medicine. The main place for clinical obstetric training must be the labour ward, supplemented by the ante-natal department and the puerperal wards. To obtain the full advantage of his time and study the student ought to be free to devote his whole days, and as much as need be of his nights, to clinical midwifery along with clinical gynaecology. He ought to reside in the maternity hospital, so that he may indeed "live, move, and have his being" in an obstetric atmosphere. I entirely agree with Dr. Fairbairn's recent remarks at Glasgow as to the supreme educative advantage thus obtained. I am glad to say that in Edinburgh we have advanced towards this ideal as far as our present inadequate maternity hospital provision and our present curriculum permit. But I take this opportunity to point out that, if the great new obstetric and gynaecological department in the Royal Infirmary, to which we are all looking forward, is to prove the gain which it ought to be, ample provision for students to reside in it is a *sine qua non*. Furthermore, the curriculum must be altered. The conditions of practice at present are such that a newly fledged graduate is much more likely to be called upon to attend a complicated obstetric case than to perform a major surgical operation, and public opinion expects, though to my mind quite unreasonably, that he will be fully equal to any obstetric emergency. Yet the time allotted to the vital study of clinical midwifery is approximately only one-third of that given to clinical surgery, and is practically the same as that allotted to venereal diseases, to tuberculosis, to diseases of the eye, or of the ear, nose, and throat, or even of the skin. Opportunities to alter the curriculum are few and far between; when the next one will occur I cannot forecast—they are generally preceded by volcanic rumblings in the General Medical Council, and of such I hear nothing at the moment. Meantime we must wait, like the man at the pool of Bethesda, ready to seize the chance of the troubling of the waters and press for the remedying of this source of weakness.

INDUCTION OF PREMATURE LABOUR IN RELATION TO MENTAL DISEASE.

BY

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At the Annual Meeting of the British Medical Association at Nottingham in 1926 a discussion took place on the indications and methods for termination of pregnancy before the viability of the child. The discussion, which was opened by Dr. T. W. Eden, is fully reported in the *JOURNAL* of August 7th, 1926 (p. 237). There is also a report in the *JOURNAL* of January 29th, 1927, of a joint meeting of the Medico-Legal Society and the Section of Obstetrics and Gynaecology of the Royal Society of Medicine, held on January 21st, to consider the medico-legal and ethical aspects of abortion; this discussion was opened by Dr. Fairbairn.

In the course of the last twenty-seven years I have been consulted in a certain number of cases in which the question of terminating a pregnancy has arisen in connexion with mental disorder. I think it will be of interest to set out these cases in two groups: I, cases in which the pregnancy was allowed to continue; II, cases in which the pregnancy was terminated before viability of the child. I have given the cases in considerable detail from my case-books.

I.—Cases in which the Pregnancy was Allowed to Continue.

CASE 1.

Mrs. A., aged 31; seen July 25th, 1900, with Dr. Lavies.

Family History.—Uncle "nervous" and depressed; sister "nervous."

Previous History.—Much trouble and strain from illness in family. Married in 1897. "Hysterical" the day before marriage; also shock of brother's death by accident six weeks after. A child was born in 1898; no breakdown after, but did not nurse child. In October, 1899, had a miscarriage. In the winter of 1899 her husband was ill with phlebitis for three months; she refused to have a nurse for him and became much run down.

Present Attack.—In July, 1900, she was sleepless and excited

CONCLUSION.

