service at the time.

The pregnancy was unplanned – she had come off the pill and was just using condoms. Initially, on discovering her pregnancy at 8–9 weeks, she was happy about it.

2. Events leading to the abortion
Fiona visited her GP to request an abortion. She had been advised by everyone else to have it "due to living on my own, my job and my financial situation. Also my emotional well-being". The official reason stated was "the well-being of the child and mother". Later, however, Fiona states "I don't see why they have to categorise reasons for the abortion. Why do you have to have a *reason* for having an abortion?" She decided to have the abortion at 10 weeks.

Regarding this decision she told the Commission "…you haven't got time, that's the problem, to think about it. You are also numbed by the fact that you are pregnant".

3. The abortion
She was referred by her GP, who had told her a bit about the operation itself, and had the operation at 12–15 weeks. There was no scan and no counselling at the

clinic even though when she went she was crying and crying. "Nobody really spoke to me at all…nobody offered me any counselling before. It was almost compulsory to *have* the abortion. It was horrid."

"I cried for an hour up to going into the theatre, and when I came 'round I was crying…I felt as though I'd lost part of myself, and part of my life and future".

Fiona wrote that she found the operation more painful than expected but had no physical complications during or after. However, "nobody either explained what would happen to my body…I was bleeding and didn't know if it was normal".

4. After the abortion
After the abortion Fiona felt numb. She suffered emotionally for two years, saying "…it was awful – really, really bad". She adds "March 26th every year was very sharp in my mind, and also the time it was due to be born."

When asked about the effect on her relationship she replied: "It didn't help because I used to use it in arguments…He had regrets as well, and used to get quite upset about it at times."

Since the birth of her daughter, however, "…a lot of it has gone, and I don't mind so much…I got through the two years and things have been much easier since." "It was five years ago. I hardly think about it now".

5. Counselling
When asked about this, Fiona said she would have liked:

"Somebody who could almost put it in black and white – what it would be like if you had a baby on your own. And then what it would feel like when you've got rid of it".

"Its like anything, you can think and think about it, in circles and end up thinking, 'get me out of this'!".

"There just wasn't proper help."

She would have liked counselling to include her partner "…he's the father, he's part of it. I'd have rather had him there too".

6. Conclusion
"I think that if there hadn't been an option of abortion available then I'd have stuck in and got on with it. It's the option that threw me – that I could get rid of it."

"If I fell pregnant now, by mistake, I'd probably have the child. But that's with hindsight".

SUMMARY OF WRITTEN AND ORAL EVIDENCE – JANE

1. Background
Jane is 46 years old and is single, with no children. Her abortion took place in 1975, at a private clinic, when she was 28 years old and working as assistant editor of a small magazine.

She was living on her own, with no friends, having newly arrived in England as an illegal immigrant. She became involved with someone for two months, whilst using pessaries as contraception, which she assumed were fully effective. Her pregnancy was unplanned and only discovered (at 9–10 weeks) after she missed two periods .

2. Events leading to the abortion
"I didn't know what to do. I had no money and no friends…there was no-one here that I was close to. I was just in such a mess."
She also felt it may be her only chance to have a child and perhaps she 'should', however "…then I thought that was just ridiculous, so I went to an advisory centre at Kings Cross. They were very good and helpful."

3. The abortion
Jane recalled saying, when at the centre, 'maybe I shouldn't have it' but she writes that the girl there was 'quite helpful', and 'quite strongly in favour of the abortion'. The operation was explained to her, and what would happen. It took place on 23rd December, when she was under 12 weeks into the pregnancy.

"I was terribly freaked out before the abortion, so as soon as I woke up I thought 'thank God, it's over'".

4. After the abortion
Jane spent Christmas at her cousin's flat and says "I remember sitting there listening to Radio 4. I did have a couple of cries but on the whole I was glad it was all over. Occasionally I'd think maybe it was murder, as I

listened to carols, ceremonies etc. All things considered though, I came through pretty well."

The father was "well gone by then" and she had no contact with him after the abortion.

5. Counselling
She writes "While extremely relieved, I still felt very guilty and needed reassurance".

At the clinic she had been given a list of psychotherapists she could contact afterwards, so she did so, although she said this was also partly to try and avoid deportation!

