TERMINATION OF PREGNANCY ON PSYCHIATRIC GROUNDS

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Whilst there is general agreement that certain physical illnesses may justify the termination of a pregnancy, there is a wide divergence of opinion on what may be held to justify the operation on so-called "psychiatric grounds." As the field of psychiatry has enlarged to embrace wide biological issues, so has there been a tendency for the psychiatrist to condone the operation of abortion for reasons which appear to deviate from both the ethic of medicine and the law of the land. That this has confused the general practitioner is indicated by the frequency with which psychiatrists are called into consultation in cases in which the therapeutic termination of pregnancy is the point at issue. It is true that in many consultations the practitioner is merely seeking a second opinion in order to support his own refusal to interfere, but in some cases there is genuine surprise at the information that social considerations have no place in the consultation or that mental symptoms of one kind or another are not necessarily a justification for emptying the uterus.

The consultant who refuses to recommend the operation will sometimes be suspected of allowing his religious scruples to override his medical judgment, but, in point of fact, the Christian opposition to therapeutic abortion is far less securely based than that of the physician whose sole interest is the preservation of life and health. The Christian opposition is based to some extent on a mis-translation of the abstract laws of the ancients, whilst the medical opposition is based wholly on a scientific appraisal of the actual results of pregnancies in the sick. A survey of this kind was carried out by A. L. Robinson in 1933, and nearly a hundred alienists answered his questionnaire. The majority opposed the induction of abortion in the treatment of mental disorder, but it is probable that a similar survey at the present time would reveal a larger proportion of psychiatrists as being in favour of the operation, the treatment of mental disorder having become adulterated with considerations which have little bearing on the actual course of a particular illness in a particular patient.

My own experience in a small series of cases supports the view that therapeutic abortion is hardly ever justified on psychiatric grounds. The subject is, however, so surrounded with personal prejudices, often founded on a misinterpretation of history or the law, that it is worth while outlining the historical background and the present legal position.

Historical Background

There would appear to be a primordial revulsion from the destruction of the embryo, and most of the early religious and legal authorities condemned it; thus we have the *Vendidad* of Zoroaster and the *Manu* of the Hindus expressing unqualified disapproval over a thousand years before the birth of Christ. Centuries later we find the Greeks divided in their views. Whilst Hippocrates was expounding the Medical Ethic, "I will not give to a woman a pessary to produce abortion," Aristotle was teaching, "If in marriage couples have children in excess, then shall abortion be procured before life and sensation have commenced; what may or may not be lawfully done in matters of this kind depends on this question of life and sensation." The Romans were

even more liberal in their views. Intentional abortion was not only legal but fashionable. By the *Lex Aquilia*, the inducing of abortion was treated only as a personal attack upon the mother, and if she consented to the assault there was no offence.

The ancient Hebrews, too, allowed the operation if the husband agreed: thus in the Hebrew version of Exodus (Ch. XXI, v. 22) we find, "If men strive together and hurt a pregnant woman so that she hath a miscarriage and yet no harm to her result, he shall be fined, as the woman's husband shall determine, and he shall pay for the miscarriage." It follows that if the woman was unharmed and the husband agreed to the operation, there was no punishment. The passage continues, however, "But if any harm follow then shalt thou give life for life, eye for eye," etc. This comparatively liberal point of view was mistranslated in the Septuagint, and the Christians were subsequently to base their own doctrine on this inaccurate Greek version of Hebrew law. Instead of laying down that punishment should depend on whether the mother is harmed or unharmed, as in the Hebrew version, this translation maintains that it depends on whether the foetus is formed or unformed (Kent, 1907). This led the Christians to formulate much more uncompromising laws than was intended by those who framed the original passage in Exodus. It also had the disadvantage of focusing too much attention upon the embryo as a separate unit rather than upon the pregnant woman as a whole.

Thus Tertullian, following the teaching of Aristotle, devoted all his ingenuity to deducing when the embryo became "formed," that is to say, when it acquired a soul. As the ritual purification after delivery was laid down as 40 days for a male child and as 80 days for a female child, he concluded that a male embryo acquired its soul 40 days after conception and a female after 80 days. This astonishing piece of logic was translated into Latin by Jerome, extolled by St. Augustine, and perpetuated in the 1st Section of the *Corpus Juris Canonici* (Cap. 9). Legislation in the various European countries followed the teaching of the Church: thus in Germany the Bamberg Enactment of 1507 regarded abortion as murder if the foetus were animate (that is to say, more than 40 days old), and in England the *Ellenborough Act* of 1803 adhered to the difference between the "quick" and the "not quick." The first revolt against this artificial distinction had come from the medical profession in protestant Germany. Thus at the beginning of the eighteenth century August Leyser, Professor at Wittenberg, had stressed that there was no special moment of animation, and a century later the lawyer Philip van der Broecke was to claim that the foetus was merely part of the mother's body and, as such, had no special privileges.

