"Recent Advances in Psychological Testing for Brain Damage." Dr. R. R. Hetherington.

"Problems in Communication in the General Hospital." Mr. Phillip Ley.

"Delusions of Infestation (Acarophobia)." Professor Frank Fish.

Papers

Wednesday, 3 May, 1967

There was a Symposium on **Postgraduate Training in Psychiatry** in which the following speakers participated:

Professor Sir Denis Hill;
Dr. R. H. Cawley.

The discussions was opened by Dr. G. Hopkinson.

Professor Malcolm Millar;
Dr. C. P. B. Brook.

The Discussion was opened by Dr. C. Tetlow.

Section Meetings

At the meeting of the Research and Clinical Section a Symposium on **"Anankastic Disorders"** was held under the Chairmanship of Dr. D. W. K. Kay, and the following papers were read:

"Obsessional Disorder and Neurological Illness" by Dr. L. Grimshaw.

"Under-inclusion: a Cognitive Characteristic of Obsessional Disorder" by Dr. G. Reed.

"Patterns of Meaning in Obsessional Neuroses" by Dr. I. M. Marks.

"Perfection and Discrimination" by Dr. H. B. G. Thomas.

Dr. P. Pinkerton read a paper on **"Teaching by Tape: a Method of Postgraduate Instruction in Psychiatry"** at the meeting of the Child Psychiatry Section.

At the meeting of the Psychotherapy and Social Psychiatry Section Dr. Robert Kellner read a paper entitled **"The Methology of Research in Psychotherapy."**

Hospitality

Members were the guests of the University of Liverpool at a Reception on Tuesday, 2 May, and were received by Professor White, the Pro-Vice-Chancellor of the University, and Mrs. White.

The Chairman of the Liverpool Regional Hospital Board, Sir Thomas Harley, received members at lunch on Wednesday, 3 May.

AUTUMN MEETING

18 November, 1966

DISCUSSION ON THERAPEUTIC ABORTION

The opening paper was read by Sir DUGALD BAIRD, formerly Regius Professor of Obstetrics and Gynaecology in the University of Aberdeen (see *Journal*, this issue, p. 701).

Dr. C. M. B. PARE read the following paper entitled: **"A Follow-up Study of Patients referred for Termination of Pregnancy on Psychiatric Grounds".**

Between 1961 and 1965 I saw 118 patients for consideration of termination of pregnancy and was able to follow up the majority of these personally. In 21 cases (2 terminated, 19 refused) information had to be obtained from the relatives or G.P., and 4 patients (3 terminated) could not be followed up.

Of the 114 patients followed up, 53 were terminated on my recommendation. In 61 cases termination was not advised. In both groups there were nearly twice as many married as single women (Table I).

TABLE I

Patients Referred for Termination of Pregnancy

	Married	Single	Total
Terminated	33	20	53
Refused termination ..	39	22	61
Total	72	42	114

Patients Terminated

None of these 53 patients had any serious ill-effects from the operation. As other people have mentioned in the past, the more maternal traits a patient had in her personality the more likely was she to have feelings of guilt about the termination. Conversely, the more immature, hysterical or psychopathic, the more a termination left the patient unaffected. In fact mild guilt feelings were relatively common, though usually they only lasted a matter of two to three weeks and very few lasted as long as six months.

Patients Refused Termination

Of the 61 patients who constituted this group, only 38 (62 per cent.) continued the pregnancy and had a live baby; 23 (38 per cent.), had an abortion in one

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way or another or, in 3 cases, had a premature delivery and/or stillbirth. Furthermore, of the ones who continued the pregnancy a further 9 (16 per cent.) had the baby adopted or fostered. In other words, less than half the patients of the group continued their pregnancy and kept their baby.

Looking at the possible reasons for these figures, social factors appear very relevant. Two-thirds of the women who were married and had a reasonably stable home took my advice, continued their pregnancy, accepted the baby and were glad to have it. On the other hand, patients who were either single or estranged from their husbands only continued the pregnancy and kept their baby in one-quarter of the cases (Table II).

TABLE II

Illustrating the Relationship between Outcome and Marital Status in Patients who were Refused a Termination of their Pregnancy

	Kept Baby	Abortion or stillbirth	Baby adopted or fostered	Total
Stable Marriage	21	8	1	30
Single or Estranged	8	15	8	31
Total	29	23	9	61

I must stress that these were patients attending a Central London hospital, and are almost certainly not representative of the United Kingdom as a whole.

