Requests for abortion in general practice

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Summary

The requests for abortion occurring during a three year period in an urban general practice have been analysed and discussed.

The introduction of the contraceptive pill, the passage of the 1967 Abortion Act, and the present agitation for population control have all affected general practice.

For 23 years I have been a general practitioner in Manchester, and for the last 17 years have practised from the University of Manchester, Darbishire House Health Centre —the general-practice teaching centre. The practice contains many university students, several halls of residence, a chiropody school, and many nurses from the United Manchester Teaching Hospitals. Before the Abortion Act the abortion requests were negligible and although I have practised in the slums of Manchester for a quarter of a century I can only remember seeing three definite cases of criminal abortion.

I have become aware that unwanted pregnancies cause endless suffering both mental and physical—suffering often borne with patience and stoicism and occasionally giving rise to violence, strife and crime. It is true that a family doctor is unable in his own practice to collect a large series of abortions comparable with those presented by a gynaecologist, but it is also true that his understanding of his patients' problems both spoken and unspoken may be wider and deeper than the consultant's. Diggory *et al.* (1970) have described how the pattern of abortion practice was developing up to 1969 and this paper may be compared with their initial findings. The information used here was collected during the three years 1970 to 1972 and the paper is concerned with 69 patients who attended the surgery requesting an abortion. To ensure anonymity some details have had to be excluded but this does not affect the main picture.

Age

The 69 patients seeking termination are shown in table 1 according to their ages and the information is presented separately for the three years. The numbers in the age groups are expressed as a percentage of the total 69 women and these percentages are compared with the percentages of the practice population in the corresponding age groups for the age range 15–49

TABLE 1

AGES OF 69 PATIENTS REQUESTING ABORTION 1970 TO 1972

Age	1970	1971	1972	*Total*	*Per cent of women in survey*	*Per cent of women in practice population*
15–19	4	4	3	11	*16*	*11*
20–24	11	11	18	40	*55*	*31*
25–29	1	4	5	10	*15*	*19*
30–34	3	0	0	3	*5*	*12*
35–39	1	0	0	1	*1·5*	*9*
40–44	1	1	1	3	*5*	*10*
45–49	0	1	0	1	*1·5*	*8*
Total	21	21	27	69		

Consideration of the ethnic groups of these patients reveals that the majority were European Christians with a few West Indians, Indians and Black Africans. Nearly a third of the patients came from abroad—Eire, India, Africa, Mauritius and the West Indies. About half were Protestants, a quarter Roman Catholics and a small number of Muslims, Hindus and other persuasions.

Social class

Table 2 shows the social class of the female patients and their consorts. By far the greatest number of women and men were in class 3 and a much smaller number in class 5. The table shows that most of the women became pregnant by men in their own class.

TABLE 2

SOCIAL CLASS DISTRIBUTION OF WOMEN AND CONSORTS

Men's social class	1	2	3	4	5	
Women's social class						
1	1	0	1	0	0	2
2	0	0	0	0	0	0
3	3	2	39	1	7	52
4	0	0	1	1	1	3
5	0	0	2	0	10	12
	4	2	43	2	18	69

Stage of pregnancy

The stage of pregnancy at first interview was next considered. It is obvious that the earlier the woman consults the doctor, the easier is the termination, other things being equal. I have shown the figures separately for 1970 to 1972 because there is clearly a tendency for the woman to arrive earlier in pregnancy in 1971 and 1972 compared to 1970.

The earlier arrival of these women included some who were not pregnant but who had amenorrhoea from other causes.

TABLE 3

STAGE OF PREGNANCY AT FIRST CONSULTATION

Number of weeks	1970	1971	1972
5	1	4	3
6	6	10	7
7	2	2	4
8	3	3	4
9	3	0	1
10	2	0	5
11	2	0	2
12	0	1	0
15	1	0	1
22	1	0	0
26	0	1	0
	21	21	27

In 1970 seven women came at six weeks or before, compared to 14 in 1971 and ten in 1972, and even up to eight weeks the figures have improved.

