REFRESHER COURSE FOR GENERAL PRACTITIONERS

MEDICO-LEGAL ASPECTS OF ABORTION

BY

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The Interdepartmental Committee on Abortion in 1939 estimated that between 110,000 and 150,000 abortions occurred annually in this country. If these cases sought medical advice, though many probably did not, it would appear that the average medical practitioner would see two or three cases of abortion every year.

The basic law about abortion is contained in the Offences Against the Person Act, 1861, and may be briefly summarized as follows: "... whosoever, with intent to procure the miscarriage of any woman, whether she be or not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life." The same law applies to the woman who attempts to procure her own miscarriage only when she is pregnant. A subsequent section in the Act deals with the supplying or procuring of poisons or instruments, which is in itself a misdemeanour, whether the woman be pregnant or not, providing that the intention is there. The use of the word "unlawfully" in this Act has led medical practitioners to believe that there is such a thing as the "lawful" use of an instrument.

Therapeutic Abortion

There are, therefore, two main medico-legal problems which may confront a medical practitioner. The first concerns his ethical behaviour towards so-called therapeutic abortion, and the second his professional and civil behaviour once an abortion or attempted abortion has taken place. It should be said at the outset, however, that there is evidence to suggest that 60% of the abortions which occur in this country and in the United States of America (the figures are virtually the same) are natural, or, at any rate, non-criminal events. In other words, the practitioner should not assume that every abortion is the result of some form of criminal interference. It has generally been thought that the only lawful justification for a therapeutic abortion is to save the life of the mother; this idea was greatly amplified in the case of *R. v. Bourne*, where the judge considered that it was the surgeon's duty to perform the operation of abortion if, on reasonable grounds and with adequate knowledge, he was of the opinion that the probable consequence of the continuation of pregnancy would be to make the patient a physical and mental wreck. The precise reasons or arguments for therapeutic abortion need not be gone into in detail here. They will depend greatly upon the individual, but briefly such conditions as advanced heart disease, chronic nephritis, and tuberculosis are the most common reasons put forward. Psychiatric reasons may be more difficult to substantiate, and ethical, economic, or social reasons have, at the moment, no support in law.

It is in relation to these last reasons that we must consider the question of the termination of pregnancy following maternal infection with rubella. In a recent leading article (*British Medical Journal*, 1951, 2, 592) a factual analysis of the material then available led the writer to the conclusion that if a woman has rubella during the first three months of her pregnancy there is a serious chance—perhaps 25%, perhaps over 80%—of her baby having one or more abnor-

malities, but these will not necessarily themselves be serious. From the available figures it would seem that the risks of congenital abnormality following maternal rubella are probably greater in Australia than in this country. Even taking the lower figure of a 25% incidence of congenital abnormality there seems to be some social argument for the termination of pregnancy in circumstances where further pregnancies are probable and not contraindicated. However, there can be no doubt that the strict interpretation of the law would make such termination illegal.

When a practitioner is consulted about the advisability of abortion, he must obviously take steps to safeguard his professional integrity. This can best be done by consultation with one or more practitioners, preferably specialists in the disease from which the patient is suffering. If their opinions support his views, then the emptying of the uterus should be performed as overtly as possible, preferably in a public hospital, and with the patient's and her husband's written consent. An eminent psychiatrist, who is not infrequently consulted about the advisability of therapeutic abortion on psychiatric grounds, informs me that in cases in which he advises the termination of pregnancy he charges no fee. He thus safeguards himself from any suggestion that he benefits financially from advising abortion. If a practitioner wishes to cast suspicion upon himself as an abortionist, he can do no worse than perform the operation or assist at the operation in an unlicensed nursing-home some distance from the woman's ordinary domicile and for a high fee.

Criminal Abortion

Much commoner than the problem of therapeutic abortion, however, are the cases in which the practitioner is consulted after the attempted abortion has been made. He now has to consider his code of professional secrecy, so far as the patient is concerned, and his civil duty to prevent the repetition of a felony. His first duty is, of course, to the health and life of his patient, but it is frequently of value in the treatment of patients suffering from the effects of abortion to know something of the aetiology of the condition. The chances of infection and other complications in abortion from natural causes are very much less than when an instrument has been used, and a knowledge that instrumentation is responsible will obviously put the practitioner on the look-out for the more dangerous complications.