Whereas patients terminated on my advice had no serious ill-effects, this was far from the case in those to whom termination was refused. Two of the 61 cases can be said to have been disasters. These two women, one married and one single, kept their babies on my advice and fully accepted them, but though they were perfectly well and free from psychiatric symptoms before the pregnancy, they developed quite serious and relatively disabling neurotic symptoms as a consequence of the stress of looking after the child, and two and four years later still require regular support and, on occasions, admission to hospital. Three others, including one who had to be hospitalized for the last four months of her pregnancy, suffered considerably from having a termination refused.

Two other patients died. On patient had a history of depression; she relapsed after having an illegal abortion and within two months committed suicide. Another single woman, who had a history of mild episodic asthma, had a sudden attack of status asthmaticus four months after an illegal abortion and died before admission to hospital. In both these cases one must wonder what would have happened if termination had taken place through the proper channels.

I wish to acknowledge the help of the obstetricians and gynaecologists who allowed me to follow up their cases, and also the help of Miss P. Bartlett.

DR. ELIZABETH TYLDEN read a paper on **"Abortion Law Reform".**

There is a change in the official attitude to the operations used to terminate a pregnancy. Such operations have become more and more common, and when carried out by doctors and nurses, with modern anaesthetics and adequate antibiotics, carry a lower risk of death or permanent damage to the woman's reproductive apparatus than ever before. The stringency of past laws against abortion has been partly ethical but partly because termination of pregnancy by artificial means has always been a hazardous affair. At Pompeii the guides show visitors the curettes and probes of Roman abortionists, chattering about the sinfulness and decadence of a civilization which could sink to such practices. A few miles away, in the caves outside Naples, babies drag out a miserable existence for a few hours, days or months, partly because of the philosophy that reproduction must not be checked, however unplanned the society and however sparse the availability of food, shelter and cleanliness, commodities essential to the rearing of a normal child.

But we live in a different part of the European family, we have tried to legislate particularly for the needs of babies, and we have a large organization devoted to planned parenthood. It might seem surprising that we need any such organization as the Abortion Law Reform Society; that we have one, however, reflects our own awareness of the shortcomings of our Family Planning and of our general overall planning for the mother of today and the adults of tomorrow during their vulnerable years. The fact of the matter is that marriage is an institution in our urban society which too often isolates young parents from a cohesive social group and lands them with the sole responsibility for rearing children on their own. This is an inefficient way of catering for babies, and throws too heavy a physical and emotional burden upon parents. The 'Wider Family' of Africa, the harem, the kibbutz, and the systems of Day Nurseries as used during World War II, all offer the child a wider physical and emotional security in which the capacity to grow and develop normally is not threatened should parents fall ill, suffer an accident, or have to nurse their own parents, or

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should the mother have a difficult and complicated pregnancy.

Our society has, however, pushed inexorably towards the "little boxes" in which single families struggle independently to rear children, and a "little box" is virtually the only place in which a woman can rear a baby; marriage providing the only social institution which is recognized as making provision for normal children. By definition in our society children who are born outside marriage, or are orphaned, or are cast to become a burden on their family, are automatically labelled underprivileged, and the special provisions made for them, whether foster homes or children's homes, are of varying degrees of difference from those available in the "little boxes". Such children are in fact different from children brought up in a normal family. Adopted children are too often passed like a parcel from hand to hand because of the machinery of adoption. This happens in early infancy at a time when maturation requires a consistent background if it is to proceed uneventfully. The resulting disturbance may or may not subside in the bonds of adoptive parents.

Similarly, society as such makes no provision which is satisfactory for the woman whose pregnancy occurs in circumstances which bar her from her "little box" or whose pregnancy is the last straw on an overburdened family. Both married and unmarried women become relatively helpless for a period of months, at the end of a pregnancy and the beginning of the life of a baby. Tiny babies need incessant supervision in a consistent environment; the mother usually has the drive to provide this, but only a stable marriage offers an easy way for her to do it. True, the State is usually relatively generous to mothers of small babies, but an allocation adequate for a new-born baby is rapidly outgrown, and anyhow the allowances fall pitifully short of providing a standard of living as high as that to which a secretary, a student or a woman in a profession is accustomed. Added to this, the stream of activity in a university or a profession is normally one which is smooth and well defined, it is not geared to an interruption of months or years, and women who are in this stream face interruption and demotion. This is not merely financially punishing but extremely emotionally disturbing: the sort of thing which society as a whole would regard as justifying a full-scale nervous breakdown in a man.