She says she no longer feels guilty about it, nor has regrets, simply feeling it is sad that it had to happen at all. Although later she did say "Every now and then you do think 'what would they be like now, growing up?' But only as a fleeting thing."

6. Conclusion
"I had no job, no support, no family. What would I do with a child? I had no viable alternative...I did do the right thing."

SUMMARY OF WRITTEN AND ORAL EVIDENCE – ALISON

1. Background
Alison is 31 years old and separated from her husband, who was the father of the aborted baby. She has no children. Her abortion took place in 1987, at a private clinic, when she was 25 years old. It was just 4 days before she got married to the father. At the time Alison was working as a Scientific Officer. Her pregnancy was an accident but she knew very quickly that she was pregnant, and did a home test to confirm this.

2. Events leading to the abortion
Alison was very keen to have the abortion as quickly as possible. "I just knew if I went down the aisle pregnant I'd have to have it...there's that psychological switch that meant being single and having a termination was alright but being married wasn't". Other factors in play were the small studio flat she lived in with her fiance, her 'immaturity', a volatile relationship and lack of support, particularly from her fiance:

"He said it was my decision alone...he wouldn't say, he just would not say, whether he wanted it or not...I did wonder if I could carry it through therefore". "I felt dreadfully isolated and after that probably any feeling of wanting to keep the baby was lost in the feeling of carrying the responsibility of childbearing...I would always be responsible...I felt it would be unfair on the child...I wouldn't have been a good mother".

However she does also say "...there was a bit of me that thought I would quite like to go through with it", and later on she also said "I think if he had told me not to do it, then I wouldn't have gone ahead with it".

Alison didn't know what to do so spoke to a friend, who recommended she have a termination. She did not tell her family, except her sister.

3. The abortion
She decided to have a termination in London, as she did not want to go anywhere local, and she did not visit her GP in case he either 'forced' her to have the baby, or it took too long to arrange. She saw a counsellor and gave her her reasons for the termination, although she does admit lying a bit because she was scared she would not get the abortion. However Alison said she was not pressurised, although the lady was 'quite strongly in favour of the abortion' and agreed a termination was best. She does not recollect any alternatives being offered and said the whole process was very quick.

When Alison came around from the anaesthetic she was very weepy, and was treated very unsympathetically by the staff. She was given printed information about the operation, and counsellors she could contact, but never felt she needed it.

4. After the abortion
"Emotionally I didn't think about it...I was just glad it was over and I could go home, to my wedding, knowing that was it. It was over and done with". She continues: "I've often thought about the way I felt about this, and the way I feel now, and I don't feel an awful lot different. I did it for very practical reasons, and I often feel that I *should* feel more guilt...I don't have any unresolved feelings about it." Later on in the conversation, however, she said that when her husband left she realised there were not going to be any children "...almost like, I suppose, I'm not going to be able to absolve my guilt by *having* a child".

Her husband refused to ever talk about it and never expected her to be emotional about it. Later she says "...because he had cut himself off from the decision that was probably the end of the relationship. I found it hard to feel close to him sexually ever again...it got so bad I couldn't connect with his heart again".

"It's worse now because I'm 31 and I think am I ever going to have children? And I regret it more now than I ever did then because looking back I did it thinking there would be children".

"This conversation is very useful for me because I've never fully rationalised the way I feel about it. It's obviously because I've completely cut it off".

5. Counselling
"Faced with somebody who just would not talk about it you have no emotional contact. Maybe in that respect if I had had contact with someone who could counsel me before I reached the decision to have the abortion maybe I'd have felt able to have the baby".

By the end of the conversation she says: "I've never personally solved my emotions about it. I can't understand the way I feel, and I don't believe that I don't really feel anything about it, but I just don't know how to get at the way I really feel about it. I try to justify it in terms of practicalities."

6. Conclusion
"I've probably never realised all the emotional impact that it's had because when my friends are getting pregnant, in stable relationships, I just think 'wouldn't it be nice...' but not many people know how I feel."

"People said to me about the termination that I did the right thing and I couldn't cope with a child, and I think 'no, no, that doesn't justify it, that just doesn't justify it'. And when he left I thought I wish I'd had it, I wish there was something to show for our marriage".

