Services.

The unsuccessful Euthanasia Bill 1969 contained exactly the same safeguards word for word for conscientious objectors to opt out of involvement in euthanasia. Unless separate euthanasia units and the appropriate consultants were to be provided, and this would surely destroy much of the so-called benefit, euthanasia would be administered in the main units of our hospitals – in the geriatric, surgical, medical, gynaecological, and cardio-thoracic departments, to name only the obvious ones. It is then inevitable (and I use that word deliberately) that only doctors would be appointed to these departments who would be prepared to cooperate. To believe the assurances that safeguards would be introduced would be to delude oneself. Neither in this proposed Euthanasia Act nor in any amendments to the Abortion Act are the safeguards to conscience likely to remain secure for five minutes.

Pressures on the patient

Experience of the Abortion Act has taught a third practical lesson. A certain number of requests are rejected in our unit because in one or other of the separate interviews the woman has with the gynaecologist and with the social worker it comes to light that she herself is not the prime mover in this request. She is being pressurized by mother-in-law, or by mother who is not willing to have a baby in the house, or by the husband who will miss his wife's earnings. The woman's relief when her request for termination is refused is apparent and she frequently admits that she is anxious to continue the pregnancy. I am convinced that this is the tip of the iceberg and for every woman who is pushed into a consulting room there are many who manage to withstand the pressures at home. They did not have to do this before 1967 but the existence of the Act and the option of termination has introduced a new element of doubt and of dissension, even when the pregnancy was planned. Today there are in Britain many tens of thousands of women, legitimately pregnant, in turmoil because this option has to be considered.

If euthanasia becomes legal the crippled, the aged, or the housebound invalid is going remorselessly to be subjected to similar doubts and tensions, and similar tensions and questions will afflict their relatives and those looking after them.

In the writer's view of the status of the previable fetus and of the intention of the operator, abortion is not euthanasia. Nevertheless for practical as well as ethical reasons set out in this paper no Euthanasia Bill must ever reach the Statute Book.

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Commentary

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The Abortion (Amendment) Bill, introduced by Mr James White, MP, is arousing a great deal of controversy. Regrettably the issues have become polarized around two extreme views: either that abortion is a good thing and therefore any decrease in its frequency is to be deplored or opposed, or that abortion is a bad thing and therefore any reduction in its incidence, however accomplished, is a gain. It is relevant to comment that both these opposed attitudes tend to be associated with the biologically absurd view that the acquisition by the embryo of human status (with an implied right to protection) takes place abruptly at a particular instant in time, that is, either at the moment of conception or at the moment of birth. This is in sharp contrast with all that is known of the gradual processes by which embryogenesis, growth and functional development occur as a continuum.

The 28th week – an ethical watershed?

At present the fetus does not enjoy 'protected' status until the end of the 28th week and abortion can be lawful up to that point in time. But is this arbitrary point of administrative definition really an ethical watershed? Dr Gardner has argued that the attainment of 'viability' should be regarded as the crucial consideration on assigning human status to the unborn. However, with technical advances the survival of infants of extremely low birth weight becomes commoner and this argument points now to the 20th rather than to the 28th week, as the Abortion (Amendment) Bill proposes.

Others would dismiss these ethical uncertainties and advocate abortion on request – ‘let the woman choose’. This view is naïve in ignoring the irresistible pressures which may be exerted by the woman’s partner, by parents, by peers – and above all, by society in general. The fallibility of this view is exposed when it is applied to the management of self poisoning. A request for abortion, like an overdose, is always a cry for help, but not always a considered free choice for the destructive consequences which may follow.

Motivation of the abortionist

If abortion is considered to have some intrinsic moral quality, bad or good, there is not much room for a middle view. Perhaps we should focus more attention on the motivation of the abortionist. It is, after all, generally agreed that the main abuses of the 1967 Act have resulted from the greed and commercialism of much of the ‘private sector’. Mr White’s Bill approaches this aspect of the problem in a crude and professionally unacceptable fashion, erecting numerous administrative ‘traps’ for the doctor or other health professional, and placing the onus of proof of innocence on the doctor himself. This repressive proposal would not be tolerated by the medical profession. At the same time the clear intention of Parliament in the 1967 Abortion Act to protect the individual gynaecologist’s freedom of conscience has been gravely eroded by subsequent events, and this loss of professional freedom has been condoned by the Lane Committee in its report. An equitable answer will not be easily found.

Background to the Abortion (Amendment) Bill

The background to the Abortion (Amendment) Bill

is a situation in which, in Scotland, one in 10 pregnancies is terminated, and in England and Wales one in seven. Japan has passed through a period when this ratio was 1:1. The question must be faced: What is the desirable ratio of abortions to births in a developed country and a small, overpopulated island? What are we aiming at in demographic terms? If abortion, as well as contraception, is ‘free’, on what scale will each be adopted? The answer will probably differ in women of different age and marital status.

Effects of abortion on women

Finally, what effects on the life and health of women result from changing attitudes and practices in relation to abortion? At present mortality rates following both childbirth and abortion are declining, and, overall, are about equal (around 0.5 per 100 000). However, the risk of death due to childbirth shows a steep increase with advancing age, so that in older women childbirth is generally much more hazardous than abortion. In young nulliparae the risks of abortion are relatively greater, unless the procedure is completed in the first eight weeks of pregnancy. Morbidity following childbirth or abortion is more difficult to estimate and impossible to summate and compare objectively. The benefits of relief from an ‘unwanted’ pregnancy have to be set against the physical and emotional sequelae of abortion. There are too few non-partisan studies in this area, so that value judgments are often derived from the scantiest basis of fact. Without follow-up data on a comprehensive scale, correlated if possible with predictive factors, it remains difficult to select the better course of action for the individual patient, and the temptation to adopt an all-or-nothing policy is evidently at work.