Babies are easily conceived, and the injudicious intermittent use of "the pill" in very young women renders them particularly fertile, in a society in which casual sexual contact is condoned. It is possibly for this reason that there are now more than enough babies for would-be adopters, who in the 50's might have had to wait five years for a baby. "The pill" is, of course, far more likely to be taken by women in the groups exposed to further education; such women are articulate and able to express their rebellion in the press and have access to the legislature.

Unfortunately procuring an abortion is not a simple matter, so much so that there are many differences of opinion about methods and techniques. In this it reflects a general law of medicine that the less efficient any part of this craft is, the greater the number of techniques offered and the more dogmatic is each craftsman in the exposition of his own technique.

There are, however, certain principles which can be generally accepted. (1) There is no drug, hormone pill or chemical which will procure an abortion without permanently damaging or even killing the mother. Either the mother is seriously damaged in getting rid of the pregnancy, or the method doesn't work.

(2) From the beginning of the pregnancy until the tenth week a pregnancy can be induced to abort by perforating the growing ovum through the cervix by the vaginal route. Illegal abortionists often hope that a strong douche will do this, a douche which damages the conceptus through the cervix would have to be so violent however, as to perforate the tract in other places and such a procedure is moreover so dirty as to cause general infection. Owing to female anatomy any instrumental interference requires the full cleanliness and ritual of an operating theatre, otherwise fatal infections and perforations ensue, leaving aside a risk of sudden death peculiar to this operation; this is, however, diminished by expert anaesthesia. The termination of pregnancy by the vaginal route requires from 2 to 3 days in hospital. Complications can prolong this for up to 10 days, but these are ununcommon.

(3) After the tenth week many gynaecologists perform an abdominal hysterotomy. This is convenient when an older woman with a large family needs sterilization at the same time, though this is seldom considered under the age of 30. In a young women, however, as well as the risks of haemorrhage peculiar to the operation, one has to consider the fact that scars in the abdomen and the uterus can be inconvenient and are better avoided.

In Czechoslovakia, there is a method in use whereby abortions are procured in the out-patients department using a vacuum extractor. This method too has its risks, and English surgeons are reluctant to use it until the results are better known. Out-patient abortions were abandoned some years ago in the Soviet Union because they proved so dangerous to the mother, and this may hold true when the results of vacuum extraction can be analysed.

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At the moment, to be safe, any woman has to be admitted to hospital for an abortion. The operation has to be performed by a gynaecologist, and following operation the patient needs skilled nursing. Owing to many factors both trained people and hospital beds are so limited that every hospital has a waiting list for any gynaecological operation; this wait varies between a couple of weeks to three years, depending on the urgency of the condition. All abortions have to be admitted as emergencies, displacing women on the waiting list; early abortions occupy a bed for three days. late ones for ten days. Medical and nursing staff tend to enter the profession to preserve life, and many of them not only regard abortions as taking away a human life but also bitterly resent the fact that women having abortions are using a bed which could be used to cure serious disease such as cancer. The fact that a gynaecologist is prepared to do abortions does not guarantee that his staff agree with him, and in every ward there are staff who disagree either because of their religion or because life has denied them children. It is a great advance in nursing care that nurses must take their own emotions into account when caring for their patients and not retreat into a cold professionalism. Emotions in this situation are, however, particularly exaggerated. After abortion many women are surprised at the depth and intensity of their reaction, nurses who are reacting equally emotionally can find this extremely difficult to deal with.

The moral of all this is that it is better to use efficient contraceptives than to acquire an unwanted pregnancy. An unwanted pregnancy's safest outcome is a live baby; the mother who asks for an abortion is asking the doctor to make her temporarily ill—sometimes dangerously so—by carrying out an abortion. If the doctor is honest, he must weigh this against the severity of her mental illness should the pregnancy continue, and the extremely remote possibility of suicide.

The present condonation of abortions is already putting severe pressure on gynaecological consultation times, waiting lists for admission and theatre time. There is a gross inequality between adjacent hospitals, whether or not a woman can get an abortion depends on where she lives and whether she can get to a doctor who considers this operation permissible. There is little point in changing the law unless there is an increase in gynaecologists, the psycho-social services, and the number of beds available for the patients needing them. It is inefficient to carry out abortions at the expense of women rendered chronically uncomfortable and socially impaired while waiting a gynaecological investigation and operation. Abortion, aside from its physical unpleasantness for the patient, inevitably carries with it a load of fear, of guilt, and of ambivalance. Staff who are torn between their duty to the woman with an unwanted pregnancy and the more obviously easy duty to prevent cancer and chronic disability can find these former patients difficult to handle.

