SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Case Western Reserve Law Review

Volume 17 | Issue 2

1965

Humane Abortion Laws and the Health Needs of Society

Kenneth J. Ryan

Follow this and additional works at: https://scholarlycommons.law.case.edu/caselrev

Part of the Law Commons

Recommended Citation

Kenneth J. Ryan, *Humane Abortion Laws and the Health Needs of Society*, 17 W. Res. L. Rev. 424 (1965)
Available at: https://scholarlycommons.law.case.edu/caselrev/vol17/iss2/6

This Symposium is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Case Western Reserve Law Review by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

Humane Abortion Laws and the Health Needs of Society

Erratum

PAGE 427, F00TNOTE 13, LINE 4: change "Seatle" to "Seattle."

This symposium is available in Case Western Reserve Law Review: https://scholarlycommons.law.case.edu/caselrev/vol17/iss2/6

Humane Abortion Laws and the Health Needs of Society

Kenneth J. Ryan, M.D.

At present, there are no universally accepted guidelines for the medical profession in making decisions on the interruption of pregnancy. Beginning with the basic premise that modern medicine should be concerned in a positive way with the health needs of society, instead of responding only to its ills, Dr. Ryan critically examines factors which might possibly serve as the basis for an acceptable code regulating abortion. He eliminates population control and the reduction of criminal abortion as possible bases. Dr. Ryan concludes that abortion should be allowed when pregnancy constitutes a grave threat to the life or health of the mother and believes that this judgment should be left to the medical profession. Such a procedure, he states, would provide a workable solution to the problem of therapeutic abortion in modern society.

ALTHOUGH the laws in most states allow interruption of pregnancy to protect a mother's life, and although all accredited hospitals have review committees covering the procedure, the medical profession is besieged by legal and moral questions regarding indications for abortions which society demands, but for which no universally acceptable guidelines have been established. These demands for abortion have been based on a possibly defective child, illegitimacy, rape, incest, a challenge to the mother's mental or physical health short of immediate, life-threatening conditions, and complex social and economic factors which, in some way, result in a home where the prospective child is unwanted.

THE AUTHOR (M.D. Harvard University) is the Arthur H. Bill Professor of Obstetrics and Gynecology, and Chairman of the Department of Obstetrics and Gynecology at the School of Medicine of Western Reserve University.

In desperation, women seek physicians who will perform an abortion with or without some compliance with legal sanction; barring this, women seek unlicensed practitioners who, in the course of the act, further jeopardize the mother's health and life. The ethical considerations are complex, and although most of society will condone an abortion to save a mother's life, a lesser threat to the mother's life or the child's well-being is often judged inadequate to justify abortion. The central issue is always whether the problems of a given pregnancy can best be solved by the sacrifice of the unborn child.

In Japan, abortion has been allowed upon request as a rather ef-

fective countermeasure to population pressures.[1] In Scandinavian countries, abortion laws have been liberalized to include many of the social indications alluded to above.[2] In certain iron curtain countries where religion is no longer a powerful political voice, abortion is freely available.[3] However, it is unlikely that the American Judeo-Christian society will subscribe completely to any of the above solutions.

Whenever surveys of physicians have been conducted, a majority of these physicians respond in favor of a liberalized abortion law.[4] Physicians, however, may be impressed with the recent, problem cases that provide the greatest moral challenge and may thereby misinterpret the sentiment of the bulk of society. The wide publicity afforded the thalidomide tragedy in Europe, the recent rubella epidemic in America, and the age-old dissatisfaction with dealing with juvenile rape and incest make this a propitious time to open the issues in a public forum. The intent of this article is to critically examine the bases upon which an acceptable code can be established.

I. POSSIBLE BASES FOR AN ACCEPTABLE CODE REGULATING ABORTION

A. *Health Needs of Society*

While medicine can be narrowly defined as that science involved in the treatment of disease, a more modern interpretation would be that the absence of disease does not constitute health and that medicine should be concerned in a positive way with the health needs of society, rather than responding only to its ills. In this context, the preservation of individual dignity, adequate nutrition, housing and education, and proper attitudes toward life's problems become essential professional considerations for the physician. The rendering of health services, the planning of family size, and even the outcome of a given pregnancy depend so much upon socioeconomic factors that medicine can no longer consider these functions outside of its domain. The practice of abortion falls into a category where tra-

[1] See George, *Current Abortion Laws: Proposals and Movements for Reform*, 17 W. RES. L. REV. 371, 373 n.12 (1965).

