The Linacre Quarterly

Volume 28 | Number 3 Article 3

August 1961

The Moral Law and Obstetric Practice

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IF A Medico-Moral Seminar such as this had been held thirty years ago, we would have found that there were wide areas of disagreement between what was then thought to be good obstetrical practice and the natural moral law.

I remember this well because at that time I was a medical student and was undecided whether I should go into obstetrics or pediatrics. In discussing my problem, a well trained Catholic physician said to me, "I don't see how a Catholic physician could be very happy doing obstetrics because of the great conflict between the moral law and obstetrical practice."

It was the thought of the day that pregnancy was a great burden, not a physiological act, and that the pregnancy should be interrupted if the patient's health was impaired by any medical complication such as pyelitis, heart disease, vomiting of pregnancy, multiple sclerosis, et cetera.

In 1930 it was also true that some bewildered daughters of Eve attending our Catholic Colleges seemed to remember only one bit of misinformation from th ethics course: that it was the du of the Catholic physician to a w the mother to die and to save baby. To paraphrase Gilbert a Sullivan, the lot of the Catho obstetrician was not a happy e.

However, the last thi years have brought great chan Now almost everyone agrees t as the obstetricians increased i visdom and understanding they ddenly discovered they were in a eement with natural moral law id that there were no longer an medical indications for therapeu abortion.

There were many lead s in the struggle to establish th concept that good obstetrical pra ice is in agreement with both th natural and moral law.

I should just like to o er a few words of appreciation a d gratefulness to all those disc ing and courageous obstetrical le ers who made the practice of ob tetrics a little sounder and easier or all of us. Particularly, I shou like to mention a certain few wh directly influenced me.

First, Dr. James F. Norton, Chief of the First Division of the Margaret Hague Maternity Hospital whom many of us knew as a former President of the Medical Society of New Jersey and as a Vice-President of the American Medical Association.

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In the early days of the Margaret Hague Maternity Hospital, Dr. Norton worked many extra hours with Dr. John Connell and the other members of the First Division to prove that in medical complications of pregnancy the best treatment was to "forget the pregnancy" and to treat the disease.

Dr. Norton also developed a technique of extraperitoneal section for infected cases,[1] which proved to be much safer for the mother and the child than the performance of a craniotomy. Today craniotomy on a living child has been completely discarded as an obstetrical procedure.

After twelve years of experience as Medical Director of the Margaret Hague Hospital, Dr. Samuel Cosgrove, of happy memory, became convinced that medical indications for therapeutic abortion were not justified.

In 1944 he presented his views in a paper before the New York Obstetrical Society, "A Consideration of Therapeutic Abortion."[2]

This particular paper has been widely quoted and was probably the turning point in the struggle because the incidence of therapeutic abortion for medical reasons has steadily declined since then. Of all Dr. Cosgrove's contributions to the science and art of Obstetrics this was one of his greatest, and Catholic physicians owe a great debt of gratitude to this devout Methodist and fine Christian gentleman.

We also owe a debt of gratitude to Dr. Harold Gorenberg, the Chief of Medicine at the Margaret Hague Hospital who — as I will later show — has proven that pregnancy is not deleterious to the patient with rheumatic heart disease.

Dr. Roy Heffernan of Boston has always been in the foreground of this controversy, and with Dr. William Lynch contributed a scholarly article "Is Therapeutic Abortion Scientifically Justified?"[3] which musters the strongest medical evidence against so-called indications for therapeutic abortion.

Dr. Joseph McGoldrick of Brooklyn and Dr. Bernard J. Hanley of Los Angeles also made excellent contributions. There were, of course, many others throughout the country who contributed to the decline of therapeutic abortion for medical reasons, but to these named physicians I owe my personal gratitude.

Let me now give you the facts and figures that demonstrate why at the Margaret Hague Hospital (a County hospital) only eight therapeutic abortions were performed in 215,000 deliveries and why since 1947 there has not been a single therapeutic abortion in the last 115,000 deliveries.

