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RECENT STUDIES OF THERAPEUTIC ABORTION

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Publication in June 1945 in the *American Journal of Obstetrics and Gynecology* of Kuder and Finn's¹ careful analysis of 280 pregnancies which were interrupted for therapeutic reasons in the New York Lying-In Hospital, cannot but stimulate interest in the problem which none other than Taussig² has designated as "probably the most wasteful of known ills in its expenditure of human life and human health" (Quoted in ³).

This review is not intended to be a critical evaluation of the problem or of the pertinent literature. It is intended rather to be a comparative abstract of two recent publications, a comparison of which is abundantly justified, not only by the intrinsic importance of the subject matter of two studies but also by the great divergence of statistical results of general conclusions, and of philosophical viewpoints as reported and expressed in the two papers in question.

The two papers which are here brought into sharp contrast are the paper entitled "Therapeutic Interruption of Pregnancy" by Katherine Kuder, M. D., and William F. Finn, M. D.,¹ in the *American Journal of Obstetrics and Gynecology*, June 1945, and the paper entitled "A Consideration of Therapeutic Abortion" by S. A. Cosgrove, M. D., and Patricia A. Carter, M. D.,³ in the same journal of September 1944. Both of these papers deal with large sequences of pregnancies, the first with 46,861 pregnancies in the New York Lying-In Hospital of New York City and the second, with 67,000 deliveries in the Margaret Hague Maternity Hospital, of Jersey City, New Jersey.

KUDER AND FINN'S FINDINGS¹

The observations of Kuder and Finn, dealing, as just said, with 46,861 pregnant women, extend over the period September 1932 to December 1943. Among these pregnancies, 280 were interrupted for therapeutic reasons, 233, or 83.2% of the 280, frequently accepted as indications for "therapeutic abortions." The incidence of therapeutic interruption is in this study 0.6%. This incidence percentage as reported by Kuder and Finn is probably the chief reason which prompted this reviewer to undertake the writing of this comparative abstract. In the paper by Cosgrove and Carter, the incidence of abortions is reported as four in 67,000 deliveries, an incident of 0.006%. An incidence percentage which for presumably comparable reasons is found in one case to be one hundred times greater than another, undoubtedly merits consideration and probably suggests the desirability of an explanation.

Kuder and Finn report that 44 indications for interruption of pregnancies are included in their series and that these 44 may be grouped under nine major headings. Of the nine groups, toxemia was described as

an indication for abortion in 97 (34.6%) of the 280 cases and cardiac disease in 66 cases (23.6%). Toxemia and cardiac cases together, therefore, account for 58.2%, or almost three-fifths of all the interruptions. Interestingly enough, pulmonary disease was regarded as an indication for interruption in only 31 cases (11.1%); neurologic and psychiatric disease in 16 cases (5.7%); urologic disease in 27 cases (9.6%); medical disease in 14 cases (5.0%); obstetrical complications and gynecological complications each in 10 cases (each 3.6%); and finally, miscellaneous conditions in 9 cases (3.2%).

Among the interruptions due to toxemia, 97 in number, that arising from renal disease is by far the most frequent, as in this series it accounts for 56 cases. Toxemia due to hypertensive disease was regarded as an indication in 21 of the interruptions; pre-eclampsia and eclampsia was regarded as an indication for interruption in 11 cases; vomiting of pregnancy was taken as an indication for interruption in 7 instances; all of them, however, prior to 1938, since Kuder and Finn are of the opinion that because of the facility in administering intravenous glucose and parenteral vitamins, pregnancy by reason of vomiting need ordinarily not be interrupted.

