

May 1971

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### Recommended Citation

Fitzgerald, James A. (1971) "Ramifications of Permissive Abortion," *The Linacre Quarterly*: Vol. 38 : No. 2 , Article 6.  
Available at: <http://epublications.marquette.edu/lnq/vol38/iss2/6>

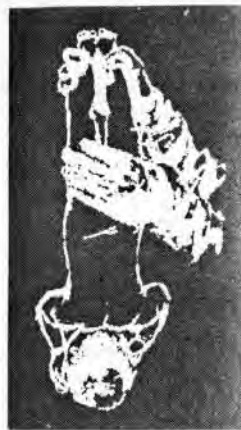
## Ramifications of Permissive Abortion

James A. Fitzgerald, M.D.\*

The effects of permissive abortion are protean.

Accepting the pro-abortionists' thesis at once subtly alters the physician's attitude toward the patient and the public's concept of the physician. From Hippocrates to the liberalized abortion era, the practitioners of medicine were the custodians and guardians of the life process. From Withering and his foxglove to Wakesman and his Streptomycin, each advances in medicine was so designated because it contributed to the easeful maintenance of life. Medicine had no other

goal or objective. The growth in the knowledge of public health, the establishment of effective therapies in contagious processes, in oncology and in degenerative diseases, the relief of pain with analgesics, opiates and anesthetics — all these were accomplished to further the vital mechanisms. Means and measures for anti-life purposes were relegated to the



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realm of the Borgias, the Medicis, and others of homicidal bent.

The pro-abortionists have established a new course for medical practitioners. The new pathway has as its end the recreativity of the physician as a determinant in death. There is an order in priorities in healing. Its sequence is physical, social, economic, demographic. If these are not feasible an alternative is now proposed; death may be elected.

This divergence from previous goals, this choice that hitherto did not exist, is a source of cultural and religious trauma to many in the medical profession. The physician is asked to see with a new eye, to evaluate with a different mind, and to determine with criteria that had never a prior worth. The doctor is asked to begin at the beginning, to consider abortion, to condone it and practice it. And even not accepting it, the careening mind once having entertained the concept leaps on to what follows; the appraisal of the patient not only in terms of life, but death.

Prior to permissive abortion, I am sure that I and my confreres were scrupulous in not emptying a uterus in a woman threatening to miscarry until we had established with certainty that the pregnancy would not continue. Some of us waver now. The weeks of bleeding which establish the apparent ineffectuality of our treatment, the patient's personal and economic inconvenience, coupled with our recent exposure to liberalization, may persuade us to perform the curettage. Not many yet, I assure you; but we are only at the beginning of our new thinking.

Once we are established in this new therapeutic repertoire, we may expect to advance further for the cause of death. The newborn child with multi-

ple anomalies, I am reasonably certain, will not survive. I can guarantee its death with an injection of morphine. Our gynecologic patients, young and old, with widely disseminated cancer, cannot be cured with present medical knowledge. With sufficient pentothal in a syringe and the availability of the patient's antecubital vein, we can conclude the matter in seconds. The querulous seniles serve no purpose, are burdensome and expensive to maintain; in our new role our service to them can have only one intention.

There are other categories for termination therapy: the refractory alcoholic; the insane; the defective child; the habitual criminal; the child molester; the psychopathic personality; the aberrant sexualist. We thus proceed from foeticide to infanticide to homicide to euthanasia. Any intolerable deviation in this new philosophy comprises a disease. We may unconscionably broaden our definitions and consider as deviant those of varying ethnic pattern, individuals not co-religionists, others with different skin coloration, as well as those with contrary political beliefs. Genocide thus enters the therapeutic arena.

The patient, who from the beginning of medicine considered the practitioner as exerting his role only in the direction of the healing arts, for the first time will comprehend that he may be evaluated in another aspect. This circumstance will occur when his situation is grave, his prognosis poor, or his condition terminal. It will occur quite logically when the afflicted is no longer utilitarian. It may happen when the family tires of the trial.

As abortion on demand is abortion on request and the aborted would not be consulted even if they could be, the seriously ill will find that their demise is wrought by parties other than themselves. There is little reason for the profoundly sick to sign their own

death permits; many would be incapable, others would not have a full comprehension of their commitment, and some, without wisdom, might refuse.

A death-oriented society might more rationally actuate euthanasia before permissive abortion. There may be more compassion in extinguishing the life of the ill than in causing the death of a normal fetus. There is an obvious disparity in offering death to these two categories; one is always sick, the other usually well. But being an artful society, we find it easier to destroy what we cannot actually see and what we have not really known. Given time and practice, we can overcome this inhibition and convert the waning quick into the final dead.

