Memorandum 23

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The serious Morbidity and Mortality associated with Induced Abortions

A submission to the Science and Technology Committee of the House of Commons

Executive Summary

Which is safer, to have a baby or an induced abortion? All abortion decisions hang on this.

1. Accepted practice, promoted by the Royal College of Obstetricians and Gynaecologists (RCOG), is that induced abortion is safer for the mother than a delivery. Is this true?

2. We present the flaws in current evidence for this.

3. Mortality is in fact several times higher in the year after abortion compared to the year after delivery.

4. Induced abortion and higher mortality have a causal link.

5. Suicide is much increased after induced abortion.

6. Morbidity from induced abortion far exceeds a delivery and has been understated.

7. *Conclusions*: the RCOG advice is unsound and harms women.

8. *Recommendations*: the Act should be re-enforced to protect women through evidence-based guidelines for doctors and reliable information to patients.

Introduction

This paper outlines strong evidence from a range of studies that termination of pregnancy poses a far greater risk to the life and health of the mother than continuing the pregnancy.

1. Background

1.1. The Royal College of Obstetrics and Gynaecology (RCOG) maintain that risks of induced abortion to a mother are lower than continuing the pregnancy to term at any gestation.[135] For this reason many doctors justify the interpretation of the Ground C under the Abortion Act in a way that allows any

[135] The care of women requesting induced abortion. RCOG September 2004:29

woman requesting an abortion to be offered one because continuation of pregnancy would pose a 'greater risk to her physical and mental health, than if she had an abortion.'

1.2. Such a claim also permits a health professional to arrange an abortion without parental consent for someone under 16 who can be considered to fulfil 'Fraser competency' in other ways.

1.3. This paper looks in more detail at the basis on which such claims are made, and the accumulation of scientific evidence that the risks of induced abortion to the woman far outweigh the risks to her if she continues her pregnancy.

2. Basis of current claims about the mortality associated with induced abortion

2.1. The usual source of statistics for the relative mortality associated with pregnancy and abortion is the Confidential Enquiry into Maternal Deaths.[136] The most recent report, covering the three years from 2000-2002, records only five deaths due to abortion. This was out of a total of 261 pregnancy-associated deaths. These five were early deaths from medical rather than psychiatric causes. This might suggest that induced abortion contributes little to pregnancy-related maternal mortality.

2.2. However, there are several reasons for considering that this data is far from complete:

2.2.1. **Underreporting of late deaths.** Deaths caused indirectly, especially from psychiatric causes, often occur some months after the induced abortion. The Confidential Enquiry recognises this ascertainment weakness in the comment, "It is not surprising that these (late) deaths were not reported since, by the time they died, these women would have lost contact with their maternity health professional, the person who reports these cases."[137] In order to explore such missed cases a linkage study quoted in the report found a further 32 out of 50 deaths caused by suicide, which had not been reported to the Enquiry. It is not specified how many of these followed induced abortion.

2.2.2. **Abortion as an antecedent is often deliberately hidden.** Health professionals may not recognise that a woman's death is caused by induced abortion because she may have hidden her abortion from family and friends as well as health professionals. Induced abortion often occurs at a distant facility out of the sphere of a woman's usual medical care.

2.2.3. **The sensitive nature of abortion.** Health professionals may be reluctant to raise the issue of a possible association between death and induced abortion in order to avoid offence to the grieving family.

3. Can the risks of induced abortion be more accurately assessed?

3.1. We suggest that the inaccuracy of the Enquiry data has lead to false conclusions. Better information can be obtained from so-called linkage studies. These identify women of child-bearing age who have died and then

[136] Why mothers die 2000-2002. The Sixth Report of the Confidential Enquiries into Maternal Deaths in the UK. Chapter 1
[137] ibid

seek out their medical history from available records. Two such death linkage studies have been published – one from Finland, and one from the US.