[2] See Skalts & Norgaard, *Abortion Legislation in Denmark*, 17 W. RES. L. REV. 498, 499 (1965).

[3] See Hoffmeyer, *Medical Aspects of the Danish Legislation on Abortion*, 17 W. RES. L. REV. 529, 544-45 (1965).

[4] A report from the New York Academy of Medicine indicates that 87.6% of New York obstetricians answering a questionnaire favored a change in the law. N.Y. Times, Jan. 31, 1965, p. 73, col. 5.

ditional medicine blends into the total health needs of the community, depending upon a wide range of medical and so-called social problems. Society and physicians, as members of society, have no definitive answers to the question of how appropriate an abortion is for dealing with the many, life situations for which it is requested. The problem is cloaked in religious and moral issues, legal tradition, and a strong emotional bias that almost defies a rational approach. This is just as true for those who favor liberalized abortion laws as for those who oppose them. Recently frustrated attempts to revise the laws in California[5] and New York[6] indicate that a majority of voters did not respond in a positive fashion to the reforms offered; and this occurred in the face of the well-known fact that abortions were illegally performed in accredited hospitals without official reproach and in spite of the wide publicity given to fetal deformities due to rubella.[7] Medical students have often asked how it is possible that reputable physicians will perform illegal abortions. The reply the author gives is that society will condone such practices for its own convenience providing that it does not have to collectively assume the moral responsibility for openly justifying them.[8]

As a practicing physician, educator, and pragmatist, the author would suggest that society is ready to revise present laws to conform to those already in existence in several states[9] and the District of Columbia,[10] which permit abortion where necessary to preserve the life and health of the mother. The social and fetal indications for abortion have undoubtedly been deterrents to reform. Ironically, the physician could honestly and effectively deal with all these abortion requests in order to preserve the life and health of the mother if the intent and interpretation of "life and health" are in the broadest sense. The responsibility then becomes an individual one among the family, the physician, and the immediate community. Society in general is not called upon to shoulder the moral burden

[5] For a discussion of the proposed statute, see Packer & Gampell, *Therapeutic Abortions: A Problem in Law and Medicine*, 11 STAN. L. REV. 417, 449-55 (1959). For a history of the fate of this bill, see George, *supra* note 1, at 399.

[6] An attempt to liberalize the justification necessary for abortion, PROPOSED N.Y. PENAL LAW § 130.05 (1964), met with subsequent defeat, N.Y. REV. PEN. LAW § 125.05 (1965).

[7] Life, June 4, 1965, p. 24.

[8] Gambling, prostitution, and the handling of traffic deaths are other areas where society has followed a similar course.

[9] ALA. CODE tit. 14, § 9 (1959); MD. ANN. CODE art. 27, § 3 (1957); ORE. REV. STAT. § 677.190 (1963).

[10] D.C. CODE ANN. § 22-201 (1961).

which in this country, at least, it has been traditionally unwilling to assume.

B. *Status of the Unborn Child*

To the medical profession operating within its present framework, the conceptus, prior to twenty weeks of age, does not have the same legal status as one after that time. Should there be an untimely birth before twenty weeks, the act is considered an abortion, not a delivery, and is not listed on the mother's parity record. A birth or death certificate is not required and the body is handled as a pathological specimen without requiring legal interment.[11] In spite of this altered legal status, state laws allow interruption of even an early pregnancy only when it poses a threat to the mother.[12] In addition, injuries to the fetus, even at this early stage, which result in damage have been the bases for redress in courts of law.[13] The conceptus at all intrauterine ages does, in fact, have some status in society; it is this status which is the pivotal point of all discussions on abortion.

Physicians recognize that the mother's attitude toward her child may change once she feels life near the end of the first trimester of pregnancy. A recent example was a patient with severe renal[14] disease for whom abortion was recommended by all consultants as a safeguard to her life. Before it could be performed, she felt life and thereupon refused the procedure. This and many other examples suggest that there is a strong cultural force that equates identity with the first-recognized movements of life; prior to this time, abortion can be performed with less remorse. On the other hand, some religious teachings and the strong convictions of many dictate that life begins with conception (joining of sperm and egg) and is inviolate thereafter.[15] It is unlikely that the Western Culture, which is so steeped in the traditions of the rights of the individual,

---

[11] See, *e.g.*, OHIO REV. CODE § 3705.21.