Dr. J. G. HOWELLS read a paper entitled: **"The Woman and Extended Birth Control".**

"I will not be the earth to an unwanted seed", said the woman.

By this the woman meant that she should decide what grows inside her body and she does not want it used against her wishes. Her body, she feels, is her own, and hers alone the right to put an end to the growth in her uterus of a fertilized ovum; in the early months this is something which in her mind is as yet amorphous.

Agreement with the woman amounts to the extension of birth control into pregnancy freely given to her as a legal right. Should her beliefs on the matter be accepted, it follows that legislation will be successful only if it meets these beliefs. The legislation suggested to date fails to do this and, however permissive, would ultimately lead to malpractice in the attempt by woman and doctor to contend with the real requirements of the situation.

But let us examine the woman's beliefs.

The Control of Childbirth

The woman's position must be assessed against the background of the control of childbirth. No sect of the Christian religion objects to demographic control. They may disagree about methods, claiming that some are more natural than others, which creates some philosophical difficulty, as it is not clear how man, a natural phenomenon, can act in a way contrary to his nature. At times procreation is haphazard, with terrible consequences. With increasing knowledge, man now strives to limit the population to a dimension that will offer the optimum conditions for his welfare and happiness in the circumstances in which he finds himself. Thus, to control the number of children born, we destroy potential life.

We may check potential life at many points. The refusal to have children in marriage, for instance, destroys potential life. Again, the use of the "safe period" destroys potential life. Indeed, contraception in any form destroys potential life. Yet again, nature itself is wasteful of potential life, as one in three of fertilized ova will never develop (1), and at least twelve per cent. of first pregnancies end in spontaneous abortion.

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Extended Birth Control

Should this control of potential life be extended into the pregnancy? The woman behaves as if it should. Between eighty and one hundred thousand abortions (2) are induced annually; *yet* the law permits less than three thousand in National Health Service Hospitals (3). This gross disparity between the practice of the woman and a law which is apparently designed for her well-being, must provoke closer examination of the origins of the motivation in the woman.

Allow me to presume to understand. And let me at this point remind you that a woman, even a woman who wants an abortion, does not bow to man in her fondness for children. Many women having abortions already have children. Perhaps in her intimate involvement she feels more strongly about the circumstances of the birth of children than a man does.

Pregnancy can come by chance and from unforeseen situations. The safety of birth control measures varies with changing circumstances and is not the same for all. Children, she feels, should be born of love and joy and gaiety, and not from chance, morbidity or misery. A child should be born of affection, it needs parents to want and love it; wanting and loving go together. Too many children are already unloved and we must support the aspiration to produce them wanted, loved children, with a capacity for happiness.

But the central thought of woman is that she does not want her body violated or trespassed on. She wishes to be able to decide what should grow within her body, and under what conditions. She abhors the idea of her body being used against her wishes. To demonstrate her viewpoint let us imagine the turmoil precipitated by the knowledge that within her is growing the product of rape, an unwished for trespass by a hated being; she has been violated, used, and made to grow what is hated and repellent. In the same way, the woman can feel equally strongly about other trespasses. She does not want to be used, she wants to want a child.

The Destruction of Potential Life

One might ask, "Is the woman not aware that she destroys potential life?" The probable answer is that she is not aware. The woman does not regard the embryo in the early months as a child. She has no image of a child. Therefore, she cannot kill something which has no reality for her. She regards her act as an extension of birth control and often refers to it as "starting a period". She may, indeed, be aware of the illogicality of a situation, which in one voice says that before pregnancy children are loved things to be planned for, and wanted, and that in another voice states that after conception they must be grown irrespective of the feelings of wanting and of loving.

If she were aware of theological and legal matters, she would know that before the 28th week the foetus, except for the Roman Catholic Church, is not an entity that requires baptism by the English Church, or notification under the law.