The public is beginning to see us in a different cast. It will discern that we supply a new service. It is beginning to guess that we have new potentials, and it wonders about our other novelties. For want of a cure it will anticipate that we may propose a more convenient solution in place of expensive, inconvenient care. Already there is a chorus of voices chanting the benefits of termination therapy; they have become more audible and insistent with the advent of permissive abortion. The new physician is a benefactor if possible, a terminator if impossible. This is the new image of the healing arts. It flows from the cornucopia of abortions unlimited.

The data on legal abortions now being performed in the United States is impressive. Rates in some major hospitals have reached 300-500 abortions per 1000 births, and continue to increase. In California, since the liberalized law took effect in November, 1967, the rate for the entire state doubled for each six month period. In September, 1970, it approached 60 per 1000 births. Yet, despite the 15,000-odd legal abortions performed

in California in 1969, it is fairly reliably estimated that 76,000 illegal abortions were performed upon California women during that time.

New York City health authorities report 9000 legal abortions in the first six weeks of the new law, and project 100,000 legal abortions in New York City by the end of the first year. The increment from the rest of New York state will be added to this figure. If we include the figures from Alaska, Hawaii, Colorado, and other liberalized policy, the total may approach one half to one million legal abortions in one year in America.

This carnival of death is contrasted with the fact that the birth rate in the United States is near its recent record low. The Demographers also specify that population density in the United States is not a problem (the United States has only 56 persons per square mile, compared to 588 for England and 975 for Holland). While people in America have been migrating into cities and suburbs, states like the Dakotas and Wyoming have been losing population, leaving vast open spaces that were once inhabited.

Japan is the most crowded nation in the world. It has 102 million people - half as many as the United States - all crammed into a string of narrow islands that are smaller in total area than Montana. Abortion has been permitted in Japan for twenty years, and the chief method for curbing the birth rate is induced abortion. Birth control pills are used very little if at all in Japan. The government has not approved the sale of contraceptive steroids and the medical profession believes these pills to be too dangerous for use. The intra-uterine device is not popular in Japan and is officially prohibited.

In 1947 there were 2.7 million live births in Japan. In 1953 there were 1.9 million live births and 1.07 million

abortions. By 1968 the abortions were 0.75 million. Authorities now report with concern that the combination of abortion and contraception has skewed the Japanese population so far toward the older age groups that commercial interests are now openly predicting a severe labor shortage by the end of the 1970's. The gross reproduction rate has shrunk from 2.2 to less than 1.0. There has been a sharp decrease in the population of children below the age of 15, and a sharp increase in the population over 65. Those in political and economic power in Japan are now seeing the disadvantages of a falling birth rate over a 22 year period. Labor shortage, consumer shortage, and disproportionate numbers of the population over age 65 are causing a restudy of present policies of abortion and birth control.

The effects of permissive abortion are protean . . .

1. The acceptance or tolerance of abortion alters the attitude of the physician to the patient and the public's concept of the medical profession.
2. Permissive abortion has actuated the new field of termination therapy.
3. In at least one society, it has so altered age-population proportions that the young in that society decline and the aged increase.
4. There is evidence that easy abortion fosters illegitimacy, and no evidence that it has appreciably reduced the figures for illegal abortions.
5. Permissive abortion has other diverse effects - for the most part not beneficial.

The more immediate effects of permissive abortion are outlined in a report of the Royal College of Obstetricians and Gynecologists. The volume of abortions, which has been running at upwards of 55,000 per year in England and Wales alone, has caused

shortages of operating rooms and staff, and has taken valuable time from the busy gynecologists' practice. It has adversely affected the training and teaching of junior medical staff and students. Abortion patients have pre-empted hospital space required for women with "genuine gynecological disorders". Cases have been reported of women with cervical cancer whose admission to the hospital was delayed because priority was given to abortions.

Evidence from Britain and other countries practising abortion indicates that "easy abortion can in fact encourage unplanned pregnancy." The Royal College feels that abortion offers little protection to a woman from "further mistakes or misadventure," and that it does not "necessarily safeguard her physical and mental health. Eight British maternal deaths were recorded out of the 27,331 abortions in this survey. This reflects a mortality rate of 0.3/1000 abortions, which was higher than the maternal mortality for all abortions, including criminal, for a comparable period in England and Wales.