May I, in conclusion, summarize what I have been endeavouring to lay before you? My first point is that the whole position requires to be considered in broad outline and freed from questions of detail in treatment, which often only tend to obscure the big general outline of the situation. My second point is the need to apprehend fully the newer doctrine of the essentially preventive nature of midwifery practice. This embraces in the first place the doctrine of ante-natal examination and supervision; secondly, the supreme advantages of obtaining a natural labour wherever possible. As a corollary to this there is the urgent necessity of increasing maternity hospital accommodation for complicated cases and for women whose houses are unsuitable for even a normal delivery. In the third place, the consideration of midwifery from this preventive standpoint stresses the necessity of carrying out adequate post-natal care of the mother and the linking up of the work of the obstetrician with that of the pediatrician so that the child's life may be protected. The intimate relation of the work of venereal clinics with maternity work in this connexion needs only to be mentioned. In the next place there is an admitted need for fuller clinical teaching of medical students. Lastly I would repeat that if we are to make any real advance in regard to conditions of practice we must be prepared to welcome the assistance of the official administrative section of the profession. Without their help we shall be unable to move in these matters as we ought to do, and we must be prepared to give them the advice and guidance of our experience in the matter. If I may borrow a sporting metaphor, I would say that those of us who are engaged in the active practice of midwifery, and who are, so to speak, in the front line, must use our heads as well as our weight in the scrummage, and heel the ball out so that the executive back line may be enabled to carry it forward to the goal towards which we are all striving.

and gradually developed acute mania. She remained at home with nurses. On August 12th Dr. Lavies reported a suspicion of pregnancy, as she had missed one menstrual period. After a short improvement she became much worse and had to be certified. She was placed under care at The Priory. In November her physical condition had much improved; catamenia still absent and so there was a strong suspicion of pregnancy, although, of course, cessation of periods is a common symptom in such acute cases. In January, 1901, she was still maniacal, but there was no doubt as to pregnancy. In April she was advanced in pregnancy, was still incoherent and jocular, but was not so excited.

She gave birth to a child on April 9th, while still under care. There were no bad symptoms. By August she had steadily improved mentally, and in September was quite recovered.

In this case there were no indications that the patient's life or recovery was endangered by the pregnancy, and it was left to run a normal course.

CASE 2.

Mrs. B., aged 30; seen December 4th, 1909, in consultation with Dr. F. D. S. Jackson and Dr. (now Sir) M. Craig.

Family History.—Sister committed suicide.

Previous History.—Had been married five or six years and had had two miscarriages. Had been living apart from her husband for two years, and he was not supporting her, but occasionally visited her. Two years before had had right salpingitis; no operation was done. Recently her sister had shot herself just after returning from America with the patient. This was a great upset to her; she was very depressed, said she had nothing to live for, told her doctor she was going to shoot herself, and also that her husband had forced his way into her flat and had overpowered her, and that she was in the family way. She was sleeping badly, constantly imagined she saw the future child with a wound on its head, the same as she had seen in her sister's forehead. When seen by an obstetric physician, who thought she was pregnant, she said, "That decides it." She was crying all day and sleeping very little; said she would end it and would not have the child; could not bear it, and could not go through with it. She refused to have her relatives or her husband told. The question of premature labour was raised.

On examination she was agitated and depressed; said she would be an "absolute ass" to live under the circumstances; felt certain her child would be marked by a wound; declared that her husband, who had not seen her before for two years, "forcibly overcame" her about two months ago. Said if she had a child her husband would never leave her alone, as he generally did. Wondered why she had not already committed suicide; thought herself a sentimental fool not to have done it because of her brother and sister. She could not go on with her work (journalism). She spoke of having been to a woman for abortion, but nothing had been done.

This seemed to be a case in which the continuance of pregnancy might be associated with a very severe attack of melancholia, with great risk of suicide, and therefore premature labour might be justifiable. There was, however, the question of the husband's legal position. It was decided to watch events. Shortly after this the patient wrote saying that she had thought over the matter further, and was very thankful to us for talking to her, and that she had now decided to let the pregnancy go on.

CASE 3.

Mrs. C., aged 22; seen January 22nd, 1910, with Dr. Arthur Gervis.