The Basis of Legislation

The woman, too, may know of the present unsatisfactory state of the law. The Cambridge study (4) showed that 90 per cent. of terminations are asked for on grounds of psychological distress. Yet we must know that only a few psychiatric conditions are worsened by pregnancy. Our response to her is the response to the appeal of a woman anguished at the thought of an experience distasteful to her. And so we find a medical reason to bring her relief. The amendment to the law now before Parliament and the formulations of the British Medical Association (5) and the Royal Medico-Psychological Association (6) would lead to relaxation in the law. This relaxation will allow us even greater opportunity to find medical and psychiatric rationalizations, but will still obscure the fact that we are acting because of the overwhelming need to relieve the woman in an intolerable situation. Thus, the law will again be unclear and dishonest.

The woman would wish that we put aside these dishonest formulations, frame the law on the facts as they are, and give her, openly, the right to refuse what she does not want.

This general acceptance of the situation would go a long way towards relieving the terror and tyranny of guilt; this relief would extend not only to the mother, but also to the doctor. Everyone, of course, both doctor and mother, would be free to act in whichever way they thought best in the circumstances. Those bound by religious convictions, such as those belonging to the Church of Rome, could act freely by those convictions.

The Later Months

If the control of childbirth should extend into pregnancy, how far should it extend is the next issue before us. Terminations after three months should be few, because the issue will have already been determined in the first three months. However, due to a combination of circumstances, in a few instances, the issue may have to be decided in later months.

But, in these later months another strong emotional feeling on the part of the mother begins to emerge. Although the law may not accept the child as an an entity until the 28th week, by this time it may well

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have become a real entity to the mother. It would seem that this begins to develop when the mother feels foetal movement, or "quickening", at about the 16th week. When the infant becomes a reality, and a psychological reality is no less a reality than a legal, moral, or social one, then there may be a reluctance on the part of the mother to destroy what she now regards as a child. She, the mother, like us, is a representative of public opinion. Public opinion may share her view that the psychologically real child should not be destroyed without good reason. The mother may feel that legal adoption for an unwanted child may be a more acceptable solution than termination of her pregnancy.

Thus, at this moment, it may be necessary to adopt stricter criteria, perhaps based on considerations similar to those of the Royal Medico-Psychological Association (6), allowing termination when there is serious threat to the life, health and welfare of the mother.

It is implicit in what has been said that the psychological reality of a child develops before the legal and religious reality. Thus, it may be convenient to fix a point at about four months up to which time termination should be freely possible on the request of the mother, and after which time termination should be legally controlled on defined criteria. It might be argued on gynaecological grounds that three months might be more suitable in that an abdominal operation is not required normally.

Modern advances are frequently merely the systematizing of rediscovery of an old truth. Thus, we are not surprised to find that Aristotle (7) anticipated us about 320 B.C., when he said: "There must be a limit fixed to the procreation of offspring, and if any people have a child as a result of intercourse in contravention of these regulations, abortion must be practised on it before it has developed sensation and life; *for the line between lawful and unlawful abortion will be marked by the fact of having sensation and being alive.*" (My italics). So, Aristotle makes clear the distinction between permissible interference in early pregnancy and abortion in later pregnancy, which he prohibits.

The Woman Decides

If we accept the woman's view that she has a right to stop the growth of a fertilized ovum in her uterus up to the time it becomes for her a psychologically real child, then we have to consider whether the woman alone should decide the issue.

Women themselves are adamant that the right is theirs. In the National Opinion Poll (8) only 31 per cent. thought the fathers should be able to prevent a woman having an abortion. Can a man doubt the good sense of this? If he does, then perhaps he might ask himself: would be he agreeable to giving the same right to his wife in the control of his body? While the final right would be the wife's, the husband would clearly be consulted. Should there be no consultation, it is unlikely that there would have been any profit in it.

In the same poll a substantial number of women however, sensibly, said that they would wish to consult a doctor. It is desirable and necessary to be sure that the woman has thought round every implication of her situation, that her decision is realistic and unlikely to be regretted later. In the early months there would be no legal issue to be decided. The doctor would be a counsellor. Advice and consultation would necessarily have to be, of course, in confidence. Should the law become permissive, but in practice create embarrassment and lack of confidentiality, then rather than face this the woman will continue to "go around the corner".

The Doctor

Another issue which remains is: what part would the doctor play in this new policy? By tradition doctors can be conservative. We take to new advice with caution. Formal statements of our views are particularly cautious. It is not unlikely that many, if not most, doctors find the present situation unsatisfactory (9), and would wish to be able to deal with the matter of termination honestly, freely and openly. If public opinion were to support what many feel already—that this is not a matter for guilt, but a logical and proper way to respond to the unhappy situation of a woman—then they would be relieved of guilt.