3.2. A robust Finnish study[138] collected national data on all women who died between 1987 and 1994 for one year after their abortion or delivery. The researchers found that compared to Finnish women who delivered a baby, those who had had an induced abortion have increased mortality – from both natural and unnatural causes. This increased risk can be best expressed as the 'age-adjusted odds ratio', which is the number of times more likely that a woman of a certain age after an induced abortion dies in a particular way than if she kept her baby. The odds ratios are 1.63 for deaths from natural causes, 4.24 for deaths from accidents, 6.46 for deaths from suicide, and 13.97 for deaths from homicide. The suicide rate was independent of the gestation of abortion i.e. the raised mortality from suicide would not be affected by avoiding late abortions.[139]

3.3. A study of Californian low-income women confirms the increased mortality associated with induced abortion. It looked at the outcome after first pregnancy for eight years after a state-funded abortion or delivery between 1989 and 1997. Over the eight years the age-adjusted odds ratio of dying following an induced abortion was 1.44 for deaths from natural causes, 1.82 for deaths from accidents, 2.54 for deaths from suicide and 1.59 for deaths from homicide.[140]

3.4. These studies would substantiate the concern of the Enquiry that late pregnancy deaths from suicide are common and frequently missed. This is especially because the increased risk from abortion continues so long after the event.

4. Is the increased mortality rate after induced abortion causally related?

4.1. We can conclude from the above studies that women who undergo induced abortion are at substantially greater risk of violent death, especially from suicide than those who deliver. However, association does not prove causality. Could it be that the greater incidence of violent death simply reflects a greater pre-abortion psychiatric disposition? Put another way; is it that disturbed people are more likely to have an abortion? And are they more likely to experience a violent death afterwards, irrespective of having had the abortion?

4.2. The RCOG clearly considers that any association is incidental and not causal. In their advice leaflet to women considering abortion[141] they ask, "How will I feel after an abortion?" They reply as follows, "Some studies suggest that women who have had an abortion may be more likely to have psychiatric illness or self-harm than other women who give birth or are of a similar age. However, there is no evidence that these problems are actually caused by the abortion; they are often a continuation of problems a woman has experienced before." But does the evidence from studies support such bold reassurance?

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[138] Gissler M et al. Pregnancy associated deaths in Finland 1987- 1994. Acta Obstetricia et Gynecologica Scandinavica 1997;76:651-657

[139] Gissler M. Personal communication. Data available from author

[140] Reardon D C et al. Deaths associated with pregnancy outcome: a record linkage study of low income women. Southern Medical Journal 2002; 95: 834-841

[141] About abortion care: what you need to know RCOG September 2004:7

4.3. There are several reasons for recognising a strong causal association between violent death, especially from suicide, and induced abortion:

4.4. The association remains after adjustment for pre-abortion psychiatric state. The Californian study included an assessment of the psychiatric history one year prior to the delivery or abortion. Adjusting for this, the likelihood of violent death and suicide increased after induced abortion as compared to delivery.

4.5. The same study shows a temporal relationship between the deaths from suicide and the time from the abortion, with a steady decrease in suicide rates over the eight year study period. This contrasted with the women who delivered, in whom the suicide rate rose slightly over this period. These observations support a causal link between suicide and induced abortion which wears off very slowly over an eight year period.

4.6. Another study from Wales[142] supports a causal relationship between abortion and vulnerability to suicide. The researchers looked at admission rates for suicide attempts before and after a pregnancy event. Rates almost doubled in women who had had an induced abortion, compared with a slight diminution in those who delivered. This also confirms the observation from other studies that there is a psychiatrically protective effect when pregnancy ends in birth.

5. **Why are women who have had an induced abortion so much more likely to commit suicide?**

5.1. Researchers in the Californian study suggest that this is caused by 'increased psychological stresses related to unresolved guilt, grief, or depression.' Is there any research evidence that this is the case? There are a number of recent studies that show raised levels of psychiatric morbidity such as depression, deliberate self-harm and suicidal ideation following induced abortion, all of which are recognised predisposing factors to committing suicide.