Characteristics of the women

About one third (26) of the women in the survey had previous children alive. Two women had had stillbirths and two had had children who had been born alive but had died. Six women had had miscarriages and one sought termination twice during this survey.

What sort of relationship existed between these women and their consorts? Many were married (14), some in a state of stable cohabitation (four), and 12 hoped to marry. While 30 agreed their relationship was transient, nine women described a variety of doubts about their situation, e.g. one woman who had a continuing relationship over a period of years and still didn't know whether to marry; one woman was pregnant by a man wanted by the police and he had disappeared; one woman had been consorting for five years with a man, and one woman's lover had gone off to sea, though she had thought they intended to marry.

Of these women 55 per cent had had more than one sexual partner but only 26 per cent had had three or more, if we regard this arbitrarily as promiscuity. Why and how do these women get pregnant? With extensive contraceptive education and advertising how is it that they expose themselves to the danger of pregnancy?

Contraception

Table 4 shows the contraceptive method, if any, used by these women at the time of conception.

TABLE 4

CONTRACEPTION USED AT THE TIME OF CONCEPTION

Method	*Number of women*
Nil	45
Pill	5
Sheath	9
Rhythm	6
Withdrawal	3
Cap	1
	69

Many (45) did not use contraception. These included many women with above average knowledge of contraception, e.g. students and nurses. Enquiry into the women's contraceptive knowledge revealed that 14 considered they had none; 28 thought they had average knowledge and 27 above average knowledge. Of the 45 women who used no contraceptives, 13 had little or no contraceptive knowledge, 18 had average and 14 had above average contraceptive knowledge and these included doctors' wives and midwives. Diggory (1969) reported in 1,000 cases that requests came from 18 women doctors and 99 nurses, so clearly contraceptive knowledge is no safeguard against illegitimate conception.

The great majority of the women (53) in the survey had experienced ten or more acts of intercourse whilst eight admitted to having sexual relations six to ten times and eight had relations one to five times in their lives. A sizeable number (24) were let down by the method of contraception they relied upon. Six women were disappointed in the use of the rhythm method; in five cases the pills were not available; three couples relied on withdrawal and in nine cases the sheath failed, and once the use of the cap was blamed.

What of those 45 women who didn't use contraception? Why did they fail to make use of the services available? Would the current pressures to make contraception more easily and freely available have encouraged these 45 women to have used birth control?

I asked the question " If contraception was not used; why not "? The answers to this question were as varied as the women in the survey:

" I don't believe in it " (not a Roman Catholic)—" It just happened"—" No contraceptive available "—" It was stupid "—" There are no contraceptives in Spain "—" Drunk "—Probably the commonest answer was " I don't know ".

Relationship

I next inquired into the likelihood of a continuing relationship with the father of the child. Twenty nine women foresaw no further relationship with the father of their pregnancy. Some had associated with their men for years, some had hoped to marry, but with the occurrence of pregnancy there was suddenly no future. In some cases the men had disappeared; or the men and the women experienced a change in emotion which ruled out marriage.

The 23 women who were confident of future relationships included 15 married, so only a few could say that illegitimate pregnancy did not alter their expectations of continuing relationship. One usually visualises the first interview with this type of woman as an emotionally traumatic experience, and 37 were upset or very upset. However, 32 women were calm at first interview and this included the married women, women who were sure of their continued relationship with the father; and a group of girls who were quite confident of getting an abortion one way or another.

Outcome

Of the 69 patients in this survey 46 were accepted immediately by a gynaecologist or clinic to which they were referred. Some went to NHS hospitals, some to the rooms for private consultation, some straight to private abortion clinics. Five had some difficulty in achieving their aim.

Two other women who were refused termination took the matter further. One was a student, illegitimately pregnant and she went on to a private clinic. The other woman induced the abortion herself and was admitted to the hospital which had refused her, in a very shocked condition.

In 14 cases referral to the gynaecologist was not necessary because the patient was either too late (two), disappeared (two), decided to have the baby (two), had a spontaneous abortion (two), had no grounds in my opinion (one), was found not to be pregnant (five), five women went to term with their pregnancies, and three disappeared. Of these five going to term two became resigned, two were happy, and one of them was having her fourth illegitimate baby. Two babies were adopted.

