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The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong.

I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion.

The above paragraph was taken from the Hippocratic Oath which physicians now practicing medicine observe. Throughout the centuries this oath has been challenged but has stood undaunted to the present day. Is the oath wrong? Are these principles different today from what they were yesterday? Will they be different tomorrow? Presently, therapeutic abortion may only take place when it is adjudged *medically necessary* to save the mother's life. The proposed change in these laws would permit abortions to be performed in licensed hospitals when two or more physicians agree that (1) the pregnancy would gravely impair the physical or mental health of the mother, (2) the child would likely be born with grave physical or mental defects and (3) the pregnancy resulted from rape or incest. The proponents of the bill falsely mislead the public to believe that the indications for therapeutic abortion are based on medical facts. This is far from the truth as this article will fully show.

When the permission to procure an abortion or to destroy fetal life is stated or implied in an American statute, it is invariably based upon a supposed medical necessity. It would be reasonable then to expect that a movement to facilitate therapeutic abortion would betoken a growing demand by the medical profession, that is, a general demand for a much wider use of such therapy in the complications of pregnancy already recognized as medical indications for emptying the womb or for recognition of new medical indications. We find, on the contrary, that medical opinion is evermore skeptical, more critical of the therapy of abortion and of embryotomy.

In 1931 the Margaret Hague Maternity Hospital opened in Jersey City as one of America's great hospitals. Dr. S. A. Cosgrove, head of obstetrics at Columbia University, was medical director from its opening until a few years ago. He had one therapeutic abortion among the first 4,000 deliveries. When he reported this, other hospitals were doing from one in 600 to one in 100. His report jolted the medical profession into serious inquiry and resulted in abandonment of many of the indications accepted up to that time. Greenhill in his 1951 revision of DeLee, reduces the original DeLee list. "Therapeutic abortion is rarely indicated and medical therapy has improved so much that few affections justify its performance." (Greenhill, 1951.)

Meanwhile, the Hague Memorial Hospital was delivering more than

100,000 babies, with only *eight* therapeutic abortions, and had *abandoned the use of therapeutic abortion entirely in 1939*. Its influence was being felt. In 1951 Dr. R. J. Heffernan, of Tufts, had declared to the Congress of the American College of Surgeons, "anyone who performs a therapeutic abortion is either ignorant of modern medical methods of treating the complications of pregnancy or is unwilling to take the time to use them." And, Dr. Heffernan has reiterated this view with renewed emphasis.

Margaret Hague Hospital had two therapeutic abortions for rheumatic heart disease, both in 1935. Of these, one mother died four days later. Since that time the hospital had over 500 cardiacs with no therapeutic abortions and a maternal loss of two; that is .4% as compared with 2.6% loss among all women, puberty to menopause; this expanded through the years of 1939 to 1952. A 10-year followup on all rheumatic cardiacs entering this hospital from 1937 to 1942 totaled 260, showed 188 still alive, those with most pregnancies having the longest life.

A re-evaluation as to all of these complications of pregnancy is at first view encouraging. Yet, as the incidence of recognized medical therapeutic abortion is reduced, the effect of medical treatment substituted, we find new indications of a wholly different sort being urged. Psychiatric indications had long been suggested without getting much attention. In recent years they have been widely invoked, but by obstetricians, rather than by psychiatrists. The judgment of the latter has been against induced abortion for psychotics and personalities which might easily become psychotic.

"At the present time, there is no indication for performing therapeutic abortion in psychotherapy *per se*—there exist very few, if any psychiatrists who feel that therapeutic abortion is indicated in any of the psychoneurotic reaction types." (Ebaugh and Heuser, 1947.)

"By and large, obstetricians have performed therapeutic abortion on psychiatric indications begrudgingly. They have been inclined to regard indications which their psychiatric colleagues bring to them as too esoteric and intangible to be convincing; and the thought has not infrequently crossed their minds that a clever, scheming woman is simply trying to hoodwink both psychiatrist and obstetrician. The present volume goes far toward correcting these misapprehensions on the part of the obstetricians. Indeed, from the statements and case histories which psychiatrists present in this volume, it is clear that their opinion is veering rapidly toward greater conservatism. The guilt complex which sometimes follows artifically produced abortion receives special emphasis. Author after author uses such phrases as 'the sense of guilt or inadequacy which appears directly related to an abortion,' 'psychic "hangovers" from abortion,' 'traumatic experience of an abortion,' 'the effect of the termination on the

integrity of a woman's personality structure,' 'emotional trauma which the woman will subsequently experience,' to say nothing of the stress laid on 'exceedingly depressed hysterectomized patients' and suicidal tendencies in vasectomized men.

