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The surgeon inserted:

one tiny incision
made the difference of

A wieldy blade of grass

cutting flesh of a curious finger.

He cut, the fervor filled him

The way summer days

spent stripping thorns

from a rose

Found him seeking perfection. The virgin

steel suffered so, how it cried

blood dew drippings:

A splattered chaste floor.

But what about

the girl? Where does

The life snipped from her soul

withdraw with satisfaction,

when he must discover

The frontiers of men

are behind them? O sure

the Knights will survive without

Him, the war will march on

stoccado, orchestrated,

in dying color, he will

Never even query of

the road not taken. The doctor

will wonder for both of them.

Christopher E. Heller
February, 1970

Reforming the Abortion Laws:
A Doctor Looks at the Case*

DENIS CAVANAGH, M.D.

As I have traveled around the country this past year, I have been

shocked by the fact that everywhere I go there are programs designed

specifically to push the case for liberalization of our "outmoded

abortion laws." The situation with regard to liberalization of the laws

seems to be this: About 15 per cent of people in the United States are

opposed to abortion, even to save the life of the mother, and so are vocal

opponents of any attempt at liberalization of the current laws. About 15

per cent are for "abortion on demand" and have as their aim the

introduction of loose "mental health" or "social" clauses or the complete

removal of the abortion issue from the law. About 70 per cent of the

people would like a moderate degree of reform but have some considera-

tion for the fetus and are definitely opposed to abortion on demand.

My own position with regard to liberalization of the abortion laws has

changed over the past year. At the Senate Judiciary Committee

hearings in the state of Missouri in the spring of 1968, I spoke in favor of moder-

ate liberalization of the Missouri Abortion Law along the lines of the

American Law Institute proposals. I took this stand because I was im-

pressed by the arguments about the inclusion of cases of rape, incest and

fetal anomalies and by the statement that a large number of physicians

were not able to practice good medicine, in accordance with their con-

science, because of the apparently
restrictive law. I was impressed, too, by statements that doctors were being forced into dishonesty with regard to the indications for therapeutic abortion, because the law allowed therapeutic abortion to be performed only to save the life of the mother.

By the spring of 1969, however, I became convinced that, even with well-written, liberalized laws based on the American Law Institute proposals, fetuses were being sacrificed into the liberal camp, the proponents stated in their testimony that people into the liberal camp, the proponents in the United States.

17,000 criminal abortions in the state of Missouri. I can only conclude that this figure is based on the same unreliable assumption that criminal abortions run about 20 percent of live births per year (74,000) in the state of Missouri. During this hearing a Senator specifically asked one of the proponents where he got these figures on the number of criminal abortions and was told they were "from the Department of Health, Education and Welfare," because of my interest in the criminal abortion problem and because I thought this was a very important point, decided to check it out. I had my secretary call the Bureau of Vital Statistics of the Department of Health, Education and Welfare, in Washington, D.C., and asked them to check this statement. Here is the reply:

"Dear Doctor Cavanagh:
This is in response to your telephone request today. The Division of Vital Statistics has no data on criminal abortions in the United States.

Sincerely yours,
ROBERT D. GROVE, M.D.,
DIRECTOR
DIVISION OF VITAL STATISTICS

At the Missouri hearings, the dramatic rhetorical question was asked: "How many more women must die before we change the law?"

This makes two assumptions: 1) that women are dying unnecessarily because of the present law and 2) that if we liberalize the abortion law maternal mortality will be reduced. Neither of these assumptions is supported by the facts. Frequently the figure of 8,000 deaths from criminal abortion per year in the United States is given out by proponents of liberalization. Again, I would emphasize that this figure is not available through the Department of Health, Education and Welfare statistics. The

figure is in fact based on a book by Dr. Fred Taussig, of St. Louis, Missouri, "Abortion—Spontaneous, Induced, and Suspected" (1936). Extrapolation from this would lead us to a figure of about 200 deaths per year from criminal abortion in the state of Missouri, again leading any reasonable, uncompromised person to believe there is a very serious problem, one that calls for a new solution.

