Memorandum 50
Submission from Wendy Savage

I have been Press Officer and Co-ordinator of DWCA since 1976, soon after I returned from New Zealand where I had started an abortion service with the help of the Medical Superintendent of Cook Hospital, the public hospital in Gisborne, before the law was changed. I gave evidence about this work to the Royal Commission on contraception, sterilisation and abortion in 1974. Before I went to New Zealand I had worked for a year for Pregnancy Advisory Service both seeing women pre-operatively and doing one list a week so that I saw over 1000 women during that time. I was closely involved with the late Professor Huntingford when he set up the Tower Hamlets Day Care Abortion Service in 1977 and ran this after he resigned in 1981 until a Director of Well Women’s Services was appointed in 1985, a post I had created linking the abortion service with the contraceptive and cervical screening services. I did the vast majority of second trimester abortions from 1985 until my retirement from practice in 2000.

I have attached a short personal account of my experience over 35 years of women presenting for late abortions, which leads me to the position that it is unnecessary to change the law. This view is endorsed by the members of DWCA who include GPs, psychiatrists and public health doctors as well as gynaecologists. If my evidence is thought to be relevant I would be prepared to give oral evidence to supplement the paper which follows.

Should induced abortion be linked legally with fetal viability?

Background

In 1989 Professor Colin Francome and I carried out a postal survey of a random sample of practising gynaecologists in the NHS in Great Britain. There was an 84% response rate after 3 mailings and follow up telephone calls so the results seemed valid. We found a marked discrepancy between their support for a legal time limit and their own personal time limit. (Table 1, ref 1). I would have fallen into the 8% who were prepared to do an abortion at 25 weeks or later and therefore thought my experience may be useful to the committee.

<table>
<thead>
<tr>
<th>Gestation</th>
<th>Legal limit</th>
<th>Personal limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2 (1%)</td>
<td>14 (5%)</td>
</tr>
<tr>
<td>&lt;= 12</td>
<td>7(2%)</td>
<td>71(22%)</td>
</tr>
</tbody>
</table>

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Personal experience leading to my view on abortion.

My own experience of abortion predates the passage of the 1967 Act. As a student I saw a woman in her mid-thirties die of renal failure in the Forest Gate Hospital in 1959 after she had syringed herself in an attempt to abort at about 20 weeks. She was married and felt she could not cope with a fourth child. As a pre-registration house officer in 1961 I only saw one woman who had attempted an illegal abortion with potassium permanganate whilst I worked in the Receiving Room at the London Hospital as the ambulance drivers took these women to Mile End Hospital, She was bleeding too heavily for them to make the extra mile-the pregnancy was intact..

I then went abroad and saw several young women die from unsafe abortions procured with native medicine or done by unskilled practitioners. One of these in Nigeria in 1966, was my own housemaid, a beautiful and lively 17 year old. In Kenya in 1968, an 11 year old nearly died of sepsis and had probably lost her chance of having children in the future. My housemaid had asked me to help and I had advised her to go home and tell her parents and the mother of the 11 year old had asked us in the hospital to do an abortion on her young daughter and was told it was illegal. My experience in Africa convinced me that abortion should be legalised and done by doctors to prevent the loss of life and risk of ill-health from unsafe abortion (ref2).

I returned to Britain in 1969 and got a post at the Royal Free Hospital where I learnt how to perform abortions safely. When I went to New Zealand in 1973 where the law was the same as that in Britain before 1967, I found I could not refuse to perform abortions and with the help of the Medical Superintendent a system was set up.

I gave evidence to the Royal Commission that was held in 1976 to look at Contraception, Sterilisation and Abortion, which led to a change in the law. I then returned to Britain and worked with the late Professor Peter Huntingford in Tower Hamlets where I assisted him with the Tower Hamlets Day Care Abortion Service.