[12] See George, *supra* note 1, at 376.

[13] See, *e.g.*, Daley v. Meier, 33 Ill. App. 2d 218, 178 N.E.2d 691 (1961) (automobile collision); Mallison v. Pomeroy, 205 Ore. 690, 291 P.2d 225 (1955) (automobile collision); Sinkler v. Kneale, 401 Pa. 267, 164 A.2d 93 (1960) (automobile collision); Seattle-First Nat'l Bank v. Rankin, 59 Wash. 2d 288, 367 P.2d 835 (1962) (negligence of physician treating mother during pregnancy).

[14] This is a disease affecting the kidneys. For a discussion of this disease, see Niswander, *Medical Abortion Practices in the United States*, 17 W. RES. L. REV. 403, 408 (1965).

[15] See Drinan, *The Inviolability of the Right To Be Born*, 17 W. RES. L. REV. 465, 469 (1965).

will alter the status of the fetus at any gestational age, either legally or emotionally, in a manner which would allow abortion upon demand. The socially required indications for abortion will probably always be important and have a relative scale of values depending on the factors involved.

C. *Fetal Defects*

In most proposals for a more liberal abortion law, provision is made to allow abortion when there is a strong possibility that there will be a grave physical or mental defect in the child.[16] This can be considered either a modern or an ancient concept, depending on one's point of view, since provisions for doing away with defective examples of humanity have been in existence throughout recorded history. In some cultures, the child was born before a decision for action was made, a solution which would be unacceptable in most quarters today.

It would be difficult to argue against the proposition that all infants should be physically and mentally well-born. There are, today, modern medical techniques for predicting, in some instances, on a statistical basis, when a defective child can be anticipated. The potential for mongolism and various types of severe, hereditary, mental, and physical defects can be uncovered by genetic typing which will undoubtedly prove to be a useful part of premarital medical advice. In spite of this, couples with such potential for defective offspring will only ask for help after the wife becomes pregnant. On the other hand, families with no known hereditary factors can be afflicted with a deformed child due to environmental factors such as drugs, radiation, or viral infections.

What should be the attitude toward "so-called" fetal indications for abortion? The indications that a child will be deformed are usually statistical. During the early months when most abortions are considered, one can predict deformity only by prior overall experience and not specifically in a given case. For example, the risk of a defective child in a mother who develops rubella in the first trimester of pregnancy is about twenty per cent; but the risk is sixty per cent if she develops the disease in the first few weeks of pregnancy and less than ten per cent at twelve weeks of gestation.[17]

In a careful prospective study which followed the 227 infants of

---

[16] See, *e.g.*, PROPOSED N.Y. PENAL LAW § 130.05 (1964).

[17] Rendle-Short, *Maternal Rubella, The Practical Management of a Case*, 2 LANCET 373 (1964).

mothers who contracted rubella during pregnancy, the incidence of mental retardation was no different than in the general population; ninety-two per cent of the children were attending regular schools eight to eleven years after birth.[18] Many of the defects of these children were correctable. While these statistics may indicate an overly optimistic attitude, they represent the best information available until the figures from the recent rubella epidemic in 1964-1965 have been similarly analyzed. How differently parents might respond to the threat of a deformed child if they were presented such data. Should one say there is a forty per cent chance of a normal child or a sixty per cent chance of an afflicted one?

In this country's rubella epidemic of 1964-1965, many women were aborted with and without good evidence of risk, since other viral infections often masquerade as clinical rubella. Recent laboratory tests have made the diagnosis more secure, but the tests are not always available when a decision must be made. In the report on the epidemic from a United States Public Health Services Collaborative Study, ten per cent of the patients reported exposure, forty per cent of the exposed patients developed rubella, and ten per cent of those delivered affected children.[19] It is not unlikely that the request for abortion in some quarters was so strong that studies on the value of prophylactic treatment with gamma globulin and prospective statistical evaluation will be impossible. Most physicians and patients wanted to take no chances.