VARIous FIGURES ON MATERNAL DEATHS FROM ABORTION

What figures, then, are available from the Department of Health, Education and Welfare with regard to abortion deaths? Over the period 1958-1965 there were 774,096 live births and 35 deaths from all types of abortion in the state of Missouri (including spontaneous abortion, criminal abortion, and therapeutic abortion). If we were to extrapolate this official figure of 4 to 5 deaths per year in the state of Missouri, assuming that all of them were due to criminal abortion, we would arrive at a figure of 225 criminal abortion deaths per year for the entire United States.

Some official figures are available, however, for criminal abortion deaths.

Over the 16-year period 1950-1966, according to the report of the Minnesota Maternal Mortality Committee, there were 21 criminal abortion deaths and 1,501,745 live births in the state of Minnesota. This is one of the few figures for criminal abortion deaths available in the United States at the present time. If we use this figure, at the rate of 3.5 million live births per year in the United States, extrapolation will lead us to a figure of 600 criminal abortion deaths per year in the entire United States and not 8,000 criminal abortion deaths per year, as suggested by the proponents of liberalization.

At the International Conference on Abortion held in Washington in 1967, and attended by proponents and opponents, there was general agreement that criminal abortion deaths did not exceed 500 per year for the entire United States, i.e., that the figure of 8,000 per year, which is frequently mentioned, is at least 16 times the actual figure.

At one point in the discussion a Senator asked me if I ever felt there was an indication for therapeutic abortion. I replied in the affirmative. I believe there is a place for therapeutic abortion, and there is no doubt that it may be necessary to kill a fetus to save the life of the mother. But this situation is very rare in modern obstetrical practice. I think there is no justification for the statement that mothers die because we do not have a liberal law in the state of Missouri. I am director of the Obstetrics Service at the St. Louis City Hospital. This is a hospital that serves the underprivileged almost exclusively and where one would expect a high maternal mortality rate. But over the period July 1, 1966, to July 1, 1968, we had 5,102 deliveries without a single maternal death. This compares very well with the national maternal mortality rate of approximately 3 per 10,000 live births. During this two-year period only one therapeutic abortion was considered necessary to save the life of a mother.

I submit therefore that there is no evidence that liberalization of the abortion law in accordance with American Law Institute recommendations will reduce the maternal mortality in the state of Missouri or in any other state.

It was also stated by the proponents for liberalization in Missouri.
that the typical patient requesting abortion is aged 25, has had more than 3 previous pregnancies and is married. But if you look at the report on the first year of experience with the liberalized law in the state of Colorado, you will note that although the law was supposed to be designed primarily to assist the harried mother of several children whose mental or physical health was threatened by another pregnancy, only 138 of 407 women who received therapeutic abortions (that is about one-third) were married, and 56.5 percent of the women had had three or more living children.

In the discussion, Dr. Droegemueller stated: “During the first year of operation, 41 therapeutic abortions were performed at the University Hospital, but this has not reduced the incidence of admission for septic abortion.”

There is absolutely no evidence that moderate liberalization of the abortion laws will reduce the criminal abortion rate, and all we will do is increase the total number of abortions. Thus it is not unlikely that liberalization may increase rather than decrease maternal mortality. Also there is evidence that it will increase fetal loss in future “wanted” pregnancies.

With regard to the most emotional arguments usually presented in favor of liberalization, perhaps we can learn from the experience of others.

A great deal of time is spent discussing the emotion-laden questions of rape and incest indications, and yet these indications were omitted from the English law because of the legal difficulties of obtaining proof. In Czechoslovakia, in 1966, only 22 of 86,258 abortions were performed for rape. In Colorado, in the first year of experience with the new law, 46 of 407 abortions were done for rape. This suggests that the chance of rape is over 400 times more likely in the center of the United States than it is in Czechoslovakia. Even allowing for the inclusion of statutory rape and referrals, it is evident that there is a considerable loophole here also. Incidentally, with regard to rape, all victims should be encouraged to report the incident within five days. If this is done, they can have a D & C (removal of the lining of the empty womb) performed under most existing state laws, so there would appear to be little need to consider this emotion-laden item further. Besides, early reporting of the crime will provide a greater opportunity for apprehension and conviction of the rapist.
INCIDENCE OF BABY ABNORMALITIES IN 1964 RUBELLA EPIDEMIC