In law a medical practitioner who has such reason to believe that an abortion has been criminally procured, whether by the patient herself or by another person, as to amount to knowledge of the fact, can be charged with misprision of felony if he does not report the matter. It is fair to add, however, that it is a good many years since anyone has been so accused. It is generally conceded and taught that if the abortion is thought to have been self-induced, and that the patient is likely to recover from the effects, then information gained in the professional relationship should not be disclosed. Little advantage is to be gained in the same circumstances if recovery is unlikely, from either the patient's point of view or that of the general public—unless it be to safeguard innocent persons from criminal allegation. Where information has been gained under circumstances of professional secrecy that another person is responsible for the abortion, such information should not be disclosed without the patient's permission. Here, however, the individual practitioner may feel very

differently, and particularly if he has reason to believe that a certain neighbourhood is being worked by an abortionist. Under such circumstances it is generally possible to inform the police authorities, without disclosing the particular patient's name, that such-and-such an abortionist is working in a given neighbourhood. In police jargon there is a popular expression—"acting on information received." Most responsible practitioners should be on such reasonable terms with the local police force as to be able to give such information without transgressing professional secrecy.

There are two extremes of thought on this vexed subject of professional secrecy: one held by the purist who will disclose nothing to authority, the other held by those who have seen the awful—the word is used in its strictest sense—mortality and morbidity resulting from the activities of the professional abortionist.

During the treatment of cases of abortion the question of taking a dying declaration or of instituting action leading to a magistrate's court in the hospital ward may have to be considered. To many people it will appear that it is no part of any doctor's treatment to agree with a patient that she is dying, however certain of that fact he may be in his own mind. Furthermore, a dying declaration not being subject to cross-examination is, in my experience—and in respect of abortion—not eventually given a great deal of weight by the justices. A magistrate's court on the other hand does not require the patient's acquiescence to the term "knowing that I am about to die," and her statement can be subject to cross-examination. Again, however, the patient's physical state is the prime consideration of the practitioner, and the occasions on which such a procedure can be carried through are few and far between.

Common Hazards

I have stated that probably more than half the abortions in this country are natural events; it must also be admitted that of the remainder a large proportion (in my own figures around 28% of fatal cases) are intentionally self-induced, while a small number (2% to 3%) are accidentally self-induced as the result of hygienic syringing. Furthermore, the methods which are used by professional abortionists, excluding the highly skilled medical abortionists, can be used by the woman herself, so that the method employed, if it can be diagnosed, does not give an indication of the person responsible. It may be said rather loosely that, the more severe the injuries to the vagina, the more likely is it that the attempt was self-induced, but the converse is not true, as is shown by the case of a married woman of 29 who lived in a prefabricated house with her 20-months-old son. Her husband was a serving soldier stationed on the coast.

Early one morning a neighbour heard the baby crying and later noticed that the child was still crying and that the bread and milk were still on her friend's doorstep. This neighbour managed to gain entrance to the house through the kitchenette window and found her friend in the lavatory, the door of which was wide open. She was sitting on the water-closet seat with her head thrown back, and on the arrival of the police surgeon was found to be dead. Death was thought to have occurred 12 hours previously. A chamber containing white fluid was found on the floor of the lavatory. The body was fully clothed except for knickers, which were found neatly folded on a chair in the living-room. Over the back of the chair was a pair of pyjamas, and it was subsequently ascertained that it was the deceased woman's habit to undress and dress in the living-room to avoid disturbing the baby in the bedroom. All the electric lights were on except that in the bedroom. An enema syringe, apparently recently used, was lying on the draining board of the scullery. The front and back doors of the house were bolted on the inside.

At the post-mortem examination there was no doubt that this woman had died of air embolism following the introduction of soapy fluid into the pregnant uterus. When the husband was interviewed, he stated that he was well aware of his wife's condition, that the baby was expected in July, and his wife was attending a local doctor for antenatal treatment and had made every reasonable preparation for the birth. All this proved to be true. He also stated that he had known his wife to use an enema syringe for vaginal douching, particularly in Egypt, where they were married.