Previous History.—Had been "run down" and neurasthenic for some time before her marriage, and on December 22nd, 1909, had written in her diary, "I do not think he is the man for me." On the morning of the wedding (December 23rd) she ran away to a friend's house for protection. Her mother fetched her back and the marriage took place by licence. Her husband went to West Africa after a short honeymoon. On the morning of January 13th, 1910, she attached a rope to a pipe in the bathroom, made a noose round her neck, and suspended herself out of the window 60 feet from the ground. The rope broke and she fell, and sustained a fracture of the left femur, of the pelvis, and anterior fossa of the base of the skull. The next day she said God had never meant her to marry, that no man could supply her ideal, and that God had intended her to commit suicide. A catheter had to be passed, and it was found that the marriage had not been consummated. She was treated at home, at first being in splints and under constant supervision. Later the patient improved; she went first to Westcliff, and then to Las Palmas to meet her husband on July 2nd, 1910. She then demanded intercourse and said she wanted to have a baby. In August, 1910, the husband said she was "extravagant" in her love for him, and that he thought her "sexually mad." She was not now depressed, but would sing for hours. She began to be exalted and excited, with frequent desire for intercourse; wished "a man was built like a horse," and became extravagant about money. She was clamorous to have a child, although examination had shown contraction of the pelvis. In October she had to be certified, and went to Chiswick House. She gradually improved, and was discharged in May, 1911. She returned to her husband. In August, 1911, she was found to be pregnant, and was recertified for Chiswick House in consequence of return of excitement and eroticism. It was decided to let the pregnancy continue, and in January, 1912, she was transferred to single care greatly improved mentally. Caesarean section was successfully performed by Dr. Mary Scharlieb on January 22nd, 1912, and a living female child removed. In March she was discharged from certificates as recovered. Subsequently she had to be put under care again. The manic-depressive attacks make the prognosis for the future very grave.

In this case there appeared to be no special danger to the mother's life in the continuance of the pregnancy, except for the fact that delivery could not take place through the pelvis.

CASE 4.

Mrs. D., aged 34; seen January 11th, 1914, in consultation with Dr. Walter Griffith.

Family History.—Mother died in confinement, sister died in confinement (? after induction of labour); another sister died during pregnancy.

Previous History.—The patient has contracted pelvis. Is pregnant about four to five months for the first time. Has not been told the state of her pelvis.

Mental State.—She is depressed; says she is quite sure she is going to die, and that if God Almighty told her she would be safe she could not believe it; feels she would "give herself up to die" if the pregnancy went on. Has the greatest horror of childbirth, is constantly depressed and cannot shake it off; feels she shall "let herself go" and will not trouble to keep her health up. It is a perfect nightmare to her; dreams about it and wakes up in perspiration with fear. The very thought of a child inside her makes her feel as if she were going off her head. Thinks she will die of fright before the confinement. Is worried by the family history.

She was placed under care in St. Bartholomew's Hospital and her general health and mental condition improved. She gradually regained confidence. Labour was induced in the middle of the ninth month, a female child was born, and the patient became quite happy nursing it.

CASE 5.

On August 21st, 1916, I was consulted by Dr. Collinson of Preston, who had been referred to me for a further opinion by the late Dr. R. H. Cole as to the case of a lady, aged 32, who was about two or three months pregnant.

Family History.—Father alcoholic, died at 45. Mother neurotic. Maternal uncle insane. One brother insane and another committed suicide. There was also a bad family history on the husband's side.

Previous History.—From the age of 19 to 24 she had been in a "sanatorium" before marriage. She had four children, the eldest aged 5 years and 10 months, the youngest a boy born April 8th, 1916. Labour was then natural; she did not nurse the child. She last menstruated on May 28th. She then became pregnant again, about two months after the birth of the child. There was no mental or nervous illness in former pregnancies.

Present State.—With this pregnancy she had become restless and anxious, and afraid to go on with it. The husband was afraid that this pregnancy might unbalance her and that the child might be mentally weak. Dr. Cole had seen the patient and did not notice any special nervous symptoms, and her general health was good. It was said that before marriage a surgeon and a physician expressed the opinion that in view of the bad inheritance she ought not to have children. But she had had no mental disorder in any of her former pregnancies or labours.