Every reasonable person is concerned about the delivery of an abnormal baby, and so a great deal of pressure has been developed in this area. Immediately the questions arise, of course: How affected is affected? What is a minimal defect and what is a major defect? Here are some figures on the 1964 rubella epidemic from Dr. Harvey and Thompson. Dr. Harvey is from the State Department of Health in Indiana; Dr. Thompson is in the Department of Obstetrics and Gynecology at the Indiana University School of Medicine. These men gave evidence before the Committee to Study the Indiana Abortion Law. They pointed out that in the 1964 epidemic the number of German measles cases was approximately ten times the number of women who had developed rubella during the first trimester of pregnancy.

According to the Indiana Committee's report: "From this we assume that only four abnormalities from German measles occur in a normal year and that permission for abortion is basic to the law until after all known causes of fetal anomalies have been proved effective. The legislation will then be rolled back to the anachronistic law." DO WE KILL NORMAL BABIES TO PREVENT A MINOR BIRTH DEFECT?

There are other uncommon causes of fetal anomalies, but when modern methods of diagnosis are used the evidence is almost impossible to tell for certain when a child will be born with certain defects. A prediction can usually only be based on probabilities. Thus a significant number of normal children will be killed by preventive measures that have to be taken when having what may be only a minor birth defect. After all, who is a birth defect? Adolf Hitler believed that being Jewish was a defect of birth. Some scientists, however, are against the doctrine that the human species believes it is a defect to be too stupid, too tall, too short, too white or too black.

Where life or death is the issue, it is not unreasonable to insist that a duty is owed to the living but as yet unborn fetus. If the doctor, nurse, or is engaged in a thriving abortion business, there is no appeal from his decision, no rehearing and no retrial. His judgment is final, conclusive and irrevocable. There is no tomorrow for the aborted child. The so-called humane provision regarding birth defects, unless accurately and carefully, may very well result in a significant change in the moral and legal philosophy upon which our present legal system is based. Once it has been determined that life can be taken away for birth defects, it may be taken away for other reasons. After all, the true description of the procedure with regard to the presumably deformed child is not therapeutic abortion, because there is nothing therapeutic in it for the baby. It is at the best a best fetal eugenic law.

We may learn something from the English experience. Those who were pushing for a liberalized abortion law in Britain three years ago are now talking for eugenic abortion and a Euthanasia Bill was only defeated in the House of Lords by 61 votes to 40 in 1969.

How can we call abortion "humanitarian" when discussing a presumably deformed fetus? This sounds good until you try to put yourself in the position of that fetus. It is difficult for any obstetrician, after all, to decide whether the child, even though deformed, does not have a right to be born, for the deformities may be minimal.

The New Jersey Supreme Court has frequently answered this question in the affirmative in the 1967 case of DeClerck v. Cogswell (1945-49 N.J. 21). The court declared: "It is basic to the human condition to seek life and to hold on to it however heavily burdens. If Jeffrey [the baby born deformed], whose parents brought suit, could have been asked as to whether his life should be snuffed out before his full term of gestation could run its course, our felt intu-
reproduce dying cells. It is human because it can be distinguished from other non-human embryology and once implanted in the uterine wall it requires only nutrition and time to develop into one of us.

**HUMAN DEVELOPMENT—A CONTINUUM FROM IMPLANTATION ON**

If it contains an intrinsic genetic defect, or if it is deprived of nutrition and time, it becomes a dead human fetus. I think that this is a reasonable, philosophical conclusion based on biological knowledge. It recognizes that human development is a single continuous process from implantation of the fertilized ovum in the uterine wall to the achievement of adult personhood. It seems quite irrational, even if convenient, to choose a given point in this biologic continuum—e.g., the appearance of the heartbeat, or the feeling of movement, or even expulsion from the uterus—as the beginning of human life. It seems evident that the fetus is only different from you and me in that it has not yet been given the time to develop its whole potential.

