This paper will examine data published in the medical literature about the complications of abortion. You will see that all the references are recent (mainly late 1980s and 1990s) and so reflect the current situation. Furthermore the vast majority of references quoted are written by doctors carrying out abortions, or closely associated with them, and so cannot be regarded as reflecting biased 'pro-life' opinions.

## Introduction.

Before discussing the complications of abortion I would like to address some of the arguments used in favour of abortion, and see how they stand up to scrutiny when compared to published medical data. These are:-

1. Legal abortion is needed to prevent women dying from back street abortions.
2. Abortion to save the mother's life.
3. Abortion in cases of severe fetal handicap, especially those which are so severe that the baby will die at or soon after birth.
4. Abortion where there is a risk of suicide by the mother.
5. Abortion so that the woman can receive treatment for cancer.

### 1. Mortality from back street abortions.

The graph on the right, which is taken from official government statistics, clearly show that deaths in women who have recently been pregnant (which must by definition include back street abortions that were not recognised as such) was declining in England well before the introduction of the 1967 abortion act, and that the introduction of legal abortion made no significant impact on the already declining death rate.

### 2. Abortion to save the mother's life.

This argument can only properly be considered if it is examined in the context of how commonly it occurs in practice. In a parliamentary answer it was revealed that of the 3.6 million abortions carried out in England and Wales since the introduction of the abortion act, in only 151 abortions (ie 0.004%) did the doctor declare that it was done to save the life of the mother (Hansard 13th May 1992.) The fact that the fact that a doctor has declared that the abortion was done to save the mother's life, does not prove that she would have died without the abortion. This is clearly seen in this next study. The National Maternity Hospital in Dublin investigated in detail the 21 deaths which occurred among the 74,317 pregnant women whom they looked after in the years 1970-1979. They found that there was not a single case where an abortion would have saved the mother's life. (Irish Medical Journal. 1982 vol 75 pages 304-306). They discussed in great length the details of the death of one woman who had severe congenital heart disease (Eisenmenger's syndrome). All doctors would agree that this condition is life
threatening and pro-abortion doctors would certainly have no hesitation in advising an abortion, on the grounds that it is needed to save the mother's life. Yet the authors of the study found that the published medical evidence was that this condition carried a 30% mortality in pregnancy (you can look at it the other way which means that 70% of women survived pregnancy to deliver their baby.) No doctor would disagree that even in the non-pregnant state, this condition carries a significant risk of death with any surgical operation - however minor. The authors, however, were unable to find any medical evidence which showed that abortion was safer than continuing to term. A gynaecologist from Letterkenny (in Ireland) told me that one of his patients with the same disease (Eisenmenger's) suffered a miscarriage which needed a D&C because some tissue was left behind. She sadly died during the D&C operation. A D&C is very similar in stress (for the heart) as a suction abortion - demonstrating that an abortion would have also killed the woman. It is also relevant to point out that two other women with this same condition (Eisenmenger's syndrome) safely delivered three babies during the ten years of the study.

3. Abortion on the grounds of severe fetal handicap. It is often argued by doctors that when a diagnosis of severe fetal malformation is made, abortion avoids the additional physical risks of continuing to term, and it lessens the emotional burden. However a recent paper in the prestigious american journal (New England Journal of Medicine. 1992 vol 326 pages 1217-1219) summarises the evidence and states:
   a. Because such diagnoses are usually made after 16 weeks of pregnancy, the risk of maternal death from the abortion is greater than if the mother continued to term.
   b. Many babies with such severe handicap will miscarry spontaneously between the diagnosis and the end of term.
   c. There is no evidence, and in fact evidence to the contrary, that abortion helps the resolution of grief in these cases.

The authors conclude "... and there is evidence that such procedures are detrimental to maternal health." Many now recognise that the parents of a severely handicapped baby which is still born or dies soon after birth, come through the grieving process much better if they can hold and see the baby then deal with the effects of the abortion.

