Requests for termination of pregnancy in the East Midland area—Sheffield region

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Summary

A study was carried out of patients seeking termination of pregnancy through their general practitioners. Three quarters of these patients were recommended for termination. Of these 80 per cent did, ultimately, have the pregnancy aborted. A number of patients showed guilt feelings but anything approaching mental illness occurred in only two patients.

Since 1968, when the Abortion Act came into force, the General Register Office has produced quarterly figures of the number of terminations of pregnancy carried out in the various hospital regions of England and Wales. There has been considerable comment about the wide variation in the numbers terminated and there has been much speculation about the reasons for the disparities. Even taking into account the possible reluctance of a woman seeking termination in the anonymity of the London Metropolitan area to give her correct name and town of origin, there is still a marked variation between the regions. These differences have been reduced as time has passed, but they persist.

It seemed appropriate to examine one of the regions with a low termination rate to see whether there were any obvious factors which would explain its position in the list. Sheffield is such a region, but it was not possible to carry out a comprehensive coverage of all the region and this study selectively examines those patients who sought advice concerning possible termination of pregnancy from family doctors who participated in the survey. It is interesting to note (Cartwright and Waite, 1972) that the Sheffield region did not stand out as conspicuously as Birmingham region in the number of abortions turned down, nor in proportion of doctors wanting more facilities for abortion, compared with the other regions.

Before the 1967 Act there was a paucity of reports in this country from doctors who were recommending termination of pregnancy. No doubt they felt unsure of their legal position and felt it wiser not to draw attention to their clinical activities, although they were entirely within the law provided they acted in good faith (Hordern, 1971). The reports came mainly from psychiatrists who found that termination of pregnancy was without influence on the outcome of mental illness (Arkle, 1957) or who believed that the psychiatrist has no role other than considering major psychoses in any discussion about the need for aborting the pregnancy (Sim, 1963). Both the proponents and opponents of the Abortion Bill had to rely on information from Scandinavia in support of their arguments. Each was able to use the figures from the same set of papers in support of their arguments (Kay and Schapira, 1967; Sim, 1967).

Since the Act has come into force there have been several papers reporting on cases seen before 1968 or spanning the start of the Act. Two features emerge from these

papers. Firstly, where termination is not recommended nearly half these patients either abort spontaneously or illegally, or succeed in obtaining a legal recommendation elsewhere (Clark *et al.*, 1968; Pare and Raven, 1970; Beazley and Haeri, 1971). Secondly, the sequelae of termination are on the whole very mild or absent (Clark *et al.*, 1968; Diggory, 1969; Gillis, 1969). Sclare and Geraghty (1971) report that patients whose pregnancies were terminated for medical reasons tended to show rather more persistent guilt feelings than those who were terminated for psychiatric reasons.

Relative risks

Since judgment on the relative risks of terminating the pregnancy and allowing it to continue must take into account both psychological and physical factors, it is important to assess the physical mortality and the morbidity of the operation. It is generally agreed that mortality is low but there is less agreement about morbidity. Stallworthy *et al.* (1971) drew attention to the relatively high morbidity, while in the same journal Rawlings and Khan (1971) were much more optimistic. An editorial in *The Lancet* (1971) also referred to the problem and noted that reported complications during the first trimester are high in the United Kingdom compared with those from other countries. There is therefore no clear-cut evidence to help in forming an opinion of the risks of allowing the pregnancy to continue or of terminating it, whether from the psychological or the physical point of view.

Role of the general practitioner

It is this very lack of information which provides the greatest difficulty for doctors faced with a patient asking for termination of a pregnancy. It is usually the general practitioner who is first confronted with this problem and it is he who often knows the patient well and is going to have to look after her in the future whatever decision is made. His own decision may not influence the final outcome because he does not always have the means of implementing his views. He is dependent on a number of arbitrary factors, including the views of gynaecologists in his area, the length of their outpatient clinics and inpatient waiting lists, to say nothing of the pressures put on them by their nursing and medical colleagues.

This study examines some of the factors involved in the ultimate outcome of these decisions by examining what happened to a group of women who arrived at their general practitioner seeking termination of a pregnancy. It covers patients of doctors belonging to the East Midlands Faculty of the Royal College of General Practitioners. The area served is a mixed industrial and rural area extending over Derbyshire, Nottinghamshire, South Yorkshire and Lincolnshire and including the cities of Sheffield, Nottingham and Lincoln. It was considered that this area was reasonably representative of the hospital region as a whole and probably representative of any mixed population around moderate sized industrial cities.

Method

Members of the East Midlands Faculty were invited to participate in this survey. Each general practitioner who agreed to take part was given questionnaires, each to be filled in concerning any patient seeking termination of a pregnancy. This included patients who did not make an outright request for termination but hinted or requested something to bring on her periods, or whose relative, perhaps the mother or husband, requested that the operation be carried out.

