The Linacre Quarterly

Volume 19 | Number 1 Article 5

2-1-1952

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Recommended Citation
Heffernan, Roy J. and Lynch, William A. (1952) "Is Therapeutic Abortion Scientifically Justified?," *The Linacre Quarterly*: Vol. 19: No. 1, Article 5.
Available at: https://epublications.marquette.edu/lnq/vol19/iss1/5

Is Therapeutic Abortion Scientifically Justified?

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THE SACREDNESS of human life is the keystone of modern civilization. Our own nation was founded on the principle that all men are endowed by their Creator with certain inalienable rights and the most important of these is the right to live. Whatever nobility or esteem our profession may claim, derives from the fact that its members have dedicated their lives to the preservation of human life. The argument against therapeutic abortion from natural law can be stated very briefly. The unborn child is an innocent human being; its life is inviolable. To destroy that life deliberately is *murder.*

Ah! but some of our professional confreres will say: "From a strictly scientific standpoint, isn't it thoroughly justifiable to empty the uterus before viability when a continuation of the pregnancy would endanger the life of the mother?" Our answer to this question is an unqualified NO. It is *never* justified from a *strictly scientific standpoint.*

Recently it was the privilege of one of us (R. J. H.) to be one of the speakers in a panel on the "Indications for Therapeutic Abortion," held during the Clinical Congress of the American College of Surgeons in San Francisco, November 5 to 9, 1951. It was a pleasure to accept this assignment because a consideration of "Indications" for this heinous procedure has been an important but very much neglected part of obstetrical practice. Twenty-five or thirty years ago, therapeutic abortions were performed with deplorable frequency in most of the leading non-Catholic clinics.

Tuberculosis, heart disease, diabetes, hyperemesis gravidarum, neoplasms, chronic nephritis, hypertension, various types of anemia, chorea, thyroid disfunction, disturbances of the nervous system and psychiatric disorders, in fact in almost any complication of early pregnancy which did not promptly respond to conservative therapy, evacuation of the uterus would be considered. More recently, Rh difficulties, and virus infections acquired early in pregnancy by the mother have been considered sufficient reason by many physicians for emptying the uterus. These babies were destroyed because the attending doctors bowed to expediency, followed the line of least resistance and justified the murder of the fetus by saying it was the easiest, simplest and quickest solution to a difficult problem. Although we regret to

say some of these operations were done by eminent specialists in obstetrics, they were setting an example for Hitler's medical officers whose common practice it was to amputate a leg rather than attempt to set an extensive compound fracture.

Strangely enough, during this time those physicians who held intra-uterine life inviolate were not piling up tremendous maternal mortality lists. The task was and is not easy. Many patients with serious complications require long, painstaking expert care. Some of these good mothers endure extensive periods of discomfort and invalidism. They accept uncomplainingly, the expense of prolonged hospitalization, sacrifice of social activities, sometimes the censure of unsympathetic relatives and friends. They realize that these compared with the inestimable treasure of a new life with an immortal soul are a small price to pay. Their sacrifices were not and are not in vain for with proper care these women do not die. There are large numbers of well trained obstetricians, stern opponents to Therapeutic Abortion, who have successfully attended thousands of parturients with all the complications one sees in private and hospital practice. A shining example of this group is the Director and Obstetrician-in-Chief of the second largest obstetrical clinic in the United States, the eminent Professor of Obstetrics at Columbia University, Dr. Samuel A. Cosgrove. This distinguished member of the Methodist Church has won the profound admiration and gratitude of all physicians, who like Albert Schweitzer, have a true "reverence for life."

In 1944[1] he developed the thesis that the medical profession must vehemently work to maintain the ethical principle that the foetus is a human individual and that its destruction is murder. In 1946[2] he again pleaded for a rational approach to the complications encountered in pregnancy. Such rationalism he maintains, includes "the principle that medical and surgical complications of pregnancy should be appropriately medically and surgically treated, without interference with pregnancy. It does not embrace, on the one hand, blind confidence that pregnancy is and will remain physiologic, or on the other, a baseless fear that pregnancy may not be successfully managed in the presence of almost any complication. Intelligent improvement in obstetric practice will be principally predicated on thoughtful individualization of cases on the basis of such rationalism."