After full consideration it was decided that there was not sufficient justification for interfering with the course of the pregnancy. As she had previously had four children the question of inheritance could not be specially considered in relation to the present pregnancy.

CASE 6.

Mrs. E., aged 35, seen January 29th, 1927, with Dr. Burford and Dr. Clarke.

Previous History.—No previous mental disorder. She married in July, 1926. Last period August 2nd. Vomiting began on September 10th and continued unremittingly till Christmas. There was also aceturia, but no albumin or sugar. Mental symptoms of the confusional type began as the vomiting ceased, and had continued up to date; sleep deficient, attention defective; answers to questions foolish; takes food well; no incontinence; no great excitement, and no suicidal tendency. A serious complication had, however, arisen in loss of power in both legs, with wasting of muscles and contracture of thighs and knees, the attempt to straighten which caused pain. The knee-jerks were deficient, the plantar reflex flexor; there was no loss of sensation, and no loss of control over bladder or rectum. She had been found to have retinal haemorrhages and retrobulbar neuritis, and the opinion had been given that she had toxic myelitis. There was some aphonia.

Dr. Eden had seen her and gave the opinion that it was not desirable to induce premature labour from the obstetric point of view.

From the mental point of view there seemed no reason to induce premature labour, as the vomiting had ceased, she was taking food well, and there seemed no reason to doubt that she was improving mentally and in general health.

The remaining question was as to whether, if the pregnancy was allowed to continue, the condition of the spinal cord and nervous system would be detrimental to her life or might lead to permanent paralysis. The opinion of Dr. (now Sir F.) Buzzard was taken on this point, and it was decided to allow the pregnancy to continue.

The patient was delivered of a stillborn child at full term. The placenta was found to contain infarcts, due to thrombosis of the foetal arteries and not to endarteritis, but probably due to some toxin damaging the endothelium, but with no evidence as to cause. The pathological report was made by Dr. Wilfred D. Newcomb.

Eventually the patient steadily improved both physically and mentally, and was able to return home to her husband in South Africa.

CASE 7.

Mrs. F.; seen June 17th, 1927.

Family History.—Three brothers broke down mentally. One died under case; one committed suicide.

Previous History.—Has had four children; delivery always under an anaesthetic, but has never been mentally ill. Youngest child aged 2 years. Did not nurse the children.

Present Condition.—Pregnant three months. Looks robust. Says she is an "ordinary woman" physically. Has always had a terror of the pain at confinement, and a fear that the doctor would not arrive in time. Feels she has not the mental or physical strength to go through it, but does not fear anything except the pain. Always works hard; feels she does not want any more children. She had recently moved to another locality, and was advised to choose her new medical attendant and let him watch her progress.

In the first group Case 1 shows how acute insanity may run its course during the whole of pregnancy and be recovered from, and how pregnancy may be masked by the fact that cessation of catamenia is a frequent occurrence in acute insanity. When it became evident that the patient was advanced in pregnancy it seemed justifiable to allow it to continue.

Case 2 shows the advantage of deliberation and time for reflection in a patient who at first sight seemed to be in danger of a severe attack of melancholia with suicidal intent.

Case 3 was one where neither the husband nor the wife desired termination of pregnancy before the child was viable, and fortunately her improved mental condition allowed Caesarean section to be performed.

Case 4 at one time seemed likely to go down hill, but, like many cases of insanity in the early months of pregnancy, recovered before full term.

Case 5.—In view of a previous history of normal labours there was no justification for terminating pregnancy.

Case 6.—In this case the patient was nearly six months pregnant when first seen. There was the complication first of severe vomiting and then of toxic myelitis; but when seen her mental condition did not suggest irrecoverability,

and she was in no way dangerous to herself or others. Eventually she was delivered of a stillborn child at full term.