Let us consider a few embryologic facts. The ovum is usually fertilized in the lateral portion of the fallopian tube, and in from 7 to 14 days the blastocyst becomes implanted in the uterine cavity. At the end of the second week differentiation begins. At the end of six weeks all the internal organs of the complete fetus have begun to form, and at the end of the eighth week the skeleton has begun to form, so that the embryo is now called a fetus. ("Fetus," of course, is the unborn offspring, and the name is only changed to "infant" when the baby is completely outside the body of the mother, although the term applies even before the cord is cut.) After the eighth week, the major structures will be added, and further growth will consist of maturation and development of the existing structures rather than the creation of anything new. By the end of the twelfth week, the fetus can swallow amniotic fluid and the heart can be picked up by ultrasonic techniques or by electrocardiography. If delivery occurs after the 20th week, and the baby weighs approximately 500 grams, it is referred to as a premature infant rather than as an abortion.

**20-WEEK FETUS SURVIVABILITY STANDARD IS NOT FINGER SACRED**

Generally, the time of legal viability is considered to be about 28 weeks, but there is now general recognition that a baby of 500 grams should be considered as premature, since it does have some possibility of survival. (Indeed, it is interesting that in the Canadian Medical Association Journal Monroe reported, in 1939, the case of a baby weighing 397 grams on the second day of life that developed normally. To this very durable individual the term "abortion" can scarcely be applied.)

Now, it seems evident that the age of survivability can no longer be considered as immutable, because too many variables—such as DNA synthesis, test tube incubation, intraterine transfusion and chromosomal manipulation—are involved. Dr. James Diamond pointed out in his article "Humanizing the Abortion Debate" (Am. J. Obstet. Gynecol. 84: 35-49) that, in view of recent technological advances, "the 20-week survivability standard is about as sacred as the four-minute mile." He has also suggested that with the development of an effective artificial placenta, probably within the next decade, the 20-week or perhaps the 12-week fetus may survive, which you and me.

Sir John Peel, President of the Royal College of Obstetricians and Gynecologists, in an address to the faculty at the University of Melbourne, put the subject of abortion in perspective as follows:

"Let us be quite clear in our minds. The deliberate termination of a pregnancy at whatever stage in pregnancy it is undertaken before viability is the same procedure. Attempts to determine an artificial dividing line before which a pregnancy may be terminated for non-medical reasons is pure sophistry. A fetus of 10 weeks is not essentially different from one of 20 weeks, or one of 20 weeks from one of 30 weeks. It may be safer medically to terminate pregnancies at 8 rather than 16 weeks, but one is no more justified than the other if the alleged indication is a nonmedical one. In this dilemma we find the world divided politically, socially and even medically. Legalized abortion as a deliberate political policy, designed to control populations and to improve the socio-economic status of a large section of the community, has been introduced in some countries, and the doctors in those countries have acquiesced and forsaken their traditional ethics. From such countries, too, comes a great deal of evidence of changes in both the social and personal pattern of sexual behavior as the result of more liberalized attitudes toward abortion and of much heart-searching and disquiet among the medical profession. The society gives sanction to the destruction of life for one set of circumstances for what it claims to be the good of society, why should it not sanction the infanticide of the abnormal neonate, the mental defective, the delinquent, the incurable, the senile? The mind recoils from such suggestions, but let us face it, society in the past has sanctioned all of these. Is it fanciful to think that we may be moving toward a situation in which the sanctity of human life is no longer recognized—where life can be created artificially at will, and equally at will expunged? Shall we have state boards to decide who shall live and who shall die? Let you think I am romancing. I would remind you that state boards decide who shall have an abortion in some countries today, and state boards in some parts of the world decide who shall live by renal dialysis and who shall perish without it. Medicine must soon provide the means for the voluntary control of conception that will be universally acceptable and universally applicable, and society must make this knowledge and the means of applying it freely available to its citizens. But only at its peril will society strike at the fundamental roots of human rights and human dignity, and seek to destroy the medical conscience of its doctors."

**BRITAIN'S EXPERIENCE SHOWS THE SHAPE OF THINGS TO COME**

I think that the experience of Britain should be of some interest to all of us who are facing a decision on whether to keep our present laws or to liberalize them. It seems apparent that where "mental health" and "total environment" clauses are included, problems are certain to arise. These indications have been mainly responsible for the problems that have arisen under the British Abortion Act. Prior to the introduction of the liberalized law in Britain there were about 10,000 legal...
Gynecologists find themselves spending half their office hours passing judgment on patients seeking abortions and half their operating time performing them. With the same type of law, do we seriously expect conditions to be different in North America?