5.2. One landmark study from New Zealand[143] was able to adjust for pre-pregnancy psychiatric state and found that those becoming pregnant but not having an abortion had overall rates of mental disorders, including depression, between 58% and 67% of those who had an induced abortion. Such mood disturbance would clearly predispose the woman to the risk of suicide. Similar findings are noted in another study which showed that rates of depression are increased for eight years after the induced abortion.[144] A further study found levels of deliberate self-harm to be almost 3 times more frequent in those with unplanned pregnancy and who had no history of psychiatric illness, but went on to have an induced abortion, as compared to those who kept their baby.[145]

5.3. Further support for a causal association between induced abortion and suicide comes from interview-based studies. These have consistently shown extraordinarily high levels of suicidal ideation (30-55 percent) and reports of

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[142] *BMJ* 1997; 314: 902 (22 March

[143] Fergusson et al. Abortion in young women and subsequent mental health J Child Psychol Psych 2006;47:16-24

[144] Cougle JR et al. Depression associated with abortion and childbirth: a long-term analysis of the NLSY cohort. Med Sci Monit 2003;9(4):157-164

[145] Gilchrist A et al. Termination of pregnancy and psychiatric morbidity. Brit J Psych 1995;167: 243-248

suicide attempts (7-30 percent) among women who have had an abortion.[146] In many studies, the women interviewed have explicitly described the abortion as the cause of their suicidal impulses.

5.4. Interpretation of these statistical studies is aided by numerous publications describing individual cases of completed suicide following abortion.[147] In many cases, the attempted or completed suicides have been intentionally or subconsciously timed to coincide with the anniversary date of the abortion or the expected due date of the aborted child.[148]

5.5. Each of these studies absolutely contradicts the RCOG conclusion that any psychiatric illness after abortion is simply a continuation of that present prior to the abortion. Instead it is clear that psychiatric illness after induced abortion is often caused by the procedure. The above findings also contradict the RCOG when they quote the assessment of Dagg that such complications are 'on the wane immediately after the abortion'.[149] Rather they are commonly pervasive and often continue for a number of years after the procedure.

5.6. These recent studies are not saying anything new. The Royal College of Psychiatrists gave witness to the private commission of enquiry headed by Lord Rawlinson in 1994[150] which looked into the operation and consequences of the Abortion Act. The report observed "that although the majority of abortions are carried out on the grounds of danger to the mother's mental health, there is *no* psychiatric justification for abortion." The commission concluded "that to perform abortions on this ground is not only questionable in terms of compliance with the law but also puts women at risk of suffering a psychiatric disturbance after abortion without alleviating any psychiatric condition that already exist."

6. Non-psychiatric morbidity of induced abortion compared to delivery

6.1. So far this paper has addressed the increased mortality caused by induced abortion. But how does the health of women after abortion compare with those who give birth? It is widely assumed that induced abortion has low rates of complications especially when performed in the first trimester.

6.2. However, there is strong evidence that both surgical and medical abortions cause significant short and long term morbidity which is greater than undisturbed pregnancy.

6.3. Short term complications of surgical abortion

6.3.1. The RCOG[151] quote complication rates per thousand surgical abortions of 1 for haemorrhage, 10 for cervical trauma, 4 for perforation of the uterus and 1 for retained products of conception. The most common complication is secondary infection at a rate of 100 per 1000. Untreated

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[146] David Reardon. "Psychological Reactions Reported After Abortion," *The Post-Abortion Review*, 2(3):4-8, Fall 1994; Anne C. Speckhard, *The Psychological Aspects of Stress Following Abortion* (Kansas City: Sheed & Ward, 1987)

[147] E. Joanne Angelo. Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief," Linacre Quarterly 59:69-80, May 1992; David Grimes, "Second-Trimester Abortions in the United States, *Family Planning Perspectives* 16(6):260

[148] Carl Tischler. "Adolescent Suicide Attempts Following Elective Abortion," *Pediatrics* 68(5):670, 1981

[149] The care of women requesting induced abortion. RCOG September 2004:35

[150] Rawlinson Report 1994 page 15, paragraph 89

[151] About abortion care: what you need to know RCOG September 2004:8

infection can lead to pelvic inflammatory disease, which has a known association with infertility. Abortion clinics would say that they test beforehand, but considering the short time between consultation and abortion in some places it is doubtful if this can always be done.