Alison feels able to cope now, having gone through a separation and associated Relate counselling, and she felt our conversation to be opportune and useful in "laying the past to rest". However, she says she would not have a termination again, if she became pregnant and she concluded by saying: "It's at the back of my mind and hasn't gone away. For practical terms I can cut it off but there is an emotional part of me that thinks I shouldn't have done it...I don't want to get old without children".

SUMMARY OF WRITTEN AND ORAL EVIDENCE – ALICE

1. Background
Alice is 33 years old, married to the father of the aborted baby and they have 3 children. Her abortion took place when she was 18 years old and employed as an office worker.

2. Events leading to the abortion
She remembers the pregnancy being unplanned and being very shocked by it. Alice visited her doctor but the initial results were negative, then he wrote and asked her back again, and told her she was pregnant. He offered her an abortion there and then, and she signed the form immediately. She was not told how many weeks pregnant she was, and comments "I was very shy and shocked and didn't really want this to be happening...I think I just blocked it all out".

An appointment came through and Alice went to the hospital for a blood test and pre-medical. She was not given any information about the abortion procedure nor possible consequences.

Later she says "I hadn't made up my mind at all but was just being influenced by others. Looking back, I would have liked more time. I regret not being able to make up my own mind...At the time we both blocked it all out". She also said later that she felt she wasn't making an informed decision, and she let the doctor tell her what to do because she thought he would know best, especially as she was only 18 years old. "You can't even think straight when you have an unplanned pregnancy".

3. The abortion
It did not take long for the appointment to come through from the hospital. She does not remember much about the operation, except that just before the injection she told them she didn't want to have it done, but they carried on and didn't say anything.

Her immediate feeling when she woke was 'I wish I hadn't done it'. She says "I woke to a room full of screaming women. It was horrendous. I thought they must be feeling how I was, because it was so immediate.

When I woke I knew I'd done something terrible". She was not offered anything after the operation except bedrest.

4. After the abortion
The first few years after the abortion were fine, with no real physical nor psychological problems at all, other than the immediate reaction. "Then when I had my first baby I went into shock. It suddenly hit me that this was a baby". She describes the years between her first baby and the abortion counselling:

"I had panic attacks and five years of really bad illness and thinking I would die...I went to the Doctor every month and although the abortion was on my records he didn't see it was the cause." Alice did not realise the cause either, and just thought she was ill. It was her mother who eventually suggested the illness and attacks might be due to the abortion.

She also had two miscarriages during the time when she was ill.

5. Counselling
"In the last few years I've had counselling (for the abortion), which finished about two years ago and since then, for the first time, I've lived a normal life".

Talking about her husband's feelings, Alice said "My husband feels very similar to me – he wishes we'd had more counselling. Like me, the minute he saw me in the hospital he knew we'd done the wrong thing...He hasn't had counselling since". However she says that "he does feel better about it because of me and my counselling sessions – we'd talk about them". She does feels that it has affected her relationship with her husband.

"I think you need someone to talk to you about it to tell you exactly what's going to happen and what's going to happen to you in later life."

6. Conclusion
"I felt sick about myself, how weak I was. If only I'd opened my mouth at the time and said I want to keep it then there would have been no problems".

Alice also spoke about her sister in law. "She'd got two children and didn't want a third and she got pregnant and she was saying about going and having an abortion, and I talked her out of it. She's had a little boy and she's pleased as punch that she's got him".

"If I was advising a girl in the same situation I would tell them to have lots of counselling and not to go ahead with it either...It will sort itself out a few years later but abortion doesn't, does it? It goes on affecting you". She added at the end "It's hard to bring all this back again".

(Following this interview, Alice was ill for a week as a result of having to think through all her experiences again)

SUMMARY OF WRITTEN AND ORAL EVIDENCE – LUCY

1. Background
Lucy had her abortion in 1992 when she was 35 years old, married, with 2 children. The father of the baby was not her husband.