One woman was very upset after the abortion. A professional woman, she stated that the nurses in the hospital where she had had the abortion had made life " hell " for her. Because of this she would never go through such an experience again. One girl of 16 was upset because her baby was adopted. Three were resigned, and of these one was illegitimately pregnant again within a year; and one was having an illegitimate baby for the second time, and the other girl of 15 hardly seemed to know what was happening.

The vast majority (52) seemed happy after abortion—ranging from responses of " feeling wonderful " to " I feel happy but if I really thought about it I could be a bit sad—but I'd have the abortion again ". So far I cannot assess the later effects of abortion in these women but already I am aware that my decision to send the women for abortion and for the gynaecologist to accept them was not always correct. Three women were pregnant again within the year, one of them was a young girl of 16; the other a single woman of 34 with two illegitimate children—but a woman of low I.Q. with an invalid father who I'm sure was telling us she wanted to be loved and to have something to love.

Putative fathers

I sought to interview the putative fathers of these pregnancies but this rarely proved possible. Either the girls did not know them or they would not or could not come. I interviewed seven husbands of the married women seeking abortion. One was a soldier who arrived so incensed at the prospect of abortion that he dragged his wife physically from the surgery; five husbands encouraged termination; two boyfriends encouraged their girls to have an abortion. Of mothers interviewed—three encouraged abortion, while one refused to accept responsibility, being a Seventh Day Adventist.

Table 5 gives information of the arrangements for referral consultation.

TABLE 5

PLACE OF REFERRALS AND ABORTION PERFORMED

	Place of referral	*Number referred*	*Number aborted*
1	NHS direct	23	14
2	NHS and on to abortion clinic (P.A.S.) (included in 1)	2	2
3	To consultant's rooms direct	6	
4	To NHS refused and on to consultant's rooms (included in 1)	3	8 (1 aborted spontaneously)
5	To private clinic (P.A.S.) direct	26	26
6	Women not referred for abortion because they had either amenorrhoea from other causes or aborted spontaneously before consultation arrangements could be made.	14	
		69	

Table 5 suggests that the chances of getting an abortion are greatly increased by going privately to the gynaecologist's rooms or directly to a private clinic, whatever the circumstances or the duration of pregnancy. The table shows that out of 23 women referred to the NHS hospital for abortion, 14 achieved their end at hospital. Of the nine who went to the consultant's rooms eight achieved their aim. Of the 28 who went to a private abortion clinic (PAS) all achieved their aim.

During 1972, the ease with which the operation could be achieved increased enormously. The Pregnancy Advisory Service began to offer the possibility of an efficient service and during this last year I have sent all (20) of the private patients to the service. Only four obtained their operation under the NHS. No private patient was refused by the PAS. Diggory (1970) reports that 70 per cent of patients referred to PAS were aborted and that the request for private abortion was levelling off. The situation seems to differ in this practice.

Discussion

There is no doubt that the passing of the recent abortion legislation has unleashed the demand for abortion which in this practice has resulted in 69 women between 1970 and 1972 seeking termination. As was expected the 20–24 year age group provided most patients with the youngest a schoolgirl of 15 and the oldest aged 42. Of the 69 women, 18 did not have a surgical termination because two aborted spontaneously, some disappeared from the practice and five were not pregnant at all. Some 25 women were

immigrants and a wide variety of religions were present. Altogether ten Roman Catholics sought termination, which surprised me, considering the absolute ban imposed by the church and I was also surprised at the requests from Hindu and Muslim women.

A total of 15 women were married and although pregnant by their husbands, considered their family was complete and requested termination, a plea unheard of in this practice before the Abortion Act. A high number (52) of women were single and presumably would previously have had illegitimate children for adoption, fostering or rearing at great maternal sacrifice.

Social class 3 patients numbered 52 representative of the student and nursing population attached to this practice and only 12 were in social class 5. While these figures are small, the suggestion is that social classes do not appear to mix much when it comes to achieving pregnancy which generates a request for abortion. However, seven women of social class 3 were pregnant by men in social class 5.

