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EDITORIALS

ABORTION AND CONTRACEPTION

FOR INDICATIONS OTHER THAN PURELY MEDICAL

WHEN J. Whitridge Williams, in July 1928, addressed the University of Washington on Indications for Therapeutic Sterilization in Obstetrics,[1] he invited the criticism of his colleagues. In clear straightforward fashion, many of his cases were presented, "so that the justifiability of the course pursued can be criticized." Up to now no one, to our knowledge, has reviewed his opinions, either to approve or to take issue with them.

In a group of 118 women sterilized at his clinic, there were 15 sterilized for mental or psychiatric conditions, and 4 for social indications. Although he has rejected many cases sent to him, because they do violence to his conscience, he is clear on these. In the rest of the group, and here he believes that few will take serious exception, there are 45 cases sterilized by hysterectomy, or hysterotomy with exsection of the proximal end of the tube, *prior to viability of the child*. This gives him no concern, but he is not at all sure that his procedure in the first 19 cases will meet with general approval. Yet I am disturbed, because, in a specialized obstetrical experience covering many years in two large hospitals, I have not found it necessary to abort or sterilize anyone.

He discussed contraception as well, and,

like him, I find abortion, sterilization and contraception so intimately related, as to make individual treatment from a medical point of view difficult. Abortion is but a by-product of sterilization in many of his cases, and, at best, sterilization is but contraceptive treatment made reasonably certain.

Reviewing his cases briefly, we find 4 cases of pronounced feeblemindedness, 4 cases of dementia precox, 2 cases of frank psychosis, 1 case of chorea and repeated puerperal insanity, and 1 case of postencephalic depression. Seven of these patients were sterilized during pregnancy, prior to viability of the child.

As to the four social indications. One girl of eighteen with a contracted pelvis, syphilis, tuberculosis and general worthlessness was sterilized at cesarean section in her first pregnancy. Another with 2 microcephalic children had abdominal hysterotomy and sterilization in her third month. A girl of twenty, mental age twelve, was sterilized at her second cesarean section; while the fourth, age twenty-seven who had undergone two cesarean sections and four spontaneous deliveries, was sterilized because she was losing ground physically, had a worthless husband, and could not keep a position if she were constantly pregnant.

Sterilization is widely practiced, with and without much thought on the part of the operator, but often because he is influenced by the desire of the patient or by the pitiful story she tells. In a recent survey of 1805 cases of cesarean section made by the Brooklyn Gynecological Society,[2] sterilization was done in 59 out of 834 cases of contracted pelvis, and in but 16 out of 130 cases of repeated cesarean sections.

Abortion may or may not be the material corollary of contraceptive failure, but apparently it often is. Contraceptive advice is widely given, when, in the physician's opinion, pregnancy would jeopardize life, or even health, through the operation of social or economic factors over which the physician or the patient have no control. I do not contend that the physician should be prepared to induce abortion, if failure follows his instructions. Not at all. It may be though that there is no middle ground; one may follow the other. Many, however, give birth control information for reasons for which they would shrink from inducing abortion.

But even medical indications are not universally accepted and wide divergence of views exist. We have no one mind upon this important subject. There are 29 birth control clinics in the United States. Let us look at the report of one of them, one which we would expect to be the most conservative. In the First Report of the Bureau of Contraceptive Advice in Baltimore,[3] J. Whitridge Williams analyzed 168 histories of those who had been given advice, and divided them into 4 groups.

In the first group of 70, there were 38 cases in which the indications were tuberculosis, kidney and organic heart disease. There were 14 nervous disorders listed as psychoneurosis, morons, dementia praecox, and 1 patient whose husband had a mental affection. The remaining cases comprised syphilis, thyroid disease, epilepsy in the wife or husband, recent operations, fracture of pelvis, encephalitis in the husband, spina bifida, chronic asthma, breast lesion, acute gonorrhoea, and hypertension with difficult labor. A wide and varied assortment of "those presenting definite medical indications." Williams says that in nearly every instance, the indication for advice seemed thoroughly sound.

In the second group of 23, advice was given to those who complained of too frequent pregnancies, with complications listed as undernourished (2), anemia (4), general debility (3), asthenia (3), 15 miscarriages (1), running down (2), husband drunken (1), syphilis (1) and debility (6). Here Williams states that advice was justifiable both from the medical and humanitarian point of view.

The third group Williams admits is

more debatable. Sixty women had an excessive number of pregnancies within a comparatively short space of time. Here the income of the husband was held to be an important factor.

In the fourth group, the historical data were not sufficient for judgment, but Williams feels that he would have agreed had he seen the patients.

That contraceptive advice and treatment may be given as a matter of right, many will deny; but that it is common practice no one will dispute. That medical indications are far flung, this report bears solemn witness. We give advice for run-down conditions and general debility. If general housework were included, no one need have a baby.

There are, however, certain vague but widely accepted indications for abortion. It is easy enough to enumerate medical conditions, but I am sure that clinically the patient is more than a case record. Even those who would agree upon fixed indications, would probably disagree in the management of their cases. Hard and fast lines may not be drawn.

