no department of medicine which so much requires that the physician and the surgeon and all laboratory workers should be in league together.

Note.—This address is based upon an experience of many hundreds of cases of cholecystitis operated upon in recent years, but more particularly upon a series of 81 cases, in which the following examinations were made. Before operation the cholesterol and calcium contents of the blood were estimated, in many cases a Reyfuss test meal was given, and in a few a duodenal intubation was made. The gall bladders removed were first examined by Dr. L. A. Rowden and were then opened; cultures of the bile and of the gall-bladder wall were made; the calcium and cholesterol content of the bile was estimated; and sections were made of the gall-bladder wall. In some cases the blood was examined for cholesterol at varying periods after the operation.

For this work, and for the advantage of many helpful suggestions, I am much indebted to Dr. A. L. Taylor, Dr. Elaine Knowles, Dr. Aileen Wilson, Dr. Fowweather, and my research chemist, Mr. G. Collinson.

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THE PREVENTIVE FRAME OF MIND IN MIDWIFERY.*

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OBSTETRICS has, I think, always suffered by being unfairly compared with the two great sister branches of our practical work, medicine and surgery, for there is really no proper basis of comparison. Medicine and surgery are in practice concerned with conditions which are wholly pathological. In so far as they deal with the preservation of the physiological they come under the heading of preventive medicine. The functions with which the science and art of obstetrics deal partake of both physiological and pathological characters. Obstetrics is thus in a somewhat equivocal position, and, as Mahomet's coffin was believed to be suspended between heaven and earth, so it lies midway between the heaven of the purely physiological and the lower earth of the pathological. On the earthly side we have distinguished obstetricians—as, for example, Professor De Lee in America—who would have us believe that the function of parturition is becoming more and more pathological under the influence of the increasing artificiality of modern life. Our own friend Dr. C. E. Douglas had certainly one foot firmly on the earth when he propounded the suggestion that possibly there was something inherent in the condition of pregnancy which made a woman more prone to death—some diminished power of resistance to disease, call it what you will, some sacrifice which the individual woman offers to the race. On the other side you have the optimists who regard parturition as a purely normal physiological function, regardless of the false analogy which such an expression implies. As has been pointed out again and again, parturition differs from all other physiological functions in that it is performed in the interests of the race, while all others are performed in the interests of the individual only. The truth is that the proper place of obstetrics is partly on the earth and partly in the heavens, and our business is to keep it as far as possible on the higher physiological levels. This, I maintain, can only be done by deliberately adopting and practising a preventive frame of mind.

When we come to think of it in rather more detail, the functions of the modern obstetrician are most pronouncedly

bound up with preventive medicine. I submit that these functions may be summed up as follows:

1. To watch over the health of the expectant mother, and, as far as may be possible, of the unborn child during the period of utero-gestation.
2. To foresee conditions calculated to create difficulty or danger in childbirth, and to take steps either to remove them if possible, or to arrange for the birth to take place in circumstances in which the best obstetric skill may be available.
3. To conduct the delivery so that both mother and child are exposed to the minimum of risk and injury.
4. To restore the mother to her ordinary vocation in life with health and vigour as far as possible unimpaired.
5. To foster her capacity to nurse her child.
6. To see to it that the mother's reproductive organs return to a healthy normal condition fit for further normal functioning.
7. To watch over the health of the infant and thus begin the ante-natal care of the succeeding generation.

Could any programme well be more preventive than this?

The problem of the persistent maternal mortality rate seems to me to offer three sides upon which it is susceptible to attack and to some degree of remedy. The first of these is in regard to the methods of practice, the second is in regard to the conditions of practice, and the third is in regard to the teaching of midwifery.

THE METHODS OF PRACTICE.

How does the general principle of prevention apply to the methods of practice? The first part of the answer is obvious—to wit, that the routine and universal practice of ante-natal examination and supervision promises an immediate improvement in maternal mortality. To recall in detail the benefits to be obtained by ante-natal care would be to go over ground already familiar. But what we have to keep in view and to emphasize in our advocacy is that the benefits are not theoretical or merely possible, but certain. To avert difficulties by foresight and foreknowledge, or to prepare in advance for unavoidable difficulties, is bound in the long run to produce better results than follow from trusting to one's ability to treat unexpected complications as and when they arise. The general public requires education on this point, and I earnestly suggest that one of the duties devolving on each member of such a society as ours is to preach this gospel of ante-natal supervision amongst the public until it becomes universally understood. That the profession also needs to be educated on this point is not so generally appreciated, but it is a fact. In one sense ante-natal care is nothing new, but in another sense—in the sense of the general routine exercise of such supervision—it is a new doctrine to the great majority of present-day practitioners. It is only graduates of the last dozen years or so who have had the doctrine hammered into them as students. To all the older practitioners the teaching that such supervision is an integral part of the obstetrician's duty is new, and it is always a difficult thing to arrest the attention of the profession to new teaching except it be accompanied by some striking discovery—such as, for example, insulin. I am speaking of what I know when I say that our young graduates are sometimes actually discouraged in their efforts to practise ante-natal supervision by seniors who are not alive to its importance.