6.3.2. These rates place surgical abortion at higher risk of short-term complications than giving birth. A recent Scottish study estimated the severe morbidity rate from undisturbed pregnancy to be 3.8 per 1,000 and almost all events, including haemorrhage (incidence 1.9 per 1,000), were treatable with a good long-term outcome.[152]

6.4. Short term complications of medical abortion

6.4.1. It has been widely assumed that the introduction of mifepristone for early medical abortion would be safer than surgical abortion; and this despite the fact that its safety has never been assessed in those under 18 years. The RCOG described this method of abortion as ‘safe and effective’ and recommend its use for women up to 9 weeks gestation.

6.4.2. Relatively minor complications such as abdominal pain and nausea occur in the majority of women after taking mifepristone. Vaginal bleeding usually continues for between 9-16 days, but sometimes much longer. 5-8% of women require surgical intervention following medical termination. Therefore, medical abortions are 5 to 10 times more likely to “fail” than surgical ones; and will subsequently require surgical intervention in more advanced pregnancy. [153]

6.4.3. However, more serious still is the finding that medical abortions have ten times the *mortality* of surgical abortion. There have been at least five deaths in North America following medical abortion using mifepristone (RU-486). The women died from a rapidly progressing infection with Clostridium sordellii.[154]

6.5. Long term complications of surgical and medical abortions

6.5.1. Prolonged psychiatric disturbance has already been discussed. However, psychiatric disease is not limited to depression, suicidal ideation and deliberate self-harm. Many women also suffer from features of post-traumatic stress syndrome after induced abortion.[155]

6.5.2. In addition, induced abortions may have important effects on future pregnancies. Pelvic inflammatory disease is a recognised complication of both medical and surgical abortions and can cause infertility.[156] Future pregnancies have a greater risk of placenta praevia (increased by 7-15 times), and pre-term labour (twice as likely).[157] The latter is an important cause of chronic lung disease and cerebral palsy in the child.

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[152] Brace V et al. Quantifying severe maternal morbidity: a Scottish population study. BJOG 2004;111:481-4

[153] FDA-approved Data sheet on Mifepristone [Mifeprex, Danco Laboratories], July 2005; www.fda.gov/cder/foi/label/2004/020687lbl_Revised.pdf

[154] Fischer M et al. Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion. N Engl J Med. 2005;353:2352-60

[155] Korenromp MJ et al. Psychological consequences of termination of pregnancy for fatal anomaly: similarities and differences between partners. Prenat Diagnosis 2005; 25:253-260

[156] Mr R Balfour, consultant gynaecologist, personal communication to MH, 29.8.07

[157] The care of women requesting induced abortion. RCOG September 2004 :34

Xxii Naftalin NJ, BJOG (1999) 106,1098-9

Xxiii Paradisis M et al BJOG (2002) 109,582-4

6.5.3. There are also reported cases of post abortion morbidity such as infertility after a foetal bone was left inside,[158] and congenital paraplegia after pregnancy "reduction."[159]

6.5.4. Finally there is growing evidence (though still disputed by some) that abortion increases the risk of breast cancer (relative risk of 1.3-2). In addition, term pregnancy acts as a clear protection against the development of breast cancer.[160]

7. Conclusion

7.1. The following conclusions can be made about induced abortion:

7.1.1. Mortality following abortion, especially due to psychiatric disease, is much higher than is currently recognised by the RCOG and many clinicians.

7.1.2. A substantial part of the mortality is causally related to the abortion and occurs regardless of the gestation at which the abortion occurs.

7.1.3. Morbidity is substantial, both in the short and long term and caused by both medical and surgical abortions.

7.1.4. Doctors have failed to follow the Abortion Act in the light of known medical evidence. The RCOG advice is unfit for the purpose. It is likely that a large number of healthy women have suffered, and some have died, because of this.

8. Recommendations

8.1. In the light of these findings we recommend to the committee:

8.1.1. There is no easing of legal restrictions on induced abortion.

8.1.2. The RCOG advice to women considering abortion should be updated with evidence from recent studies about the mortality and morbidity of abortion. Women considering abortion have a right to know the potential serious long term consequences.

8.1.3. Ground C of the Abortion Act can no longer be legally applied to a woman in anticipating an improved psychiatric state following abortion compared to her keeping the pregnancy.

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[xxiv] Brind J. The abortion-breast connection. National Catholic Bioethics Quarterly 2005; Summer:303-328