2. Events leading to the abortion
Lucy said there was no prospect of a long-term relationship with the father (who was in no doubt it had to go) and her husband "wasn't too keen on sticking around". She was not sure what to do and wanted to really think about the decision. All those close to her were telling her she had to have an abortion, however she says "I thought no, I won't be pushed, I'll think about this". She says about the decision "You're really pressurised – there's this clock ticking away against you. It's got to go and it's got to go quickly...having had two children I knew how quickly it was developing".

She decided to have an abortion. "It felt to me that I had no option, even if I'd wanted to keep it. I felt that it would upset so many other people by keeping it. I'd never want to make the choice again, never. Having got two children already that made it even harder, because you know what you're doing. I thought 'it's going to be another one of these two', so I had to think of those two". Later she said "I came around to the decision, I felt, in my own way. I didn't feel pressured".

3. The abortion
Lucy said her doctor was very helpful, putting no pressure on her either way. However it took a while for an abortion to be arranged on the NHS and "I was hysterical because once I'd decided, I wanted it done quick. The NHS wheels were going to move so slowly so I went private".

She had an examination at BPAS, whom she said were very good, and was offered counselling beforehand, which she didn't feel the need to take. Lucy was told there would be a minor risk of retained products but said "they gave the impression it would all go swimmingly…like a tooth extraction…nothing was said about psychological consequences but they said I might need counselling".

Describing the place where she had the operation, Lucy said "It was just awful…they were dreadful, it was like a factory farm". She said she came around crying but no-one took any notice and she was given one hour before she had to leave. "I can't believe people can treat someone like that when that's what they go through. I mean, you're killing your child!" She adds "I can imagine for some people…going through that would live with you for the rest of your life. I don't choose to think or talk about it..I won't get over it, I won't ever get over it". She put it down to being "…all time and money" and would have liked some sympathy. "I was killing my third child and it was awful".

4. After the abortion
Her immediate feeling after the abortion was "Desolation, not really regret or relief, because I didn't like it either way. A touch of relief…and a touch of regret". She says she has probably forced herself to be matter of fact about it. "The situation arose, I wish it had never been there, and you just have to shut it up. It's easier to turn the anger outwards rather than inwards." She writes in the questionnaire: "I was distressed but also relieved. Angry and shocked. Lonely and have since had nightmares. Guilty and sad about the baby."

Lucy had trouble for weeks afterwards with retained products and infection. She visited her GP and hospital and told BPAS. "I was passing huge lumps of liver and things. There was definitely something wrong – but I never had anything done. Everyone wanted to pass the buck". She said that it eventually cleared up, several months later.

Lucy writes that the abortion had affected the relationship with the father and they have since parted.

5. Counselling
Lucy never felt she needed to return to BPAS, although she stressed they were there for her. She did, however, find help because she was on a counselling (training) course so in "all the beginning months of the counselling the subject that I chose to key into was the abortion". She certainly felt there were some issues that had come up from the abortion and suggested there is a need for counselling for women afterwards because "killing my third baby is something I'll never *really* reconcile and we did a lot through the counselling around that".

6. Conclusion
When abortion is mentioned in public Lucy tells of her reaction: "I always react – a twinge of sadness is not a strong enough word – a twinge of pain, something you know you've got to carry around with you…for the rest of your life…Even flicking through a magazine…I choose not to look at the back pages of listings clinics. There'll *always* be a twinge, always".

SUMMARY OF WRITTEN AND ORAL EVIDENCE – JULIE

1. Background
Julie had her abortion in 1991 when she was 41 years old, married, and mother to two girls aged 3 and 4 years. She was a housewife at the time.

2. Events leading to the abortion
"I didn't dream I'd get pregnant". She took the morning after pill but that did not work and she knew almost immediately that she was pregnant, even before missing her first period.

With her husband's poor health record (he had had a heart by-pass operation) and her age she said "I was 99.9% certain that I didn't want another baby". "I didn't want a baby really because I have got two wonderful children, whom I absolutely adore too much, and I didn't feel I could be a good mother to three. I thought I could be a good mother to two. Also, I had to bear in mind I could be on my own in 10 years time possibly…so I will almost certainly be a single mother of teenage children".

Her husband was not sympathetic at all and "he said to me 'no, of course, we couldn't possibly afford another one…of course, if we knew it was going to be a boy…' He wasn't really interested in it. It was my problem".