The methods of ante-natal supervision are simple. A very little practice will produce a reasonable degree of skill in estimating the relative sizes of the head and the pelvis, and in other respects the ante-natal examination is along ordinary medical lines. Another great point is that the means to carry out this principle are already to hand. Financial assistance is offered by the Government to every municipality which starts an ante-natal centre. But it is not enough to establish centres. The women must be got to go to the centres. Our experience in Edinburgh certainly encourages us to believe that, if the centres are established and well run, the patients will be forthcoming in increasing numbers. Furthermore, the practice must be adopted in private by the profession throughout the whole country; the rural districts are the most difficult in this respect. When this is done we shall be making a gallant effort, and infallibly a fruitful effort, to attack our problem. At present in Scotland not more than 9 per cent. of the

* Being part of the valedictory presidential address to the Edinburgh Obstetrical Society.

mothers attend the ante-natal centres. I venture to think that if we could convert that 9 into 90 or, better still, into 99, we should have in large measure solved our problem.

Another avenue along which the problem may be attacked on the side of the methods of practice is the improvement of intra-natal care. Here the general principle of prevention again makes itself manifest in a way which would appear, if we are to judge by results, to be not fully apprehended. It is simply that, in the absence of complications, a natural unassisted labour is always more favourable to both mother and child than an instrumental one. There is no shadow of doubt in my mind that if this were held as a guiding principle in the obstetric practice of the country the maternal and foetal mortality would be very markedly diminished. That the forceps, used under proper indications, is an invaluable instrument is a truism, but will anyone deny that it is employed many times where proper obstetric indications are wanting? This is a point upon which I submit that the specialist is more able to pronounce an opinion than the general practitioner. Only those who have experience of maternity hospital work can fully appreciate the horrors of the "failed forceps case," and only the gynaecologist realizes how many of his hospital beds are occupied with the so-called "successful" instrumental cases of five, ten, or even twenty years ago.

In this matter we can see very clearly the effect which certain discoveries have had upon midwifery. The work of Simpson and of Lister conferred upon the obstetrician a much greater liberty of action than he had previously dared to exercise. Immediately thereafter the further improvements in the axis-traction forceps gave a decided impetus to the employment of that instrument, and to instrumental obstetrics generally. Doctors and patients alike found that labour could be shortened by the use of instruments, and they appreciated this apparent advantage before the less obvious and more remote disadvantages obtruded themselves upon the professional consciousness. As matters stand to-day, the public, as well as the profession, have to be re-educated to the much greater safety, both immediate and remote, of a natural non-instrumental labour—always, of course, provided that real obstetrical indications for the forceps or other operation are absent. Until this re-education is accomplished our younger graduates will receive discouragement in this respect mainly from their patients. The young doctor who, acting up to the teaching which he has received at his medical school, gives Nature the prolonged time which she often requires to accomplish the descent and rotation of the head in an occipito-posterior position, or the moulding of the head through a slightly contracted pelvic brim, runs the risk of being most unfavourably compared by his patients and their friends with other neighbouring practitioners, who are prompt to interfere even, it may be, at the cost of a stillbirth. The pendulum has swung too far in the direction of instrumental interference, and we must try to bring it back to the greater safety of the middle line.

Now, putting aside complications such as ante-partum haemorrhage, which in the present state of our knowledge must still be labelled as largely unpreventable, and also the minor complications which form the proper obstetrical indications for forceps delivery, the fact again obtrudes itself that ante-natal examination enables us to divide our cases in advance into those in which labour is likely to be normal and those in which some form of dystocia may be anticipated. That being admitted, all I am really urging is that the cases in the first group should be allowed to remain normal. A simple application of our preventive principle, but profoundly far-reaching in its results.

This brings me to the next point. It has been shown more than once that the maternal mortality is less in the practice of competent midwives than in the hands of general practitioners. Granted that the figures adduced in support of this claim can be challenged on some points of detail, and admitting that the nurses' figures deal with cases in the main uncomplicated, yet the comparison is very striking when one considers that, so far as normal cases are concerned, the main difference between midwives and doctors is that the former cannot interfere instrumentally with the natural course of labour. Septic infection is easily the

greatest cause of maternal mortality, and equally the greatest risk associated with instrumental interference, and it seems obvious that, as has been laboriously demonstrated by Geddes and others, the doctor engaged in general practice, especially in industrial areas, is in this respect a potentially greater danger to the parturient woman than a trained, competent, and properly supervised midwife whose practice does not bring her into frequent contact with virulent organisms.