The fear and risk of a deformed child are real, but require an informed medical profession for evaluation. With an acknowledged risk of sixty per cent for a deformed child to be born to a mother with rubella in the first few weeks of gestation, the odds may be more than most parents and society can bear. If an abortion is performed, it in fact is done for the family and society, not for the unborn child. Although some parents and physicians have indicated a desire to abort out of compassion for the child who would bear these defects, this is a difficult moral line to follow. People ask, "How would you like to be born deformed?" The child might reply, "If it is a choice of that or no life at all, I might choose life." One prominent gynecologist[20] made a plea for "someone to speak for the fetus." If someone is speaking for the fetus, he must realize that it might

[18] Sheridan, *Final Report of a Prospective Study of Children Whose Mothers Had Rubella in Early Pregnancy*, 2 BRITISH MEDICAL J. 536 (1964).

[19] Medical World News, Dec. 10, 1965, p. 92.

[20] Dr. Allen Barnes.

say, "Let me live." Finally, lest one become too concerned with the cult of perfection, remember —

> They say, best men are moulded out of faults,
> And for the most, become much more the better for being a little bad.[21]

The more conservative, less popular, attitude toward fetal defects has been stressed to point out that fetal indications can be a hazardous basis for moral or medical arguments on abortion. It is difficult to justify helping a child by aborting it, if the extent of the defects, or the actual existence of a defect, is not certain but is, instead, based on statistical grounds. One popular rejoinder is that the interest involved, not the odds, should control. For this reason, the author favors an abortion law which provides for the individual family's needs in a given situation, based on the premise of protecting the mother's health. All fetal indications could be answered on these grounds. No distinction should be made between the mother's mental and physical health in this context since, in modern medical thinking, there is no real difference in terms of both being incapacitating and a potential threat to life.

D. *Needs of the Mother*

(1) *The Life of the Mother.*—Current practice, in most states, allows abortion to preserve the mother's life.[22] However, with the advances in medical technology, there are now almost no absolute contraindications to pregnancy; the threat to a mother's life with most medical diseases complicating pregnancy is relative, based on many factors besides the primary complicating ailment. For example, a woman with rheumatic heart disease who is financially capable and has help at home, no other children, the capacity to follow medical instructions carefully, and strong motivation might very well breeze through her pregnancy. Her sister with the same degree of heart disease who already has three children, lives on the fourth floor of a walk-up apartment, is incapable of following medical instructions, and is poorly motivated may well succumb either before or after delivery of another child. The point of time is academic.

It would serve no useful purpose to list all of the possible medical threats to a woman's life since the factors involved are complex

---

[21] "Measure for Measure," Shakespeare.

[22] See George, *supra* note 1, at 376.

and each case must be individualized. Progressive renal failure in pregnancy was once thought to be an absolute indication for abortion, but even this has been treated by dialysis on the artificial kidney with resultant survival of the infant and the mother. However, this involves a dubious, long-range medical success for the mother.[23]

In every large medical center there are instances when all consultants feel that abortion is indicated as a safeguard for a given mother's life, but no specific disease or set of conditions can be singled out as conclusive in all cases. Even the question of the immediacy or remoteness of the threat cannot be resolved with certainty; one is dealing with a probability as in the case of fetal defects. How much risk should one take? Fortunately, the law has not set an arbitrary figure.

Threatened suicide, as a psychiatric basis for recommending abortion, has been the subject of much discussion. Such observations as the very low suicide rate in pregnant women and the probable use of suicide as a threat to obtain abortions, otherwise legally denied, have been used to question the validity of psychiatric indications for interruption of pregnancy. Probability figures cannot determine whether a given patient will commit suicide; however, abuse by a few cannot be used, out of desperation, to discredit the motivation of all physicians dealing in this area. If psychiatric indications are used as a basis for abortion, physicians are concerned with the continued evaluation and treatment of the patient both before and after the procedure.

The threat to maternal life is the current base from which present abortion laws must be liberalized to cope with factors which do not obliterate life physically, but may do so functionally.

(2) *Health of the Mother.*—Health in the broad sense, as outlined in an earlier paragraph, is a positive concept.[24] Distinctions between physical and mental health are meaningless in terms of modern medical thinking. Health cannot be divorced from socioeconomic factors which influence people's lives since health is a product of these conditions. In applying criteria for abortion based on maternal health, the question should be the extent to which the pregnancy threatens the general well-being of the patient. The threat must justify the sacrifice of the child. As with the threat of

---

[23] See Niswander, *supra* note 14, at 408.

[24] See text accompanying notes 4-5 *supra.*

death, the risk will be relative and should not be subject to specific legislation for all patients.