A review of the literature during the past 25 years, reveals a most gratifying but startling tendency. Science, it would seem has shown a very deplorable inclination to ignore, at first, any ethical consideration when faced with a new problem. As progress is made in subsequent research one finds repeatedly, the realization that the moral law is never in conflict with the basic principle of good medical practice, the saving of human life.

Tuberculosis, for example, is still a very important complication of obstetrics. Eisele[3] pointed out that tuberculosis had moved from first place

to seventh place as a cause of death in the general population, but for young women of the childbearing age, tuberculosis is still the first as the cause of death. Tuberculosis toll of this group accounts for 20% of all deaths, twice as high in mortality as from all puerperal causes. However, many eminent authorities in this field state emphatically that therapeutic abortion is not the answer to this problem. As far back as April 1930, Barnes[4] et al, after reviewing the records of 410 pregnant tuberculous women concluded that their investigations "lend little support to the view that emptying the gravid uterus in either the minimal or the far advanced cases has value as a remedy for pulmonary tuberculosis. Most of the favorable cases in this series tending toward arrest seem to have gone on to arrest in spite of the pregnancy and the majority of the actively progressive cases appeared to have progressed with the empty as surely as with the gravid uterus. It is difficult to see how terminating a pregnancy in far advanced cases with fever and cavity can offer much hope when we note that in women who are not and never have been pregnant, most of these cases progressed to death in a few months or a year or two at the most." "About 81% of the tuberculous women who became pregnant and who were not subjected to therapeutic abortion, bore normal children. A policy which would sacrifice all these children on the apparently slight and still unproved chance of saving a mother is not easy to justify."

In 1938, James Skillen[5] et al, in a paper based on a study of 10,000 patients admitted to the Olive View Sanitorium in California concluded "by and large it seems that the tuberculous woman who becomes pregnant has a case not greatly different so far as her tuberculosis is concerned from her tuberculous sister who does not become pregnant. While so far as her pregnancy is concerned she does not differ greatly from other pregnant women."

In 1943, DeLee[6] said "if the patient with active tuberculosis becomes pregnant, abortion is not indicated; proper care will enable the patient to go through her pregnancy unharmed."

A scathing denunciation of the interruption of pregnancy was presented by Jacobs[7] in 1946, who after analyzing the literature for 30 years said "if abortion is to have any scientific justification, evidence must be sought showing that in general the harmful effects are avoided if the pregnancy is being interrupted. A study of the literature will soon convince any impartial person that no such evidence exists."

Bowles and Damzalski[8] in commenting on this problem state in 1949 "the two great purposes of the art of medicine are to save life and to relieve pain and suffering. Any situation wherein a physician not only witnesses death but is called upon to cause it must be doubly distasteful to him. A therapeutic abortion is such a situation. It is really an admission of failure on all parts to control disease and remove its threat to the life of the mother.

It is a grim and disheartening task." The authors review the 10 years of literature up to 1949 showing that the trend has been away from abortion in tuberculosis.

Stewart and Simmons[9] of England in 1947 stated "pregnancy as an event in the course of tuberculous women has little or no effect upon the progress of pulmonary disease over a period of 15 months whether this disease is active or quiescent. Deterioration in the state of some tuberculous patients must be expected, whether they are pregnant or not. Pessimism as to the influence which pregnancy has on tuberculosis and unusual zeal for the termination of pregnancy has to be avoided."

A very disturbing feature of this problem was stated by Jameson[10], of Saranac, at the Third American Congress on Obstetrics and Gynecology, when he said "there is ample evidence at the present time to lead us to believe that if the tuberculous woman received adequate treatment for her pulmonary disease, as well as proper antepartum, intrapartum and post-partum obstetrical care, the pregnancy need give rise to no particular worry from a medical standpoint. Economically, pregnancy in a woman with tuberculosis may give rise to difficulties as the added financial burden of having a baby and providing for its care after birth while the mother continues her cure is frequently more than the family pocketbook can bear. This too often necessitates the mother leaving the sanitorium before her cure is completed, to return to her home to resume the physical strains and worries of domestic life and to lose contact with physicians who are familiar with her disease and its treatment. Socially the problem is complicated by the fact that in the United States the facilities for the care of pregnant tuberculous women through the antepartum months, delivery and the puerperium are still woefully inadequate. The few sanitoria which have had the vision and initiative to set up such a service have reported remarkably good results. In most of the private sanitoria and in practically all of the state sanitoria, no provision is made for the pregnant patients and they are required either to submit to an artificial termination of the gestation or to leave the sanitorium at the end of the 3rd or 4th month. If the patient is unable to afford the added expense of private care, she must return to her home and the tuberculosis progresses from lack of proper treatment (as tuberculosis usually does) and the bad result is laid to pregnancy."