COSGROVE AND CARTER FINDINGS⁴

Interestingly enough, Cosgrove and Carter have commented with considerable detail and some incisiveness on practically all of the various conditions which are listed by Kuder and Finn as indications for the interruption of pregnancy. They state that hyperemesis "is almost always curable without abortion." In the last 10 years, they treated 290 cases of this condition "of whom none has died and one only has been aborted." Despite the fact that one of their patients was admitted to the hospital twice for hyperemesis "she went to term and delivered a 3,340 gm. infant. She had more difficulty in her second pregnancy when a therapeutic abortion by curettage was performed and in her third pregnancy, when she presented syndromes almost identical with those of her previous experiences, and yet delivered at term, spontaneously, a 3,790 gram girl. It may be questioned whether the abortion in her second pregnancy could be justified even by medical opinion which would ordinarily favor such procedure."

With reference to toxemia, Cosgrove and Carter admit that premature induction of labor may sometimes be necessary but they also state that toxemia occurs only seldom early enough to necessitate the consideration of therapeutic abortion, that is, as they understand it, "the termination of a pre-viable uterine pregnancy before the seventh month or the twenty-eighth week." Moreover, they state that a mere history of toxemia in a previous pregnancy cannot justify abortion in a succeeding pregnancy. One hundred fifty-three women in their series were observed for varying

periods up to eight years after they had had an original eclampsia in an early pregnancy. Ninety of these had 143 subsequent pregnancy in the observation period. It is admitted that the stillbirth rate in this group was higher than in the average but in more than one-half of the subsequent pregnancies, the mothers escaped completely any degree of toxemia and only two had a repetition of eclampsia.

Cosgrove and Carter devote considerable attention to hypertension as a complicating factor in pregnancy. They begin their discussion by admitting that a pregnancy in a hypertensive woman demands that consideration be given to interruption. Pregnancy sometimes accelerates the malign course of hypertensive disease. Nevertheless, each case must be individually considered. It is admitted that many mothers in the hypertensive group abort spontaneously and general percentages, therefore, offer only an inadequate indication for probabilities. Cosgrove and Carter accept with approval, the conclusions of Leon C. Chesley⁴, who shows that in approximately one-third of the cases of hypertension in his series neither is the pregnancy prejudiced nor is the hypertensive disease aggravated. Cosgrove and Carter show that they have had under observation numerous cases in which careful and prolonged hospital management has resulted in a successful outcome of the pregnancy without an aggravation of the patient's condition. They regard it as "almost a certainty" that "more general application of properly prolonged medical treatment" would increase the proportion of those hypertensive women who could carry a pregnancy through with relative impunity. Similar remarks they claim can be made regarding pregnant women who have nephritis. The authors admit that of the four abortions reported in their series, three were performed for hypertension and/or nephritis.

Cosgrove and Carter show considerable optimism with reference to the fate of pregnancies complicated by heart conditions. The definite statement is made "any cases *not* in acute failure may be prevented, in almost 98%, by good management from going into failure." Cosgrove and Carter have not found it necessary to interrupt pregnancy by reason of heart disease. In the Margaret Hague Hospital, just as in the New York Lying-In Hospital, heart disease accounts for 10% of all deaths but this group of patients is made up of patients admitted in decompensation "following inadequate management either in our own or in other hands."

The controversy regarding the influence of pregnancy on pulmonary tuberculosis is also not ignored by Cosgrove and Carter. Cosgrove and Carter express the conviction that tuberculous patients, the progress of whose disease can be checked, "can stand pregnancy," while those whose disease cannot be arrested, will not be seriously made worse by a pregnancy. This is particularly true since the application of surgery to the

control of tuberculosis. The effort to apply adequate intensive and prolonged medical treatment to certain cases is bound to be rewarded and for the most part, the medical condition would be little changed by the pregnancy.

Moreover, in some instances, the performance of an abortion when this is a complicating factor "frequently avails not at all in improving the prognosis. It may sometimes add a very direct danger of its own."

FACTORS IN THERAPEUTIC INTERRUPTION

Kuder and Finn found that in their series, 15.7% of the pregnancies that were terminated were in negro patients and 84.3% in white patients, a striking difference in the two racial groups. Renal disease accounted for 68.2% of all the interruptions in the negro while it was taken as an indication in only 11.2% of the interruptions in white women.