Once we felt that abortion was lawful only if life itself were threatened by continuation of pregnancy, but now serious or even possible damage to health constitutes a valid reason for interference. The child itself apparently is not considered.

There is general agreement that severe kidney lesions call for active intervention. If albuminuric retinitis is a positive indication, hypertension and edema certainly are not. There is much evidence to show that continued pregnancy results in further kidney damage, yet conscientious effort should be made to carry the child to viability.

The case for tuberculosis is not so convincing. In active cases, the risk certainly increases. Parturition, it is said, fans latent lesions to a flame, but there is absolutely no proof that early interference would prevent exacerbations, or that abortion may not be as harmful in its effects as labor itself. In arrested cases, I believe it does more harm than good. The chief argument against pregnancy is that it is apt to bring about forgetfulness of the lesion and neglect of treatment. But there is no excuse for that.

In heart disease, mitral stenosis or otherwise, early abortion is based upon pure speculation. Broken compensation is not due to the pregnancy, unless the uterus is of sufficient size to cause circulatory embarassment, a distress due to mechanical factors. Viability should always be awaited and cesarean section considered. Recent advance in the technique of local anesthesia, and the increasing safety of spinal, strengthen this position.

With all this we should be deeply concerned, for there is a changing point of view in the medical profession. Social, economic and eugenic reasons move us deeply. The ethical standards of the public are lower than ever, and the physician has become less and less able to withstand the pressure brought to bear upon him. Medical indications are apt to be loosely accepted at their face value, and a multitude of other reasons find steadily increasing favor with us. Times have changed, and we with them.

Modern life steadily diminishes women's capacity for childbearing. Husbands meet increasing economic stress less willingly. A safer technique and emolument has swelled the ranks of the criminal abortionists. Women are aware of our slackened conscience. Their friends have found honest doctors more sympathetic, more acquiescent, not so deaf as they once were. A little emphasis on this or that point, and her cause is as just as the next one, a vicious circle.

Common sense and thinking for ourselves has brushed aside old religious deterrents. Common contraceptive knowledge has shaken and weakened our moral fibre. Birth control propaganda grows more ardent. We are advised to space our children, to leave little or nothing to nature. "The patient may be advised to make the insertion of the pessary a part

of her evening toilet if desired, so as to be always prepared . . . [it] made a part of the daily routine of undressing." Dilatation, rupture or snipping the hymen to fit a pessary is recommended. "If this procedure were adopted by all young women before marriage, it would save considerable embarassment and sometimes much pain."[4] "It was the last straw," says another, who possibly inherited his contraceptive beliefs. "I have a very distinct memory, dating from my seventh year, of my discovery of a paper covered book on contraception, carefully hidden away in the top drawer of my mother's wardrobe, and an irreverent member of the family once referred to me as an "accident." So I can only suppose that some attempts at contraception had been made, though of their nature, duration and regularity, I have no exact knowledge."[5] Nothing is sacred. Not even our mothers.

Perhaps we go too far. If adequate reasons for contraception include general debility, general malaise may be added. There was a time, however, when abdominal sterilization, and deliberate destruction of the fetus, not because its presence jeopardized life or even health, but because its eugenic outlook was poor, would be considered a crime akin to infanticide. Perhaps it is.

Fairbairn[6] believes that none other than purely medical considerations should be allowed to influence us. Once other than purely medical factors are allowed to count, no line can be drawn between therapeutic and criminal abortion. "Nothing is worse than the mental torture of illicit pregnancy, "he says. "Are we then justified in terminating these?"

Ethics and morals are not a religious matter. Men may decide upon a basis of morality, it is true, but our conscience is founded upon and guided by something deeper than that. We do not have to invoke divine revelation. Rather do we depend upon the unchanging law of good and evil which is binding upon all of us, and finds its expression in all sorts of principles with which we are constantly in contact. The physician is not the dispenser of life and death. He is not the arbiter of the universe. Individual cases may evoke his pity and wring his heart, but he should feel no call to redress all the wrongs and cure all the wrongs and cure all the ills of society. That would keep us very busy.

To the question, "Have we the right to interfere with a normal pregnancy?" My answer is "No."

Charles A. Gordon, M.D., F.A.C.S.

[The author has made out an excellent case against birth-control and the interference of a normal pregnancy. We will be glad to receive other comments on these subjects. Ed.]

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4. Cooper, J. F. Technique of Contraception. N. Y., Day-Nichols, p. 142.
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RADIOLOGICAL DETECTION OF ABDOMINAL ADHESIONS

We frequently hear it said that the x-ray "failed to show" abdominal adhesions. Pleural adhesions, thanks to the surrounding medium of air in the lungs or in the pleural cavity, can be shown very satisfactorily but abdominal adhesions are non-opaque to the x-ray.

The detection of intraabdominal adhesions is dependent upon certain circumstances, some of which are under the control of the radiologist: first, the ad-