Matthews[11] lends further support to this opinion by stating "this relationship (cooperation between the specialist in tuberculosis and the obstetrician) will not show satisfactory results however until better provision is made in every community for the proper care of the pregnant woman who has tuberculosis. Under the present set-up, case finding methods, expert diagnosis and adequate treatment can only be carried out in the favored community that possesses the proper facilities in personnel. Surely, it is not humane to continue to care for the pregnant tuberculosis patient in the desultory and inadequate manner that many of us have had to employ in the past. We need a keener appreciation of the facts by the general public, by those in control of hospitals and sanitoria and most of all by the medical profession." This is a matter of the greatest importance. Surely no group of citizens merits the tender solicitude, sympathy and generous support of the public more than these especially burdened mothers of the future citizens of our country. Pressure should be brought to bear on public officials and all those in charge of institutions and clinics for the care of tuberculous women, to enlarge and improve their facilities so that these expectant mothers may receive adequate care.

Not only is there ample evidence that interruption of pregnancy does not lessen the severity or decrease the mortality of the tuberculosis patients but on the contrary it may even increase the hazards of this disease. Barone[12] et al in 1947, showed in his series that the mortality for patients who had delivered spontaneously was 19.2%. The mortality for patients who had delivered by cesearean section was 36.3%. The mortality for the patient in whom the pregnancy was interrupted was 38.5%. The best results in this survey were obtained in those patients who were delivered spontaneously regardless of the extent of the tuberculosis.

Heart disease in the expectant mother has been considered by many clinics as a valid indication for the interruption of pregnancy. The literature discloses again that, as in tuberculosis, opinion is definitely against this procedure.

Cohen[13] et al, as long ago as May 1927, published a report involving 196 cases of organic heart disease delivered at the Sloan Hospital for Women in New York City. They stated "it is our experience that the response to medical treatment of the pregnant women with heart disease, in circulatory stasis, is satisfactory, often quite as satisfactory as in like condition of the non-pregnant" and further "in a case in which compensation cannot be restored with thorough medical treatment, a grave situation is present. In this medical impasse, it is usually best to trust nature more and art less." Their statistics "bear out an opinion gained from 7 years experience that pregnancy and childbearing when properly supervised and safeguarded is not a great menace to the safety or life of the average ambulant case of heart disease."

Reid[14], in 1930, investigated heart disease in a series of 45,320 deliveries in three different hospitals and concluded "prognosis is affected by the care given and the skill used in the treatment of an individual patient. Undue pessimism in regard to the prognosis of all cardiac patients who are pregnant is not justified by facts. There appears to be too little faith in the ability of the heart to withstand pregnancy." In November of the same year, Reid[15]

published another important article summarizing his investigations, over a period of 12½ years, of 27 cases of rheumatic mitral stenosis ending in death. Seven of these were males, 20 were females, of whom 10 were single, 10 were married. The average age at death in the males was 38.6 years and the females 44.8. The age of death for the single female was 47.2, for the married female 42.4. These statistics obviously show that the single women lived approximately 4.8 years longer than the married women and in this small series of 10 married women, 8 bore children, 46 in all or 5.75 children per mother. Despite the fact that single women outlived married women, it is obvious also that the married women outlived the males with the same disease by 3.8 years. "I feel safe in concluding that as far as these statistics have value, they support my clinical impression, that women with rheumatic heart disease die before their time, in fact during the childbearing period, not because of marriage or pregnancy but because of a natural evolution of this disease."

DeLee[16] in 1927 stated "the conduct of pregnancy and labor complicated by heart disease has undergone much change in the last 10 years, since the cardiologists have taken a hand in the matter. They have shown us obstetricians that the heart can successfully be treated even though the woman is carrying the added burden of pregnancy."