3. The abortion
Julie went immediately to the doctor who "luckily sent

me straight to a gynaecologist who I'd actually been through a pregnancy with, and who was terribly sympathetic, made sure it was what I wanted and went ahead with it and I had it within 10 days". She was sterilised at the same time.

Her doctor fully supported Julie's decision and said he'd try to get it on her medical insurance, saying he thought it was almost a medical case. "I did get half the cost on my medical insurance, which was rather lucky".

The nurse at the clinic told Julie a bit about the procedure, but not about the development of the foetus or possible physical or psychological complications following the abortion. The gynaecologist said she could go back to him if she had any problems, although later she said she never returned to either the doctor or clinic.

4. After the abortion

"Every so often I think 'gosh, that baby would have been so and so months by now'. But that's all". She said she has suffered from no adverse feelings at all since the abortion and has had no complications since. "I don't think you'll get anyone more positive than me!"

She did say that having an abortion could be very emotional for some people. "I think my sister-in-law had an abortion and sterilisation and then went back and had it reversed and had a child. I think she found it horrendous. But she knows I've had mine and we've never discussed it".

Julie said her husband could have been more sympathetic and supportive and said she did feel a little isolated, but could cope with it. "I like him less for his disinterest" she writes. "He was very unfeeling and yes, he was horrible" she said.

5. Counselling

Julie had no need for any counselling afterwards and also said it would have been no help if her husband had seen the doctor with her, although she did say that probably in a lot of cases it would be helpful for the father to be involved more in the decision.

"Another girlfriend of mine, of a similar age, has just had an abortion...but she didn't have any counselling and that does concern me. I think a lot of people do slip through the net and don't have any counselling". She thought that counselling should be statutory before the abortion.

6. Conclusion

"The reason I answered the advert and agreed to come was because I've had this experience. I wanted to tell you it's been...a very positive thing".

Giving the reason why the whole procedure has been easy for her she said "I think it's because I love my two children so much, they're so important to me. If I didn't have children I wouldn't have had an abortion, because without children I wouldn't have known how important they are to me, how much I care for children. So I only want absolutely the best for them. Certainly when I first fell pregnant I never dreamt I'd love that child so much, that she'd mean so much to me. I think if I'd had an abortion without having children I'd have thought it was a dreadful thing to do. Now I feel I would only want a baby if I could give it as perfect a life as possible".

SUMMARY OF WRITTEN AND ORAL EVIDENCE – ALEX

1. Background

Alex had her abortion when she was 13 years old and had been going out with a boy for 9 months. She was still at school and using no contraception. She is now 17 years old.

2. Events leading to the abortion

At first Alex tried to ignore that she was pregnant, even though she was missing periods, getting larger and her clothes were tighter. She did not want to associate this with being pregnant and said her boyfriend was also denying it was happening.

Her main fear at first was telling her mother who was, however, very supportive when told and asked Alex what she wanted to do about it, saying she would support her whatever her decision.

Alex writes "I wasn't sure, I was confused and panicky, the fear of keeping it and all the worries it would cause, the change in my young life and the fact that the child would have a mother 13 years older than itself, made me decide to have an abortion. These things were all in my head and not talked about. I told my mum the next morning that I'd like an abortion".

Time was short as she was quite late in the pregnancy and was an 'urgent' case, so she went the same day for a scan. "Between the scan and operation I had one day to think, but I didn't really".

Her boyfriend also told her to do what she wanted but said he thought she should get rid of it. "We didn't talk about it much".

3. The abortion

Alex was about 16–20 weeks pregnant. "At the time I felt half relieved I'd got there in time". She was given no information about the development of the foetus, the procedure or any possible risks involved. She said that maybe her mother was told instead. "I would have liked to have known what was going to happen…I didn't realise the seriousness of the whole thing…I don't know if I would have changed my mind but I had a right to know. Even though I was only 13 it was still my body". The abortion was done on the NHS in the maternity unit. She was wired to a drip for an induced labour. Alex writes about it: "I gave birth to a white sack, I glanced down and saw a dark shadow on it, was it a leg? or an arm? I was never to know and that was it. After a few check-ups and some rest I was discharged…without any counselling or even an advice contact". While at the hospital she asked what would happen to the baby and was told it would go into medical waste. "That upset me – I knew I couldn't expect it to be buried but to know it had just gone into…waste" she found very hard.