Consider with me some of the former indications for therapeutic abortions —

HYPEREMESIS GRAVIDARUM: One abortion for hyperemesis gravidarum has been performed in these 30 years. That occurred in 1939. This

patient was again pregnant in 1941. She returned to our hospital and was admitted with the diagnosis of hyperemesis. She was treated with glucose and psychotherapy and was delivered at term of a healthy child. It would seem, therefore, that the abortion done in her 1939 admission was not medically justified. We have not had any maternal deaths from hyperemesis in 215,000 deliveries. We do not believe that therapeutic abortion for hyperemesis is justified.

It is interesting that today we seldom see a severe case of vomiting of pregnancy. This is probably due to the fact that patients no longer fear pregnancy the way they did thirty years ago. They adjust more quickly to it and also they know that vomiting is no longer an indication for therapeutic abortion. Severe hyperemesis today is a medical curiosity; and we do not see enough severe cases for the teaching of its treatment to students.

PYELITIS: For many years our cases of pyelitis were treated with indwelling catheters and urinary antiseptics. They were often very difficult problems. However, since the use of sulfa drugs and the antibiotics, pyelitis can be controlled during pregnancy. There is now no need for a therapeutic abortion in these cases.

TUBERCULOSIS: Because our next door neighbor is the Hudson County Tuberculosis Hospital, we see our share of cases of tuberculosis. Recent advances in the treatment of pulmonary tu[illegible]rculosis, both by surgical and me[illegible]al technics, have led almost a[illegible] authorities to conclude that th[illegible]terruption of pregnancy for t[illegible]rculosis is not necessary.

Schaefer and Eps[illegible]n[4] reviewed the case histo[illegible] of 63 patients who had therap[illegible]ic abortions because of advanc[illegible]pulmonary tuberculosis. They [illegible]nd that the mortality rate was h[illegible]her than in a similar number c[illegible] patients with advanced tuberc[illegible]sis who had full-term deliveries.

Robert Cosgrove and [illegible]Krueger[5] in a review of 128 preg[illegible]ancies in our hospital concluded [illegible]at there was no evidence that pr[illegible]ancy or delivery exercised a [illegible]leterious effect on patients with [illegible]lmonary tuberculosis.

Bowles and Domza[illegible]ki[6] state that every investigator [illegible]nce 1916 has consistently found [illegible]hat pregnancy has no harmfu[illegible]effect on pulmonary tuberculosis.

We have not done an[illegible] abortions because of tuberculosis and we have only had 1 death from tuberculosis in the last 152,000 deliveries. This was a non-clinic patient of 31 weeks gestation who was admitted in coma and who died within 48 hours.

MENTAL DISEASE: We have had very little experience with pregnancy complicated by mental disease. However, it is very doubtful that the interruption of pregnancy will cure any psychotic or psychoneurotic state.

Ebaugh and Hauser[7] have said that ideas of guilt and of self-deprecation, centering around infanticide, might well disturb a poorly integrated personality to a psychotic degree. You have all met the patient who for years after an induced or therapeutic abortion had profound guilt feeling. It would be my impression that many more women have been admitted to institutions because of mental disease initiated by psychic scars of abortion than there have been women cured and discharged from the institution by the performance of therapeutic abortion. We have not done therapeutic abortions in these cases.

CARCINOMA OF THE CERVIX: Treatment of this condition is essentially the same in the pregnant as in the non-pregnant woman: we treat the disease and disregard the pregnancy. If abortion should occur, it is incidental to the radium or x-ray treatment or surgery. There is under these circumstances no reason to classify it as a therapeutic abortion.

CARCINOMA OF THE BREAST: Of those authors who have had a large experience with breast cancer in pregnancy, only Adair believes that interruption of pregnancy will benefit patients with breast cancer.

T. T. White[8] in a review of 1413 cases of breast cancer in pregnancy concludes that there is no evidence that interruption of pregnancy benefits these patients or prolongs their lives.

It has been our method to treat the cancer and to forget about the pregnancy since there is no evidence to show that an interruption of the pregnancy will arrest or favorably modify the disease.

We have observed three instances of rapid spread of the cancer after the patient delivered, and one after an early miscarriage.

We have seen no evidence that termination of pregnancy in any way prolongs the life of the patient with cancer of the breast.

We do believe, however, that a patient with breast cancer should avoid future pregnancies.