The average age at which interruption occurred was between twenty-five and thirty-five years. In only 2.8% of the cases did interruption occur earlier than the twentieth year of age. The greatest number of interruptions, by weeks of pregnancy, 124, or 44.3%, were performed in the eighth or tenth week. The first pregnancy was interrupted in 49, or 17.8%, of the cases. Thirty-five of these 49 women were not known to have become pregnant again; 3 had a second interruption, and 11 had subsequent pregnancies. At the time of the interruption, 72, or 25.6%, had no living children; and a slightly larger number, 75, or 26.3%, had one living child, while the remainder, 133, or 48.1%, had two or more children. Pregnancy had been previously interrupted in 100, or 35.7%. The pregnancies were terminated by the vaginal route in 204, or 72.8%, while a laparotomy was done in 76, or 27.2%.

Thirty-eight pregnancies occurred in 30 women after a previous pregnancy had been interrupted for therapeutic reasons. Eleven of these were terminated for a second time; there were two spontaneous abortions and 25 deliveries occurred. The incidence of repeat terminations, 29 pregnancies in 26 patients, was found to be 10%. There were 16 deaths: 13 due to the disease which was the indication for the interruption; two occurred in the post-operative period; and three were traceable to other causes.

VARIATIONS IN THE INCIDENCE OF THERAPEUTIC ABORTIONS

Cosgrove and Carter give extensive consideration to the ethical aspects of the physician's practice with reference to the interruption of pregnancies. They call attention to the high moral and ethical standards of the medical profession with reference to interruptions of pregnancies but also give more than a passing hint to a certain self-complacency factor in the profession as if the mere fulfillment of graduation requirements and conformity with legal requirements endow the physician "with the honor and

the high moral ethical principles, which, we like to think, characterize each one of us in our several attitudes towards our work." Cosgrove and Carter are concerned about all this as is evident from the following paragraph "but were I today the graduate of any non-sectarian medical school in the country, what positive instruction would I have had at any point in my career as an undergraduate student which would tell me just whether and why I had any right to do abortions, and what constituted the right and wrong of such situations." In other words, what positive guidance would I have had as to the moral and ethical values involved in abortions."

The authors recognize the difficulty of inculcating "any system of ethics" in our schools. To secure some measure of unanimity of consent, they begin with a discussion of the definition. An all-inclusive definition, such as "abortion is the termination of pregnancy prior to the natural termination of complete, or full term gestation" is, of course, inadequate as the basis of a discussion of the morality of abortions since the definition includes too many instances which have widely diverse moral implications. A definition is quoted from the publications of the Children's Bureau, U. S. Department of Labor (quotation not verified by the reviewer) and is accepted by Cosgrove and Carter: Abortion is "the termination of a pre-viable uterine pregnancy; i. e. the expulsion of a live or a stillborn fetus before the seventh month (twenty-eighth week) of gestation." Taussig's definition is regarded as equivalent but neither of these definitions expresses a judgment on the ethical propriety of abortion. The authors also find difficulty with such a phrase as the "criminal abortion" as if there were a distinction between legitimate and illegitimate abortion in the law. As a matter of fact, Cosgrove and Carter point out that our law, in most of the jurisdictions of the country follows "the old English common law" under which "the unborn child, prior to quickening, has no entity, no legal existence, therefore, no rights; therefore, no possible violation of its rights; therefore, no possibility of a crime against it whatsoever."

Nevertheless, the laws of several states contain restrictions as to performing or procuring abortions, and the restrictions are so phrased as to permit the employment of abortions for therapeutic reasons. Cosgrove and Carter think, however, that the restrictions are so loosely phrased as not to constitute an effective deterrent. They cite the New Jersey and the New York laws. It seems surprising too, that very few of the jurisdictions "require that the determination of the necessity of abortion to save the mother's life must depend on medical men" or that the procedure when determined upon must be carried out by medical men. Various phases pertinent to these several questions are touched upon in the legislation of Mississippi, New Mexico, Maryland, the District of Columbia, etc.