4. There is risk of maternal suicide. This was the argument used to support the recent Irish 14 year old rape case. However records clearly show that suicide associated with pregnancy and early post natal period is very rare indeed. Whether it be the effects of the hormone changes in pregnancy or some other factor, pregnancy is protective against suicide. Over the last 12 years for which records are available in the UK (1973-1984) there were only 14 such suicides in the whole of England and Wales; this included suicides up to one year after delivery. (A suicide rate of 1.9 per million births!) In these cases the victims were psychiatrically ill at the time of their death, with schizophrenia and alcohol dependence being important risk factors. (British Medical Journal. 1991 vol 302 pages 126-127). For comparison in the same 12 year period there were 5276 suicides in women aged 15-44 years (ie childbearing years) in England and Wales. In order to make a valid comparison between these two figures, it is necessary to calculate the suicide rates per 100,000 pregnancies and 100,000 women of childbearing ages respectively. For suicide within 1 year of pregnancy/childbirth the figure is 0.19 per 100,000 births and for suicides in women of childbearing age the figure is 3.5 per 100,000. ie the risk of suicide associated with pregnancy is 1/18th that of non-pregnant women! Furthermore it has been shown that if the woman is suicidal in pregnancy, she is more likely to respond to proper psychiatric treatment than she is by having an abortion, which increases her depression and also increases the risk of severe post abortion psychosis. (Psychiatric Journal of the University of Ottawa. 1989 vol 14 pages 506-516).
5. Abortion to allow a woman to receive treatment for cancer. It is rare, but occasionally a woman may have cancer and be pregnant at the same time. Several doctors have used the possibility of this situation to argue that abortion must be done to allow treatment of the mother to take place, as they argue that the cancer drugs might produce a severely deformed child. A cancer specialist has stated (Irish Times. 29th June 1992) that "there is no evidence that pregnancy makes cancer worse. There is no evidence that termination of pregnancy makes cancer better and that the necessary treatment can be given in these cases under very specialised management." He quotes in detail which anti-cancer drugs can be used in different types of cancer (including breast cancer, leukaemia, melanoma and brain tumours) without the risk of producing a deformed baby. There is a possibility that the disease or treatment may cause a miscarriage or lead to a underweight baby, but this is very different from doing a direct abortion.

I will divide the remainder of this paper into sections and consider: -
1. Adverse physical effects of abortion
2. Adverse psychological effects of abortion.
3. Other relevant facts.

1. Adverse physical effects of abortion.

In November 1984 there was a three day symposium on abortion, the proceedings of which have been published. (Ciba Foundation Symposium. 1985 vol 115. publ Pitman, London). It is important to note the introductory comments of a paper entitled 'Sequelae of induced abortion' - It reads "Although a substantial amount of work has been published on the sequelae of induced abortion, it is generally agreed that much research so far has been faulty in method and inadequate in scope...." As an attempt to overcome this problem 1509 general practitioners and 795 gynaecologists in England, Scotland and Wales are taking part in a long term, large scale, controlled prospective study on the effects of abortion.

a. Early complications.

Overall immediate complication rate.

The interim results of this study (involving 6105 patients having an abortion) showed that in the first 21 days following the abortion, 10% of women returned to their doctor suffering from a complication attributed to the abortion. 2.1% of the complications were described as 'major complications' and 2.4% were psychiatric in type. Two patients required admission to a psychiatric hospital. (Ciba Foundation Symposium. 1985 vol 115 pages 67-82)

One hospital in Denmark did a detailed study of all its 5851 abortions done between 1980 and 1985. 6.1% developed complications which required hospital admission. The average hospital stay to treat the complication was 5.3 days. The complication rate was highest (and statistically highly significant) in those who were less than 25 years old and who were aborting their first pregnancy with 9% of the complications occurring in these groups. (Acta Obstetrica et Gynecologica Scandinavica. 1987 vol 66 pages 201-204).

A study from China (where doctors do vast numbers of abortions) showed that women having an abortion in their first pregnancy had a 2.1% complication rate during the operation, a 6.4%
'early' post-abortion complication rate and a 10.1% 'late' complication rate. (Chinese Journal of Obstetrics & Gynaecology. 1989 vol 24 pages 159-161. NB. Only the abstract of this paper is in English).

In contrast a study combining the results from 3 planned parenthood clinics in New York and involving 170,000 abortions, reported a complication rate of just under 1% (9.05 per 1000 abortions.) (Obstetrics and Gynecology. 1990 vol 76 pages 129-135) However this study under-reports the true complication rate as all patients 'at-risk' of any complications were referred to hospital for their abortion. Furthermore their follow-up relied on people returning to the clinic, or a pre-arranged doctor returning a follow-up slip, and no follow-up details were available for 8% of the women. It is very likely that many of these women may have developed complications and went elsewhere for treatment rather than return to the clinic.