It would appear, therefore, that this woman, on the night previously, was preparing to go to bed in the usual way and took with her to the lavatory an enema syringe and a bowl of diluted antiseptic solution. After douching herself, she walked to the kitchen (a matter of six or seven steps in this type of house) and laid the syringe on the draining-board. She was able to return and sit on the water-closet seat before the effect of the air embolism killed her.

Air embolism, shock due to vagal inhibition, sepsis—particularly anaerobic infection—and lower nephron-nephrosis are the commonest causes of death following abortion. The case cited above illustrates the following facts: the introduction of fluid into the pregnant uterus can be easily achieved by the woman herself; it may be so achieved accidentally; and a small amount of voluntary movement is possible afterwards. In this case the woman was capable of walking 15 to 20 paces before being overcome by the effects of air embolism. Circumstantial evidence in other cases supports the view that only the simplest voluntary movements are possible after the introduction of large quantities of air into the pregnant uterus. This restriction on activity before death makes the recognition of air embolism of great importance, since it implies that the attempted abortion was carried out in the immediate proximity of where the woman died. The observation of vagal inhibition is similarly of great forensic importance, but, being based on virtually negative findings, it is more difficult to recognize.

Sepsis, while not categorically implying instrumental interference, is strongly suggestive, particularly when the organism is an anaerobe. A full bacteriological examination of an infected abortion may help not only in the treatment and prognosis of the case but also in the identification of the cause.

Lower nephron nephrosis is much too large a subject to be dealt with here, but, briefly, it may be said to occur far from infrequently in cases of infected abortion, generally manifesting its presence by oliguria about eight to ten days after the onset of symptoms and often at a time when the patient seems to be out of the wood. It has accounted for 25% of the fatal cases which I have seen in the past five years.

Methods of Effecting Abortion

Of the instruments in common use, undoubtedly the ordinary enema syringe is the most popular, and generally the syringe is new and apparently freshly purchased for the specific purpose. The recently used syringe often smells of carbolic soap or an antiseptic, and the inside of the bulb takes some time to dry out after use.

Slippery elm bark is still available, and appears to carry a rather greater risk of infection.

A pregnant woman aged 20, who was engaged to be married, visited an abortionist in North London, who inserted a piece of slippery elm into the cervix at 6 o'clock one evening. The girl was desperately ill by noon the following day and died that evening. Her fiancé reported the matter to the police. The most significant features at necropsy were a bronzed cyanosis, presumably due to haemolysis, and extraordinary oedema of all the pelvic tissues including the uterus. Bacteriological examination gave a pure growth of *Clostridium oedematiens*, and a sample of slippery elm retrieved from the abortionist's house was subsequently examined and showed the same organism.

As might be expected, the most severe local damage is caused by sharp instruments such as knitting-needles, umbrella ribs, and the like.

A woman aged 29, engaged in a flourishing business, found herself pregnant after six months of married life. Her husband came home one evening to find her almost moribund and lying in a pool of blood in bed. She was immediately taken to hospital, where her condition was so serious as the result of haemorrhage that no extensive repair could ever be made of the severe lacerations which she admitted having caused in her vagina by means of a knitting-needle. She died some twenty hours after being found.

While drugs are undoubtedly extensively used (and easily obtained despite recent legislation) in the attempt to procure

abortion, it is very doubtful if they ever do more than effect a "trigger" action in a woman who will abort in any event, or more often give rise to a brisk attack of diarrhoea.

Conclusion

The lessons which may be learnt from a study of this wide problem are probably simple. The patient's life and health come first, and this should not be interfered with on the one hand by unnecessary questioning or, on the other, by delay in justifiable therapeutic abortion. The presence of a dangerous abortionist in a neighbourhood should be revealed to authority whenever possible without transgressing professional secrecy, and an open mind, free from bigotry, should be kept on the subject of therapeutic abortion, remembering that the law as well as medicine is progressive.

Next Refresher Course Article.—"Heart Block," by Dr. Geoffrey Bourne.