Although women with heart disease, diabetes, chronic hypertension, a severe neurosis, or an impossible home life may not die with their next pregnancy, it could so disrupt their lives that they are neither effective members of society nor effective mothers. Certainly here, gradations of risk and relative values pertain. As with the threat to a mother's life, there should be no distinction between so-called medical and psychic influences since the latter is part of the former and they both can be devastating to health.

E. *Humanitarian or Social Needs*

Most humane indications for abortion can be included in this category. Should a twelve year old child who is raped or is made a partner to incest be forced or allowed to bear the child? It is inconceivable that society would answer in the affirmative, yet there is no provision for this under the present laws which allow abortion only where there is a threat to life.[25]

Illegitimacy is a more complex point of departure since "moralists" would have the partners "punished" for socially unacceptable activities. Perhaps this could be individualized on the basis of a thorough medical evaluation of the case. The fear that the availability of abortion will lead to promiscuity is sheer nonsense; the same fear could be, and has been, leveled at contraception without any evidence that, over the course of history, either has significantly modified human behavior in this regard. Recently, there was a teen-age, unmarried patient in the hospital who has had three children. The fact that she was not aborted and did not use contraception may be a "moral" triumph, but it is neither a medical nor a social one.

II. IMPROBABLE BASES FOR ABORTION REFORM

A. *Control of World Population*

As stated previously, it is unlikely that abortion would be acceptable in this country as a means for controlling population pressures.[26] Unfortunately, until recently, even contraception was denied to that segment of the population which needed it most, by ignoring or forbidding it in public health institutions. In spite of

---

[25] See George, *supra* note 1, at 376.

[26] See text accompanying note 1 *supra*.

the more widespread dissemination of contraceptive information, certain women, at risk, will become pregnant; a humane, effective law for coping with their problem is needed. The means for effective family planning are available and must be made accessible to all within their individual religious and moral convictions. Certainly this will go a long way toward reducing the traffic in abortion, which is an even more involved moral and medical issue.

B. *Reduction of Criminal Abortion*

As other causes of maternal death decline under the impact of adequate modern medical care, the proportion due to criminal abortion by non-medical practitioners will undoubtedly increase. From both a relative and absolute point of view, the number of maternal deaths due to abortion are as distressing as they are unnecessary. A recent news release indicated that criminal abortions are the leading cause of maternal deaths in New York City.[27] In any large medical center, a sizable number of septic, incomplete abortions are admitted regularly as the result of the activities of unlicensed practitioners who are the last route of appeal for desperate women. However, abortions conducted under modern medical conditions are reasonably safe.

The plea for a liberal abortion law has often been based on the supposition that it would decrease this traffic in criminal abortions. Barring a law that allows abortion upon demand, it is unlikely that this activity can be abolished.[28] Although deplorable, the illegal abortions by unlicensed practitioners and their resultant mortalities provide unlikely bases for society to liberalize laws. The community has not legalized gambling to avoid the criminal element, has not legalized prostitution to avoid venereal disease and blackmail, and has not required a change in standards for the manufacture and operation of motor vehicles to overcome traffic deaths. Such a state of affairs would suggest that liberalization of abortion laws will be based predominantly upon other grounds. With such a change in laws, the benefits from decreased criminal interruption of pregnancy would be a welcome relief in any case.

---

[27] AMA News, Nov. 29, 1965 p. 1.

[28] In Sweden, the advent of liberal abortion laws was accompanied by a decline in criminal abortion only to be followed by a resurgence due to the time and bother of justifying an abortion before a reviewing committee.

III. CONCLUSION

The medical community has had a much more intimate exposure to the problems of and needs for therapeutic abortion than other segments of society. The patient has generally turned to the physician for help and compassion rather than to the more rigid codes of courts or churches. When medical help was withheld, the patient turned to the non-licensed practitioner in spite of the risks involved. Society has left the burden, by default, at the physician's doorstep.

Abortion should be allowed when pregnancy constitutes a grave threat to the life or health of the mother in the opinion of her physician and two consultant physicians. Whether the fear and despair of rape, incest, illegitimacy, or a possibly deformed child constitute a grave threat to the health or life of a given patient should be decided in such a manner and are properly medical decisions. Physicians would not shun this role; indeed, doctors currently have to deal with these questions without the help of the rest of society or of enlightened legislation. If properly interpreted, a law such as the one outlined above could provide a reasonable basis for physicians to deal with the problem of therapeutic abortion in modern society.