**Perforation/Rupture of the uterus.**

It is possible for the instruments used in abortion to perforate the womb and then damage loops of bowel which lie adjacent to the uterus. If the surgeon suspects that he has perforated the uterus, he will need to carry out an laparotomy (exploratory operation of the abdomen) to check the bowel and repair any possible damage. The risk of this complication varies with the stage of pregnancy. A common figure quoted for first trimester abortions (the first 13 weeks) is between 1 and 3 perforations per 1000 abortions (ie 0.1 to 0.3%).

In one study of 6408 first trimester abortions the unit reported a perforation rate of 1.3 per 1000 abortions (0.1%). However in a sub group of 706 patients who were sterilised at the same time as the abortion, they discovered that when they carried out the sterilisation through the laparoscope (a operating instrument with a telescope passed into the abdomen) they discovered that a further twelve patients had unsuspected perforations (in addition to two that the surgeon had already recognised), giving an overall perforation rate of 19.8 perforations per 1000 abortions ie 2%. (American Journal of Obstetrics and Gynecology. 1989 vol 161 pages 406-408). Fortunately in these cases, because laparoscopy was available, the surgeons were able to confirm that the bowel was not damaged and so they avoided the need for major surgery.

It is well recognised that second trimester abortions (13-26 weeks) carried out by D&E (dilation and evacuation) have a higher rate of perforation than earlier abortions. One study documents a 1.4% perforation rate (ie 10 times that of the suction method used for early abortions), which was reduced to 0.2% when done whilst under ultrasound guidance. (Journal of Ultrasound in Medicine. 1989 vol 8 pages 71-75). NB Carrying out the abortion under ultrasound control means that the doctors can clearly see what is happening as they dismember the baby's body.

The San Francisco General Hospital reported a 0.53% perforation rate in second trimester abortions. Of the 15 cases reviewed, all required laparotomy. Bowel injury occurred in 10; in seven the bowel was repaired, two required removal of part of the bowel and a colostomy, and in the other the bowel could be rejoined at the same time as part was removed. Two patients needed an immediate hysterectomy to stop uncontrollable bleeding. (Obstetrics & Gynecology. 1990 vol 75 pages 441-444)

There are numerous case reports of a wide variety of complications, but their numbers are relatively small and I feel that using them does not add to the medical case against abortion.
b. Long term complications

Effects on subsequent pregnancy.

The following data was taken from a study of 9823 deliveries:-

<table>
<thead>
<tr>
<th>Complication of pregnancy</th>
<th>Number of previous abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>nil</td>
</tr>
<tr>
<td>Bleeding in first third of pregnancy</td>
<td>8%</td>
</tr>
<tr>
<td>Premature rupture of membranes</td>
<td>4.1%</td>
</tr>
<tr>
<td>Breech or other abnormal position of the baby</td>
<td>4.6%</td>
</tr>
<tr>
<td>Low birth weight (&lt;2.5kg)</td>
<td>7.0%</td>
</tr>
<tr>
<td>Premature birth</td>
<td>6.6%</td>
</tr>
</tbody>
</table>


The medical literature is full of similar studies confirming the above findings.

The figures from the UK study reported at the Ciba symposium also indicated that there was an increased risk of having a spontaneous miscarriage in the next pregnancy. They calculate, though cautiously because of the small numbers involved, that there is an excess risk of 4 per 100 patients. (ie for every 100 women becoming pregnant after an earlier abortion, 4 will lose that baby as a result of the earlier abortion.) Their reaction to this finding is however disturbing:- "Even if these findings were confirmed as significant, it seems unlikely that their magnitude would be great enough to alter doctors' or patients attitude to abortion or its management, nor would they change the management of the subsequent pregnancy." Maybe we should not be surprised by this reaction - if a doctor is happy to end the lives of many babies by abortion why should he worry about a few more dying!

