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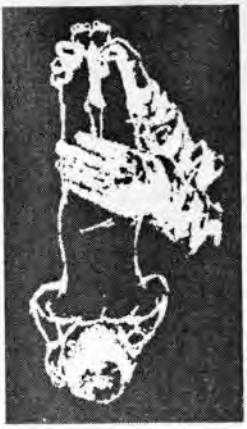
Reforming the Abortion Laws: A Doctor Looks at the Case

Denis Cavanagh

As state legislatures around the U.S. move to discuss and vote on liberalized abortion laws, a well-placed observer comments on the figures, arguments and experiences that mark the debate



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 struck 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 consideration 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 moderate liberalization of the Missouri Abortion Law along the lines of the American Law Institute proposals. I took this stand because I was impressed 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 conscience, because of the apparently

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[DENIS CAVANAGH, M.D., is chairman of the Department of Gynecology and Obstetrics at the St. Louis University School of Medicine.]

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 in large numbers, patient care was worse and dishonesty was much more prevalent than it had been under the older and more restrictive abortion laws. Accordingly in April, 1969, at the Missouri Senate hearings on liberalization of the Abortion Law (Senate Bill 206), I appeared as an opponent of liberalization. The final factor that precipitated my action was the so-called factual testimony given by the proponents of liberalization in March, 1969.

Presumably with a view to stampeding responsible but uncommited people into the liberal camp, the proponents stated in their testimony that 1.25 million criminal abortions were performed in the United States every year. No such official figure for criminal abortions is available in this country, and the figure is probably a gross exaggeration. It is even higher than the most commonly quoted figures of 800,000 to 1 million criminal abortions per year—figures apparently derived through extrapolation from those obtained from the Margaret Sanger Birth Control Clinics over the period 1925-29, as quoted in *Birth Control in Practice* (1934), by Marie Elizabeth Kopp.

BIAS IN FIGURES RESULTS FROM UNRELIABLE ASSUMPTIONS

It was said, further, that there were 17,000 criminal abortions i[n] [t]he state of Missouri. I can only con[clu]de that this figure is based on th[e] [so]me unreliable assumption that [cr]iminal abortions run about 20 [p]ercent of live births per year (74,0[00] [i]n the state of Missouri. During t[he] hearing a Senator specifically aske[d] one of the proponents where he [go]t these figures on the number o[f] criminal abortions and was told [th]ey were "from the Department [o]f Health, Education and Welfare." B[e]cause of my interest in the crimina[l] abortion problem and because I th[ou]ght this was a very important point [I] decided to check it out. I had my [se]cretary call the Bureau of Vital S[ta]tistics of the Department of Health, [Ed]ucation and Welfare, in Washington, [D].C., and asked them to check this [st]atement. Here is the reply:

"Dear Doctor Cavanagh:
This is in response to your te[le]phone request today. The Division of [Vi]tal Statistics has no data on criminal [a]bortions in the United States.

Sincerely yours,
ROBERT D. GROVE, [M].D.
DIRECTOR
DIVISION OF VITAL [S]TATISTICS"

At the Missouri hea[r]ings, the dramatic rhetorical que[s]tion was asked: "How many mo[re] women must die before we change the law?" This makes two assumptions: 1) that women are dying unnece[s]arily because of the present law and 2) that if we liberalize the abo[r]tion law maternal mortality will be [re]duced.

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, *Abortion–Spontaneous and Induced* (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, uncommitted 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 from 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 1,301,745 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 60 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 vey 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 hard-pressed 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 no previous pregnancies. Only 22.4 per cent of the women who had therapeutic abortions performed had three or more living children.

THERAPEUTIC ABORTION IN A GOOD HOSPITAL – NOT ENTIRELY SAFE

It is frequently claimed by proponents that therapeutic abortion performed in a good hospital is a completely safe procedure. I challenge this statement.

In the *World Medical Journal* (Vol. 13, 1966, pp. 78-80), Mueller has reported that in the 8-year Soviet experience with free abortion, operative mortality was 0.7 to 1 percent, perforation of the uterus and its consequences of hemorrhagic shock being the most common cause of death. Inflammatory conditions were frequent, and tubal pregnancy a common sequel.

It might appear, of course, that though these findings apply in the Soviet Union they do not necessarily apply in the United States or Canada; but I submit that this information should be balanced against the "magnificently safe" rep of 3 deaths per 100,000 abor s from Hungary. It is interesting, o, that while statements are bein ade to the effect that abortion is er than pregnancy, this does not p e to be so in either Sweden (40 ths per 100,000 abortions) or Gr Britain (30 per 100,000).