Hoffman and Jeffers[17] in 1942 studied 61 fatalities from rheumatic heart disease in pregnancy. They concluded that "of the factors influencing death, the most important one amenable to control was the cardiac status of the patient at the time of delivery. Since this is almost solely dependent upon prenatal care the significant decrease in the number of maternal deaths due to rheumatic heart disease only can be obtained through an improvement in this care." They make no suggestions that therapeutic abortion should be performed in these cases.

The most enthusiastic endorsement of the principle that cardiac disease during pregnancy should be managed with thorough, intelligent care rather than by therapeutic abortion comes from Harold Gorenberg[18] who reviewed 223 cases of pregnancy complicated by heart disease and added these to a previous review of 345 cases in which no therapeutic abortion was performed. He states "it is probable that practically every pregnancy encountered in a patient with heart disease can be brought to a successful spontaneous termination if adequate prenatal care is instituted and if absolute bed rest is enforced when indicated."

Correll and Rosenbaum[19] investigated multiple pregnancies in patients with rheumatic or congenital heart disease. The 53 patients in this series had a total of 364 pregnancies or an average of nearly 7, 6.87 per patient. All patients had 4 or more pregnancies, carried through to delivery, or at least through the second trimester. The number ranged up to a maximum of 16. There were 5 deaths in the 364 pregnancies, a maternal mortality of 1.3% per pregnancy. One of the deaths was due to heart failure, another was due to peritonitis resulting from self-induced abortion. Another fatality was due to bacterial endocarditis, secondary to a peritonsillar abscess. One resulted from generalized septicemia secondary to erysipelas and the final death occurred from a cerebral embolus following a therapeutic abortion performed in a patient with congestive heart failure, fibrillation and repeated emboli. Heart failure occurred in 15 of the 53 patients or in 41 of the 364 pregnancies, 11.3%. This is an incidence less than that usually reported in cardiac patients. Congestive heart failure did not increase in frequency as the number of pregnancies increased, a finding which confirmed the belief that parity per se bears no direct relationship to the development of heart failure. This series of patients indicates that multiple pregnancies are compatible with considerable life expectancy in some women with heart disease. Of those that developed failure during pregnancy, the average age at death was 44 and of those who had no failure during 4 or more pregnancies the average age at death was 55. The overall average age at death was 49.5 years.

The opinions of these eminent cardiologists support the contention that heart disease complicating pregnancy can be successfully managed by competent prenatal care. This involves an early evaluation of the cardiac status of the patient. In severe cases, success depends upon teamwork. The attending physician and a well-trained cardiologist, the patient and her family must all cooperate in carrying out the necessary therapeutic procedures. The most important of these is, frequently, absolute rest. Many such cases are admittedly difficult to handle. They call for an attitude of courage and all the resources that modern medicine affords and if these are properly used, Gorenberg's statement to the effect that practically every pregnancy encountered in a patient with heart disease can be brought to a successful spontaneous termination will be realized.

Although improved methods of treating organic disease of various types complicating pregnancy has lessened the excuse for the interruption of pregnancy in many clinics, it has been disturbing to note in the recent literature a trend toward the performance of therapeutic abortion in an increasing number of cases for psychiatric conditions. Ebaugh and Heuser[20] are of the opinion, however, that the interruption of pregnancy may do far more harm than good to a person with a well-balanced nervous system and may cause considerable damage to the patient with a psychiatric difficulty. They state "These changes coupled with ideas of guilt, self-depreciation, some recurrent preoccupation centering around the abortion and the general theme of 'I let them kill my baby' might well disturb a poorly integrated personality even to psychotic proportions. Feelings of love, admiration and

respect for the male partner in the result of pregnancy may well be distorted in the aborted woman to ideas of disgust, hate and disrespect; 'he gave me a baby then took it away.' The unconscious motivation and the even flow of emotions during the readjustments to a normal sexual nonpregnant cycle may result in deeply engrained feelings of hostility toward the husband. Abortions we may say can produce psychologic cicatrix."