4. After the abortion

Alex said she first felt relieved that it had gone. She had asked the midwife the sex of the baby and when told it was a boy named him Jamie Robert Lee.

Alex then slept with her boyfriend two days later. "I wasn't really hurting but I did want some comfort and that was the way it was easy to get the comfort". Also, she had not been told not to sleep with him, although she was told she should be using contraceptives. Her mother told her off for this, but did not ask how she was feeling.

5. Counselling

"I went to see a psychologist after a while because I started to emotionally break down because everything (the abortion and her parents divorce) was too much". However Alex did not feel that the advice she was given was right, saying it was not from God, she was told long words and she did not understand it. She felt it was pushing it all further away.

Alex has now received counselling from a couple at her church. "We went through it all, prayed about it. They've been very good". Yet she also says "I know it has not all been let out". Later she says "Sometimes…I do get tearful but only around people I'm close to who know about it". Otherwise she is careful not to show it.

6. Conclusion

"I'd like to be able to…offer someone the advice that you can't destroy this life. I probably would say you can't destroy this life, but still with me…I chose it because of my circumstances, I chose it myself on the evidence that I had". She adds "If it happened now I wouldn't have another abortion, I'd have the baby".

Alex writes "Until this very day I feel that I was treated unjustly. Maybe if someone had told me all the many years of suffering that would follow and the emotional scar it would leave, who knows, maybe I'd have a beautiful bouncy 4 year old boy today".

ANNEX 7

The London Hospital (Mile End)
275 Bancroft Road
London E1 4DG

Telephone 01 980 4855 Ext 283

Director: Professor P J Huntingford

INFORMATION BEFORE AN ABORTION

You have decided to have an abortion. As the pregnancy is early, it will not be necessary to admit you to hospital. Arrangements have been made for your operation as follows:-

1. IMPORTANT

On the morning fixed for your operation have nothing to eat or drink. For your health and the safety of the operation follow all advice given in this leaflet, otherwise we may not be able to operate as arranged.

2. Please remove nail varnish and, if possible, have a bath before you come. Bring a dressing gown and slippers with you and leave all valuables at home. If you wear make-up, be prepared to remove it before the operation.

3. On.....
at.....
kindly go to: The Outpatient Department
The London Hospital (Mile End)
Bancroft Road
London E1 4DG

4. You will be shown to a waiting area near the operating room, where you will change into a gown. You will not be shaved or have an enema before the operation. You will simply be asked to empty your bladder.

5. After the operation you will wake up in a bed near the operating room where you stay (usually two to three hours) until you are fully awake and fit enough to leave. Be prepared to spend from 2 to 4 hours from the time you arrive until the time you leave the hospital.

6. You may wish to bring a friend with you to the hospital. He or she may wait with you until you are ready to leave, or may choose to return at the time when it is likely you will be able to go home (about 4.30 pm). You should be accompanied home. You should not attempt to drive a car yourself, so do not drive yourself to the hospital unless there is someone else who will drive you home.

If you are not accompanied home it will be necessary to admit you to the hospital for the night.

7. Small amounts of anaesthetic can remain in the body for several hours, even after you feel fully awake. You are therefore advised to stay at home until the day after treatment.

Until the next day
- do not go to work
- do not drink any beer, wine or spirits
- do not drive any vehicle or operate machinery
- do not walk or travel on public thoroughfares unaccompanied
- be careful when using domestic appliances at home, especially gas or electric cookers, kitchen utensils, heating systems etc.

On arriving home you will probably wish to eat, preferably a not too heavy meal. There is no need to go to bed immediately, but you should rest quietly at home for the remainder of the day. Somebody should be with you overnight.

You should be fit and able to resume your normal activities the day after the abortion. You will be provided with more detailed information on leaving the hospital.

Further Information

1. Your blood will have been tested before the operation. If you belong to the Rhesus Negative blood group, you will be given an injection immediately after the operation to prevent the formation of antibodies that might otherwise cause problems later on if you have a baby.