Here are several passag rom an article, in the March 1, 19(issue of the *American Journal of bstetrics and Gynecology*, "The Fir Year Experience in Colorado wit he New Abortion Law," by Dr mueller, Taylor and Drose:

"On reviewing the hosp records, we were impressed by t spectrum of complications that foll ed therapeutic abortion proced s. Hemmorhage was the outst ing one, with 8 per cent of the ients requiring one or more trans ons." (A single unit blood transf on today carries approximately he same mortality rate as uncomp ated elective appendectomy.) ter, the authors state: "All infe ons were short in duration and v e readily responsive to antibiotic ugs. Five patients had uterine perf tions that occurred at the time of u ne evacuation; four of these perf ions were followed by explorat laparotomy." Again: "Not eno time has elapsed to determine wh er or not such complications as rility, incompetent cervical os d delayed reactive depression will b significant factors in the future." e authors state further: "Our predi on is that it will be a long time before the Colorado law is made liberal as some European laws, alth ugh we are sure there will be a co inuing discussion by groups who favor even greater liberalization and greater opportunity for termination of the unwanted pregnancy.'

LIBERALIZATION WILL NOT REDUCE CRIMINAL ABORTION RATE

In closing 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 psychiatric indications, which were included in the Missouri Liberalization bill, I will only state that especially when "mental health" is substituted for "serious mental illness," the law is left too loose because of lack of clear definition. The size of the loophole that may be created can be judged from the fact that 88 per cent of therapeutic abortions done in the state of California in the first year of the new Abortion Law, which I felt was a good law, were for psychiatric reasons and only about 5 per cent of the women required therapeutic abortion on the grounds of organic disease. It is obvious that serious mental illness is not 17 times as common among pregnant women as serious physical illness, so we can only conclude that the "mental health" clause was abused even in accredited hospitals. Incidentally, with regard to the frequently quoted "suicide threat," it has been reported by Barno in an article on "The Minnesota Mortality Study," in the Jan. 15, 1968, issue of the *American Journal of Obstetrics and Gynecology*, that the actual suicide rate is four times as high in the general female population as it is in the pregnant woman. It is interesting, too, that none of the 14 suicides occurring over a 16-year period in the state of Minnesota were in association with illegitimate, and thus presumably unwanted, 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 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 cases seen in a normal year, yet only 43 anomalies were found among 280 babies born of women who had developed rubella during the first trimester of pregnancy.

According to the Indiana Committee's report: "From this we assumed that only four abnormalties from German measles occur in a normal year and that permission for the destruction of the 280 fetuses to find the 43 was too many to consider." These figures of course apply only to the state of Indiana, but could as well reasonably apply to the state of Missouri or elsewhere. I may say that there is a considerable discrepancy between this figure of about 14 per cent and the 85 per cent figure for affected babies given by one of the proponents for liberalization in Missouri.

WITH VACCINE, RUBE[LLA] TO DISAPPEAR AS U.S. PROB[LEM]

Another point seldom me[ntioned] is the fact that rubella vacci[ne will be] in full use before the ne[xt] rubella epidemic. By the use of th[is] vaccine rubella should disappear [from the] United States as a signific[ant] problem, just as poliomyelitis [has] disappeared since the introducti[on of the] polio vaccines. And reme[mber that] rubella is by far the mos[t common] cause of fetal abnormalti[es at this] time. The proponents a[re well-in]formed people who know [that this] indication will disappear [with the] vaccine, but they selectivel[y forget it] because it weakens their [case. And] yet, does anyone here re[ally believe] that once the vaccine [has been] proved effective the legisl[atures will] quickly repeal the anachro[nistic law?]

DO WE KILL NORMAL B[ABIES] TO PREVENT A MINOR BIRTH DEFEC[T]

There are other uncomm[on causes] of fetal anomalies, but [often with] modern methods it is usu[ally impos]sible to tell for certain wh[ether a child] will be born with certain [defects. A] prediction can usually onl[y be based] on probabilities. Thus a [significant] number of normal childr[en will be] killed to prevent the bi[rth of one] having what may be onl[y a minor] birth defect. After all, wha[t is a birth] defect? Adolf Hitler bel[ieved that] being Jewish was a defe[ct of birth.] Some scientists intereste[d in pre]serving only the best of [our human] species believe it is a defec[t to be too] stupid, too tall, too short [or 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 has erred in his diagnosis, has acted unreasonably 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 analyzed carefully, may very well result in a significant change in the moral and legal philosophy upon which our culture is based. Once it has been determined that life can be taken away for a birth defect, 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 fetal euthanasia.

We may learn something from the English experience. Those who were pushing for a liberalized abortion law in Britain three years ago are now pushing for euthanasia 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 eloquently answered this question in the affirmative in the 1967 case of *Gleitman v. Cosgrove* (1945-49 N.J. 22). The court declared: "It is basic to the human condition to seek life and to hold on to it however heavily burdened. 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 intuition of human nature tells us that he would almost surely choose life with defects as against no life at all." Leaving aside all the theological and legal arguments, as Theocritus said, "for the living there is hope but for the dead there is none."