The effect of pregnancy on mental disease is discussed by Arbuse and Schechtman[21] who write "There does not seem to be any one condition which absolutely indicates interruption of pregnancy. The mental state is seldom justification for induction of abortion. Abortion per se is unquestionably a shock. It may be conceivably more detrimental than continuation of the pregnancy. If it could be shown that conception may lead to permanent psychosis in certain definite cases, then the termination of pregnancy would clearly be in the best interests of the patient and the operation would conform to the desired standards but the contrary appears to be the rule. The psychosis initiated by pregnancy rarely persists but tends to recover after an apparently short period, and in some cases may clear up spontaneously before full term is reached. Women who show permanent impairment of mentality following childbirth belong to the class of potential psychotics for whom pregnancy is merely a subsidiary factor in the pathogenesis of the psychosis. Upon the mentality of such women a therapeutic abortion cannot be curative and it may exert a deleterious effect that is more harmful than the continuation of pregnancy." And for those who recommend interruption of pregnancy for eugenic reasons they say "there is no psychiatric disorder that is hereditary to the degree that the occurrence of mental illness in the offspring of the patient can be predicted with reasonable certainty."

The therapy of psychiatric disorders in pregnancy, while somewhat more prolonged is as feasible as in the non-pregnant state. They demand only special interest and effort on the part of both the obstetrician and the psychiatrist. Feldman[22] et al, in reviewing the subject found that there was good evidence that shock therapy, including electro-shock, could be safely employed in pregnancy, when indicated.

In considering the neurological complications of pregnancy, as an indication for therapeutic abortion, one is impressed by the work of Viets[23] et al, in a paper entitled "Effect of Pregnancy on the Course of Myasthenia Gravis." He states "before the use of prostigmin, abortion was frequently carried out, usually at the end of the first trimester or the early part of the second trimester. This is well recognized now as the most dangerous time in the whole 9 months. In a case reported by Burr and McCarthy death occurred in the 3rd or 4th month in the second pregnancy. Kohn's patient had an abortion induced at 4 months; Indeman's 20 weeks; Laurent at 6 months and 4 other pregnancies terminated in miscarriage before 6 months.

Wolf's patient had an abortion induced in 4 months and Montaris in 2 months. It seems likely in view of our most recent experience with patients under the prostigmin therapy, that many, if not all of these abortions would not now be indicated. Abortion moreover may not relieve the patient of her symptoms but may even permit a fatal termination of the disease."

"Kohn's patient died a week after abortion. At the present time abortion for therapeutic reasons is rarely if ever needed provided adequately controlled prostigmin therapy is instituted. In our series probably neither abortion was justified. There is no reason to believe the patient aborted could not have been carried through to term. Patient 6 had her abortion induced on the untenable hypothesis that the disease might be transmitted to the child. There is no evidence either in the literature or our experience to lead one to believe that such evidence is fair." The author's conclusions were as follows: "effect of pregnancy on myasthenia gravis is usually favorable, most patients experience a definite remission in symptoms and if relapses occur they are mild. Pregnancy, labor or nursing does not affect the course of the disease unfavorably under present conditions of treatment." This is a striking example of a panicky resort to a destructive procedure and the murder of the fetus because of ignorance of the disease and its proper method of treatment.

Multiple sclerosis is an unhappy disease which when combined with pregnancy may present a problem in management and so has been a target for therapetuic abortion. The disease may be extremely difficult to diagnose. It is characterized by remissions and exacerbations of symptoms and its treatment is non-specific. It *can* be argued that the patient with multiple sclerosis may have a remission during pregnancy with as much likelihood as she may have an exacerbation. It may *not* be argued validly that pregnancy is the cause of either a remission or an exacerbation since these features are almost pathognomonic of the process itself.

The chief argument proposed for therapeutic abortion in these cases is to avoid a "stress situation." As Baker[24] has put it, these patients should avoid injuries, infections, pregnancy, undernutrition, chilling and exposure. Admittedly this may be desirable, but certainly a therapeutic abortion can increase the 'stress' by frustration of motherhood, development of guilt complexes and the ever present danger of infection.

Furthermore, on the constructive side, these patients can and do manage pregnancy very competently. McElin and Horton[25] investigated the effect of Histamine on 15 patients with neurological disease who were pregnant. Twelve of these patients had multiple sclerosis. They suffered no complications. They all delivered normally, had normal children and six of them nursed their infants. These patients were treated, not aborted. It is sub-

mitted that such an attitude is in keeping with the proper ideals of the profession.

Pregnancy is a troublesome complication in the women suffering from chronic nephritis or hypertension. However, most of the serious difficulties that arise in these patients develop after the period of viability. Prior to this, miscarriage frequently occurs and nature thereby solves the problem.

