Editorial

THE NEED FOR MORE FACTS ABOUT ABORTION?

Is it not likely that whatever the law the conscience of the woman tells her that abortion is fundamentally wrong? . . . The same conscience that makes the aspirin bottle a more inviting proposition every time the anniversary of the abortion comes round.

(Litchfield and Kentish, 1974)

Twenty to 30 percent of women become sterile after induced abortion.

(Kotaskek, 1971)

ALTHOUGH such awe-inspiring claims are not based on sound evidence, they always attract wide publicity, and so far no reliable figures are available to prove them unfounded.

In England and Wales the number of induced abortions for residents rose from 22,300 in 1968 to 108,600 in 1972 (Tietze and Dawson, 1973), a rise in abortion rate from 2·4 to 11·5 per thousand women of childbearing age. It is clear, therefore, that in this country the medical profession has shown an increasingly liberal attitude towards abortion. This was also shown by Cartwright and Waite (1972) in their study of attitudes among general practitioners before and after the Abortion Act of 1968. Leaving aside moral and philosophical arguments, there is still a great variation in opinion about the place of induced abortion in fertility control. Much of this difference is due to the lack of factual evidence concerning the sequelae of the procedure.

One of the main problems is that changes have occurred so rapidly in public and professional attitudes, and in operative techniques, that many issues once thought to be all important have become bypassed events, while the increasingly widespread use of induced abortion reveals new problems and poses new questions which were not, and could not be answered at an earlier time (Illsley and Hall, 1973).

Past research into the consequences of induced abortion has been inadequate in scope, faulty in methodology, unsystematically organised, and, in general, motivated towards idealogical rather than scientific considerations. Sampling methods have often been inadequate and there has been a high degree of self-selection, not enough efforts having been made to follow-up patients who did not return voluntarily. The division into types of abortion, spontaneous and induced, legal or illegal, has also not always been clearly defined, and the relationship between pre-abortion and post-abortion psychopathology has often been obscure (Walter, 1970). Rarely have studies considered factors such as age, parity, and spacing of children. In the study of psychiatric sequelae a major limitation has been that most surveys have been carried out by psychiatrists dealing largely with patients referred to them with serious psychiatric indications for termination. It is likely that many of these patients were psychiatrically disturbed before pregnancy, and according to the Royal College of Obstetricians and Gynaecologists (1972) information about patients terminated for psychosocial reasons has been seriously lacking.

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Perhaps the greatest failing of past research into the consequences of induced abortion is that almost all large studies have been retrospective and not prospective.

The need for factual information about the subsequent lives of women undergoing induced abortion is accepted by pro-abortionists and anti-abortionists. However, according to Illsley and Hall (1973) the difficulty is that except under the ethically unjustified strategy of randomised samples, it will never be possible to state whether an abortion was or is justifiable on the grounds of its sequelae. Where termination is granted we can only compare the subsequent life of the woman and her previously existing family with what might have been had another child been added. Where abortion is refused we are only able to compare an actual with a hypothetical situation.

Thus, problems posed in the study of sequelae of induced abortion are numerous. Illegal abortions are impossible to follow-up. Legal abortions are also difficult, because of the frequent change of name and address, and the natural concern on the part of the patient to forget the episode. The problem that abortions are done by a number of very different procedures and at different times during the pregnancy by different operators at different centres, also complicates evaluation of sequelae.

Up to the present time no large well-controlled prospective study concerning the long and short term effects, both medical and psychosocial, of induced abortion has been reported. In Great Britain the family doctor has several advantages if used as the central point for such a long-term study. He usually supervises the health of the patients over a number of years, and possesses records and knowledge of their illnesses and socio-economic problems. He is not only able to find patients requesting abortion, but also an adequate number of controls, for example, all patients on his list who become pregnant during a specified period of time.

The success of the Oral Contraception Study, organised by the Manchester Research Unit and carried out by members of the College, gives credence to the possibility of a study of induced abortion centred on the family doctor. With this in view, the same Unit is setting up a joint study with the Royal College of Obstetricians and Gynaecologists, the main objects of which will be to compare the subsequent experience of women requesting an induced abortion with that of other pregnant women, with special reference to reproductive efficiency, mental health, and other morbidity. At the present, pilot trials are in progress in four centres, Edinburgh, London, Lincolnshire, and Manchester, and it is hoped that information from these trials will be adequate to allow the main study to start in late 1975. The importance of such a large-scale prospective study involving these two Colleges cannot be overestimated, and its successful conclusion could have a profound influence on the future of induced abortion in our community.

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