Experience in some large practices and considerations such as we have been discussing suggest that no slight advantage might follow the adoption of the plan of handing over a larger proportion of normal cases to the care of carefully chosen competent midwives. An essential condition of this would be that every pregnant woman should see a doctor at least once or more during her pregnancy, and should receive adequate ante-natal examination and supervision, as well as a subsequent post-natal examination. The separation of those in whom conditions are perfectly normal throughout pregnancy, and in whom labour may be expected to be normal, from those in whom there are existing complications or conditions likely to lead to difficulty in labour, can and ought to be made only by a qualified medical practitioner. But with this proviso the plan offers certain advantages. It would avoid the ever-present temptation, to which medical men and women are exposed, of hurrying a delivery because of other calls upon their time, and would thereby secure a considerably larger number of normal spontaneous deliveries. In the second place, it would, if our reasoning is correct, lead to a diminution in sepsis through the diminution in instrumental interference. In the third place, it would relieve the medical practitioner of a great deal of work that is often irksome and harassing, as well as physically exhausting, and would give him more time and leisure to study and to interest himself in the cases which present pathological features.

When we come to consider how best to deal with the second group of cases, in which difficulty is to be anticipated, we find ourselves facing one of the complexities of any such remedial schemes. Logically and, I believe, actually, complicated cases occurring in general practice can be much better dealt with if the patient is placed either in a maternity hospital or in a nursing home where the conditions are suitable for operative intervention. This brings us at once to the all-important point that an increase in the provision of maternity hospital accommodation is an urgent necessity throughout the whole country. But, if pressed to a logical conclusion, this plan would in many cases mean that the family doctor would have almost no midwifery to do. Many doctors would be greatly relieved at such an outcome, but others who are interested in midwifery would feel aggrieved. This is one of the points which require careful consideration, but in considering it let us not lose sight of the big general principle that complicated obstetric cases are in the same category as surgical operations, and obstetric operations are no more suited for performance in the average conditions of general practice than are such surgical operations. Where circumstances permit the family doctor to do his own surgery, then presumably they would also allow of his doing his own difficult midwifery, but where either the inclinations, skill, and experience of the doctor, or the conditions in which he practises, are adverse to his undertaking surgery, then my contention is that they should be accepted as equally adverse to his undertaking difficult midwifery.

Another proposal, which has received support from Professor Munro Kerr among others, involves again the establishment of maternity hospitals in all large centres of population, and maternity departments in existing hospitals in smaller centres, and also the establishment of an official maternity service ramifying from these centres over the whole country. From the point of view of obstetrics alone this is merely a further and more complete development of the plan which we have been considering. The maternity service would exercise practical supervision over all maternity nurses and midwives, and the scheme would include sweeping as many as possible of cases, both normal and abnormal, into hospitals. It would involve the appointment of obstetric specialists in an increased number who,

in the larger centres, might well be whole-time salaried specialists, while in the smaller centres such work would naturally devolve upon doctors engaged in other practice as well. Such part-time appointments would of themselves constitute a formidable difficulty in the harmonious working of such a scheme, and, however logical, admirable, and desirable it may be, the plan would, in my view, lead directly to obstetrics becoming wholly a specialty. I am not at all clear that this is a desirable solution, and I should personally regard with considerable reluctance any scheme which would deprive the doctor, who has a natural interest in obstetrics, of the opportunity of midwifery practice unless he was prepared to specialize wholly in obstetrics. Such a separation of obstetrics from the practice of medicine and surgery would, I think, tend still further to degrade the status of the family doctor in the eyes of the public, and, as Dr. Douglas has so ably shown in his recent Alexander Black Memorial Lecture,* this is a very real danger. I would suggest that an adequate provision of maternity hospitals or maternity departments in cottage hospitals, where family doctors who wish to attend their own obstetric cases could do so under aseptic conditions conducive to the safety of the patients, provides a possible and suitable compromise; and there can be no doubt that the provision of more hospital accommodation and the general encouragement of women to enter hospitals for their confinements—although, in the case of small local hospitals, not necessarily to place themselves in the hands of specialists—would tend to raise the standard of midwifery among the profession generally.