WOMAN'S RIGHTS VERSUS THE CHILD'S RIGHT TO LIFE

The crux of the moral and legal debate over abortion is, in essence, the right of the woman to determine whether or not she should bear a particular child versus the right of the child to life. The most vigorous proponents of liberalization talk about the fetus as "a blob of protoplasm" and feel it has no right to life until it has reached a certain stage of development. This is given variously as from 12 weeks to 28 weeks of intrauterine life, and some apparently feel it has no right to life until after full-term delivery. On the other hand, the most vigorous opponents of liberalization maintain that the fetus is human from the time of conception, and so interruption of pregnancy cannot be justified from the time of fertilization.

I have some doubt about whether the fetus can be recognized as a separate human being from the time of fertilization. But it certainly seems logical that from the stage of differentiation, after which neither twinning nor recombination will occur, the fetus implanted in the uterine wall deserves respect as a human life. If we take the definition of life as being said to be present when an organism shows evidence of individual animate existence, I think that certainly from the blastocyst stage the fetus qualifies for respect. It is alive because it has the ability to

reproduce dying cells. It is human because it can be distinguished from other non-human species, 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 movements, 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 of the cardiovascular and nervous systems begins. At the end of six weeks all the internal organs of the complete human being are present, although still in a rudimentary stage of development. By the end of the eighth week the skeleton has begun to form, and the eyes, fingers and toes are evident, 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 th body of the mother, although th term applies even before the cord cut).

After the eighth week, new major structures will be add , and further growth will consist o natur- ation and development of the isting structures rather than the cre on of anything new. By the end f the twelfth week, the fetus can allow amniotic fluid and the heart an be picked up by ultrasonic techn ues or by electrocardiography. If livery occurs after the 20th week, d the baby weighs approximat 500 grams, it is referred to as a p nature infant rather than as an abor

20-WEEK FETUS SURVIV ILITY STANDARD IS NO NGER SACRED

Generally, the time of leg viabili- ty is considered to be a ut 28 weeks, but there is now general recognition that a baby r 500 grams should be considered as pre- mature, since it does have s e pos- sibility of survival. (Indeed, i s inter- esting that in the *Canadia Medical Association Journal* Monroe ported, in 1939, the case of a baby eighing 397 grams on the second d of life that developed normally. To is very durable individual the term bortus" can scarcely be applied.)

Now, it seems evident tha the age of survivability can no long be con- sidered as immutable, be use too many variables – such s DNA synthesis, test tube incub ion, in- trauterine transfusion and chromo- somal manipulation – are nvolved. Dr. James Diamond pointe out in his article "humanizing the Abortion Debate" (AM. 7/19/69) tha , in view of recent technological adva ces, "the 20-week survivability st ndard is about as sacred as the four-minute mile." He has also sugge ted that with the development of a effective artificial placenta, probably within the next decade, the 20-week or perhaps the 12-week fetus may survive to become as 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 nonmedical 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 or less 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 ethos. 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.

"If 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? Lest 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 English experience 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

abortions per year. In the first eight months under the new law there were 22,256 legal abortions. Gynecologists and nurses working in the Department of Obstetrics and Gynecology are particularly unhappy about the present situation because the Abortion Act has created a shortage of hospital beds. Too many are being used for patients demanding abortions, and there are not adequate facilities for patients with gynecological problems.

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 ler the present laws and the e lity of opportunity that will re from liberalization.

Mrs. Knight has recently de two other important observati . First, because of the very exist e of a liberal law, women now el they have a "right" to have an portion, and they consider that the so have the right to sue a doctor a nurse who refuses to participa in that abortion. In the construct of the English law (and for that atter in the writing of the Colora law) no effective "conscience cl e" was included. Thus a doctor a nurse who refuses to participa in the performance of an abortio for "the ordinary and usual reaso is presumed guilty until inno nce has been proved.

Secondly, she noted t at a recent meeting of Royal Academy of Nursing it w reported that the morale of the stu nt nurse is being undermined by th prospect of facing abortions in the perating room.

Describing the present s uation in Britain, the *Sunday Telegra* h of July 9, 1969, stated that the sent law has gone a long way towa "making uncontrolled abortion" a eality in Britain. "Experience has own that once the view is aband ned that abortion is only permissibl on medical grounds, it is almost im ossible to define any other ground in satisfactory legal terms."

We often hear that the ecision to abort is a "medical dec ion" and should be left up to the octor and the patient. But is it reall logical to leave the decision entirely p 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 plaintive 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 attemps 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 "patsy" position by requesting that illegal 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 Hellegers has called the brave new world of "Aborticare"?

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."