

OUTLINE STATEMENT OF JONATHAN VICTOR LARSEN
To be called as an expert witness on behalf of the plaintiffs.

My address is 181 Amberfield, P/Bag X010, Howick 3290, kwaZulu-Natal.
My qualifications are MB, ChB (Cape Town), FRCOG (London).

A. Short CV

I qualified in Medicine in 1962, then specialised in Obstetrics and Gynaecology when I gained the Membership of the Royal College of Obstetricians and Gynaecologists in 1972. I was elected as a Fellow of the same College in 1988.

Apart from 4 years spent in specialist training in the Obstetrics and Gynaecology Department of the University of Cape Town Medical School, I spent my working life in mission hospitals and public sector hospitals in KwaZulu-Natal.

From 1978 to 1981, I was Senior Lecturer in Community Obstetrics in the Department of Obstetrics and Gynaecology at the Medical School of the University of Natal, Durban. From 1982 until I retired, I acted as an external examiner for the undergraduate examinations of that Department.

From 1982 to 1997, I was Regional Obstetrician for varying sections of Zululand, employed first by the Departments of Health of Natal and of KwaZulu Government, then of the Dept of Health KZN. From 1997 to 2003, I held the post of Senior Specialist in Obstetrics and Gynaecology at Eshowe Hospital.

My full CV is available.

B. Personal Experience of Induced Abortions.

My conviction is that abortion on demand does not meet the needs of women in crisis or of couples in crisis. Its wide acceptance does serious damage to the nation's view of the sanctity of life.

Having said that, I accept that there are situations when an early termination of pregnancy (TOP) is justified: e.g.. When a mother suffers from severe cardiac disease or severe renal disease with hypertension. In these situations pregnancy may seriously endanger the mother's life, and usually it is not a choice between 2 lives. The object of treatment is to save the mother's life and so avoid losing both lives.

I also believe that there is a place for TOP when a baby has a fatal malformation such as anencephaly, in which the baby will survive only a few hours.

I have carried out TOPs in these circumstances and also in the case of rape. In every case, extensive counselling was offered and the alternative options were explored.

C. Expertise in abortion

In 1978, I wrote the first review article on the subject of “*Induced Abortion*” in the South African Medical Journal (SAMJ). Since that time I have taken a special interest in the subject and have kept abreast of the changes in SA law. I have been particularly concerned about post abortion risks to maternal and paternal health and family relationships as the number of TOPs has grown in the nation as a result of the Choice on Termination of Pregnancy Act of 1996.

In 1984, two colleagues and I were the first to report uterine rupture as a result of the vaginal use of Prostaglandin E2 to induce labour in term pregnancies. Misoprostol is a very much more stable and powerful derivative of natural Prostaglandin E2, and I have followed its use for induction of labour and for TOPs closely.

In 1997, I spent 6 months on sabbatical as “professional in residence” at Regent College in Vancouver, Canada. One of my concerns was to investigate the consequences of liberal TOP legislation on the health of women and couples in a nation in which such legislation had been in force for some years. I spent some time in the Pregnancy Crisis Centre at Vancouver and graduated from their training modules in Pregnancy Crisis Counselling and in the care of people suffering from Post Abortion Syndrome (PAS). My wife and I spent time with women who were recovering from the latter, listening to their stories and learning from their experience. I also sought out Philip Ney MD and Anna Peters, who have published much in this field. PAS was little recognised in RSA at the time. Now it is gradually gaining recognition.

D. Post Abortion Syndrome

On my return from Canada, I wrote to the SAMJ on this subject. My article was published as a letter under the heading “The Post Abortion Syndrome - A Grief Subverted.” This letter summarised the dynamics of PAS as far as we can understand them. The only responses received were a few letters in support.

In western countries where abortion has been widespread for more than 2 decades, there are increasing numbers of excellent studies showing the psychological and spiritual devastation of women from PAS.

A good example is the excellent publication by Gissler et al in 2005. This showed that the age-adjusted, induced abortion related mortality rate from external causes (homicide, suicide and unintentional injuries) was 60,3 per 100 000, compared with 10,2 age-adjusted mortality rate per 100 000 for women who went through with their pregnancies. For suicide, the age-adjusted mortality rate for abortion was 33,8, compared to 5,5 for pregnancy or birth.