"The feeling is apparently growing among the leaders in psychiatry that therapeautic abortion on psychiatric grounds is often a double-edged sword and frequently carries with it a degree of emotional trauma far exceeding that which would have been sustained by continuation of the pregnancy." (Eastman, 1954.) Eastman, one of the top recognized authorities in the world in obstetrics, is Prof. Emeritus in Gynecology at Johns Hopkins University School of Medicine.

"The fact that no abortions have been done for neuropsychiatric reasons during the last two years at the University of Virginia Hospital means that a change of attitude has been successful in helping many people solve their problems in living, problems which seem to be without solution at the time the case was presented. Neuropsychiatric disease is not necessarily an indication for abortion, since persons with serious reactions can be treated while pregnant by shock therapies as well as by psychotherapy. Readjustment of family attitudes frequently allays immediate panic and just as frequently makes the hated pregnancy become a cause for working out the elements behind the family disunity." (Wilson, 1954.)

Report on 139 therapeu abortions with 31,581 deliveri , as to psychiatric reasons (41 o 139): "In the literature this gr) constitutes the least logical a most hazardous of all indication -I feel that, except for the nex group (neurologic), it is the le justifiable of all indications. edical men have devised better t tment of severe disease associat with pregnancy and have been ble to markedly reduce the th peutic abortion rate throughout t country only to find that this le justifiable of all indications, ps hiatric reasons, had been allowed o run rampant. Throughout the ountry most authors (citing) repo an increased rate of therapeut abortions for psychiatric reasons. Manic depressive psychosis and schizophrenic: "The problem her is one of institutional care and c rtainly therapeutic abortion will n t solve it." (Scherman, 1958.)

However, neurotics were quickly substituted for psychotics; nd in one writing after another w begin to find suggestions that the medical man should recognize un medical indications—economic, soci l, the wish of the patient—to determine his course as a medical man.

It becomes hard for a layman to avoid feeling that there is an element in the profession that wants induced abortion and is determined to find some justification for it. It is equally hard to avoid a feeling that the real pressure for liberalized abortion comes, not from medical men concerned with medical needs,

but from involuntary parents of unwanted children.

"A survey shows that the attitude and experience on therapeutic abortion is the same in Germany as in Russia. Social indications are not acceptable, but may give some support to a medical indication. It is necessary to guard against doctors making pretense of the presence of basic disease merely as a cover for action on social indication." (Kratz, 1958.)

"If one completely eliminates all socioeconomic reasons, then one automatically eliminates therapeutic abortion for all fetal reasons, and also eliminates therapeutic abortion for any reason, for the most part. The efforts of many workers have shown that with adequate hospitalization and treatment, similar cases to those which in the past have been aborted, can be carried to normal termination with little or no increase over their aborted counterpart in maternal morbidity or mortality. " (Scherman, 1958.)

"Since therapeautic abortion entails destroying the fetus, it is a grave undertaking and must never be considered unless there is imminent danger of death of the mother as the result of pregnancy, or of great bodily or mental harm. Therapeutic abortion should never be performed without the written approval of two *consultants*. Neither the law nor medical ethics permits the procedure for sociologic reasons, such as illegitimacy, poverty, or rape.

The operation of therapeutic abortion, whether done vaginally or by abdominal hysterectomy, is not without intrinsic danger. Therefore, in considering the justification for therapeutic abortion in a given case, it is not enough to reason that pregnancy will be harmful, but it must be indisputably clear that the risks involved in the continuation of pregnancy are greater than the hazards of the operative procedure. Since the patient is ordinarily a sick woman, with perhaps advanced cardiac or hypertensive disease, these operative hazards may be substantial. Indeed, even in normal, healthy women, the mortality and morbidity rates of the operation are considerable.

This statement is documented by data from countries in which therapeutic abortion is frequently induced for eugenic or humanitarian reasons and hence performed for the most part on women who are physically and mentally normal. In 23,666 therapeutic abortions performed in Denmark, the mortality rate was 0.7 per 1,000 operations, while serious but non-fatal sequelae ensued in 3.2 per cent (Berthelsen and Ostergaard). These sequelae included 82 cases of perforation of the uterus and 122 cases of salpingitis, peritonitis, and septicemia. In addition, 113 cases of non-fatal but serious complications followed 5,320 abdominal hysterectomies, or 2.1 per cent. According to the eminent Japanese demographer, Yoshio Koya, not less than 47 per cent of women in Japan experienced postabortal complications following induced interruption of pregnancy in his country. (Eastman, 1966.)