2. You may have already decided what contraceptive you wish to use after the abortion. You will already have had the opportunity of discussing contraception with us at your first visit. You may wish to continue this discussion on the day of your operation either before or afterwards.

If you wish to have an intra-uterine device fitted, this can be done under the anaesthetic immediately the abortion has been completed. If you wish to use an oral contraceptive, a supply of the pills for three months can be given to you before you leave the hospital. You can start using them the day after the operation. We shall be glad to discuss other methods of contraception, including male and female sterilisation, if you wish.

3. Because of unforeseen complications, it is sometimes necessary to keep people in hospital overnight following an abortion. Make allowances for this.

4. Finally, if you wish to change your mind about having an abortion, or wish to discuss the matter further, please do not hesitate to tell us. Telephone 980 4855 ext 283.

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Information Concerning Termination of Pregnancy by Prostaglandin Injection

After 16 weeks of pregnancy, it is generally safer to carry out abortion by starting off a miniature labour. This is how it is done:

1. You will be admitted to Spencer Ward.

2. At a time to be arranged after you are admitted, the injection will be made into the womb to start off the abortion. This is usually done in Spencer Ward, occasionally for convenience it is done in the operating theatre. You will be asked to lie flat. Your tummy will be cleansed with an antiseptic solution. You will have an injection of local anaesthetic solution to numb the skin and underlying tissues of the tummy wall over the womb, about half way between your navel and pubic hair. Through the numbed area another needle is put into the womb. We know that it is in the correct place when we can suck off some of the fluid in the pregnancy sac. A thin plastic tube is threaded through the needle which is then removed. These preparations take between 5 and 15 minutes.

3. An injection of prostaglandin is then made through the plastic tube into the inside of the womb (which make the muscle of the womb contract like labour to open the cervix (= neck of the womb)) and also urea which kills the fetus and the placenta.

4. Once the womb begins to contract you will feel pains like labour in the lower part of your back and stomach. The pains come with increasing frequency and strength until the neck of the womb is opened up enough to allow the fetus and the afterbirth to pass into the vagina so that it can be easily removed. The pains may last from 6 - 12 hours before the abortion occurs, and they may not begin immediately after the injection; there is sometimes a quiet period for up to 12 hours before anything happens. It is occasionally necessary to give a second injection, but this is easily done through the plastic tube which is left in place until the abortion is complete.

5. Sometimes not all of the afterbirth (placenta) comes away cleanly and it is necessary to give, in between one-third and one-half of all women, an anaesthetic to scrape the inside of the womb clean and complete the abortion.

6. We advise that you stay with us for 24 hours after the abortion is complete, which means that you should be prepared to be in hospital for 3 -4 nights, including the night before the abortion is started. You should be fit to return to work 2 days after the abortion is completed.

7. Individual explanations and further instructions will be given to meet your own particular circumstances.

November 77 PJ Huntingford

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TOWER HAMLETS PREGNANCY COUNSELLING AND ABORTION SERVICE

The London Hospital
4th Floor
Fielden House
Stepney Way, London E1

Tel No: 071 377 7044
071 377 7000
Bleep No. 1739
Brenda Williams - Day Care

Director: Dr Fran Reader

INFORMATION BEFORE AN ABORTION

You have decided to have an abortion. As the pregnancy is early, it will not be necessary to admit you to hospital. Arrangements have been made for your operation as follows:-

1. On ..... at .....
go to CAMBRIDGE WARD, ALEXANDER WING, LONDON HOSPITAL, WHITECHAPEL

2. INSTRUCTIONS FOR YOUR OWN SAFETY

   a) DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT ON ..... YOU MUST NOT EVEN HAVE A GLASS OF WATER.

      If you vomit while you are asleep under the anaesthetic you might choke.

   b) MAKE SURE YOU HAVE ARRANGED FOR SOMEONE TO COME TO THE CLINIC TO COLLECT YOU. Tell them to come at 12.00 to wait for you. They can stay with you all morning at the clinic if you wish.

   c) PLEASE REMOVE ALL NAIL VARNISH AND IF POSSIBLE HAVE A BATH BEFORE YOU COME. DO NOT BRING VALUABLES TO THE CLINIC.

      Bring a dressing gown and slippers with you and remove all make-up before you come.

