Correspondence

Psychiatric referrals since the Abortion Act 1967

SIR—I was interested to read Dr Kenyon's paper (*Postgraduate Medical Journal*, 1969, 45, 718) on 'Psychiatric Referrals since the Abortion Act 1967'.

Little has been reported in the literature about those patients that present to psychiatrists with a view to obtaining termination of pregnancy. How different are they from patients presenting for other reasons? Are the patients referred those with psychoses and a history of mental hospital admissions on the one hand, or are they patients who have no psychiatric illness at all on the other? Are they referred from gynaecologists or general practitioners? How has the population referred changed since the Abortion Act was adopted?

Dr Kenyon has gone part of the way to satisfying our curiosity on these points. In his practice he has seen no schizophrenic patients, but the majority are diagnosed as suffering from psychiatric morbidity. In fact, the majority have a history of previous psychiatric disturbance, and a substantial minority have had earlier referrals to psychiatrists for treatment.

However, in some respects Dr Kenyon leaves our thirst for knowledge unassuaged. He does not cross-correlate the variables that he considers: in my experience patients with no past history are sent up mainly from general practitioners—the gynaecologists refer predominantly patients with known psychiatric disability. We do not know whether this is his experience. Clark *et al.* (1968) have helpfully analysed the characteristics of those patients who were accepted for termination; in Dr Kenyon's paper there is no breakdown either of this category or of any of a number of possible interesting interactions between variables.

The other drawback of the paper is that, despite the abundance of descriptive statistics there are no inferential statistics. How many of the changes that have taken place since the Act, for instance, reach statistical significance? It is difficult for the reader to do Dr Kenyon's homework for him, because the changes are given as rounded off percentages. Given the misallocation of a fraction of a patient here or there I calculate that almost all of the changes he describes as occurring since April 1968 fail to reach statistical significance. In fact the only change in percentage that falls below the 10% level of probability is the increase in proportion of first pregnancies in single patients (χ^2 , corrected for continuity, = 3.97, $P < 0.05$, two-tailed).

The increase in the length of the history (presumably of the presenting illness) appears to be substantial, although there is no way of testing its significance without further information. It would seem that there is a tendency for the population of patients referred to be increasingly those with psychiatric morbidity prior to pregnancy. If this is an accurate reflection of what is happening on the national scene there would be no reason to assume that psychiatric referral is being used as a means of trumping up a case for termination under the second main clause.

This impression is consonant with the negligible increase in the proportion of patients recommended for termination in the present series.

How is this compatible with the great increase in the number of terminations carried out? The majority are performed under the second clause, and it is widely assumed that the grounds are those of possible injury to the woman's mental, rather than physical, health (*British Medical Journal*,

1969). It may be that, although these are the grounds, that with agreement reached between the general practitioner and the gynaecologist, psychiatric referral is not considered necessary. It is possibly a counsel of perfection to suggest that all such patients should be so referred, since few psychiatrists would wish to provide merely a rubber-stamp to the decision to terminate, and although Dr Kenyon does not go into the subsequent fate of these patients, in my experience the psychiatric symptoms of the vast majority of them improve dramatically after termination, and untoward mental sequelae are uncommon at least in the short term follow up. Diggory (1969) estimated that two patients out of his series of 1000 had social or emotional problems as a complication!

It is debatable whether the present 'mix' of patients referred to the psychiatrist approaches the ideal. Perhaps not many would go as far as Dr Tredgold (1969) in suggesting that the doctor should advise on the relative risks and leave 'the final decision to the mother'. It would seem, however, that if one wished to avoid the relatively few psychiatric sequelae that do follow terminations, then those patients should be referred who, although having adequate grounds for termination, are more ambivalent about the prospect than the average patient in this situation, since it is the ambivalent patient that is the one in whom depression would be predicted after the termination, and psychiatric skills can be used to resolve the ambivalence one way or the other.

The informal conversations that I have had with others doing research on this subject, as well as the views expressed at the Symposium on therapeutic abortion in north-east Scotland held at the Annual Scientific Meeting of the British Medical Association earlier this year (*British Medical Journal*, 1969) would tend to confirm as general the findings by Dr Kenyon that the typical patient referred for psychiatric opinion is one who may be either married or single, who almost certainly will not claim to have been raped, but who is unlikely to have used adequate contraception. Many will have had a previous psychiatric history, and most will be suffering from a demonstrable psychiatric illness at the time of the examination; this will rarely be a psychosis, and will usually be a depressive illness.

What is less clear are what the changes are since the Act has become law. It remains to be seen whether those trends noted by Dr Kenyon will be confirmed in other parts of the country.

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