Brown[26] investigated a series of patients with this condition and his conclusions were: "judged by the general condition, height of blood pressure and cardiac changes, the pregnancy does not seem to have had any ill effect in 52 of the 65 patients. In 7 the effect of pregnancy was unknown as their condition before pregnancy was unknown; 6 are dead, 9.2%. In spite of these 6 fatal cases, we believe that a large majority of patients with chronic hypertension may pass even through several pregnancies, go to term and give birth to live infants without suffering any demonstrable deterioration in their condition."

Glomerulonephritis is a sibling of hypertension and carries with it the added feature of kidney damage. Admitting its sinister influence in pregnancy, there again is adequate reason for approaching the situation constructively and hopefully. Mussey[27] has recently reviewed the condition and states "It is true that some patients whose renal damage is mild, appear to tolerate pregnancy well and may be found subsequently to have little or no evidence of their glomerulonephritis. Reid and Teel found 11 of their 15 patients to be in no worse condition 6 months to 5 years after pregnancy, and Dodds and Browne made the same observation in 9 out of 17 patients. The latter stated that they "Were unable to ascertain that the worsened renal status in the other patients was induced solely by the pregnancy rather than by the usual downhill course of the glomerulonephritis itself." And again, "Theobald on the other hand assembled mortality rates for England and Wales since vital statistics had been collected and found the death rates for chronic nephritis to be higher in men than in women. During the same period (1911 to 1922) the mortality rates for chronic nephritis were approximately equal in married and single women up to the age of 55 years. He interpreted his findings as indicating no causal relation between pregnancy and chronic nephritis."

Patients with chronic nephritis and hypertension complicating pregnancy may be conservatively treated today with proper diet, rest, the use of hormone therapy, thoraco-lumbar sympathectomy and the administration of vascular anti-spasmodics, far more safely than by the interruption of pregnancy with its possible attendant hemorrhage and infection.

Benign pelvic tumors are a frequent complication of pregnancy but it is difficult to understand how there were 2 cases of therapeutic abortion performed for fibroids in a series of 134 operations reviewed by Hesseltine[28] in 1940. When complications develop in these benign tumors during the early months of pregnancy, surgery may be necessary, but it is possible usually to conserve the pregnancy. Benign pelvic tumors have no place in the consideration of therapeutic abortion.

On the other hand, cancer of the pelvic organs is a serious problem. When a diagnosis of malignant disease is made in the early months of pregnancy, it may be treated either by total extirpation of the pelvic organs or by the efficient use of radium or x-ray. The indirect interruption of pregnancy in these cases is the undesired, unintentional and inevitable result of the radical attack on the malignant disease and is not a therapeutic abortion.

Tumors involving other organs as in the gastrointestinal tract, lungs, kidneys, etc., should be given individual consideration and removed if they are judged to be harmfully affecting the expectant mother. It should be emphasized that they have no special influence on the pregnancy. Even tumors of the brain may be removed safely during pregnancy.

Rand and Adler[29] in 1950, emphasized that in many cases, the removal of a brain tumor in pregnancy saves the life of both the mother and the baby and causes no harmful effect to the pregnancy.

Serious blood conditions sometimes are diagnosed during pregnancy. One of the most troublesome of these is sickle cell anemia. Beecham[30] et al, in 1950, reported on a series of 51 cases of this condition in pregnancy. They conclude that "The patients do poorly with surgery and consequently therapeutic abortions are deemed unwise." Moloney, Heffernan and Kasdon[31] in an article on leukemia in pregnancy published in 1943 state "The natural course of leukemia is apparently uninfluenced by gestation. Leukemia per se is therefore not an indication for the interruption of pregnancy." Severe secondary anemia of various types, pernicious anemia of pregnancy and other unusual hematological conditions should be treated by efficient modern methods.

Many therapeutic abortions are done today for problems involving the Rh factor. This attitude is untenable. The grave danger of interrupting a normal pregnancy on the basis of rising titers or other assumed warnings of erythroblastosis developing in the infant is well brought out in a paper of Kendig and Waller[32] published in 1948. They report 2 cases in which the Rh factor ostensibly was a serious matter. The first patient had had one erythnoblastic baby and in the pregnancy under consideration the titers were rising rapidly. One of the "leading authorities" on the subject advised that interruption of the pregnancy seemed justifiable. Pending this decision, the patient withdrew her permission for a therapeutic abortion and subsequently delivered a ***healthy infant*** who was Rh negative.