In these circumstances it might not be difficult to arrange facilities that, in the great majority of cases, would involve simple procedures. With the new freedom might come experimentation and simpler techniques. Risks in a healthy sample of women would be very small. Many instances would be within the compass of the General Practitioner who might well feel it his business to deal with this aspect of families, whose trials and tribulations he knows so well. Should special clinics be necessary in the interim, it might be considered a function of birth control clinics.

It will be a happy day when we shall see the end of back-room abortions, and when their distressing consequences will no longer occupy hospital beds. With the new policy, terminations in late pregnancy too will become fewer and fewer.

Conclusion

Extended birth control is only one measure amongst a number in the begetting and caring for children. There must be a safe and active birth control policy.

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Sterilization of male and female should be more freely available. In those cases where birth control measures have been ineffective and children are unwanted, careful adoption will help to give an answer; but adoption is not the whole answer to unwanted pregnancies because no one wishes to carry and give birth to a child for someone else's convenience, and, furthermore, a large increase in the number of children for adoption would make adoptive homes difficult to find. Paradoxically, some elements in society, so anxious to condemn abortion, can still make it almost impossible for the single woman to look after her wanted child. Here again there is room for change in public attitude.

Most laws are made by men, but in the instance before us it is necessary to enter the world of women. We, as doctors, are particularly privileged to concern ourselves with the areas of feelings. Here the situation is a complex one, and we have to meet with the legislator, philosopher, humanitarian, sociologist and theologian. This difficult ground has its fascination, but it is one which induces humility.

The woman has put before us that she should have the sole right to stop the growth of a fertilized ovum, before it has for her the reality of a child. Her view merits thoughtful and compassionate consideration. We may then come to say to the woman: "You will not be the earth to an unwanted seed."

References

1. Stevenson, A. C., Dudgeon, M. Y., and McClure, H. I. (1959). *Ann. hum. Genet.*, **23**, 395.
2. Rhodes, P. (1966). "A gynaecologist's view." In *Abortion in Britain*. London: Pitman Medical Publishing Co.
3. Hospital In-patients Enquiry of 1958, Part II. Ministry of Health and Registrar General's Office.
4. Therapeutic Abortion (1966). *Brit. med. J.*, *i*, 1105.
5. Therapeutic Abortion (1966). Report of B.M.A. Special Committee. *Ibid.*, *ii*, 40.
6. Summary of Memorandum by R.M.P.A. (1966). *Ibid.*, *ii*, 44.
7. Aristotle. *Politics*. VII, xiv, 10. (Translated by Rackham, H. London: Heinemann.)
8. National Opinion Polls, Ltd. (1966). Survey on Abortion. For the Abortion Law Reform Association.
9. Abortion Law Reform Association (1965). *Survey of Doctors*. London.

Dr. Ørnulv Ødegård spoke as follows:

Until recently we had in Norway no special legislation on abortion. Practice was based upon the general principle that an action which is in itself unlawful can be justified if it is necessary in order to protect human life or correspondingly important interests. The decision was largely left to the individual doctor, and the only official guidance was s statement given by the Faculty of Medicine back in 1899. Within this vague framework medical practice developed gradually under the influence of changing social and ethical attitudes. According to a special survey, there were, in 1954, 3,157 legal abortions performed by doctors in hospitals, and to this figure should be added an undetermined number of non-registered but legal cases performed on an ambulatory basis. In the same year there were 6,460 registered spontaneous abortions. The number of "criminal abortions" was estimated at 7,300, based upon information given by the various hospitals about suspicious cases admitted. The number of live births amounted to 62,739.

This situation was in itself hardly satisfactory. The number of criminal abortions was much too high, the legal status of the doctors was ambiguous and sometimes difficult, and for the women the situation was unpredictable because it depended upon the personal standpoint of the doctors available to her. From a psychiatric standpoint it was felt that the procedure would quite often lead to pathogenic guilt feelings in the woman, and for the psychiatrist the position as an intermediary between the patient and the gynaecologist was sometimes disturbing.

Besides, we have in Norway relied much less than you have in this country upon the principle of common law. Our traditions are more in the direction of codified legislation. Nevertheless we have hesitated before the problem of a codified abortion law, and several reform bills have been dropped. It has been felt that a law which would more or less confirm the established abortion practice would be unacceptable to fairly wide circles of the people. At the same time a more restrictive law would most likely be unenforcible. It was in fact not until 1959 that the gap between conflicting convictions was bridged to an extent which made it possible for Parliament to find a compromise solution.