MULTIPLE SCLEROSIS: Fifty years ago, Von Hoesslin — on the basis of only four cases — wrote in the German literature that multiple sclerosis was aggravated by pregnancy and that therapeutic abortion should be performed. This statement kept recurring in the literature, and therapeutic abortions have been performed because of multiple sclerosis.

In the last ten years, Tillman[10] at the Sloane Maternity Hospital and Sweeney[9] at Cornell have reviewed their cases and have been unable to discover any deleterious effect of pregnancy on multiple sclerosis or vice versa. Our experience in a few cases has been similar. We have not done any abortions because of multiple sclerosis.

RHEUMATIC HEART DISEASE: Two therapeutic abortions for rheumatic heart disease have been performed in the Margaret Hague Hospital, both in 1935. The first patient died four days after the

operation. Since the analysis of 345 of our patients with rheumatic heart disease was published in 1941 by Gorenberg and McGeary[11], we have not done cesarean section or therapeutic abortion because of rheumatic heart disease. Instead six rules have been set down for the care of pregnant cardiacs:

1. Extra bedrest, especially in the last three months, for all pregnant cardiacs.
2. Weekly visits for the cardiacs who are twenty-five years old or more.
3. Immediate hospitalization for Class III and Class IV cardiacs and absolute bedrest until after delivery.
4. Immediate hospitalization for the patient with a history of cardiac failure, with absolute bedrest until after delivery.
5. Immediate hospitalization on first suspicion of decreased cardiac reserve. In the clinic we do not treat colds, bronchitis, sinusitis, and so forth, in a cardiac. We think that the only thing that can happen to a pregnant cardiac is heart failure, until proved otherwise.
6. Cesarean sections are performed for obstetrical indications only. The most recent analysis shows that the incidence of cesarean section in our clinic cardiacs is 1.3 per cent against an overall hospital incidence of 4 per cent.

This March we shall have completed 15 years without th death of a clinic patient with rl matic heart disease; this represe s over 900 consecutive clinic ca acs in approximately 40,000 clin deliveries. We do not see ho therapeutic abortion could h e improved this record.

Does pregnancy shorte he life of a cardiac?

A followup of 260 car cs delivered between 1935 to 0 was done in 1952 by Goren g and Chesley.[16]

The cases were divided nto two groups of 1) those with o later pregnancy and 2) those ho had a subsequent pregnancy pregnancies.

The percentage of surv al after the ten year period wa slightly greater in the patients ho had one or more subsequent regnancies, a circumstance wh would seem to prove that preg ncy *per se* did not have a bad ffect on rheumatic cardiacs.

This conclusion is not nique, it has also been pointed out by Nathan Flaxman of Chicago[12], Boyer and Nadus[11] in Boston, and Gilchrist and Murray-Lyon in Great Britain.[18]

Another group of 133 severe cardiacs who between 1931 and 1941, had either 1) auricular fibrillation 2) history of previous failure 3) presence of failure in first trimester of the present pregnancy 4) Class III or IV before onset of pregnancy, was followed up 13 years later.

The severe cardiacs who had a subsequent pregnancy or pregnancies did as well and even a little better than those who had no subsequent pregnancy or pregnancies.

In his textbook Jensen[14] states that the annual death rate for rheumatic cardiacs between 20 to 40 years of age is 26 per 1000 per year. The annual death rate of rheumatic cardiacs in our clinic series is 4 per 1000 per year.

In other words it would seem that pregnancy has reduced the risk of death in cardiacs.

Is pregnancy good for heart disease or is it that pregnancy brought these patients under the care of a competent cardiologist?

We can conclude that a pregnant woman with rheumatic heart disease under the care of an obstetrician and cardiologist is as good a risk as a non-pregnant female with rheumatic heart disease of the same age.

HYPERTENSIVE DISEASE: Patients with fixed hypertension sometimes present complications resulting from a superimposed toxemia of pregnancy which is an imminent threat to the mother's life. Chesley and Annitto,[15] in a review of 218 hypertensive patients through 301 pregnancies in our hospital, made the following observations:

1. Forty per cent of the patients showed a significant drop in mid-pregnancy blood pressure.
2. Fifty per cent went through the pregnancy with essentially constant blood pressure.
3. Two-thirds of our patients went through pregnancy without superimposed pre-eclampsia. There were no immediate maternal deaths in this group.
4. However, among the third of the hypertensives whose pregnancy was complicated by pre-eclampsia, there were six maternal deaths, or 7 per cent. If we could only determine which patients would escape superimposed pre-eclampsia, a good prognosis could be offered to two out of three hypertensive women.