Altogether 26 women were still being educated (students and nurses) and it may be argued that education does not necessarily involve sex education, but 28 women in this survey had ' average ' contraceptive knowledge and 27 had ' above average ' knowledge. These are obviously arbitrary criteria.

It is encouraging that there was a tendency to consult earlier in the pregnancy in 1971 and 1972 compared to 1970, and 50 per cent came by the sixth week. This is important if termination is to be completed vaginally. At the other extreme a professional woman 26 weeks pregnant made her own arrangements privately and was terminated without incident.

Twenty-six women had previously had one or more babies but for the rest, 30 women described their association with the consort as " transient " and when asked, " why did you not use contraception? " the answers were as varied as the women involved.

About half of the women had had more than one partner and 26 per cent had three partners or more. A definition of promiscuous is " indiscreet " and we might arbitrarily take three partners as being indiscreet. Forty-five of the 69 women used no form of contraception and yet 32 of these had average or above average contraceptive knowledge.

Is further education or the provision of free contraception likely to affect these people? Education might help the 24 who claimed contraceptive failure i.e. 33 per cent. These relied on the safe period or relied on improper use of sheath or on withdrawal. Of the 45 pomen who used no contraception (table 4), 13 had no contraceptive knowledge and so perhaps might be encouraged by education to take more responsible attitudes. The other 32 would appear unlikely to be affected by any campaign. On the basis of these figures, with luck we might save 13 out of 64 illegitimate pregnancies i.e. 20 per cent. This gives a patient saving of 20 per cent plus 33 per cent (above) i.e. 53 per cent.

On the basis that any public health campaign is fortunate if it achieves a 50 per cent response rate we must halve this 53 per cent and reach an estimated 25 per cent reduction in abortion demand if we mount an intensive contraceptive and educational campaign. No patient in this survey offered the cost of contraception as an excuse for not doing it. I supply free contraception frequently on medicosocial grounds.

The vast majority (53) had had ten or more acts of intercourse and so the plea " it was the first time " was not often heard, although one woman claimed that she conceived after four out of five acts of intercourse. Once conception has occurred the relationship of the woman and consort is endangered; 29 women saw no future and the 23 who were confident were all married. Few (five) could say that the illegitimate pregnancy had not altered the relationship. Out of 23 women referred to the National Health Hospitals for termination, 14 secured their objective but of nine referred to the consultant's rooms

eight secured their aim and one aborted spontaneously. Two were referred to a private abortion clinic after NHS refusals and 26 went straight to that clinic. All 28 secured termination.

I find the most efficient way of dealing with these women is to seek abortion privately if they can afford it, thus ensuring rapid termination and leaving the few NHS consultations available for those poor women who have no resources to fall back on.

Personal opinion

Finally I state my own feelings about abortion. As a family doctor I have found it difficult to be dispassionate in dealing with these patients and after 23 years in this practice I have changed my views. In my early years I used to regard it as my duty to attempt to instruct my patients in a moral code but I discovered that others are not prepared to accept my standards.

I am now of the opinion that it is not my role in life to interfere with the morals and attitudes of my patients. Once a girl has made a decision about her sexual habits then I don't comment or attempt to interfere. If she consults me as to what these habits should be—then that is a different matter and I feel free to comment and advise. If as a result of her indiscretions a girl is illegitimately pregnant, I believe that she is entitled to receive from me every assistance in dealing with her problem and the way that she has decided. In other words I believe that " the woman herself must decide if she wishes an abortion."

REFERENCES

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CONTRACEPTION—REACHING THOSE AT RISK

The very groups most at risk—those with less-developed social skills and, most importantly, recent immigrants—may well accept contraception as part of our way of life if it is "on the National Health" through the still charismatic figure of a general practitioner. The special clinics and the still too literate health education effort reach only the more educated, highly-motivated and socially mobile. The increase in attendance at the three clinics is not caused only by the economic factor. It seems that influences other than, say, 35p a month are required to explain such large differences.

REFERENCE

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