Cosgrove and Carter find no help in their predicament in the codes of such organizations as the American Medical Association and the American College of Surgeons. They admit that it would be possible "to find such ethical standards in the teachings of several religious bodies." They think it undesirable to resort to the teachings of any particular religious group, for one reason, if for no other, that unfortunately "there is enough difference in attitude between the several currently extant religious congregations, . . . to make specific religious teachings in respect to minutiae of doctrine, a difficult and insecure basis for approach to certain problems." Hence, Cosgrove and Carter must find some other basis on which to erect an ethical standard. To them, the matter is simple: the basis is, physiologically, the fact that the unborn human being at any time after conception *is* a human being (they use the word 'entity' but the context is clear) "with all the potential life possibilities of any other (human) creature" (insertion of the word "human" is ours); and, therefore, secondly, this being is entitled to the protection of its life potentialities as any other human being is thus entitled. The corollary is inescapable if it is the duty of the profession to preserve and save human life, the profession must also save and preserve fetal life. In case of a conflict between the duty to conserve the life of the mother and the duty to conserve the life of the child "effort to save human life . . . must not deliberately and of itself jeopardize the life of another individual, nor of the same individual." The authors refer to discussions concerning the ethical propriety of certain operative procedures which, while intended to conserve life, may expose the particular patient to an immediate operative mortality risk. The statement they make in this connection is specially worth preserving "It is not legitimate, even with the object of direct salvage of human life, to employ a means of therapy so formidable that its inherent risk is significantly large in relation to its potential salvage possibilities."

These are the three basic considerations which Cosgrove and Carter lay down as the foundation for an ethical structure designed to facilitate ethical judgments with reference to the interruption of pregnancies.

They now raise the question, is abortion murder? They recognize that society has certain inherent rights to deprive certain persons of their life. They point out too, under what peculiar circumstances such privation of life is justifiable, what antecedant safeguards against indiscriminate use of such powers must be used, or what considerations must be given weight in the absence of the possibility of such antecedant safeguards. The question, therefore, arises "Is then murder which is abortion ever justifiable?" Cosgrove and Carter report that "The considered, honest opinion of many, probably the majority, of medical practitioners of high scientific attainment and unimpeachable moral character is 'Yes!'" They base their opinion on the fundamental idea that (a) under some circumstances the

existence of the pregnancy is a definite, direct and imminent threat to the mother's life; and (b) termination of the pregnancy is, in some instances, the only (?) therapeutic resource to avert that imminent threat. They conclude that under such conditions and with such safeguards, the murder of the fetus is justified.

This conclusion, of course, makes it necessary to study the safeguards against the indiscriminate justification of abortions. First of all, evidence must be carefully weighed, and that too by more than one competent and competently authorized person; secondly, the evidence must show that the threat to the mother's life is really imminent. To Cosgrove and Carter, the question of the imminence of the lethal risk to the mother is "the crux of the consideration of the evidence." They express themselves as opposed to the acceptance of the remote threat to the mother's *life* and as opposed to the acceptance of a threat to the *health* of the mother as indications for therapeutic abortion; in other words, they are opposed to the broadening of indications for justifiable feticide since it tends to the practical removal of all deterrents to the interruption of pregnancy.

Certainly it cannot be justifiably stated that just because any pregnancy is a threat to the health of any woman, therefore, the interruption of pregnancy is justified, since "every pregnancy necessarily entails some inherent risks." Taussig is quoted as citing Lord Riddell, a British legal authority, as follows "A woman who becomes pregnant, must be prepared to undergo the ordinary discomfort of pregnancy and to take the ordinary risks. Therefore, the practitioner must not be influenced by the adjurations of the patient to relieve her of these."