Other authors have shown that women who choose abortion are 34% more likely to suffer from generalised anxiety disorder, 14,3% more likely to suffer from post traumatic stress

disorder, 65% more likely to score in the “high risk” range for clinical depression, 4,5 to 10 times more likely to engage in substance abuse, and have a 144% higher risk of child abuse than women who have a spontaneous miscarriage or carry to term.

There is evidence that PAS can continue to deeply affect a woman’s well-being many decades after TOP. 70% of American couples who choose TOP, whether married or not, separate within a year of making that choice.

E. Complications in more advanced pregnancies and subsequent pregnancies

It is now widely accepted in the profession that the risks associated with TOP increase significantly from 12 weeks. The reason is that induction of labour with a live foetus in an uncomplicated pregnancy before 34 weeks, (when the cervix begins to soften for normal birth,) requires high doses of induction agents to produce much higher expulsive forces with the associated increased risk of damage to the cervix and uterus. That is because the cervix of mid-pregnancy is long and firm. It is not physiologically primed for labour, and resists attempts to initiate labour.

The damage to the genital tract under these circumstances may include lacerations of the cervix, or even rupture of the uterus. Such ruptures can lead to damage of other organs such as the bladder. Complications include severe haemorrhage and infection which may necessitate hysterectomy to save the mother’s life. For that reason, termination of pregnancy in the mid-trimester is normally undertaken in a referral hospital. It is fortunate that Crystal did not apparently suffer any such trauma, but the hospital record does not indicated that any attempt was made to examine her cervix for lacerations and for partial thickness damage to the lower segment of the uterus. This is an important omission, because such lesions do not necessarily bleed and may remain a weak point predisposing her to lacerations or rupture of the uterus in a subsequent labour.

Even when there is no evidence of an obvious laceration of the cervix, however, that is no guarantee that there has not been permanent damage to the integrity of the circular fibres of the cervix. In normal pregnancy, these circular fibres hold the baby in the uterus until the hormonal changes near term cause them to relax and allow expulsion of the baby without damage to the uterus, cervix or baby. When such damage is done during a TOP, a cascade of problems in subsequent pregnancies may result. They include an increased likelihood of spontaneous mid trimester abortion and premature labour. Many such births take place before 31 weeks. Such babies are at great risk of dying from the complications of prematurity, and many survivors suffer from cerebral palsy and other prematurity-related complications. The likelihood of cerebral palsy in a baby born at 20-27 weeks is a massive 38 times higher than the general new-born population. The cost to the parents and to the health services of raising such babies is considerable and the cost to the parents in grief from recurrent pregnancy losses can be very severe. Careful studies done in Germany investigating the outcomes of pregnancies after TOPs showed a 2,5 fold increase in the likelihood of delivery before 31 weeks after one TOP, a 5,2 fold increase after 2 previous TOPs, and a massive 8,0 fold increase after 3 or more TOPs. Those studies involved mainly first trimester TOPs. When a much larger foetus has to be forced

through an unprepared cervix in a more advanced pregnancy, the likelihood of damage to the cervix is greater. At 28 weeks, the likelihood of damage could hardly be greater.

F. The abortion-breast cancer risk.

There is a higher risk of cancer of the breast in societies in which mothers do not breast feed. There appears to be a similar “loss of protection effect “ when women choose to abort a pregnancy when the breast has been stimulated with the high levels of oestrogen normal in early pregnancy, but not fully prepared for lactation by the very large hormonal changes which occur late in pregnancy. This effect is greater the younger is the woman when she has a TOP, and the more advanced is the pregnancy. Dr Janet Daling in a 1994 Cancer Institute study reported that if a woman is under 18 when she has her TOP, her risk of breast cancer later in life increases 150%. If she is under 18 and her baby’s gestational age is greater than 8 weeks at the time of the TOP, her risk of breast cancer later increases 800%.

Other studies suggest that the incidence of cancer of the breast is also dependent on the length of the delay before the patient conceives and carries to term. They suggest that, after a late termination of pregnancy like Crystal’s, the risk of cancer of the breast doubles if she has a pregnancy within 10 years, but increases fourfold if she delays 20 years or never conceives again.