Present Legal Position in England

Against this background various Statutes on the subject have been drawn up and various important judgments given. In this country, 1861 marked the introduction of the *Offences Against the Person Act*, in which Section 58 gives almost unequivocal protection to the embryo. In 1929 the *Infant Life (Preservation) Act* was introduced to legalize destructive operations on the foetus of 28 weeks or more, such an operation being allowed unless it should be shown that the act causing the death of the child was not done in good faith for the purpose only of preserving the life of the mother. It will be noted that there is still undue emphasis on the age of the foetus, the embryo of less than 28 weeks being protected by the older and more conservative Statute; even this, however, implying by the nature of its wording that there are lawful indications for "procuring a miscarriage," although these are not defined.

The task of interpreting these Statutes, and of supporting lawful indications as they arise, has fallen to the courts. Mr. Justice Macnaghten, summing up in the case against Bourne in 1938, was able to digress from purely physical indications in order to give support to the view that termination is also

lawful in those cases where the mental health of the mother is seriously threatened. After indicating that the wording of the relevant Acts threw the onus of proof of bad faith upon the prosecution, the learned judge concluded:

"Mr. Oliver wanted you to give what he called a wide and liberal meaning to the words 'for preserving the life of the mother.' I should prefer the word reasonable to the words wide and liberal. . . . Apparently there is a great difference of opinion, even in the medical profession itself. Some there may be, for all I know, who hold the view that the fact that a woman desires the operation to be performed is a sufficient justification for it. Well, that is not the law; the desire of a woman to be relieved of her pregnancy is no justification at all for performing the operation. On the other hand, there are people who, from what are said to be religious reasons, object to the operation being performed in any circumstances. That is not the law either. On the contrary, a person who holds such a view ought not to be an obstetrical surgeon for, if a case arose where the life of the woman could be saved by performing an operation and the doctor refused to perform it because of his religious opinions and the woman died, he would be in grave peril of being brought before this court on a charge of manslaughter by negligence. . . . If pregnancy is likely to make the woman a physical or mental wreck, the jury is entitled to take the view that a doctor, who in the circumstances and led by his belief operates, is operating for the purpose of preserving the life of the mother."

For the psychiatrist, the importance of this statement is that it makes it justifiable for him to recommend termination if he honestly believes that continuation of a pregnancy will make a woman a mental wreck. Lesser degrees of emotional upset are not enough, nor are social disturbances of any magnitude nor eugenic forebodings of any kind. More recent attempts to extend his scope have not succeeded; thus Lord Amulree's Bill, which was introduced to the House of Lords on January 26, 1954, was withdrawn, and a recommendation by the Magistrates' Association that abortion should be per-

mitted if there is a grave risk of the child being born mentally defective has not yet been given the authority of law (*British Medical Journal*, 1955).

Present Investigation

The cases here reviewed were assessed entirely in the light of Mr. Justice Macnaghten's observations, and, in point of fact, in none was there considered to be sufficient justification for termination. The patients were seen consecutively during a period of two years, but they have been classified in the Table in a different order from that in which they were seen.

Patients fell broadly into one of three classes. First, there were those who were known to have had a previous psychotic episode associated with a pregnancy; secondly, there were those who were known to have had treatment for serious mental illness not associated with pregnancy; finally—and this was by far the largest group—there were those who were referred, not on the basis of their previous history, but on account of the symptoms present when seen.

The diagnosis given is in each case that of the predominant condition when seen. The remarks which cover the course of the pregnancy have likewise been simplified to indicate only whether the behaviour of the patient was such as to require hospital care or such that could be tolerated at home: "domestic disturbance only" could be of severe degree, for it included one patient who jumped down a flight of stairs regularly until she sprained her ankle and had to abandon this method of drawing attention to her plight.