The second patient had had 2 spontaneous abortions and two severe erythroblastotic babies and during the pregnancy in question had been advised twice to submit to a therapeutic abortion. Close to term, she required a caesarian section and was *sterilized*. Her baby was a perfectly healthy, Rh negative infant. Interruption of these pregnancies would have destroyed *normal children*.

The Rh factor has produced its share of abnormal children. However, the positive constructive approach (not the destructive approach of therapeutic abortion) to the problem has salvaged a gratifying number by the exchange transfusion.

The difficulties arising from the Rh factor have emphasized a new aspect of therapeutic abortion which has been carried over, as will be seen, to the situation found in rubella in pregnancy. In such cases, therapeutic abortion is being recommended in the *absence of a threat* to the mother's health and life but merely in the face of a *possibility* that the child would be born defective. Such therapeutic abortions are illegal, even in many states where the operation is 'legalized' and from a medical point of view they must be condemned since they assume untenable predictions to be facts, they are destructive in their approach, and are separated, by the mere width of the uterine wall, from the concept that defective children and the incurably ill should be sacrificed 'for the good of the community.'

The monumental work of Gregg[33] of Sydney, Australia in 1941, established a definite relationship between the acquisition of rubella by the mother in the early months of pregnancy and the development of cataract and various other abnormalities in the fetus. The incidence of congenital defects in these cases was found to be almost 100%.

Wesselhoft[34] in 1947, commenting on this investigation stated "To date the available evidence points to a 10 to 1 chance that a woman who has rubella in pregnancy, will give birth to a child with gross congenital deformity . . . the likelihood that such a deformity will follow rubella in the first and second months is the greatest. It was first estimated at a 100% by Australian authors, later this was modified to 118 to 4 by a compilation of Australian surveys. Utilizing the figures on normal babies alone, I should lower the incidence still more". . . . However, Morton[35] of Los Angeles estimated that only 4 out of 10 women who get German measles in the early stages of pregnancy are likely to have abnormal babies.

Fox and Barton[36] in 1946 published the results of their investigations in 22,226 cases of rubella in the city of Milwaukee: "Of the 11 pregnant women who had rubella, the disease in 5 occurred during the first 2 months and 4 during the second to fourth months; 1 in the seventh month; and 1 in the ninth month. One stillbirth occurred among the 11 cases; 1 woman had twins, both normal; 1 woman gave birth to a child with congenital cataracts during a normal pregnancy and at the time during which she had rubella in the 2nd month of her pregnancy she delivered a normal child." They conclude "Our records do not justify consideration of termination of pregnancy because of rubella. The occurrence of congenital malformations following virus disease in pregnant women is a subject deserving of further careful investigation."

Other virus diseases have also been indicted as a cause of congenital malformations in the newborn. Among these are mumps, ordinary measles, chicken pox and infectious mononucleosis. Although at first these malformations were thought to be due to the infection of the fetus by transplacental migration of the virus, grave doubt as to the validity of this hypothesis has been developed by recent investigations. These have shown that both restricted maternal diet and fetal irradiation are capable of causing anomalous development in the offspring of laboratory animals. Gilman, Gilbert and Spence[37] produced in experimental rats malformations such as hydrocephalous, spinabifida, cardiac defects, eye defects and anomalies of other sytems by interfering with the protein metabolism of the mother. This they accomplished by injecting trypan blue into the maternal rats. Their experiments tend to demonstrate that the effects of trypan blue and, by inference, rubella virus are not direct effects on the fetus but cause remote preceding metabolic states which subsequently interfere with fetal development. They suggest that the supposed mode of action of the rubella virus on the human fetus be re-examined as passage of the virus through the placental barrier is debatable.

This relationship of virus disease and congenital malformations is a serious problem. However, reports which followed Gregg's pronouncement 10 years ago have indicated that the early profound pessimism of the Australian investigators was unwarranted. In this short time further investigation has shown that therapeutic abortion performed on a woman who has suffered from a virus infection during pregnancy might result in the destruction of a normal baby. Pending the development of more adequate specific therapy for the cure of virus infections during pregnancy it would seem advisable to recommend that young women before marriage be exposed to these mild infections so as to acquire immunity against them.