According to the law of 1959 (which came into effect on 1 February, 1964) an abortion can be performed on three types of indications:

1. *Eugenic*, when there is serious danger of the child having a grave mental or bodily defect.

2. *Ethical*, when the woman is insane or a low-grade mental defective, or if the pregnancy is a result of rape or correspondingly serious offences.

3. *Medical*, when an interruption of the pregnancy is necessary in order to protect the woman against a serious danger to her life or health.

A fourth group of "social indications" was unanimously proposed by the Royal Commission which drafted the bill (and of which I was the psychiatric

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member), but this turned out to be politically unfeasible. Instead the law includes what might be called "extended medical indications": In evaluating the danger to the woman's life or health the doctor should take into consideration her conditions of living and other circumstances which could lead to a lasting break in her somatic or psychic health. This clause is clearly (or perhaps unclearly) a result of compromise, and might be said to let the social indications in through a back door. It has probably been one of the main reasons why it has proved difficult to reach a uniform practice all over the country.

But apart from such local variations, the general pattern has remained very much the same as before the law. In the year 1965, 4,715 women applied for an abortion and 3,455 of these applications were granted (43 of them after appeal). (All figures can be multiplied by 10 in order to obtain data corresponding to the population of the United Kingdom). As to the illegal abortions, we have less opportunities than formerly of reaching a reliable estimate, because complications are so easily avoided by the use of antibiotics. What information we do have seems to suggest that the number has remained about the same.

On the whole, therefore, it appears that the law has not made much of a difference, and this is consistent with experience in many countries. During the preparatory work it was, as a matter of fact, stated repeatedly that the law should aim at nothing more than a status quo, and that the social evil of abortion should be prevented by other methods.

It is of interest to note that the attitude towards this new law is divided according to well-known political and ideological lines: "conservatives" feel that it has gone too far, whereas "radicals" regard it as too restrictive. The medical profession sees it as a duty to put up a barrier of ethical, social and medical considerations, which is not too dependent upon the wording of the law—but the pressure on the part of pregnant women asking for help will always tend to overflow the barrier.

Professor W. M. Millar, referring to practice in Aberdeen over many years, said that women considered for termination were referred in the normal way for obstetric and psychiatric opinion. Some cases were terminated and others were not, but in every case the best treatment plan was worked out after full consultation with the family doctor, the obstetrician and the psychiatrist. The law in Scotland had made it possible for termination to be approached as a medical problem, and it was in the context of good medical practice that all these cases were considered. All relevant factors—medical, psychological and social—were taken into account.

Dr. W. L. Neustatter, who said he had had the honour of speaking with Sir Dugald Baird at the F.P.A. meeting in April 1966, warmly endorsed Sir Dugald Baird's views. Dr. Neustatter said that, like many of his colleagues, he felt that the frequently propounded view that psychiatrists were not fitted to deal with social factors was nonsense. They were always having to deal with them. He also disagreed with the view that doctors could not judge a mother's capacity for parenthood.

For example, he had had a patient who had killed her child. When she had another child, no less than three different sources wanted his opinion on the difficult question as to whether she was fit to look after the child, or whether it should be taken into care. This was an obvious example of having to decide on fitness for motherhood.

The present law makes it impossible to recommend termination, for example, in severe subnormality, psychopathy or chronic psychosis, where, especially in the former two, it could not be shown that termination would alleviate the mother's condition. Yet what more unsuitable mother could there be than an irresponsible, drug-taking psychopath having a number of illegitimate pregnancies? It was illogical when we spoke of increasing instability and delinquency due to bad homes, that such children should be reared. In a world of rapidly expanding population, a realistic view of these problems was needed.

Dr. S. I. Cohen said that at the London Hospital the Psychiatric Department several years ago initiated regular monthly meetings with the Gynaecological Department in which all patients referred for termination of pregnancy or sterilization during the preceding month were discussed. The purpose of these meetings was to clarify our understanding of the grounds on which they recommended or refused termination or sterilization. Decisions in individual cases remained the responsibility of the doctors directly in charge of the patients, and had, in fact, almost always been taken by the time the monthly meetings took place.

These meetings had been a great help to all of them, and an interesting fact had emerged. The average frequency of recommendation of termination was about 40 per cent. When these meetings began, one member of the staff was recommending termination in over 60 per cent. and another in about 25 per cent. of cases. After several years, both were recommending termination at about the average rate of 40 per cent.