Similarly, the social summary illustrates only the extent of the mother's failure in the home a year after her confinement. In the highest category, and the one which can be regarded as normal, are those mothers who are able to look after a baby themselves with only slight neglect of other household duties; in the second category are those who can

Analysis of Cases

Case No.	Age of Patient	Marital Status	No. of Pregnancy	State of Pregnancy (in Weeks)	Reason for Referral	Previous Psychiatric History	Diagnosis When Seen	Course of Pregnancy and Puerperium	Mental State One Year After Confinement	Social Aspect One Year After Confinement
1	28	M	4	8	Previous puerperal psychosis	Puerperal psychosis (3rd pregnancy). Vol. patient for 12 months	Anxiety state	Uneventful	Improved	Able to care for child
2	32	M	7	12	" "	Puerperal psychosis (6th pregnancy). Vol. patient for 3 months	Hysteria	Domestic disturbance only	No change	Unable to care for child
3	25	M	3	20	" "	Puerperal psychosis (2nd pregnancy). Vol. patient for 2 months	Depressive psychosis	Vol. patient during pregnancy and puerperium	Improved	Able to care for child
4	37	M	4	8	Psychosis unrelated pregnancy	Schizophrenia. Vol. patient on two occasions (E.C.T.)	Schizophrenia	Vol. patient during pregnancy	No change	(Child stillborn, anencephalic)
5	18	S	1	12	" "	Schizophrenia. Vol. patient for 2 months	"	Vol. patient during pregnancy and puerperium	Worse	Unable to care for child
6	37	S	1	28	" "	Manic-depressive. Cert. patient for 3 years (leucotomy)	Hypomanic state	Uneventful	No change	" "
7	39	M	3	22	" "	Schizophrenia. Vol. patient for 3 months (deep insulin)	Schizophrenia	Domestic disturbance only	" "	Grossly neglecting home
8	29	M	2	16	" "	Schizophrenia. Cert. patient for 5 months (deep insulin)	"	Uneventful pregnancy. Vol. patient in puerperium	" "	Able to care for child
9	31	M	4	10	Patient's symptoms	Previous pregnancies uneventful	Hysteria	"Spontaneous abortion" at 12 weeks	—	—
10	37	M	4	6	" "	" " "	"	"Spontaneous abortion" at 8 weeks	—	—
11	33	M	3	8	" "	Hysteria in 2nd pregnancy (terminated)	"	Unknown (patient left the area)	—	—
12	35	M	3	8	" "	Hysteria in 2nd pregnancy	"	Domestic disturbance only	No change	Able to care for child
13	31	M	11	8	" "	Depression in 10th puerperium	"	Vol. patient during pregnancy	" "	" "
14	32	M	4	12	" "	Hysteria in 1st, 2nd, and 3rd pregnancies	"	"Therapeutic termination" (in another area)	" "	" "
15	26	M	3	14	" "	Previous pregnancies uneventful	Anxiety state	Uneventful	Improved	Able to care for child
16	35	M	4	8	" "	" " "	" "	"	No change	" "
17	38	W	5	13	" "	Hysteria in 1st pregnancy (illegitimate)	" "	"	" "	" "
18	30	M	3	7	" "	Previous pregnancies uneventful	" "	"	" "	" "
19	27	M	2	12	" "	History of delinquency	Psychopath	Domestic disturbance only	" "	Unable to care for child
20	28	S	1	8	" "	"	"	"	" "	Grossly neglecting home
21	25	M	3	8	" "	Previous pregnancies uneventful	Mental defect	" " "	" "	" "
22	32	M	4	12	" "	" " "	" "	" " "	" "	" "

manage their home only if the child is cared for by someone else; in the third group are those who grossly neglect their home whether their child is there or not. The lowest category was to have included those who had deteriorated to such an extent that more or less permanent hospital care was required, but fortunately there were no such examples in this series.

The assessment of the changes in mental state which occurred as the result of each pregnancy presented great difficulties. The patients were reviewed one year after their confinement, but few had been assessed from a psychiatric standpoint prior to becoming pregnant, and their state in the early stages of pregnancy was not a fair guide. The comparison is intended to be with their mental state immediately before the pregnancy under review and is based largely on accounts given by relatives and family doctors, the gradings being the simplest possible—"improved," "no change," "worse," and "grossly deteriorated."

The inevitable conclusion to be drawn from these results is that in the vast majority of cases the decision not to intervene was the correct one as judged by the law in this country. Not a single one of these patients has become a mental wreck to the extent that mental hospital care is now required. In the one case which appeared to show deterioration the impression gained was that this deterioration was the natural progress of the disease and that the pregnancy had had little effect on it. In some cases, indeed, the mental state of the mother appeared to show improvement, and it seems likely that, to an unbalanced woman, the stimulus of a normal pregnancy is less deleterious than the sudden interruption by operation of the normal physiological changes taking place.