Information was collected about the woman's social and marital status, age, duration of pregnancy, the putative father, use of contraception and the view of the general practitioner about what decision should be reached. He was also asked what further steps he took to implement his decision.

The form was then returned for coding to the authors, but the general practitioner

retained a slip giving the name and address of the patient and the code number so that the authors knew only the reference number, thus preserving the confidentiality of that patient. Six months later a follow-up form was sent to the general practitioner seeking information about the outcome of the pregnancy. It was recognised that there would be an inevitable loss of information because many patients were temporary or moved away from the area, either because of the pregnancy or due to other circumstances.

Results

One hundred and thirty general practitioners agreed to take part in this survey. These were all principals in general practice; on some occasions there were several partners from one practice included in the survey. One rather special unit was the Young People's Centre in Sheffield and seven of their doctors participated in the survey. However, because of the unusual nature of the group these results have been kept separate and have been labelled '408 Clinic' and reported in an appendix. Doctors came from an area extending from Sheffield in the north, to Sleaford in the south, Grimsby in the east and Bakewell in the west.

Sixty-nine doctors completed at least one interview form. It is not possible to know whether the remainder saw no patients requesting termination, or whether they were unable for some reason to participate in the study. It is therefore virtually impossible to estimate the population concerned.

The survey was expected to last for at least 18 months in order to collect enough patients. In practice, because this survey started soon after the warnings about the high oestrogen contraceptive pill (February 1970) there was a large number of unexpected and unwanted pregnancies occurring and, as a result, the expected number was achieved in less than 12 months. In all 200 records were collected.

Details of age and marital status are given in table 1. Forty-one patients, that is 20 per cent, of the single women had had previous children. Eight of them had had previous abortions, one of them having had two. In all seven patients had had previous known therapeutic abortions.

TABLE 1
AGE AND MARITAL STATUS

Age	*General-practitioner group*					
Years	*Single*	*Married*	*Separated or divorced*	*Widow*	*Co-habiting*	*Total*
Less than 16	7	0	0	0	0	7
16–20	36	4	0	0	0	40
21–30	33	40	9	0	2	84
31–40	4	45	9	0	1	59
Over 40	0	7	2	0	1	10
Totals	80	96	20	0	4	200

Patients were asked about their attitude to the pregnancy and in general the predominant attitude was that of willingness to consider continuing the pregnancy, but 33 of the women were frightened at the prospect of the pregnancy, five were angry and 29 rejected the child and could not consider the prospect of coming to care for it.

Most requests for termination were received about the second missed period, but twice the request was received as late as the fifth month.

As has usually been described, the putative father was either the husband of married women, or a steady boy friend with whom there was a semi-permanent relationship (table 2). In 33 patients (16·5 per cent) the pregnancy was the result of a casual relationship. Only one out of the whole group was the result of rape and in one case there was incest, in a girl aged 16.

TABLE 2
RELATIONSHIP OF PUTATIVE FATHER

Putative father	*General-practitioner group*	
	Single	*Married*
Husband	5 (co-habitor)	90
Steady boy friend	67	2
Casual boy friend	29	4
" Stranger "	1	0
Rape	1	0
Incest	1	0
Totals	104	96

Patients were asked about their usual method of contraception and also whether it was used at the time of the pregnancy (table 3). Ninety-six patients (48 per cent) used no contraceptive at any time. Details of other methods are shown in the table. One patient reported a pregnancy after an operation for sterilisation. Among those patients who agreed that they normally used a contraceptive, 105 stated that the pregnancy was a result of non-use at that time. A small proportion of these were patients who had been on the contraceptive pill but had become frightened by reports of risks of taking the high oestrogen pill and had stopped the pill without making adequate alternative arrangements.

In general the enquiry for termination was an outright request by the patient; 151 made a direct request and there were 32 hints. In 13 cases the request was made by the patient's mother, including four married women. In four cases the doctor recommended termination in the first instance. Of the 200 referrals, 73 per cent single women and 73 per cent of married women were recommended for termination, and a total of 54 (27·0 per cent) were refused. It is interesting to note that while in 82 patients psychiatric reasons are given for recommending termination, only six patients were referred to a psychiatrist in the first instance.

Information about participating doctors

The doctors participating in the study came from a wide span of practices and ranged in age from recently qualified to near-retirement. A summary is given in table 4. A wide range of religious denominations are included and 36 out of the 69 claimed to be practising their religion. There was a great variation in the number of cases sent in by individual doctors, from a maximum of 14 to single referrals. This finding coincides with that of Parry Jones and Grimoldby (1973).