The first scheme—of encouraging the handing over of normal cases in large numbers to the midwife, with the doctor exercising a general supervision and available at need—seems practicable, always provided it is associated with regular routine ante-natal and post-natal examination by the doctor. In a sense it is a reversal of the great struggle which the profession waged and won in the eighteenth century to remove midwifery practice from the control of the midwife. But the difference between the trained midwife of to-day, practising under the supervision of the doctor and the legal control of an active Central Midwives Board, and the ignorant, untrained, and uncontrolled handywoman of the earlier century, is so vast that I do not think such an apparent reversal of the evolutionary process would necessarily be a retrogression. All complicated cases would still come under the care of the medical practitioner, either outside or inside hospital, and in this way the profession, with, I am quite sure, the weight of an enlightened public opinion and the authority of the State behind it, would continue to hold complete control of the whole position.

These, then, seem to me to be two avenues opening before us, and along one or other of them, perchance in some measure along both, the future practice of midwifery is, I think, bound to develop, if we are going to make any serious effort to improve conditions. I do not think that either line of advance is wholly devoid of difficulties and disadvantages, and I do not wish to appear to be advocating either to the exclusion of the other. All I want to do is to lay the matter before the profession in the hope that it will give earnest consideration to it. We cannot afford to stand still, nor can we afford to advance blindly. We must consider the ground carefully from every point of view, and then advance along the line which promises best.

THE CONDITIONS OF PRACTICE.

The second side upon which the problem of maternal mortality is susceptible of improvement is in the conditions of practice. This is mainly a matter for legislative and administrative action, but the medical profession outside the official medical services must exercise effort to secure such action, and be prepared to offer skilled and experienced judgement to mould and guide it. As already said, the public must be made to realize that for the safety of the mother a confinement demands conditions comparable only with those which it is accustomed to associate

with a surgical operation. Nothing has done more in recent years to educate the public on this point than the economic and domestic conditions during and after the war, which made maternity nursing homes in many cases a necessity. Even from this educational point of view alone we do well, I think, to encourage patients to enter such homes. It is an interesting fact that maternal mortality is not necessarily or always at its highest in the poorest slums. The unfortunate denizens of those areas seem to be protected by Providence by a process of immunization through constant contact with dirt. But that does not alter the great principle involved. To my mind by far the best solution of this problem is to provide the necessary increase in maternity hospital accommodation, and then to encourage, or if need be seek powers to compel, every woman in such slum areas to go into a lying-in hospital for her confinement. If experience proves that it is not enough—to adapt in all reverence the words of the parable recorded by the Good Physician—"to go into the streets and lanes of the city and bring in the poor," then we must go further, as the Lord in the parable did, and "send out into the highways and hedges and compel them to come in."

In the next place there is the economic factor as it touches the medical profession. The profession is not an organized system of philanthropy, and, despite the fact that our work affords us more opportunities of helping our fellows than fall to the lot of other professions—opportunities which one is proud to think are usually grasped—yet we have our full share of human failings. It is futile to expect in medicine, any more than in mining, that poorly paid work will be done as well as well paid work. Midwifery in industrial-class practice is not adequately paid, and we cannot hope to raise the standard of obstetric practice very much unless the public, individually or collectively through the State, is prepared to pay for it. This is an unpalatable statement to make, and it is usually for that reason neglected, but I believe it to be a fundamental truth of great importance in this connexion, and I am certain that it is an aspect of our problem that must be considered and remedied.

There are many other points on which I might touch in connexion with the conditions of practice, but I will conclude by saying that a general proposition to keep in view here is that we must welcome and not resent the co-operation of the official and administrative section of the profession in these matters. Without their help we cannot press home the attack along this line.

THE TEACHING OF OBSTETRICS.

This forms the third line of attack on our problem, and I will deal with it very briefly. If the general practitioner has been criticized in the discussions which have been proceeding in a more or less desultory way upon our main topic, the teacher of obstetrics has, of a truth, not escaped censure. I think and hope that we have not made the mistake of confusing criticism for abuse, but have taken the censure in the right spirit and have tried to apply it. Personally I have yet to meet the teacher of obstetrics who is satisfied with the present position. The main weakness, and the only one of which I propose to speak, lies in the limited opportunities available to the student for gaining practical clinical experience before he embarks on practice. The cause of this lies partly in the number of subjects which require to be crammed into a curriculum to which economic conditions put, in general, a time limit; partly in the fact that most teaching hospitals are engaged in training nurses as well as medical students, and a difficulty arises in making adequate provision for both. The obvious solution is the increase of the number of maternity beds available for teaching—a consummation towards which, you will observe, we come by all three lines of approach to our main problem. But until this consummation is achieved, and even afterwards, more stress should, I think, be placed upon what has been described as "an obstetric atmosphere." The naturally erratic incidence of deliveries in any maternity hospital removes the clinical teaching of practical obstetrics from any very fair or helpful comparison with the teaching of clinical surgery or clinical

* See BRITISH MEDICAL JOURNAL, June 18th, 1927, p. 1120.

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.