G. Conclusions

For the reasons outlined above, an induced abortion at 28 weeks could hardly be more damaging. Certainly it gives rise to substantially increased risks in the three areas outlined in paragraphs D, E and F above.

For Crystal, the risks of serious psychological and spiritual consequences are very high. This is because the decision to abort was taken without access to her primary caregivers, only after consultation with her teacher and her boyfriend. They both may well have had a vested interest in a quick fix.

It must be acknowledged that any woman who has carried a baby for more than 3 months will view herself as a mother, whether she is willing to do that or not. Crystal was clearly ambivalent about taking the tablets. Had an accurate assessment been made of her period of gestation, and had she been informed about the fact that the baby would deliver alive, she would, from my experience of similar cases, certainly have changed her mind and summoned up the courage to face her parents with her problem.

As the situation was in fact managed, she delivered a baby who lived for several hours. She will live with the knowledge that she destroyed that life. Even if she is still in the denial phase of her grief, eventually she must face the phase of anger which will inevitably be directed at those who hastened her into that decision and anger against herself. As discussed above, that anger could lead to self-destructive behaviour which may appear as serious risk-taking, sexually and otherwise, to substance abuse and to

inexplicable rage with their very serious dangers of physical trauma. And she faces an increased risk of suicide during her recovery from the depression phase which is likely to follow. Considerable and potentially costly psychological and spiritual care will be required for some years to come to help her recover successfully. This may be especially true as she comes from a religious background.

If her psychological issues are not adequately dealt with, the chances of her developing serious difficulties with intimacy in later life are very high. The effects of PAS can be very prolonged. I spoke with a woman in Canada who chose a TOP in her sixth pregnancy at the insistence of her husband 20 years before. Her marriage collapsed within a year, and only 20 years later did she finally find healing in a group of women who had also coped with PAS.

I have also counselled a woman in her 40s who had had a TOP as a student at University at the insistence of her father. She lived in denial of this event for 16 years, when the loss of another child was associated with diffuse, unfocussed anger which threatened to tear the home apart. And she became severely depressed. Healing only began as she acknowledged her grief from all those years ago, and dealt with that loss and that anger.

Other Matters of Expertise I have been asked about:

1. Is TOP, even when done lawfully, an inherently dangerous procedure?

It is physically more dangerous than proceeding with a normal pregnancy if that pregnancy has gone beyond 10 weeks. But of course, the psychological dangers with their associated risks of suicide and accidental death must be added to those of damage to the genital tract, infection, deep vein thrombosis etc. A trained guidance counsellor should have known about physical and psychological dangers. A midwife should have known about the greatly increased dangers associated with mid-trimester termination, and the absolute necessity of getting an accurate assessment of gestational age before proceeding with the TOP if there was any doubt at all about that. She must have known that such an assessment is of particular importance in a pregnancy near the duration of extra-uterine viability in which there was no medical reason to consider termination.

2. What is the right way to assess the period of gestation (duration of the pregnancy)?

Asking about the date of the last normal menstrual period and calculating from that.

Asking about the date of the onset of morning sickness.

Asking about the date on which foetal movements were first felt.

Physical examination of the abdomen and pelvis. The physical examination of the abdomen should include measuring the pubic symphysis to fundus height and comparing that with the correct population norms. It should also include feeling the size of the foetal head beyond 24 weeks, assessing the volume of fluid in the uterus and listening to the foetal heart. Using those criteria, it is usually possible to make a pretty accurate assessment of the duration of pregnancy if the mother is not obese.

An ultrasound scan of the abdomen is normal practice when there is discordance between

dates and physical findings. A properly done scan will allow an assessment of gestation to be made with a margin of error of about 2 weeks at 28 weeks.

As stated above, if an accurate period of gestation had been made, it is, in my experience, extremely unlikely that Crystal would have proceeded with the TOP, and a great deal of grief and trauma would have been avoided.

I must point out that health workers doing TOPs are at serious risk of developing PAS. When they do, they are likely to distance themselves from their patients and their needs. That almost inevitably leads to a drop in the normally expected standards of care they deliver. Perhaps this was a factor in this case.