Case 7.—There seemed to be no justifiable reason, physically or mentally, for terminating the pregnancy. There was no doubt that "res angusta domi" had some influence in the desire for abortion, and this could not be held sufficient reason for it.

II.—Cases in which Pregnancy was Terminated.

CASE 1.

Mrs. G., aged 30; seen November 17th, 1903, with Dr. Wethered.

Family History.—Mother insane, one child idiotic.

Previous History.—Three and a half years ago, and before the birth of the fifth child, she had become depressed and apprehensive that the child would be an idiot like the other; after its birth she was depressed and then excited. She recovered, but was inclined to depression and irritability since at each period.

Present Attack.—Three weeks previously the period did not come on, and before this she was excited and threatened to cut her throat. Her mother had broken down and had gone to an asylum about two months before, and patient had visited her there and was much upset, and crying. On November 13th she tried to get a razor and to burn herself at a gas fire, and rushed to the dining room to get a knife. On examination she was depressed, saying that she "could not face it," that one child was imbecile, that she could not live if she were pregnant, and threatened suicide. She was also upset about her mother's insanity. In this case it was evident that if pregnancy continued her life would be in danger from suicide, and accordingly the pregnancy was terminated and a two months' foetus removed. She made a good recovery.

CASE 2.

Mrs. H., aged 46; seen May 31st, 1905, with Dr. Howard Tooth and Dr. Walter Griffith.

Previous History.—The patient and her husband had postponed marriage for some years, hoping that the time would pass when she might become pregnant, and married hoping she would not have children. Two years before she had been rather "queer" after influenza. Had always dreaded pregnancy "because of the lines in her hand." A friend had become insane, and the patient dreaded the same in her own case. She married in December, 1904, and when seen was four months pregnant. She had been vomiting, and when told she was pregnant said she could not go on with it. She became "quite uncontrollable," constantly speaking about the friend's insanity and dreading the same result.

When seen she was lying with her eyes shut clutching at the bedclothes, complaining of a creeping sensation in her head, and as if her brain were balanced on a small area and very little would upset it. Thinks she will become imbecile if she has a child. Does not want to live, but does not threaten suicide. Later she had three convulsive attacks and hysterical paraplegia. She became more depressed and confused, and in view of the physical and mental condition it was decided to terminate the pregnancy. She afterwards recovered.

CASE 3.

Mrs. I., aged 24, first seen April 9th, 1908, with Dr. R. J. Walker.

Family History.—Brother alcoholic and delirious.

Previous History.—Always rather unstable. Her first child was born on March 15th, 1906. During the whole of the pregnancy she had vomiting after every meal and bad constipation. Labour was easy. Had much pain in the breasts, and so breast feeding was abandoned. She began to be sleepless, depressed, and suicidal, and passed through an attack of puerperal melancholia, from which she recovered.

After the former attack she became pregnant again in 1909, and premature labour had been induced. A year before she had measles, followed by an attack of melancholia which passed off. Seen again on November 1st, 1911, in consultation with Dr. Barker and Dr. Hey. She was now two months pregnant, and suffered from constant vomiting "night and day," associated with great depression and sleeplessness. The vomiting was said to be worse than in the first pregnancy; she prays to God to take her, and hopes she will not live; dreads breaking down and being put under care. Dr. Gow had been consulted about terminating the pregnancy. In view of former attacks of depression and the return of vomiting, and the probability that more severe mental disorder was likely to follow if the present pregnancy were allowed to continue, the opinion was given that it would be right to terminate it.

CASE 4.

Mrs. J., aged 27; seen January 18th, 1911, with Dr. Mackintosh.

Family History.—Father had melancholia and shot himself. Mother died of chronic alcoholism.

Previous History.—Had been married four and a half years; had two children, a boy aged 3½ years and a girl 10½ months. The first labour was difficult; she nursed the child for three weeks, then became depressed and suicidal, but recovered. The second labour was easy; she did not nurse the child. She again became depressed and suicidal, was ill for about five months but recovered. Had only been back at home since August.