Of the more debatable indications for therapeutic abortion, the two most frequently encountered are psychiatric disease and potential abnormalities of the fetus. Among 4,675 thereapeutic abortions performed in New York City between 1951 and 1962, inclusive, the major indication for the operation was some type of mental disorder (Gold and co-workers). *Nevertheless, the belief is growing that interruption of pregnancy on psychiatric grounds is often a double-edged sword which may aggravate rather*

than ameliorate psychotic tendencies. Thus, in the opinion of both Pearce and Martin, when the operation is carried out on mentally unstable women, it leaves 25 to 59 per cent of them with remorse and feelings of guilt. Even when it is performed for non-psychiatric indications. Gebhard and associates found evidence of prolonged psychiatric trauma in 9 per cent of a sample of American women in whom abortion had been induced therapeutically or criminally. The English psychiatrist Sim goes so far as to state: *'There are no psychiatric grounds for termination of pregnancy'.* Potential abnormality of the fetus as an indication for therapeutic abortion comes up most frequently in connection with maternal rubella. Here, likewise, there is great diversity of opinion; some obstetricians and opthalmologists believe that the operation should *never* be performed on this indication while others believe that it is justified in *certain carefully selected cases."* (Eastman, 1966.)

"Since therapeutic abortion to save the life of the woman is rarely necessary, it follows that the great majority of such operations being performed in this country go beyond the letter of the law." (Eastman, 1966.)

"As the result of a sharp and continuing decline in traditional medical indications (heart disease, hypertension, pulmonary tuberculosis, hyperemesis, and so forth), the number of operations performed on these grounds has fallen dramatically over the past two decades with the result that a justifiable interruption of pregnancy on physical indications is becoming rare." (Eastman, 1966.)

"At a planned parenthood seminar on abortion, New York, 1958, Dr. Kinsey insisted that the greatest number of induced abortions were found among those using ntraceptives who grew careless (Calderone, 1958.)

Therapeutic abortion act n the fetus only to destroy it; t t can hardly be called therapeut as to the infant. Abortion can ly be considered therapeutic as the mother if in a substantial per ntage of cases, it notably increa s her length of life or restores her good health. There are no adeq e figures to show this result.

"Until as recently as t past decade, therapeutic abortio was a relatively common procedu well accepted by the majority o physicians as properly indicated r the preservation of the mother's ife or immediate health in certain mplicated pregnancies . . . Dur g the past 10 years, however, the have been growing appreciations f the fact that many indications f ther-apeutic abortions are no lon r tenable in the light of continu g advances in medical and rgical knowledge. This realizati has stimulated many institutio s and organizations to study th pro-cedure carefully and to re-e aluate their methods of managing he associated problems." (Russel, 953.)

"Therapeutic abortion is a gravely abused operation and the in idence of the procedure the coun y over is much higher than it shou d be." (Williams, ed. Eastman, 19 6.)

"As Eastman has pointed out in the foreword to a book by Rosen, this change also has come about from a realization that pregnancy if properly managed, seldom aggra-

vates organic disease." (Nelson and Hunter, 1957.)

"The statistics presented show evidence of a very important trend in regard to therapeutic abortion. All major organic illnesses have shown a considerable disease infrequency as indications. It shows that, even in the face of the serious complicating diseases, with competent care, diseases and pregnancy are compatible in most instances." (Scherman, 1958.)

"Treatment of the conditions which are aggravated by pregnancy has been so improved that they are now managed satisfactorily without interfering with the gestation. Therapeutic abortion accordingly is rarely justifiable." (Beck and Rosenthal, 1958.)

I therefore submit, as I have shown, that therapeutic abortion based on medical indications in the very best of hands under the very broadest liberalization medically is almost non-existent at the present time and that there is no increased demand by medical men for greater license for abortion on purely medical grounds, but that the real pressure for the liberty to have these abortions is for the convenience of the mother. Purely medical reasons have been almost completely abandoned with the shifting to the protection of mental health on which psychiatrists are not agreed, but to which most are opposed. The further shift to neurotic indications has become a medical man's judgment of the economic and social or purely selfish factors which he believed to be responsible for the patient's condition.

Regarding eugenic causes for therapeutic abortion, there exist two major conditions, (1) the Rh factor and (2) rubella commonly known as German measles. This has been the subject of discussion for approximately the last 20 years, and within the next few years both will cease to be a medical problem at all.