In the early years, four pregnancies were interrupted because of hypertensive disease. There were two immediate deaths. The third patient died of cerebral hemorrhage six years after the abortion. The fourth patient was aborted in the Margaret Hague Hospital in 1931 because of severe hypertensive disease. She again became pregnant in 1932, refused to be aborted and was delivered at term of a normal baby. In 1935, at the Peck Memorial Hospital, she was aborted and had a tubal ligation. In 1936 she had an ectopic pregnancy. In 1945 she had a Smithwick operation, which was uneventful. In 1952, twenty-one years after the therapeutic abortion she was still hypertensive, alive and well, having had a living child in the interim. I doubt that the abortion in 1931 was medically necessary, since she had no signs of pre-eclampsia at that time.

We cannot expect to cure a patient of hypertension by abortion.

The most one can do is to cure a patient of a superimposed preeclampsia by terminating pregnancy.

The pregnancy itself does not have a deleterious effect on hypertensive disease. Chesley on a followup of 218 patients over a fourteen year period has shown that there is no increase in the annual death rate of those hypertensives who have had four, three or two pregnancies over those who have had only one pregnancy. He concluded that repeated pregnancies in hypertensive women have not significantly increased their death rate.

ECONOMIC AND SOCIAL REASONS: Can the patient afford to have another child? Will the older children have sufficient educational opportunities if their parents have another child? Aren't three children enough? Will this one be missed? I'm afraid that such questions are frequently weighed in the consideration of a proposed therapeutic abortion. I will grant that these social and economic factors are seldom put down on the record as the primary indication for abortion. But they are frequently "secondary" indications, and too often influence judgment of the physician.

Don't you think it was fortunate for American Medicine that Sir William Osler made the rounds of our American Medical Schools as a full grown Professor of Medicine and not as a six weeks fetus in the womb of his mother, who already had eight children and was the wife of a poor minister? It was equally fortunate for the foundation of the American Republic that when Mrs. Abiah Franklin, the wife of a poor Boston tallow maker, was pregnant for the fifteenth time that she did not have the opportunity to ask some of our present day meddlesome physicians if they thought her pregnancy was a poor socio-economic risk, because if she followed the advice that they would probably have given her, *Poor Richard* would have been curetted into a specimen jar. Instead, Abiah went to term and delivered her fifteenth child and tenth son, Benjamin Franklin, a founder of the Republic, the Dean of American Ambassadors, a famous scientist and certainly one of the best educated Americans of his or any subsequent day—*Poor Richard*, indeed!

How many of the students in any medical school today, many of whom were born in the depths of the depression around 1930—would have been considered good economic risks at the time of their conception? How many of you, your grandfathers, or great grandfathers were good economic risks? Let us continue to be physicians and not act as demi-gods or false prophets. Let us believe that America is still a land of great opportunity. Let us not deny a life in America to any unborn child simply because his parents are as penny-poor as our illustrious and indomitable progenitors were, almost without exception.

COMMENT

At the Margaret Hague Maternity Hospital only 8 therapeutic abortions have been performed during 215,000 deliveries, and none in the last 115,000 deliveries. Our uncorrected maternal mortality in the last 115,000 deliveries is less than 5 per 10,000 live births. This figure is just as low as those in other large city or county hospitals or similar institutions throughout the United States where therapeutic abortion is much more frequently performed.

It would seem that it might act as a deterrent to clinics which have a very high incidence of therapeutic abortion, if therapeutic abortion were included with antepartum, intrapartum or neonatal deaths in calculating an overall fetal mortality. A fetus which is deliberately killed regardless of its period of gestation should be included in fetal mortality just as is a fetus which dies because of an accident of childbirth.

If we had performed therapeutic abortions on one per cent of our admissions (which is not an uncommon incidence among clinics reporting during the last 20 years) then we would by now have terminated the lives of 2500 children. Even allowing for a large antepartum, neonatal infant, and annual death rate, there are over 2000 people alive today who would not be alive if our incidence of therapeutic abortion had been 1 to 100 instead of 1 to 2700 deliveries, and none at all in the last 143,621 deliveries.