In any study of the prognosis in patients referred for termination of pregnancy it was most important to obtain as complete a picture as possible, and in

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order to do this the questions which were asked must be carefully chosen. This was illustrated by some remarks of a patient who was followed up by Dr. G. A. Heasman, one of their Senior Registrars, three years after termination had been refused. This patient was a single woman, and when asked how she felt about having her boy of two years, she said: "He's wonderful; I wouldn't be without him for the world." But when she was asked whether she thought the hospital had made the correct decision three years earlier, she said she was sure it had been wrong and added: "It has ruined my whole life."

PROFESSOR T. FERGUSON RODGER, in commenting on the discussion, said that what struck him most was the fact that on an impressionistic basis the indications which Professor Sir Dugald Baird had outlined were those which were followed by many psychiatrists throughout the country, and any variation in the frequency with which the operation was carried out on the recommendation of psychiatrists depended on how much local gynaecologists were prepared to co-operate. This point had been well brought out by Dr. Tylden. It seemed that gynaecologists did not always understand the basis of psychiatric recommendations. The memorandum by the Royal College of Obstetricians and Gynaecologists showed a very lukewarm attitude to the role of the psychiatrist in this respect, a point which was emphasized by their miscalling them psychologists in that report.

There would seem to be a need to discuss these matters with gynaecologists so that they could have a better understanding of our position, and perhaps we ought to follow the lead of Dr. Cohen in having conferences on those cases in which the operation has been suggested.

SOUTH-EASTERN DIVISION

THE SPRING DIVISIONAL MEETING was held at St. Francis Hospital, Haywards Heath, Sussex, on Thursday, 6 April, 1967, by kind invitation of the Hospital Management Committee and the medical staff.

Members were conducted around the hospital and were shown wards and centres of special interest, including the W.R.V.S. Shop, the excellent newly built swimming pool with its view of the South Downs, the occupational therapy department, industrial therapy units, and the admission villa.

The Chairman of the Hospital Management Committee, Mr. J. C. Donne, welcomed the Division on behalf of St. Francis Hospital, and Dr. B. M. Gilsenan, Chairman of the Division, replied on behalf of the Association,

The Secretary read the Report of the Divisional Committee of Management. In this report the matter of amalgamations between general and psychiatric hospitals was again mentioned. Following advice from Sub-Committees, Council had recommended that no further amalgamations should take place, and they had forwarded this advice to all the Authorities who might be concerned. The Autumn Meeting was planned to be held at St. Clement's Hospital, London, while a later meeting of the Division would be held under the aegis of Dr. Monro at Long Grove Hospital. The future of the Medical Assistant Grade had come under discussion but no unanimity of views had yet been reached and the matter continued to be considered by Council.

In accordance with the Bye-laws, the following nominees of the Divisional Committee of Management were elected for the current year:

Chairman	Dr. B. M. Gilsenan
Secretary	Dr. A. J. Oldham
Assistant Secretary	Dr. D. M. Leiberman
Junior Representative on Council	Dr. D. I. Brough

Dr. A. G. Mezey was duly elected to the Divisional Committee of Management.

The following were elected to ordinary membership of the Association:

BARNES, KENNETH HARLEY, M.B., B.Ch., D.P.M., Consultant Psychiatrist, The Priory, Priory Lane, London, S.W.15.
Proposed by Drs. J. Flood, I. Black, Carice Ellison.

BICKNELL, DOROTHY JOAN, M.B., Ch.B., Psychiatric Registrar, Queen Mary's Hospital, Carshalton, Surrey.
Proposed by Drs. B. H. Kirman, Valerie Cowie, Elaine Donoghue.

BRUDE, TERENCE JOHN ROBERT, M.A., M.B., B.Chir., M.R.C.S., L.R.C.P., Senior House Officer, Fulbourn Hospital, Czmbridge.
Proposed by Drs. O. E. F. Hodgson, H. B. G. Thomas, S. N. Wolkind.

CHAIKIN, YOALL MEIR, M.B., B.S., Assistant Psychiatrist, Leavesden Hospital, Abbots Langley, Watford, Herts.
Proposed by Drs. E. W. Shepherd, J. T. R. Bavin, C. I. Finn.

CHAPPELL, JOAN, M.B., Ch.B., Registrar, Marlborough Day Hospital, London, N.W.8.
Proposed by Drs. J. Bierer, P. M. Turquet, R. Gosling.

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