Discussing the Rh factor, "erythroblastosis fetalis is usually not looked upon as an indication for therapeutic abortion. In serious instances of this disease the child is either stillborn, dies in the first few hours of life, or survives. When it survives, a good prognosis can be given for normalcy if, when indicated, copious exchange transfusion is promptly carried out." (Guttmacher, 1954.)

More advances are taking place regarding the Rh problem in which we are now able to do intrauterine transfusions of the infant. The infant, on becoming anemic through hemolysis of the red blood cells, can be transfused in earlier stages of pregnancy, thus preventing intrauterine death. Ammocentesis, or testing of the bag of waters fluid, gives a very accurate report on the baby's status during Rh pregnancies and thus more infants can be saved. More important, we are on the verge of completely solving the entire problem.

Regarding German measles, five years after their first report, Krugman and Ward had determined that

the work done on this problem since 1953, required further consideration. They published the result of the re-evaluation showing only .9% contraction of rubella among 541 immunized pregnant women exposed to it, as against 11.2% for a control group of non-immunized pregnant and non-pregnant. Then as to the child: "The risk of congenital malformation resulting from a first trimester pregnancy complicated by rubella can best be determined by perspective studies. The early estimates of 90% or more were derived from retrospective studies which originated with the damaged infant; the normal infants, therefore, did not come to the attention of the observers. In recent years a number of surveys of the perspective type have been reported . . . these studies have originated with the rubella infection in the pregnant women, and ended with the newborn infant—normal or abnormal. The accumulated data at the present time indicates that maternal rubella infection in the first trimester may be followed by congenital malformations in 10% to 12% of these cases." (Krugman and Ward, 1958.)

More recent studies indicate during the first four weeks of actual pregnancy, if a woman has rubella she has approximately a 45% chance of having *some* form of congenital anomaly in the offspring. In the second four weeks of actual pregnancy, exposure and acquiring rubella gives fetal congenital anomaly rate of approximately 20% to 25%; and finally, du g the third four weeks of pregn y the possibility is 5%. Keep mind, however, that these pe ntages entail all forms of anomal from moot to gross. Therefore, or example, if rubella is contra l during the first four weeks pregnancy, of the 45% chanc f congenital anomaly, how n y of those anomalies will be m r and how many will be major? A in, as with the Rh factor, we ar n the verge of solving this pro m of rubella during pregnancy.

Finally, the third s gested change in the abortion b that pregnancy resultant from pe or incest is a cause for the peutic abortion: I fail to see the d for solving this problem with knife. There is no medical, moral, thical, or other objection to a di tation and curettage following e posure to this rape being done wit in approximately the first five t seven days following the rape or ncest. However, if a girl is exp ed to rape, and within a period o up to eight days she reports this o her physician, then she can be ut on pills for five days, and th s will prevent pregnancy from re ulting. Why therapeutic abortion r incest or rape? Why not di tation and curettage, if the knife e desired, done within a short period of time following this and or, in the 1967 fashion, why not obtain the use of pills to insure that pregnancy will not ensue?

Incest or rape are not medical indications for abortion. They might be sociological, they might

be economical, they might be moral, but certainly, they are not medical.

In conclusion, I would like to point to a few salient features. It is recommended that therapeutic abortion should provide for proper medical control through established hospital staffs, or competent medical committees. First, can licensed hospitals be of any size—large urban to small community? Secondly, two physicians? Perhaps a dermatologist and an opthalmologist? Perhaps a bone doctor and a radiologist? Or, perhaps an ear, nose and throat specialist and neurosurgeon? Does this make sense? If therapeutic abortion is to be permitted, then these cases should be reviewed before full therapeutic abortion boards that would consist of at least two obstetricians, a pediatrician, two psychiatrists and an internist. The men who sit on these therapeutic abortion boards should be specialists in their fields, should sit for a sufficient length of time to hear more than one or two cases and should become expert in the field in which they are deciding judgment. There should be a limited number of these boards for many reasons, one including the experience acquired from hearing vast numbers of appeals. What would happen to our small towns with, let's say, two, three or four general practitioners practicing, and one doctor consults the other on therapeutic abortion. Would he usually disagree with his cohort in this small town? Therefore, if therapeutic abortion is to be continued on a recognized medical basis, even in spite of the medical testimony against it, it should (1) be confined to no-fee clinics, (2) should appear before a specialized board, as previously mentioned, (3) a follow-up record on each patient should be required, and (4) therapeutic abortion should be denied to anyone who asks on a social or other non-medical ground or allied non-medical entities.

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