Present Attack.—Pregnant about three months, as confirmed by Dr. W. Griffith. Patient much upset at the idea of being pregnant; had been sleeping badly and was agitated. Dreads breaking down again with depression, and feels certain it will occur and that it will be worse this time. Has lost 9 lb. in weight.

In view of the previous attacks it seemed justifiable to terminate the pregnancy, which was done. Dr. Griffith removed the uterus and contents.

CASE 5.

Mrs. K., aged 25; seen in consultation with Dr. (Sir M.) Craig, February 10th, 1911.

Previous History.—Married at 18. Was ignorant about marriage, and from the first "loathed" it and began to dislike her husband. One child born in 1908. During that pregnancy had block of left ureter and was under Dr. Williamson and Mr. Pardoe. Labour was induced at the eighth month. Had albuminuria for months after confinement. Was physically run down and had periods of depression, and took a dislike to the child. In 1909 she had delusions and thought imps and devils were sitting round her; contemplated suicide, and in the autumn of 1910 made an attempt with drugs. She recovered.

Present Illness.—Became pregnant again two and a half months ago. Began to sleep badly and to have "terrors"; dreaded the pregnancy and threatened suicide; loathed the idea that there was something inside her, "put there by someone she hated." Said she was going to perdition and would never recover; that she was going to "make her bow and depart," and that it would be kinder to her husband and everyone else. She dreaded a return of the kidney trouble. Considering her former attack of depression, the kidney trouble, and the present recurrence of depression, the opinion was given that the uterus should be emptied.

CASE 6.

Mrs. L., aged 25; seen January 21st, 1914, in consultation with Dr. Chambers and Dr. Comyns Berkeley.

Family History.—Father died of some malignant disease; no insanity in family.

Previous History.—Had had two children; the first died aged 2½; a second child was living aged 1½. The confinements were normal and no mental disorder followed. The first child had died of tuberculous meningitis. After the second confinement the patient had an abscess in the armpit, followed by a succession of abscesses. She was seen by Mr. Watson Cheyne, and had vaccine treatment. She was ill altogether nine months, was much pulled down, and made up her mind she would never have another child.

Present Condition.—Pregnant two months. Dr. Comyns Berkeley did not feel justified in advising termination. In November she had become pregnant, and at once became depressed and spoke of suicide. Sat all day silent and gloomy, and took little food and had little sleep; felt convinced the child would not be normal; said she did not care what happened to her.

The opinion was given that if the pregnancy continued she would have a bad mental attack and might commit suicide. The pregnancy was terminated and she recovered.

CASE 7.

Mrs. M., aged 33; seen November 19th, 1918, with Dr. Stevens.

Family History.—Four members of her family, including one brother, have been insane and three others "nervous." Was a Russian, and the family had been ruined by the revolution.

Previous History.—She was musical and artistic, and had dabbled with Rosicrucianism and "magic." She married in November, 1917; her husband was a widower, aged 46, and was in the navy.

Present Condition.—Pregnant two or three months; she dreads having a child and wants to commit suicide; feels incapable of having a child; thinks it is too like an animal or a frog; vomits when she thinks about it; feels like a doomed thing and like a prisoner who will die, that this is her end, and that she is between life and death.

It was agreed that continuance of the pregnancy would evenuate in a severe attack of melancholia, and that she might commit suicide. The pregnancy was terminated.

CASE 8.

Mrs. N., a Swede, aged 30; seen February 14th, 1921, with Dr. Wyatt.

Previous History.—Has three children, eldest 4½, youngest 1½. Last child born October, 1919; after confinement had puerperal sepsis. The uterus was scraped out and she recovered, but at Christmas, 1919, had rheumatic fever, after which she became depressed, was taken to Sweden, and there passed through a bad confusional attack which had left a blank in her memory. She returned to England in September, 1920, apparently recovered, but was weak and unable to manage her house. In January, 1921, was depressed, but found to be pregnant again. Was said to have been for three weeks "very ill in her mind," spoke of going away and never coming back, was irritable and restless and sleeping badly, and sometimes desiring to commit suicide.