CLINICAL RESEARCH IN THE NATIONAL HEALTH SERVICE*

BY

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There is a great tendency for the medical profession and the laity to think that clinical research can be carried out only in hospital, where modern equipment is at hand and every aid to diagnosis is provided. But this is very far from the truth. Let us consider for a moment what is meant by clinical research. It is the painstaking investigation of individuals in the course of treating and caring for patients; it leads to an accumulation of knowledge which may be invaluable in the prevention and treatment of disease and in the maintenance of health. This knowledge may aid the advance of the practice of medicine in any of its many branches. It may confirm or refute established practice. It may point the way to new discovery or treatment.

The essence of clinical research is that it is carried out by a clinician—be he general practitioner or specialist—and it is research on the "human animal" during the course of his normal health or during illness.

The Past

In the past, practitioners of the various branches of medicine could be divided into three groups: (a) The humble and honest man who learnt his trade and then proceeded to apply what he had learnt. But he just applied it conscientiously and without thought; he never improved either himself or medicine as a whole. (b) The "quack" who plied his trade always with a view to his own advancement and with little care for the patient. (c) The true clinician, the man who studied his patients, their reactions to disease and treatment, who thought about his work, and who daily became a wiser and better doctor. If this last man kept records of his observations and as a result altered his treatments, improved his results, made original observations, etc., he was in fact a clinician carrying out clinical research on "human animals." We all know of such men in practice, and it is a great pity that their important observations are not handed down to future generations. It is only

the general practitioner who has continuous access to his patients over many years and sees them in sickness and in health. He is their guide, philosopher, and friend who knows all their peculiar backgrounds and their habits. Such a doctor has far better opportunities for studying and recording the natural history of disease than any other medical man.

Great Names of the Past.—If we think back there are many names that come to our mind, all of whom have made many discoveries in the clinical field. To mention only a few: Hippocrates, Withering, Raynaud, Bright, Jenner, Addison, Hunter, Lister, and Mackenzie. What did they have, these "great names"? They had no x-ray films, no pathological laboratories, and not much in the way of diagnostic laparotomies. But they all had a natural and incurable curiosity, a capacity for hard work, a determination to keep detailed notes of their patients, the ability to observe big and little things which gave them clinical acumen, a healthy scepticism, and culture, and they lived in a more leisured and more slowly moving age.

The Present

What are the conditions prevailing with regard to the teaching of medical students who will become the practitioners of the future? It is good to be critical in these matters, as good may come out of them. Let us consider the present position of:

(a) **Professorial Units.**—Is everything being done to stimulate the student in clinical acumen? Is there not a tendency to promote abstruse research with a bias towards experimental detail? Teaching should be their forte, and they should teach the student to do his own clinical research on the patients. How many professors are true clinicians? Let us have research professors by all means, but in addition teaching professors who are clinicians engaged in the study of patients and their disease. How much are we missing to-day with the present over-specialization of professorial units or even of the average firm in a teaching hospital where the chief has a bias?

(b) **Hospitals.**—Not enough advantage is taken of the clinical material in hospitals, both teaching and non-teaching, and this is a great pity. In looking for the reason for this one is bound to admit that the records are so often poor because note-taking is so skimpy. Also, frequently there are too many patients for the staff to deal with adequately.

(c) **General Practitioners.**—There are many reasons why general practitioners do practically no clinical research. First, they have to deal with too many patients, many of whom are not ill at all; and those that are really ill are taken away to the specialist. This means that the practitioner loses interest in his work and patients; it sometimes means that there is a gulf which may increase between the practitioner and the specialist. The practitioner is too often divorced from his local hospital. Again, the average practitioner has little or no time for leisure or facilities for study, and if he is on his own and takes a holiday it is not a "holiday with pay." He has to pay for his holiday, and he has also to pay the locum. This seems an anomaly.

Having considered the conditions which prevail at the present time, let us look at the future.

The Future

The Ingredients of Clinical Research

The Doctor.—(a) **Right Type.**—This is being forgotten to-day in the selection of medical students. It must be remembered that it is not usually the bookworm who makes the good doctor. It is often the footballer or cricketer, the good organizer, the man who lives and is human who will in the end be the better "type"—he who loves his fellow men. (b) **Right Training.**—It is essential that the training of medical students should develop their curiosity and their power of observation. Medical students who have not read *The Adventures of Sherlock Holmes* should be advised to

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