ANNOTATION

Self induced abortion

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If the Abortion Act has considerations of merit, then one of these may be the displacement of the self induced abortion. It is of interest, perhaps historical, to record one method of inducing abortion.

Mrs B. claims to have induced abortion for herself successfully on 23 consecutive occasions. This claim has been repeated to a number of practitioners during the past four years and there is a credible consistency in the records.

Each abortion followed a single interference procedure. In some instances there was an induction–abortion interval of several days. Abortion was induced at various times between the eighth and 30th weeks of pregnancy, though the majority were performed at 8–12 weeks.

The first abortion was a near disaster, being associated with severe haemorrhage and shock demanding intensive blood transfusion in hospital. During all the remaining abortions Mrs B. claims to have continued with her usual employment and seems to have suffered remarkably little constitutional disturbance.

Method

1. On the evening before the attempt, take a block of toilet soap. Flake the soap into a bowl and add two pints of boiling water and two tablespoonsful of 'Dettol'. Allow the mixture to cool to form a jelly.

2. On the morning of the following day take the jelly and add a further pint of boiling water and one tablespoonful of 'Dettol'. The resulting mixture is gelatinous and of a consistency to pass freely through a Higginson syringe. Allow the mixture to cool to an acceptable working temperature.

3. Selection of the day is important. It should be the first day of the projected menstrual cycle, usually in the eighth or 12th week.

4. When the mixture has cooled, the suction end of the syringe (recently boiled) is placed in the bowl. Great care is taken to ensure that the end remains at all times below the surface level of the fluid.

5. The other, and longer, end of the syringe is introduced into the vagina. Whilst the bulb of the syringe is intermittently compressed to pump the fluid, the end of the tube in the vagina is manipulated until it is known that "the membrane at the neck of the womb has been broken". This knowledge came to Mrs B. by way of "a sudden sharp and severe pain in the navel".

6. Immediately this pain is felt the procedure is terminated as abortion is then "certain to follow".

Mrs B. attributes the success (23 out of 23) and the safety (22 out of 23) of her method to an adherence to a number of important practices. These are:

1. Always add the 'Dettol' It "prevents septicaemia setting in".

2. Always boil the syringe before use.

3. Always ensure that the end of the syringe in the bowl is below fluid surface level. "The introduction of air can be very dangerous".

4. Never continue the procedure once the "pain in the navel" has been felt.

The method has acquired disrepute because some women fail to observe these simple precautions.

Discussion

The patient's medical record contains no reference to anaemia since the first abortion. The

haemoglobin is now 13·4 g per 100 ml, and Mrs B. states that she has never taken supplemental iron.

Twenty-three pregnancies suggests either remarkably resilient fallopian tubes or a minimal introduction of pathogenic organisms. Mrs B, now aged 46 is menopausal and clinical examination of the pelvic organs reveals no abnormality.

Mrs B. was asked if she had supplied her method to other women and replied with an offended air, "Good gracious no, doctor, that goes against my ethics".

Summary

One method of self induced abortion is described in detail.

GENERAL PRACTITIONER AS MINISTER OF HEALTH

Dr Richard Potter, M.D., a member of the Canadian College of Family Physicians has been appointed Minister of Health for the province of Ontario, Canada. He was formerly a Minister without Portfolio in the Conservative Government of the province. Dr Potter left practice two years ago.

In an interview with the editor of the *Canadian Family Physician* Dr Potter is quoted as follows:

Woods: "How about drugs?"

Potter: "I'm sure many physicians have had the same experiences as I have had—prescribing drugs for patients who come back after two or three weeks with no difference in their condition. Eventually, they admit that they didn't get the prescription filled because they didn't have the money to pay for it. So I think that drugs too are eventually going to have to be covered by the programme."

Woods: ". . . What are some of your priorities?"

Potter: ". . . From a family physician's standpoint I would say that I am very anxious to see more projects developed similar to the one we started in Belleville recently on the self care unit where we can provide other types of accommodation—or other ways of treating patients —rather than keeping them in expensive active treatment hospitals when they do not need to be there."

Woods: "You would see the family physician as a key figure in the health care structure of the future?"

Potter: "No question about it and I think it is a big challenge to the family physician to accept this role, to co-operate and to help develop this structure."

Woods: "Community health centres staffed by physicians?"

Potter: "That's right. I would like to see family physicians become more receptive to this type of care rather than become hospital orientated as so many of us have over the past 40 years."

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HEALTH VISITORS AND NURSES

The number of health visitors has increased to a record of 6,035 full-time equivalents, an increase of 5·4 per cent.

The number of home nurses has increased to 9,069 full-time equivalents, an increase of 5·3 per cent.