The extremes to which the advocates of therapeutic abortion may go has been exemplified in the history of otosclerosis. In this condition those who would advise destruction of the fetus would accomplish this heinous procedure simply to prevent the child from being born with a deficiency of hearing or an aggravation of the maternal otosclerosis. Greenhill[38] summarizes the problem as follows: "In Barton's series of 133 women with otosclerosis who experienced one or more pregnancies, 72% suffered loss of hearing with the first pregnancy and 50% with subsequent ones. Barton believes an abortion

is never justified for these reasons: 1) The effect of pregnancy on otosclerosis is extremely variable and unpredictable; there is no exact relation between the two conditions. The effect of previous pregnancies is not an accurate index of the possible effect of subsequent ones. 2) The favorable effect of abortion on the otosclerosis is also inconstant. The progression of the deafness with pregnancy may or may not be arrested by abortion. 3) The disease does not endanger the life of the mother as do tuberculosis, heart disease and toxemia. 4) This type of deafness is not the severe handicap that it once was owing to the advent of modern hearing aids and the promise of surgical treatment.

"Since the fenestration operation is usually successful, there is seldom need to perform a therapeutic abortion because of this condition.

"Sterilization or other eugenic measures are futile in the control of otosclerosis because the hereditary nature of the disease is not known accurately, because it is impossible to prophesy deafness of progeny and because the unfavorable effect of pregnancy on otosclerosis is not constant. In Barton's series, the patients had a 50% chance of having successive pregnancies without further loss of hearing." It is a harrowing thought that babies sacrificed in the past because their mothers had otosclerosis would, if alive today, be able to *hear* of the success of the fenestration operation.

Ulcerative colitis may be a troublesome complication during pregnancy. A number of these cases were reviewed by Bargen and Mussey[39] in 1939, who stated: "This series of patients presents an interesting problem. It cannot be said that the patients in whom good effects follow pregnancy were simply those in whom the colitis was milder. In all of them it was moderately severe and several of the patients who recovered and who have never had a recurrence of the disease suffered from the fulminating septic type of ulcerative colitis. One of the women has had no signs or symptoms of her former colitis for 12 years."

Medical authority, as attested by the foregoing excerpts from the literature substantiates the conviction that therapeutic abortion is not scientifically justified.

An impartial view of the literature will show that the best obstetrical experience justifies the opinion voiced by the senior author at the recent Congress of the American College of Surgeons that "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."

It is submitted that therapeutic abortion derives its origin from a train of thought which is foreign to the entire medical tradition in that its only effect is the destruction of life and offers no constructive effort to the solution of disease and the hazards of living.

And the subject is not closed. It is estimated that 18,000 therapeutic abortions were done in the United States last year. And their advocates are urging more—for "economic and social reasons." Medicine cannot and must not admit economic and social conditions to influence professional decisions. Such practices lead only to a situation wherein "political reasons" will control medical policy and practice. The recent unholy "controlled" experiment" in Nazi Germany proving this contention must remain a permanent and eloquent lesson to the profession.

The great Dr. Albert Schweitzer[40] has well summarized the general thought which should motivate the physician faced with a serious problem. "What shall be my attitude towards other life? It can only be of a piece with my attitude towards my own life. If I am a thinking being, I must regard other life than my own with equal reverence. For I shall know that it longs for fullness and development as deeply as I do myself. Therefore, I see that evil is what anihiliates, hampers or hinders life. And this holds good whether I regard it physically or spiritually. Goodness, by the same token, is the saving or helping of life, the enabling of whatever life I can influence to attain its highest development." And again[41], "A man is really ethical only when he obeys the constraint laid on him to help all life which he is able to succor, and when he goes out of his way to avoid injuring anything living. He does not ask how far this or that life deserves sympathy, is valuable in itself, or how far it is capable of feeling. To him life as such is sacred."

Therapeutic abortion is an unworthy and unwholesome paradox in modern medicine. The "unenlightened physician" of the pre-modern era with limited means, a faith in his Creator and an undying hope and optimism, challenged disease. Today, with so many of his dreams realized in the armamentarium of modern medicine, some of his successors would shrink from the challenge, face difficulties with pessimism and, bowing to expediency, would destroy life.

Therapeutic abortion is a deliberate destruction of innocent life, morally evil and scientifically unjustified. Therapeutic abortion is legalized murder.

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