The effect of an abortion during early adolescence appears to have an even more dramatic effect on the subsequent pregnancy. A study from Yugoslavia found that 14-16 year olds who had a previous abortion and were pregnant again had a 10.7% spontaneous miscarriage rate, compared with only 5.5% of older adolescents with a previous abortion. 24.0% of the 14-16 year olds who had a previous abortion delivered a premature baby compared with only 10.3% of girls of the same age who did not have a previous abortion. (Jugoslavenska Ginekologija i Perinatologija. 1986 vol 26 pages 49-52.)

Risk of post abortion pelvic infection.

Following the sexual revolution of the 1960s, (helped by the now discredited 'Kinsey' studies) it is now not unusual for individuals to have a number of different sexual partners. With this there is an increasing risk of becoming infected with one of the many sexually transmitted diseases. An important such organism is Chlamydia, which infects the cervix (neck of the womb). One reason for its importance is that it often causes no symptoms in women, who
therefore are unaware that there is a potential problem. The majority of studies report that between 10-25% of women requesting an abortion carry this infection, though isolated studies report rates as high as 43%.

Of concern is that the carriage rates for Chlamydia is highest in younger women. One study from Scandinavia reports:-

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rate of Chlamydia Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;19 yrs</td>
<td>16.8%</td>
</tr>
<tr>
<td>20-24 yrs</td>
<td>11.5%</td>
</tr>
<tr>
<td>25-29 yrs</td>
<td>7.4%</td>
</tr>
<tr>
<td>30+ yrs</td>
<td>3.2%</td>
</tr>
<tr>
<td>Overall</td>
<td>9.3%</td>
</tr>
</tbody>
</table>


The reason for the problem is that when an abortion is performed, the instruments as they are passed into the womb, carry the organisms from the cervix into the womb itself. The raw tissue and blood clot left behind after the abortion are an ideal environment for the organisms to grow and so set up an infection which can then spread into the fallopian tubes. (The medical term used for this infection is "Pelvic Inflammatory Disease")

A study from a day care abortion clinic in Liverpool found that in patients presenting for abortion 11% had Chlamydial infection, 18% had Mycoplasmal infection and 18% had other vaginal infections. (NB Do not add these totals together as women often had several infections and are therefore included in each group). At the first post abortion follow up visit, 4% of all women had symptoms of pelvic inflammatory disease and 8% had symptoms of less serious infection. To use the authors own words "An untoward outcome of termination of pregnancy was found in 12% of patients on their first post operative visit to the clinic or family doctor..... These women were clinically ill, with symptoms and signs of upper genital infection requiring urgent chemotherapy." They also report that a further 8% developed infections subsequent to the first visit and were treated by their own doctors. ie 20% of patients developed a post abortion infection. (Genitourinary Medicine. 1987 vol 63 pages 182-187) Another fact to emerge from this study was that 35% of those women who developed post abortion infection had had 4 or more sexual partners while only 12% of those who did not get post abortion infection had 4 or more partners.

To summarise, various studies have shown that between 10-40% of women going for abortion have Chlamydia infection, and of these 10-25% will develop post abortion pelvic infection. ie. Between 1 and 10% of all women going for abortion will develop serious post abortion pelvic infection. (NB In America many abortion clinics now screen for genital infections and treat prior to the abortion. This practice is not routine in England.)

So what are the problems resulting from post abortion pelvic infection?

One prospective study looked at the number of women developing various symptoms following abortion with associated pelvic infection and compared them with women who also had an abortion but did not develop a post abortion infection.
The results were as follows:-

<table>
<thead>
<tr>
<th>Problem</th>
<th>Women with abortion and post abortion pelvic inflammatory disease</th>
<th>Women with abortion but no post abortion inflammatory disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent spontaneous miscarriage</td>
<td>22%</td>
<td>5%</td>
</tr>
<tr>
<td>Subsequent infertility</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>Dyspareunia (painful intercourse)</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>Chronic pelvic pain</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td>A further episode of pelvic inflammatory disease</td>
<td>41%</td>
<td>5%</td>
</tr>
</tbody>
</table>


The above study did not have any women who had an ectopic pregnancy, which is also a possible consequence of pelvic inflammatory disease. However a study done by the World Health Organisation in Hungary and Korea, with the aim of looking at the risk of subsequent infertility, found that in 229 pregnancies after an abortion they had 4 cases of ectopic pregnancy, yet in 292 pregnancies after a live birth there were no ectopic pregnancies. (Studies in Family Planning. 1984 vol 15 pages 291-295)

An editorial on pelvic inflammatory disease in the British Medical Journal (1990 vol 300 pages 1090-1091) states that after a single episode of pelvic inflammatory disease there is "a one in six (ie 17%) chance of tubal infertility (and the risk doubles for each attack), a sevenfold increase in the risk of ectopic pregnancy, a one in five (ie 20%) chance of chronic pelvic pain, a two in five (ie 40%) chance of deep dyspareunia (painful intercourse) and four in five (ie 80%) chance of menstrual disturbance. Overall, sexually transmitted diseases now underlie about three quarters of all cases of pelvic inflammatory disease."