THE INCIDENCE OF ABORTION

This leads Cosgrove and Carter to devote some discussion to "the incidence of therapeutic abortion in a few representative clinics." Their table shows that the percentage of therapeutic abortions of the total number of deliveries varies between 2.88% in the Johns Hopkins Hospital to 0.006% (six thousandths of one per cent) in the Margaret Hague Maternity Hospital.* The ratio of abortions to deliveries varies from 1:35 at Johns Hopkins to 1:16,750 at the Margaret Hague Maternity Hospital. Cosgrove and Carter state that they have no desire of imposing on others the dictates which appeal to their conscience with reference to this matter but they also insist that where undergraduate students of medicine are educated "there should be recognition of responsibility for inculcating the moral and ethical phases of that training." Naturally, Cosgrove and Car-

*Cosgrove and Carter quote statistics from official reports for other institutions in addition to Johns Hopkins Hospital and the Margaret Hague Maternity Hospital. The incidence at the Woman's Hospital, New York, was 1.2%; at Bellevue, it was 1.16%; at Sloane, 0.69% at New York Lying-In, 0.66%; at Chicago Lying-In, 0.51%.

ter's table mentioning the Johns Hopkins Hospital and quoting the authority of the official reports of that institution, drew forth a reply from that institution. Professor Nicholson J. Eastman, the Director of the Department of Obstetrics, replied under date of October 5, 1944, and his letter was published in the *American Journal of Obstetrics and Gynecology*, December 1944.

Dr. Eastman studies the statistics of the Johns Hopkins Hospital from 1927 to 1944. He finds that the statistics should be divided into two periods: 1927 to 1935, when the ratio of abortions to deaths was 1:55 and 1936 to 1944, when it was 1:65. In the individual years, the percentage of abortions to deliveries ranged from a minimum of 0.5% in 1928 to a maximum of 3.0% in 1931. In the second period, the per cent ranged from a minimum of 0.6% in 1938 to 2.9% in 1942. There have been marked fluctuations from year to year. Professor Eastman shows that in the period under consideration, there were three departmental directors in this eighteen year interval, Dr. J. W. Williams from 1927 to 1931. Dr. J. M. Bergland from 1932 to 1936, and Dr. Eastman himself from 1936 to the present. Dr. Eastman points out that it is rather difficult to believe that "the obstetric conscience of all three of us should differ from that of Dr. Cosgrove as widely as the tremendous difference in figures would indicate."

Professor Eastman raises the question "How in the world can one practice good obstetrics (and I do know that the practice of obstetrics at the Margaret Hague Maternity Hospital is excellent) with a therapeutic abortion rate of only 1:16,750 deliveries? If an incidence of 1:50 was cited or even 1:1000, I would have regarded the report with envy and esteem, but 1:16,750 leaves me bewildered." Professor Eastman calls attention to the very low incidence of hypertensive vasculo-renal disease in Dr. Cosgrove's series. He also calls attention to the singularity of the fact that apparently there has been no single case of carcinoma of the cervix or of rheumatic heart disease or of a recent cardiac failure. He concludes, therefore, that instances in which the imminence of lethal risk to the mother is incontrovertible "rarely reached the Margaret Hague Maternity." Have Dr. Cosgrove's views on the interruption of pregnancy been so widely voiced in Jersey City that women requiring interruption of pregnancy go elsewhere? There should be an answer to this question, for it would seem to follow that if patients requiring interruption of pregnancy remain away from the Margaret Hague Maternity Hospital, there should be a correspondingly higher rate of interruptions in the other hospitals of Jersey City. As a final consideration, Professor Eastman suggests that in estimating the medical implications of this question not only must fetal wastage be considered but also the ultimate maternal mortality which is implicit "in too rigorously withholding therapy."