Discussion

It will be seen from the above results that, although the various confinements produced no serious ill effects from the purely medical standpoint, there were, nevertheless, unsatisfactory repercussions in the general social field. This aspect of the problem has received special attention in the legislation of certain other countries. Thus in Sweden, by Statutes dating from 1946, abortions are permitted to an extent unequalled by the laws of any other country. There the operation may be performed for any one of four reasons—medical, social-medical, humanitarian, or eugenic. The first, or medical, consideration permits abortion for the same reasons as it is permitted in this country—that is, to preserve the life or health of the mother if the pregnancy directly endangers her. The second, or social-medical, consideration allows the operation if the mental or physical health of the mother is likely to be severely impaired as the result of childbirth or even by the subsequent care of the child. The third, or humanitarian, consideration justifies abortion in cases where the mother has been raped or is under age. The fourth, or eugenic, consideration allows the operation if there is reason to believe that either of the parents of the child may be causing the hereditary transmission to the offspring of insanity, mental weakness, or any other serious disease.

The emergence of these laws in a country freer than most from interference by Church, if not by State, is bound to cause us to ask whether our own legislation takes too little account of social-medical, humanitarian, and eugenic considerations.

In the above series, in only about half of the cases could the social aspect of the situation be regarded as even moderately satisfactory; in several cases, indeed, the mother appeared to be permanently incapable of looking after the child. The humanitarian motive for terminating pregnancy in the case of a young schizophrenic (Case 5) was almost irresistible, and the possible eugenic justification for termination stood out in several cases, notably in the known psychotics and defectives.

Be that as it may, the lack of deterioration in the mental state of these patients as the result of their pregnancies does not give support to the recommendation of termination as a

therapeutic measure in the mentally disturbed. This absence, or otherwise, of mental deterioration can be the only criterion in this matter. If once other considerations are allowed to obtrude, then there is no end to the catalogue of the various degrees of social inconvenience or of genetic undesirability that may result from a pregnancy. The psychiatrist must not allow the sociologists and the geneticists to deceive him into exceeding his duty as a physician. The law of the land should be sufficient guide to those who cannot accept the Hippocratic tradition. Some further observations by Mr. Justice Macnaghten do, indeed, sum up the whole matter: "The killing of the unborn child was, by the Common Law of England, a grave crime. The protection which the Common Law afforded to human life extended to the unborn child in the womb of its mother. But, as in the case of homicide so also when an unborn child is killed, there may be justification for the act." For the medical practitioner the only justification is the protection of his patient from harm; and let it never be forgotten that the amputation of her child is the most harmful operation that the soul of woman can be asked to bear.

Summary

Attention is drawn to the frequency of requests by patients and practitioners for termination of pregnancy on psychiatric grounds.

The historical background and the present legal position are outlined, and the results of pregnancy in a series of cases referred for consultation on account of the mental state of the patients are summarized.

The conclusion is drawn that termination of pregnancy on account of the mental state of a patient is rarely justified by the law of this country, and the doubtful wisdom of extending the indications for abortion, as in certain foreign countries, is discussed.

I am indebted to my general-practitioner colleagues not only for much help in the assessment of these cases, but also for the example they set in managing the more histrionic patients with such forbearance and humour.

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Dr. J. F. SKONE, M.O.H. of West Bromwich, Birmingham, gave some figures about coloured immigrants in his area at a recent sectional meeting of the Royal Society of Health. By 1955, he said, it was apparent that the number of coloured people in West Bromwich was beginning to increase rapidly. Last year a census had shown a total of 838 in the area, of whom 505 were West Indians. The remainder were Indians (248) and Pakistanis (85). As immigrants from the Commonwealth who are not aliens are not subject to a detailed medical examination on arrival in Britain, a local survey of their health and welfare problems was carried out. Since 1951 17 had been notified as suffering from tuberculosis, but, said Dr. Skone, there was nothing to suggest they had the disease on arrival in Britain. Of the 17 cases only one was in a West Indian. Coloured persons formed the majority of patients seen at the local V.D. clinics in 1955 and 1956. West Indians formed the majority of those with gonorrhoea, and an increasing number of cases of granuloma inguinale were being seen—a disease formerly only rarely encountered here. One Indian had been diagnosed as having non-infectious leprosy. He had returned to India.