I ran this after he resigned in 1981 until 1985 when I was able to create a post of Director of Well Women’s services which combined contraceptive, cervical screening and abortion services. I continued to do the second trimester abortions

<table>
<thead>
<tr>
<th></th>
<th>13-19</th>
<th>20-23</th>
<th>24</th>
<th>&gt;=25</th>
<th>Not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at abortion</td>
<td>15(4%)</td>
<td>42 (13%)</td>
<td>203(64%)</td>
<td>40 (13%)</td>
<td>10 (4%)</td>
</tr>
<tr>
<td>Percentage</td>
<td>142(43%)</td>
<td>74(22%)</td>
<td>16(5%)</td>
<td>8(2%)</td>
<td>3(1%)</td>
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</tbody>
</table>

Ref 1 (1989) Numbers may not add up to 100 because of rounding n+318

**Should induced abortion be linked to fetal viability?**

My view is that the time limit for abortion should not be linked to fetal viability because if one is looking at the woman’s health her needs are paramount. She is a live sentient human being with a nexus of relationships and expressed hopes for the future. The fetus has the potential to become a live baby but whilst in the womb is dependent on its mother and is not a sentient human being. I believe that as pregnancy advances the rights of the fetus become greater but never override the rights of the mother. The law already allows for exceptions to be made after 24 weeks if there is a lethal or serious fetal abnormality.

I saw no need to change the law in 1990 as very few abortions were done after 24 weeks gestation and as most doctors are reluctant to perform later abortions they were only done for compelling fetal or maternal reasons. It laid the way open for the anti-abortion organisations, (who really want to outlaw all legal abortion) to seize on this emotive topic and campaign for a lowering of the time limit by claiming that there have been significant improvements in the survival of babies on the threshold of viability and yet there is little, if any evidence to support this claim (ref 3). More importantly if an artificial womb were to become a reality in the future and it became possible to keep a fetus alive at 12 weeks does that really mean that the rights of a 12 week fetus should over-ride those of its’ mother?

Secondly, in practice is rare for women to present after 24 weeks and even rarer for them to present after 26 weeks. This was true when 28 weeks was taken as the time when a baby might survive even without neo-natal intensive care.

I reviewed the case notes of all the women who had presented after 20 weeks in Tower Hamlets in 1983, (one of the most deprived areas in the country). 12 or 1.5% of the requests were made after 20 weeks. No abortions were done for fetal abnormality in that year. There were seven women and five girls aged 12, 13 and 14 respectively and two aged 15. The 14 year old was recently arrived from Bangladesh where she had been raped on the way to collect water from the well. Her parents had sent her off to her aunt and uncle but not revealed that she was pregnant. She was 30 weeks pregnant and the only case that had presented over 28 weeks in that decade (ref 4).

I have seen over 3,500 women presenting with an unwanted pregnancy in four different countries and the case above was one of only two over 28 weeks. The other young woman was referred to me by the Pregnancy Advisory Service after the doctor had said they could not do an abortion so late and was concerned that she might harm herself. After discussion I did not think she was suicidal but desperate because of her social problems. She was not from Tower Hamlets
either. She remained in the antenatal ward for 18 weeks until she was re-housed and went home with her baby at 6 weeks. This was in the late 1970s. Nine months later I met her by chance in the market and enquired after the baby. She told me he had died as a cot death at five months. Interestingly, the Bengali baby had been placed for adoption and suffered a cot death at five weeks whilst with experienced foster parents. Seven abortions were performed and of the five pregnancies that continued only one baby was alive after a year.

In the decade before I retired when the limit had been lowered to 24 weeks I saw one English business woman in her twenties and one Nigerian teenager in her late teens, both threatening suicide and neither from Tower Hamlets and two Bengali girls, one aged 11 and one aged 12 whose mothers requested termination of pregnancy. One had been abused by the Iman allegedly giving her lessons in the Koran in her bedroom. I performed these abortions after 24 weeks under what is now ground B as I thought ‘it was necessary to prevent grave permanent injury to the physical or mental health of the woman’.

For example when a woman threatens suicide because she cannot face continuing with a pregnancy, one needs a psychiatric opinion to assess her mental state and what mental health care she needs. The Professor of Psychiatry at the London Hospital in 1989, after a consultation with such a woman, estimated the risk of her actually committing suicide was, in his opinion (based on experience which started before 1967), as ‘only 1-2%’. Compared with the maternal mortality rate of 10 per 100,000 at that time I felt this was sufficient to comply with the grounds in the Act and carried out an abortion at 26 weeks. He also stated that in his experience, once the acute crisis had passed most of these young women’s mental health improved miraculously and they rarely required ongoing psychiatric care.

In conclusion

Firstly, if the woman’s health is taken as the most important factor when performing an induced abortion then it is wrong be link it to viability.

Secondly, in practice, in my experience, women do not request induced abortion after 26 weeks gestation.

References