CONCLUSIONS

1. Hyperemesis gravidarum, pulmonary tuberculosis, multiple sclerosis, pyelitis, mental disease, rheumatic heart disease, and economic or social reasons are no longer valid indications for therapeutic abortion.
2. Pregnant patients with hypertensive disease may be given a "trial of pregnancy."
3. Since 1946 we have delivered over 900 consecutive clinic rheumatic cardiacs without a maternal death. We do not believe therapeutic abortion or cesarean section is indicated because of cardiac disease.
4. Therapeutic abortion is a highly dangerous procedure. It has a fetal mortality of 100 per cent, and can have an immediate maternal mortality of 5 per cent (Moore).[17] We believe that its frequent use in many clinics is not medically justified. They have not shown significant reduction in their maternal mortality because of therapeutic abortion to justify its employment obstetrically.
5. From the above experience in more than 215,000 deliveries, therapeutic abortion for medical reasons can no longer be justified.

6. The Catholic physician and other physicians guided by the natural moral law have made and can make a real contribution to the art and science of Obstetrics.

7. Good obstetrical practice is in agreement with and not in opposition to the moral law.

BIBLIOGRAPHY

1. Norton, James F., Paravesical Extraperitoneal Cesarean Section Technique, Vol. 51; 519, 1946, *American Journal Ob. and Gyn.*

2. Cosgrove, S. A. and Carter, P., Consideration of Therapeutic Abortion, *American Journal of Ob. and Gyn.*, Vol. 48; P. 299, 1944.

3. Heffernan, R. and Lynch, W., Is Therapeutic Abortion Scientifically Justified? 19 *The Linacre Quarterly* 11 (1952).

4. Schaefer, G. and Epstein, H. H.: *Am. Journal Ob. and Gynec.* 63:129 (Jan. 1952)

5. Krueger, A. L., Cosgrove, R. A. and Cosgrove, S. A., Pregnancy and Tuberculosis, 78 *Virginia Medical* Monthly 417, 421, 1951

6. Bowles, H. E. and Domzalski, C. A. Jr.: *Hawaii M. J.* 9:17 (Sept.-Oct. 1949)

7. Ebaugh, F. G., and Hau[illegible] K. D.: *Postgraduate Medicine* 2[illegible]5 (Nov. 1947)

8. White: T. T., Prognos[illegible]f Breast Cancer for Pregnant a[illegible] Nursing Mothers, Surgery, *Gyn. a*[illegible] *Ob.* 100: 661: 1955

9. Sweeney, W. J.: *Am. J*[illegible] *Obst. and Gynec.* 66:124 (July, 19[illegible]

10. Tillman, A. J. B.: *A. F*[illegible] *Nerv. & Ment. Dis. Proc.* 1948, 2[illegible]8 (1960)

11. Gorenberg, H. and McG[illegible], J.: *Am. J. Obst. and Gynec.* [illegible]44 (Jan. 1941)

12. Flaxman, Nathan: *Ame*[illegible]*n Journal Ob. and Gyn.* 39.814: 1[illegible]

13. Boyer and Madus: *Ar*[illegible] *Int. Med.* 20:99, 1944

14. Jensen, J.: *Heart Dise*[illegible] *in Pregnancy*, Mosby, St. Loui[illegible]: 1938)

15. Chesley, L. C. and A[illegible]to, J. E.: *Am. J. Obst. and G*[illegible]*c.* 53:372 (Mar. 1947)

16. Gorenberg, H. and Ch[illegible]ey, L. C.: *Obst. and Gynec.* 1:15 [illegible]n. 1953)

17. Moore, J. G. and Ra[illegible]ll, J. H.: *Am. J. Obst. and Gyne*[illegible]53:28 (Jan. 1952)

18. Gilchrist, A. R. and [illegible]rray-Lyon, R. N.: *Edinburg Medica*[illegible]*Sec.* 40:487: 1933

19. Adair, F., Cancer of the [illegible]reast, *Surg. Clinics of North Ame*[illegible]*ca* Vol. 33, P. 313, 1953