In the last 20 years all western countries have experienced a dramatic increase in ectopic pregnancies. In the USA the incidence of ectopic pregnancies has risen from 4.5 per 1000 pregnancies (0.4%) in 1970 to 16.5 per 1000 pregnancies (1.6%) in 1987! (Journal of the American Medical Association. 1992 vol 267 pages 534-537) The trend in England appears to follow that of the USA, but the detailed statistics are not so accurately recorded. (NB. It is important to recognise that post abortion infection is only ONE cause of pelvic inflammatory disease, with ⅓ being due to sexually transmitted diseases.) Following an ectopic pregnancy, 30% of women are infertile.
2. Psychological complications of abortion.

The medical profession now recognises that women who suffer a miscarriage grieve for their baby, as illustrated from the following statement:- "I can state most assuredly that couples with recurrent, unexplained or explained early pregnancy losses grieve as intensely as those with later losses or losses of live-born children." Clinics in Obstetrics & Gynecology. 1986. vol 13 pages 115-116) In abortion however the woman's grief is not acknowledged because the reality of her child's death is not acknowledged. Doctors have told her that they will remove a "blob of tissue", "a product of conception" and that "her problem will be solved" so that she will be able "to get on with her life" as if nothing had happened. Yet deep down the woman knows from the physical changes that are taking place in her body, that she is expecting not "a blob of tissue" but a baby. To cope with this contradiction the woman has to employ the full force of psychological defense mechanisms; it is therefore no surprise that studies soon after an abortion find the women feel relieved and so claim that they suffer no adverse effects.

Despite these studies the medical journals are now becoming filled with other papers. The opening words of an article on the psychological effects of abortion summarises the data with the following words:- "There is a popular consensus in the medical profession and the laity that spontaneous and induced abortions have few psychologic sequelae. A review of the literature reveals that this is not true; the incidence of symptoms ranges from 7% to 41%." (Southern Medical Journal. 1987 vol 80 pages 817-821)

Another review article (British Journal of Psychiatry. 1992. vol 160 pages 742-749) states that approximately 10% women having an abortion will suffer marked, severe or persistent psychological or psychiatric disturbances.

To further illustrate this point a selection of different papers is given:-

In Germany all 263 women who had an abortion within the Kiel postal district in the first 3 months of 1982 were invited to take part in a study of the long term emotional effects of their abortion; 45% agreed to take part in the study. They were investigated both before the abortion and one year later. At one year they found that "14% were still in a state of emotional imbalance, 7% were clearly impaired emotionally and in their everyday functioning." The main factor which was predictive of the post-abortive emotional problems seems to be an external motivation for the abortion, such as the partner wanting the abortion or a difficult financial situation. Another very important factor was ambivalence towards the abortion. (Fortschritte der Neurologia Psychiatria. 1986 vol 54 pages 106-118)

Much of the language in papers on effects of abortion are worded so as to emphasise the positive aspects. For instance we read "Women with an unwanted pregnancy who obtain a legal abortion during the first trimester typically report positive emotional effects. Fewer than 10% of such women have long term psychiatric or emotional reactions such as sexual dysfunction, severe neuroses or suicide attempts." (American Family Physician. 1992 vol 45 pages 137-140) This paper then goes on to identify those most at risk of suffering emotional disturbances. They are:- Abortion in adolescence; Abortion after 13 weeks; Abortion for medical or genetic reasons; Previous psychiatric problems; Multiple previous abortions; Lack of support from partner or others. They state that "women who have abortion for medical or genetic reasons are at high risk of prolonged psychiatric treatment or hospitalisation in the 12 months after the abortion." They quote a study of 48 women who aborted for medical reasons where 77% had acute grief reactions immediately after the abortion and 46% had continuing psychiatric problems six months later and needed
continued psychiatric support. For comparison, in a control group of patients who had suffered a miscarriage, not one patient showed any need for continued support.