In an attempt to assess whether religious conviction or age played any part in likelihood of recommending termination the doctors were allocated to one of two

TABLE 3
CONTRACEPTIVE USAGE

Usual contraceptive method	*General-practitioner group*	
	Single	*Married*
None	66	30*
Coitus interruptus	12 (2)	12 (2)
Sheath	17 (9)	33 (1)
Rhythm	0	0
Cap	2 (1)	4 (1)
I.U.D.	0	1 (1)
Pill	5 (2)	12 (3)
Spermicidal cream	2 (0)	4 (1)
Totals	104	96
Claimed to be in use (bracketed)	14	9
Agreed to be not in use	38	67
Not known	52	20

* Includes one patient previously sterilised.

TABLE 4
INFORMATION ABOUT PARTICIPATING DOCTORS

Age range	21–30 (2)		31–40 (24)		41–50 (25)	
Religious attitude	*Pract.*	*Non-pract.*	*Pract.*	*Non-pract.*	*Pract.*	*Non-pract.*
Over half referrals terminated	0	1	7	7	4	10
Less than half referrals terminated	0	1	5	5	5	6
	0	2	12	12	9	16

Age range	51–60 (16)		Over 60 (2)		*Total*
Religious attitude	*Pract.*	*Non-pract*	*Pract.*	*Non-pract.*	
Over half referrals terminated	8	4	1	0	42
Less than half referrals terminated	3	1	0	1	27
	11	5	1	1	69

categories, those who recommended more than 50 per cent of their referrals for termination and those who recommended less. Included in the latter group would be those who saw only two patients and referred one for termination and those who only saw one patient and did not refer that one for termination. With these limitations in mind there is no gross difference between the " religious " and " non-religious " doctors in terms of proportions of patients referred for termination; 33 of the doctors came into the group who acknowledged practice of their religion and of these, 20 referred more than half of their referrals for termination and 13 referred less than half. Thirty-six doctors came into the non-practising group and 22 of these referred more than half their cases for termination while 14 referred less than half.

As would be expected most of the doctors participating in the trial were prepared to recommend a relatively large proportion of patients for termination of pregnancy. Where religious conviction precluded a doctor from recommending this procedure it is likely that he would not agree to take part in the trial in the first instance. Table 5 shows the various religious affiliations and the number of doctors who recommend more than 50 per cent of patients referred for termination and those who recommend less than 50 per cent of patients who requested termination.

TABLE 5

RELIGIOUS AFFILIATION OF PARTICIPATING DOCTORS

Stated religion	*Number of doctors who recommended at least half requests for termination*	*Number of doctors who recommended less than half requests for termination*	*Total*
Church of England	13	6	19
Non-conformist	11	2	13
Agnostic	8	1	9
Church of Scotland	5	2	7
Jewish	2	2	4
Roman Catholic	1	2	3
Atheist	1	0	1
Humanist	1	0	1
Not stated	8	4	12
			69

Follow-up study

Of the 200 patients originally recorded, further information was obtained from 163 (81·5 per cent). Somewhat surprisingly there was no great difference in follow-up returns from married patients (78·1 per cent) compared with single patients (71·1 per cent).

Three patients were found not to be pregnant at later enquiry, nine patients had undergone spontaneous abortion and 122 (61·0 per cent) had, ultimately, received a therapeutic termination of the pregnancy. The general practitioner was asked whether he was satisfied with the decision or regretted it. In 101 cases he was satisfied that the correct

decision had been taken, while in eight cases there were some doubts and in three cases severe doubt, with no opinion stated in ten. Some guide concerning the reason for this opinion was that while 30 patients were described as showing some degree of guilt, none showed severe guilt where the practitioner was satisfied that a correct decision was made, whereas where there were some doubts five showed guilt feelings and two had shown severe guilt feelings, amounting almost to frank mental illness.

Twenty-nine patients (14·5 per cent) had gone on to produce children. Two of these were stillborn while one was abnormal.

No information was available on the kind of operation carried out. Twenty-one patients underwent concurrent sterilisation, the majority being between the ages of 30 and 40 but two were between 20 and 30 years of age. In the older age group, seven were reported to have more than four children before this pregnancy. One patient underwent hysterectomy. Only half of the operations were carried out during the first ten weeks of pregnancy when the morbidity may be considered lowest (table 6). Ninety-one of the operations were known to be done under the auspices of the National Health Service. Only five of the 45 women who were treated outside the Health Service were married, suggesting that the usual reasons for seeking private medical treatment were not applicable.