Present Condition.—She complained of being "nervous" and depressed, dreaded another attack, recognized that in 1920 her "mind was quite away" and she had been in a mental home in Sweden; was emotional and weeping. It was agreed that there was great risk of another mental illness if pregnancy was continued, and it was terminated.

CASE 9.

Mrs. O., aged 30; seen June 18th, 1921, with Dr. Bevan.

Family History.—Sister broke down mentally after hysterectomy and early menopause.

Previous History.—Has had three children; was quite well after the birth of the first. The second child was born in 1916, after which there was an attack of melancholia lasting four or five months. The third child was born in January, 1919; there was much haemorrhage and (?) inversion of the uterus, followed by a

second attack of mental depression associated with lactation. The husband had been warned against further pregnancies.

Present Illness.—Now pregnant about six weeks. Became depressed again, spoke of "frightful forgetfulness" and of having a blank spot in her memory.

In view of the two previous attacks of melancholia, the complication at former confinement, and the apparent beginning of another attack of depression, it was decided that the pregnancy should be terminated.

CASE 10.

Mrs. P., aged 36; seen November 17th, 1924.

Family History.—Two sisters had been under care for mental illness but recovered.

Previous History.—Has had two children. Had been much concerned about husband's money difficulties. Had been depressed since June. Recently had tried to poison herself by gas in a bedroom, but promised not to make further attempts. Had been, however, allowed to sleep in a room alone in a friend's house, and one morning had precipitated herself from the bedroom window, sustaining fracture dislocation of the right ankle, dislocation of the left elbow, a scalp wound, and concussion. She was treated in a nursing home for the surgical troubles, concurrently with which she passed through a severe attack of mental disorder, part of the time being confused and delirious with rise of temperature, and part of the time deeply melancholic with thoughts of suicide. Late in December, when she had sufficiently recovered surgically, Dr. R. H. Cole and I saw her in consultation with Dr. Hill, and came to the conclusion that she should be certified. The husband, however, objected to this, and as the patient expressed her willingness to go under care as a voluntary boarder she went thus to a private mental hospital. She was quickly found to be unfit for voluntary treatment and was certified. Subsequently she recovered sufficiently to be discharged as "relieved" at the end of July, 1925.

In December, 1925, she became pregnant again. In view of the previous severe and dangerous attack of mental disorder there was no hesitation in giving the opinion that the pregnancy ought not to be allowed to continue.

With regard to the second group, it may be said that in each case the question of the health of the mother was the primary factor, as in all these cases the child was not "viable."

I agree with the views expressed by Dr. Fairbairn at the joint meeting of the Medico-Legal Society and the Section of Obstetrics of the Royal Society of Medicine, that only purely medical considerations should be allowed to weigh in deciding as to termination of pregnancy.

It is interesting to note the views expressed by legal authorities in the discussion of January 21st, 1927.¹ For instance, Lord Riddell is reported to have said that "induction was not only justifiable, but a duty when the pregnancy indicated grave danger to the mother's health, whether the result was likely to be permanent or not."² Sir Travers Humphreys said the practitioner "was not entitled to let anything weigh with him except the health of his patient—her medical welfare as distinct from her social or economic welfare."³ Earl Russell is reported as leaning to the German view which Lord Riddell had quoted, "in which it was insisted that the foetus was not yet an independent human being, and that every woman, by virtue of the right over her own body, was entitled to decide whether it should become one." Mr. Justice Salter, in summing up the debate, is reported as having said that if abortion were ever sanctioned outside the medical area—in the interest of eugenics, for example, or for economic, social, or personal reasons—he would have great fear that within the medical area there would arise a large class of pliant doctors who would be easily persuaded that there were sufficient medical reasons in a given case. He was certain that if it were ever proposed to extend the liberty of abortion, the spirit of unswerving opposition would arise again as it did in the attitude of the early Christian Church towards abortion.