One of the problems of Post Abortion Syndrome is that it can be difficult to recognise, because one of the defence mechanisms against the pain is one of denial. Post Abortion syndrome is a variant of "Post Traumatic Stress Disorder," first described in Vietnam war veterans. The wives of the men suffering described how they had changed:- they might be violent or abuse alcohol. A psychiatrist described to me the story of one man who suffered intractable one sided headache, particularly severe over the right temple and resistant to all types of treatment. The breakthrough in treatment came when he admitted that he had shot a Viet-Kong prisoner of war through the right temple at point blank range.

So it is with abortion:- The feelings about the abortion are suppressed, but the subconscious must have some mechanism of release and other apparently unrelated symptoms emerge.

This was clearly shown by a GP practice in North London which did the simple study of counting the number of times a woman visited her GP for the year before the abortion and then for two years after the abortion. They found that there was an 80% overall increase in attendance rates in the year following an abortion, which when analysed by reason, they found a 180% increase in attendance rates for psychosocial reasons. This level, though slightly reduced, was still maintained at 2 years post abortion. (Journal of the Royal College of General Practitioners. 1984 vol 34 pages 310-315) These figures are statistically significant, and they indicate a definite continuing level of 'being unwell' for considerable periods after an abortion.

These findings are reinforced by another study of women recruited from patient-led support groups. They found that 36% of the women reported physical symptoms ranging from headaches, abdominal and chest pains, together with gynaecological symptoms. Of great significance was that these symptoms occurred around the anniversary date of either the abortion or the due date of the baby, but none of the women had associated these symptoms with their abortion until it was pointed out that these symptoms occurred in a yearly pattern around the anniversary date. It was only then that the significance of these symptoms became apparent. Also disturbing was that the women reporting the 'anniversary reactions' also expressed concern that they were verbally abusing their children. (Psychotherapy and Psychosomatics. 1989 vol 52 pages 151-154)

Another factor making studies on the effects of abortion difficult to carry out, is that many women do not wish to be interviewed at intervals after their abortion, and so drop out of the studies. Furthermore it is the experience of many doctors in the field that women who recognise that they have an abortion related problem do not go back to the doctor who referred her for the abortion, or who carried it out. (British Journal of Psychiatry. 1992. vol 160. pages 742-749) Therefore the figures quoted by these studies probably underestimate the true incidence of the problem.

The possible link with child abuse is important. The pro-abortion lobby argue that all children must be wanted children, and unwanted children are more likely to be abused. A child psychiatrist, who works with problem families, shows the opposite to be the case. (Canadian Journal of Psychiatry. 1979. vol 24 pages 610-620) We all have a delicate balance between aggression and compassion. This can best be shown at 4 o'clock in the morning when the baby is crying - part of us wants to rush over to comfort and settle the baby, but another voice cries "For God's sake - Shut up - its four in the morning!" Hopefully the compassionate side predominates. What can be more violent than destroying the unborn child, and by doing this violence it is possible that
the delicate balance between aggression and caring is upset, and so when later the now wanted child is born, it is more likely during periods of stress for aggression to dominate. This is aggravated by two other factors. Some women, who have had a previous abortion, admit that they had difficulty touching their new born baby. This is because the pregnancy/birth reawakens thoughts about the previous abortion and what might have been, so causing a depression. This hinders bonding to the new born child, and difficulty in bonding has been shown to be a factor in later child abuse.

It is important to recognise that the causes of child abuse are numerous and complex, and do not imagine that all child abuse is related to abortion - it is one possible factor.

