The doctor's role has changed as society has changed. He should act more in an advisory capacity by helping the patient to make the wisest decision for her in the light of all the facts both medical and social. One should not lose sight of the fact that the mother's commitment is not only for the nine months of pregnancy but for the next 16 years at least, while the child is growing up. The quality of the environment in the home greatly influences the opportunities open to the individual.

The doctor-patient relationship differs in the case of a request for abortion from that in most other circumstances, because the patient can make the diagnosis that she is pregnant and can assess her personal situation. I have gradually come round to the view that abortion on request is the most realistic attitude to adopt in the present state of society, and, that while doctors should not be forced to recommend or perform abortions if they have deeply held convictions that such a procedure is wrong, they have a duty to help a patient to have access to doctors whose views are more in line with their own. I think that more patients (especially immature and inexperienced young women) would turn to their family doctor for help if they were more confident that he would discuss their problem dispassionately even if, in the end, he did not agree with their point of view.

The present failure to prevent unwanted pregnancies despite the availability of reliable methods of contraception, if not surprising, is very disappointing. Clearly more needs to be done to improve the level of general education. The efforts of parents, teachers, doctors, nurses and social agencies must be increased and better co-ordinated.

The development of health centres in which a number of doctors work suggests that the future lies in team work, with some doctors having a special interest and postgraduate training in a particular aspect of medicine in addition to their vital role as a personal doctor to those on their list. This would widen the responsibility of the general practitioner group for diagnosis and therapy.

The medical graduate, because of his knowledge of physiology, endocrinology and psychological medicine and his continuity of care of his patient and his family, will, provided he has the right type of personality, make a more effective counsellor than those who are not medically qualified and do not have these responsibilities. He should therefore coordinate the activities of parents, teachers, nurses and social workers. The general practitioner with a special interest in sex and reproduction should coordinate the work of his colleagues in this field and should be the link between the health centre and the appropriate specialist department in the central hospital or medical school.

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Commentary

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Sir Dugald Baird's article concludes that 'abortion on request is the most realistic attitude'. Politicians will misuse this statement. Perhaps the writer's influence could be rechannelled when he learns of the situation in Denmark where abortion on demand is practised. I qualified in London but obtained specialist status in obstetrics and gynaecology in Denmark and therefore take the liberty of reviewing Professor Baird's paper.

The 1930s and the present situation

'The death of a mother which would have been avoided by termination of pregnancy' is inferring that Roman Catholic priests (I'm not a Roman Catholic) were sometimes responsible for such deaths. However, in the 1930s the writer states that one third of deaths occurred in multiparae (no doubt due to prevailing obstetrical standards) and that one third of maternal deaths were due to septic abortion. The remaining one third is not quoted, presumably because there is no absolute evidence that if a fetus is not removed the mother will die.

No obstetrician can prove absolute demands for induced abortion but only relative ones, depending on the doctor-patient relationship. The problem with sick pregnant women is knowing how to prevent spontaneous abortions or premature births. The present rate of sepsis following legal abortion is still too high, and I am sure that abortion on demand in the 1930s would have created some septic legal abortions.

'No woman should be forced to bear an unwanted child': but what are the rights of the father if he wants the child? No child is unwanted in Denmark, as we have a very long waiting list of childless married couples awaiting a child for adoption. Children are a luxury commodity here.

Abortion as a method of contraception

'Abortion should not be considered as a method of contraception': Danish statistics show that legal

abortions are being increasingly used as a means of contraception. Girls are being evacuated thrice yearly in some cases, despite cheap contraceptives, high living standards and compulsory sex education at school.

'It is clear that the higher incidence of pregnancy in single women was not the result of the Abortion Act', writes Sir Dugald. Danish facts show that it is just this group which has produced the greatest rise in abortions on demand since October 1973, and it is the same girls who have the highest rate of complications at the time of abortion as well as of long-term effects following legal abortion.

The complications of abortion

'The incidence of resultant damage to the pelvic organs is not known precisely': statistics for complications following induced abortion in Czechoslovakia (Kotasek, 1971) show that 20–30% of women received permanent physical complications, and that the rate for spontaneous abortions increased by 30 to 40%. 'Unplanned Pregnancy', a report by the Royal College of Obstetricians and Gynaecologists (1972), concludes that few women remain without physical or emotional complications following legal abortion.

'Emotional sequelae are surprisingly few', it is stated, but Ekblad (1955) finds that the worse the genuine psychiatric disorder before induced abortion, the worse the psychiatric problems afterwards. Few women share their genuine conflicts with the obstetricians performing legal abortions.

Sexual mores and sex education

Recent changes in sexual mores have created ... problems', and Sir Dugald Baird's article will pour fuel on the already burning problem. Politicians are waiting for such views on abortion on demand in order to promote their sexual mores in society.

The Professor suggests that we 'improve the level of general education' in order to prevent neglect of legal abortions. Danish compulsory sex education goes hand in hand with an ever-increasing rise in legal abortions because sex is assumed to be love (by those wishing to destroy Christian European culture) knowing that the products of 'love' can be removed legally.

Politicians and doctors

The politicians who began teaching the 'ethic' of abortion on demand in the 1930s are those responsible for pushing through the present Danish Abortion Law: they believe more in Marx than in the principles of John Knox who never believed that the end justifies the means.

'Doctors should not be forced to recommend or perform abortions if they have deeply held convictions ...': that sounds very good but the right to abortion on demand is a political decision. Thus although the Danish Abortion Law gives doctors the right to refuse to perform legal abortions our medical union demands that those applying for a consultant post in gynaecology must state whether or not they will do the operation – a logical political-social consequence of our law. I have, therefore, left hospital medicine because it will be impossible to obtain a consultant appointment as a gynaecologist. Sir Dugald Baird is asked, therefore, to change his public views lest Scotland – and the United Kingdom – should come into the vicious circle in which Denmark is now enmeshed, which includes both frustrated gynaecologists and frustrated gynaecological patients on long waiting lists.

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