FURTHER INFORMATION

1. Small amounts of anaesthetic can remain in the body for several hours. You are therefore advised to stay at home that evening and not to drink any alcohol. Be careful when using domestic appliances at home.

2. Your blood will have been tested before the operation. If you belong to group Rhesus negative you will be given an injection immediately after the operation to prevent the formation of antibodies that might otherwise cause problems later on if you have a baby.

3. Please make sure that you know what form of contraception you will be using in the future. If you wish to use an oral contraceptive, a three month supply can be given to you before you leave the hospital. You should take the first Pill the day after the operation.

4. Please ring us on the above number if you change your mind about the abortion or wish to discuss it further. Also, please ring if you have a cold or chest infection as we might need to change your appointment.

5. Finally, please make allowances for the fact that if an unforeseen complication arises we might have to keep you in the hospital overnight.

TOWER HAMLETS PREGNANCY COUNSELLING AND ABORTION SERVICE

4th Floor, Fielden House, Stepney Way Tel. No. 071 377 7044

Director: Dr Fran Reader Administrator: Brenda Williams

INFORMATION AFTER AN ABORTION

You already know that you should be accompanied home on leaving hospital. Somebody should be with you on the night of the operation who knows that you have had an abortion to keep you company and to help if need be. Following the operation you may notice these things:

1. You feel light headed or 'cut off' from the world because of the anaesthetic drugs. Stay at home the evening of the operation and do not drink any alcohol or drive a car. Make sure also that you are careful if using gas or electric cookers or heaters.

2. Most women lose bright red blood from the vagina, and some clots after the operation. A few do not bleed at all. After the first day the loss becomes darker and no more clots are passed. In some women the blood loss comes and goes and in most it has stopped by 10 days. You should use sanitary towels, not tampons, until the loss has stopped.

3. Most women have some cramping lower abdominal pain after the operation for a few hours, in some the pain may last longer. Take one or two Panadol tablets to relieve the pain if necessary.

WHEN YOU SHOULD CONSULT A DOCTOR

If any of the following problems occur in the first few days after the operation then you should inform your doctor or the duty gynaecological registrar at the London Hospital Whitechapel or report to the Accident and Emergency Department at Whitechapel.

1. If the bleeding becomes very heavy.
2. If you have severe lower abdominal pain, either continuous or on and off.
3. If you feel feverish or have a raised temperature.
4. If the vaginal loss starts smelling offensive.
5. If you are worried or anxious in any way.

RETURN TO WORK

You should not return to work the following day.

FOLLOW-UP VISIT AND CONTRACEPTION

It is very important to attend your check-up appointment with your doctor or family planning clinic two weeks after your abortion. Remember that if you are going to take the pill you need to start the day after your abortion so as to prevent you from ovulating.

Once the bleeding has stopped and you are using contraception you may have sexual intercourse and it is OK to use internal tampons the next time that you have your period.

If you have any worries other than the above, then please ring Brenda on 071 377 7044.

DAY CARE ABORTION SERVICE

CHECK LIST FOR ABORTION COUNSELLING

Name .....

Letters/phone calls to home Yes/No

If no - method of contact.....
.....

[ ] Method of abortion/anaesthetic discussed

Risk of the operation

[ ] Anaesthetic Risk

[ ] Heavy Bleeding

[ ] Damage to the womb

Early Problems

[ ] Heavy Bleeding

[ ] Infection

[ ] Possibility of pregnancy continuing with early abortions (less than 8 weeks)

[ ] Mixed feelings*

Late problems

[ ] Weakness of the neck of the womb

[ ] Infertility (problems of getting pregnant again)

[ ] Mixed feelings*

Other Matters Discussed

[ ] Nothing to eat or drink from 7am on day of operation or from midnight the night before which ever is applicable.

[ ] Need for a responsible adult to collect her and take her home.

I..... have discussed the above with the counsellor. I agree to having nothing to eat or drink after 7am on the day of my operation or from midnight the night before whichever is applicable, and that I will arrange for a responsible adult to collect me and take me home after the operation.

Signed..... Witnessed.....
Counsellor/Doctor

Date.....

*** Added in 1985 to original 1981 check list.**

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