In Denmark during 1975 they monitored all admissions to psychiatric hospitals and compared those within three months of an abortion to those within three months of delivery of a baby. The results are as follows:

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Aborting women</th>
<th>Delivering women</th>
<th>Other women</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 yrs</td>
<td>11.4</td>
<td>6.2</td>
<td>4.9</td>
</tr>
<tr>
<td>20-24</td>
<td>18.9</td>
<td>10.5</td>
<td>6.8</td>
</tr>
<tr>
<td>25-29</td>
<td>20.6</td>
<td>11.4</td>
<td>7.0</td>
</tr>
<tr>
<td>30-34</td>
<td>25.4</td>
<td>16.6</td>
<td>9.0</td>
</tr>
<tr>
<td>35-39</td>
<td>17.0</td>
<td>26.2</td>
<td>9.4</td>
</tr>
<tr>
<td>Total</td>
<td>18.4</td>
<td>12.0</td>
<td>7.5</td>
</tr>
</tbody>
</table>

(Ciba Foundation Symposium. 1985 vol 115 pages 150-161)

The pro-choice lobby use the slogan "Its every woman's right to choose." But if you ask women why they had abortions, the invariable response is "Because I had no other choice" clearly demonstrating that external pressures were the main reasons for the abortion. This fact emerges when women were asked who instigated the decision to have an abortion. (Psychotherapy and Psychosomatics. 1989 vol 52 pages 151-154) The results were:- Boyfriend/Spouse - 33%; Woman herself - 30%; Doctor - 20%; Other acquaintance - 10%; and Parent - 7%

One factor to emerge as an external pressure for the abortion, is lack of partner support. In the same way that a woman starts bonding to her unborn child during pregnancy, so does the father. But recent court rulings have denied the man any rights in relation to his unborn child. So the man, if he thinks that the woman might have an abortion, will subconsciously take a step back as he will not want to bond to his unborn child which he fears he will lose. The woman then (wrongly) interprets his 'distance' that he is disinterested in her, and as result she might believe that she should have the abortion to keep her boyfriend. So by not communicating their fears to one another, the couple are reinforcing their misunderstandings. This problem has certainly emerged in good pre-abortion counselling.
Many other studies show that many of the reasons which women use to justify their abortion are ‘external’ pressures, which are important risk factors for developing post abortion psychological problems.

Most studies concentrate on the effects on women. Completely ignored until recently has been the effect of abortion on family members and other significant persons. One paper uses case reports to illustrate how the partner or close friends involved in the abortion process can suffer equally distressing psychological problems as the women having the abortion (Southern Medical Journal. 1987 vol 80 pages 817-821.) All the cases described had been refractory to previous treatment, and were solved by undergoing a 'ritual mourning' within a special celebration of the Eucharist. These psychiatrists recognised the importance of the religious dimension in certain cases.

3. Other relevant facts.

The results of some studies reveals very disturbing findings. The study described below is not representative of all women, as the patients were recruited from patient-led support groups for women who had undergone abortions. The study "explored differences in 35 women who had abortions during their teenage years with 36 women whose abortions occurred after the age of twenty." 80% of those aborting as adolescents had nightmares after the abortion compared with 44% of those aborting as adults. They also found that "antisocial and paranoid personality disorders as well as drug abuse were found to be significantly higher in the group who aborted as teenagers." (Adolescence. 1988 vol 23 pages 813-823) The authors considered the possibility that these findings were reflections of problems in adolescence which led to the pregnancy and abortions. However from a psychiatric perspective, they state that adolescence is a transition period from a state of childhood, and therefore dependence, to one of adulthood with its associated independence. They argue that the trauma of abortion, during this crucial period of personality development, could cause significant disruption to this process - and the problems described. Adolescents are more likely to use immature defences to cope with the trauma, and retreat into sexual activity or drug and alcohol abuse to escape the pain.

Conclusion.

You are probably not aware that before the introduction of widespread vaccination, only 0.1% of those infected by the polio virus developed the devastating symptoms of the disease known as 'Polio.' The remainder have a flu like illness and make a full recovery, without even realising that they had been infected by the polio virus (Processes in Pathology and Microbiology. 1984 page 292. publ Blackwell Scientific Publications, London.) Governments, worldwide, have spent millions on vaccination programs to prevent this disease. Nobody would suggest that spending this money was wasteful and unnecessary because only 0.1% of those infected develop problems. Yet a similar analogy can be drawn with abortion. There are many women who apparently suffer no problems after an abortion, but there are a significant number whose lives are devastated following their abortion. But worldwide, rather than campaigning against abortion, many agencies continue to receive funding to campaign for the widespread availability of abortion-on-demand. It clearly demonstrates that abortion has nothing to do with the true values and ideals of medicine, the first principle of which is Primum non nocere - First do no harm. There is no such things as a 'Therapeutic abortion.'

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Maternal Mortality due to abortion