In the *Journal of Mental Science* for July, 1927, is published a paper by Dr. J. R. Lord, President of the Royal Medico-Psychological Association, on the induction of abortion in the treatment and prophylaxis of mental disorder. He concludes that the only morally sound reasons for inducing abortion are medical: (a) to preserve life, (b) to alleviate or cure serious physical or mental illness, or (c) to prevent serious ill health, physical or mental, whether permanent or temporary.

The cases I have recorded seem to me to be of importance as showing the questions which have to be taken into consideration in each case as it arises.

REFERENCES.

¹ BRITISH MEDICAL JOURNAL, January 29th, 1927. ² Ibid., p. 188. ³ Ibid., p. 189.

THE TREATMENT OF "TENNIS ELBOW."

BY

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THERE is probably nothing which brings the surgical profession into greater discredit at the present time than its inability to cure a "tennis elbow." The condition is extremely common, and so helpless have we been in its treatment that most sufferers now never consider consulting a medical man at all. For while we have been gravely considering what may be the pathology of so curious a condition the osteopaths and non-medical manipulators have been curing the patients in hundreds. Let us neglect pathology and consider what we really know about it clinically.

In the first place it is almost confined to tennis players, golfers, and workers in certain trades which involve the constant use of a hammer.

Secondly, the onset of the condition is insidious; there is seldom a history of any sudden strain or accident.

Thirdly, the patient can commonly do anything with his arm without pain except the particular exercise with which the pain is associated. On the other hand, during the acute stage at any rate, a patient may suddenly bungle some perfectly simple action owing to his accidentally getting his arm into the position which produces the pain. A favourite trick of this sort is to drop a tea-cup when reaching out the hand to take it from a tray. Indeed, the action of holding a tea-cup will often produce the pain of tennis elbow, and the fact is of help in making a diagnosis.

Fourthly, in the acute stage, which may come on rather suddenly and in which the patient simply cannot hold a racket at all, there is a very strong subjective sensation that "something is out of place."

Fifthly, all these symptoms are present without any physical signs adequate to explain them. This represents only a superficial point of view and is not strictly true. I shall return to it later.

Finally, the condition is frequently cured by non-medical manipulators by some form of forcible manipulation. The test of cure is that the patient can play tennis without pain, or with only a feeling of soreness quite different from the incapacitating pain.

These, I think, represent the generally recognized facts; at any rate they were the facts known to me when I first began to take a special interest in the subject. I happened at this period to come across a number of cases in a short time. I found in all the recognized tender spot, which varied in position but was usually just above or below the external epicondyle, and, as had been described before,¹ that the pain was often produced by complete flexion of the wrist and fingers; also that on superficial examination all movements were complete. When, however, I specially examined combined movements, this was not the case. Frequently, for example, with full pronation combined with complete wrist and finger flexion the elbow would not come perfectly straight, or if it did come straight there was a distinct feeling of resistance and the process was painful. This is, of course, a complicated movement, but a similar movement of the opposite limb was free and painless. This fact, together with the known frequency of cure by forcible manipulation, strongly suggested that forcing the restricted movement might bring about the desired result. My first case was rather dramatic. The patient was a big strong man, and I insisted on an anaesthetic. Under nitrous oxide I wrenched the arm as follows: with the wrist and fingers flexed and the forearm fully pronated I forced the elbow into hyperextension, making at the same time firm pressure with my left thumb over the tender spot by the external epicondyle. There was a snap like a pistol shot and the horrified anaesthetist insisted that I had broken the arm. The cure was as dramatic as the manipulation. It was a long-standing case and had never been very severe, but the patient assured me that for the first time for many years he was able to take a hard back-hand volley without pain. Further experience has shown me that there is not always so loud a noise,