THE LAW WORKS IN FAVOR OF THE RICH, NOT THE POOR

Mrs. Jill Knight, Member of Parliament from Birmingham, England, and a Protestant, has pointed out that the vast majority of gynecologists in England are conscientious men who consider very seriously their commitment to protect life whenever possible, but about half of all abortions now being performed are being done in poorly equipped private nursing homes. These facilities have been established throughout the country, particularly in London, and legal abortions can be performed on the basis of a five-minute psychiatric interview, for a standard fee of £150 ($375) payable in advance. It is obvious that in this context and with this arrangement the poor do not have much chance to secure an abortion. Yet the propaganda favoring liberalization of the current abortion statutes always refers to a discrimination against the poor under the present laws and the equality of opportunity that will result from liberalization.

Mrs. Knight has recently made two other important observations. First, because of the very existence of a liberal law, women now feel they have a "right" to have an abortion, and they consider that they have the right to sue a doctor or a nurse who refuses to participate in that abortion. In the construction of the English law (and for that matter in the writing of the Colorado law) no effective "conscience clause" was included. Thus a doctor or nurse who refuses to participate in the performance of an abortion for the ordinary and usual reasons is presumed guilty until innocence has been proved.

Secondly, she noted that at a recent meeting of the Royal Academy of Nursing it was reported that the morale of the student nurse is being undermined by the prospect of facing abortions in the operating room.

Describing the present situation in Britain, the Sunday Telegraph of July 9, 1969, stated that the present law has gone a long way towards "making uncontrolled abortion a reality in Britain. "Experience has shown that once the view is abandoned that abortion is only permissible on medical grounds, it is almost impossible to define any other ground in satisfactory legal terms."

We often hear that the decision to abort is a "medical decision" and should be left up to the doctor and the patient. But is it really logical to leave the decision entirely up to these two people, both of whom are under stress? This would appear to be just as illogical as placing the control of nuclear weapons entirely in the hands of the military.

The latest move by the proponents of liberalized laws is to abandon attempts to pass moderate liberalizing laws aimed at gaining their objective by what the politicians know as "creeping legislation." The battle now is being carried to the courts in the hope that it will be found constitutionally acceptable for a woman to "do with her body as she wishes" — with the double play involving a claim by plaintiff physicians that their right to practice medicine is being infringed by the restrictive laws.

The American Civil Liberties Union went into federal court on Sept. 30, 1969, to challenge the constitutionality of the New York State Abortion Law, since to date three attempts to change that law in the state legislature have failed. There are four physician plaintiffs in the case. I have no doubt that these men are doing this with the best of intentions. But if they succeed, we will no longer be facing the problems of moderate liberalization; we will be facing the problem of "abortion on demand."

Already psychiatrists have realized that the dishonesty allowed by the "mental health" loophole has caused people to wonder if psychiatry is really a sound medical discipline and are taking steps through the Group for the Advancement of Psychiatry to extricate themselves from their "pity" position by requesting that legal abortion statutes should be removed from the Penal Code. But when the psychiatrists, public health physicians, sociologists, social workers and other well-intentioned groups have left the field of battle, those of us who have our primary interest in obstetrics and gynecology will be left to solve the problems their campaign has created. Before it is too late, let us face the issue squarely. The pressure is no longer for moderate liberalization; the pressure is for "abortion on demand."

Hospital physicians and nursing services are already overburdened with Medicaid and Medicare. How, then, can we possibly cope with what André Helleger has called the brave new world of "Abortionale"?

In the British House of Commons at the crucial second reading of the Abortion Act of 1967, there were only 29 votes against the Bill. Recently, an amendment to tighten the Abortion Law was only defeated by a vote of 210 to 199. When the Abortion Act of 1967 was introduced, most physicians favored it. But in a recent poll of 5,000 doctors 62 per cent of physicians felt the law should be tightened.

I would urge the 70 percent of readers who are as yet uncommitted to consider the facts, the fetus and the British experience. At this point in time, it would be well to remember that old obstetrical adage: Primum non nocere, which means "First, do no harm" — or "Let's look before we leap."