TABLE 6

TIMING AND PLACE OF OPERATION, WHERE KNOWN

	General-practitioner group	
	Single	*Married*
6–8 weeks pregnant	11	3
8–10 weeks "	22	18
10–16 weeks "	22	28
16–20 weeks "	2	5
20–24 weeks "	0	0
Over 24 weeks "	1	0
	58	54
Local hospital (NHS)	42	49
Local nursing home	4	1
Distant nursing home	6	0
London nursing home	9	4
	61	54

Discussion

It is virtually impossible to generalise about the complex chain of events linking the initial impregnation of a woman and the decision about termination or survival of the pregnancy. Some of the issues are medical decisions but many are more correctly placed in the field of moral, social and ethical judgments in which the doctor can be no more knowledgeable than any other informed layman. Nevertheless, society expects him to make an appropriate decision, bearing in mind his medical judgment, his personal

moral judgment and also recognising the general feelings of the community. The present state of affairs concerning the Abortion Act and its implementation recognises the impossibility of any consensus of opinion in these circumstances. Yet one of the prime purposes of the NHS was to iron out regional variations in the standards of medical treatment and to bring all areas of the country *up* to a high standard.

One of the criticisms of the working of the Abortion Act is the fact that there *is* wide variation throughout the country and that the chances of an individual having her pregnancy terminated or not, depend not on the clinical indications but the area in which she happens to live and the view of the medical advisers to whom she is referred (Cartwright and Waite, 1972).

In this survey three quarters of the patients who approached their general practitioners enquiring about the possibility of terminating the pregnancy were recommended for operation. Of these 184 patients a small number was found not to be pregnant or underwent spontaneous abortion. Eighty per cent of the remainder had the pregnancy terminated, while 29 patients went on to produce children.

It has been suggested that mothers come to accept their unwanted pregnancies and love their children normally. It has also been reported that some mothers return to thank the gynaecologist who refused to terminate the pregnancy. It is perhaps fortunate that the human mind is a flexible organ which can repress, perhaps without trace, disturbing and uncomfortable memories of the past. There is little doubt, however, (Forsmann and Thuwe, 1966; Crellin *et al.*, 1971) that the illegitimate child is seriously disadvantaged.

The question is whether the decision by the general practitioners was a correct medical judgment based on the particulars of the case, or whether it was influenced by such extraneous factors as the non-medical views of the practitioner concerning abortion, the extent to which these views were known to the community at large, thereby influencing the likelihood of whether the woman would go to him or not in the first place, and also the doctor's view of the likely outcome if he referred the patient to the gynaecologist, since his non-medical views would also be taken into account. One might feel happier that the decisions taken were purely clinical if it were not for such features as the high proportion of women in social class 1 whose pregnancies were terminated (4·1 per cent) and also the number of single women who received treatment privately rather than through NHS hospitals. Parry Jones and Grimoldby (1973) also comment on these discrepancies.

It is recognised that it would be most unwise to draw sweeping conclusions from a study such as this which is inevitably limited in its scope. It throws no light on physical morbidity. It suggests that there is some degree of psychiatric morbidity in that there is a significant number of reports of guilt feelings. It would be wrong to suggest that these represent mental illness since there is no doubt that women who undergo a therapeutic abortion have gone through considerable agony of mind in deciding to take this step and it is highly likely that they will feel some degree of internal guilt, to say nothing of the feelings imposed on them by disapproving by-standers. There was, however, a report of more severe guilt feeling, almost amounting to mental illness in two cases and this cannot be entirely brushed aside. But one must consider the possiblity of similar feelings of guilt developing if the pregnancy had continued and the woman had been preoccupied with the idea that she had considered the destruction of the pregnancy. These feelings determine her attitude towards her baby.

It may well be that the most likely explanation of the relatively low rate of termination of pregnancy in the Sheffield region is explained by the fact that Sheffield is also low on the list for numbers of beds and numbers of consultants in various specialties.

While this situation is slowly being rectified it has meant that a general attitude of lack of expectation has grown up among patients and general practitioners which may well be reflected in the low abortion rate.

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Appendix

The Young People's Advisory Service (" 408 Clinic ") offers advice mainly on contraceptive and other sexual problems to young people on an informal and confidential basis. While not primarily started as an abortion advisory service it is inevitable that a relatively large number of patients seek advice on this topic to avoid involving their family, general practitioners, and other official services whom they fear may pass on the information to relatives. Seven doctors, who work part-time at this centre, gave information on patients who requested termination, using the system already described.

Results

This group, 42 in number, mostly aged under 30, and with 90·5 per cent single or living apart from spouse, showed many similar patterns of behaviour. Thus although only four were married, 27 were pregnant by a steady boy friend. Ten used no contraception, 14 practised coitus interruptus, eight used a sheath and only two were regularly on a contraceptive pill. Fourteen (33 per cent) claimed that pregnancy was a result of failed contraceptives, but two thirds agreed that no contraceptives had beeen used at the relevant time.

At follow-up, information was obtained about 29 of the 42 patients. Three had continued with the pregnancy while 26 had had the pregnancy terminated. Most of this group attended early for advice and one third had an operation before ten weeks of pregnancy. However, half were operated on outside the National Health Service at a nursing home.

Five of the single women had had previous pregnancies and two, had had previous abortions, one being a therapeutic abortion.