Dr. Cosgrove in his answer⁶ disavows any weighting of his statistical material of any desire to direct its implications towards the establishment of viewpoints or theories. He also disavows any desire to direct the consciences of any of his colleagues. He does call attention to the fact that concepts accepted by Dr. Williams many years ago may have influenced the thought at Johns Hopkins throughout all the years since. The fact that in the Margaret Hague Hospital only three women whose pregnancies were complicated by vasculo-renal disease, aborted, does not mean that there were only three cases of vasculo-renal disease in the whole series. Dr. Cosgrove also points out that in Jersey City, curiously enough, there are only relatively few carcinomata of the cervix in child-bearing women. This fact has been checked by Dr. Cosgrove in both public and private statistical material. Moreover, the mere fact that the physicians at the Margaret Hague Maternity Hospital do not effect abortion in patients having carcinoma of the cervix does not indicate that such persons are not receiving proper treatment. As a matter of fact, they are subject to such measures as are judged best in individual cases. Dr. Cosgrove points out also that in his hospital, there have been cases of known rheumatic heart disease, some with recent failure, or actually in failure when seen. The attitude at the Margaret Hague Hospital is that abortion in these instances is not justifiable; instead great emphasis is placed upon medical treatment. "If medical control and treatment are adequate, the pregnancy may be virtually ignored except as emphasizing the stringency of medical control necessary (in the case)."

Dr. Cosgrove also looked into the matter of the frequency of abortions in the other maternity divisions in the hospitals of Jersey City. During a recent period during which 7,000 live births were delivered at the Margaret Hague Hospital, there were 4,292 living births in other institutions in the county in the same area as that served by the Margaret Hague Hospital. Among these 4,292 live births, there were only four therapeutic abortions, two for diabetes, one for tuberculosis and one for pyelo-nephritis. This incidence gives a rate of 1:1073 living births, much higher than that published for the Margaret Hague Hospital but by no means high enough to warrant the suggestion that the other hospitals in Jersey City have therapeutic abortions in a disproportionate ratio. The New Jersey ratio of abortions to deliveries is also much smaller than in the institutions mentioned in the footnote above. At the Chicago Lying-In Hospital, for example, the ratio was 1.195.

Finally, Dr. Cosgrove suggests that the situation at Johns Hopkins may be explained by the fact that Johns Hopkins draws its patients from wide geographic areas; the graduates "refer their own difficulties for solution (to Hopkins) on a relatively tremendous scale," whereas, the Margaret Hague Hospital serves only a relatively small area.

Finally, Dr. T. W. Jones, of Pittsfield, Massachusetts, raises the question "Is abortion murder?" and receives a reply from Dr. Cosgrove in which the latter justifies his use of such terminology in his original paper.

A WORD OF COMMENT

It was said in the beginning of this paper, that this comparative abstract is intended not as a critical review but as an objective presentation of two important papers for the purpose of emphasizing certain contrasts. It will be clear to the Catholic readers of this study (Dr. Cosgrove is not a Catholic, to the best of the writer's knowledge) how closely in his thinking Dr. Cosgrove has come to the viewpoints and principles of ethics and moral theology on this subject. A Catholic would not, of course, have hesitated, as Dr. Cosgrove hesitates, to apply the tenets of one "particular religious group" to the problem in hand. Moreover, a Catholic physician would probably have made the distinction between the attitude towards the ethics of abortion as religious or sectarian teaching and the attitude of abortion as a conclusion from the natural law. Surely, Dr. Cosgrove would be greatly assisted by a deeper insight into ethics and would be aided in his thought by the important distinction which is made both in ethics and in moral theology between direct and indirect interference with pregnancy. Moral theology would also have enabled him to define somewhat more definitely than he has done in his paper, the conditions under which indirect abortion may be permitted. His opinion as a physician did receive vigorous corroboration from the conclusions of the theologian and would thus lend, I am sure, a measure of authority to the influence which his opinions are capable of exerting.

It is hoped that this comparative study may elicit responses from the many members of the Physicians' Guilds who have faced the numerous practical problems centering in a sound attitude towards the interruption of pregnancy.

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