APPENDIX VII

REPORT OF THE COMMITTEE ON MEDICAL ASPECTS OF ABORTION

I. PRELIMINARY

1. In 1933 the Representative Body of the British Medical Association requested the Council of the Association to report upon the desirability of setting up a special committee, including members of the legal profession, to consider the case for the amendment of the law relating to abortion. During the discussion at the Annual Representative Meeting, 1933, two main arguments were put forward in support of this proposal. It was stated, first, that medical practitioners were unwilling to perform therapeutic abortion—that is, abortion for medical reasons—owing to their sense of legal risk arising from the uncertain state of the law; and, secondly, that the medical profession should endeavour to guide public opinion, which was becoming more and more interested in this question.

2. The Council presented its report to the Annual Representative Meeting, 1934. In this report, while questioning the alleged uncertainty of the medical practitioner as to his freedom to perform therapeutic abortion, the Council stated that if any real uncertainty existed on this point it might be well to get it resolved. On the question of guiding public opinion, the Council, after pointing out that abortion was not solely a medical problem but one which was related also to the criminal law and to social, economic, ethical and religious standards and opinions, proceeded to express the following view: "While medical practitioners as citizens are entitled to hold individual opinions and cultivate activities on these several issues the medical profession as such has no special right and no special competence to deal with them, and the Council therefore considers that any proposal that the profession ought to lead public opinion in such questions is one to be resisted. The medical profession in its corporate activities will best preserve its influence by keeping within the boundaries fixed by the particular expert technical knowledge of its members. If for legal, social, economic, ethical, or religious reasons an inquiry on abortion is advisable, it is for those directly concerned to incur the responsibility and expense."

In concluding its report the Council recommended:

> "That while the Association would be willing to contribute expert medical assistance and/or evidence to any committee set up by the Government to examine the various relations of the practice of abortion, the Association is of opinion that the subject has predominating interests other than medical, and that the initiation of the proposed inquiry does not properly fall within the responsibilities of the medical profession."

3. The Annual Representative Meeting, 1934, adopted the above recommendation in the following amended form:

> "That the Association would be willing to contribute expert medical assistance and/or evidence to any committee set up by the Government to examine the various relations of the practice of abortion."

4. At the same time the Annual Representative Meeting requested the Council to set up a special committee "to consider and report upon the medical aspects of abortion." Accordingly a special committee with this reference was appointed by the Council on July 25th, 1934, and reappointed on July 23rd, 1935.

5. Constitution of Committee. The committee was constituted as follows:

James Young, D.S.O., M.D., F.R.C.S.Ed., F.C.O.G., London (*Chairman*).
R. G. Gordon, M.D., D.Sc., F.R.C.P.Ed., Bath (*Deputy Chairman*).
H. S. Souttar, C.B.E., D.M., M.Ch., F.R.C.
F.R.A.C.S., London (*Chairman of Representa*
Body).
E. Kaye Le Fleming, M.D.(Hon.), M.B., B.Ch., W
borne (*Chairman of Council*).
N. Bishop Harman, LL.D., F.R.C.S., Lon
(*Treasurer*).
T. W. Naylor Barlow, O.B.E., M.R.C.S., L.R.C.
D.P.H., Wallasey.
Aleck W. Bourne, M.B., B.Ch., F.R.C.S., F.C.O.
London.
H. L. Hatch, M.B., M.R.C.S., L.R.C.P., Pinner
Sir Ewen Maclean, F.R.S.Ed., P.C.O.G., M.D.(Ho
F.R.C.P., Cardiff.
Sydney A. Smith, F.R.S.Ed., M.D., F.R.C.P.E
Edinburgh.
Dorothea E. Walpole, M.B., Ch.B., Edinburgh.

II. GENERAL CONSIDERATIONS

6. Having regard to the circumstances in which it
appointed, the committee decided to omit from its surv
such clinical matters as the technique of inducing aborti
It has also regarded abstract and specific questions
economics, equity, morality, and religion as being out
the scope of its inquiry. While it could not entir
exclude from its purview all questions which have b
economic, ethical, or religious bearings, it has confi
its attention to matters with which the medical pra
tioner is concerned in the course of his professional w

7. The term "abortion" is now generally applied
include all cases of expulsion of the foetus before
age of viability—that is, before twenty-eight weeks
seven lunar months. The former practice by wh
"abortion" was restricted to expulsion up to and
cluding the sixteenth week and "miscarriage" to ex
sion from the sixteenth to the twenty-eighth week
now generally discarded in medical phraseology.

8. The frequency of abortion has been variou
estimated. It is, at the outset, clear that on a ma
of this nature figures of accurate statistical value
difficult to obtain. It is well known that in ma
instances early abortion produces such slight clinical m
festations that its occurrence easily escapes notice.
may not be recognized by the patient herself, and it m
be regarded by the doctor as merely implying a distu
ance in the menstrual rhythm. There are many instanc
also in which abortion after two or even three month
amenorrhoea may occur without producing clinical m
festations sufficiently marked to necessitate the attend
of a medical practitioner. It is notorious also that wh
there has been unlawful interference expert advice m
be called only in the event of untoward symptoms deve
ing. For all these reasons it is obvious that there
very great difficulties in any attempt to assess the f
quency of abortion, and any statistics prepared with
object in view must necessarily possess only an appro
mate value.

9. It is generally reckoned that in this country
16 to 20 per cent. of all pregnancies end in abort
Beckwith Whitehouse, in an investigation of 1,148 wom
found that the ratio was 1 abortion to 4.8 labou
Munro Kerr gives figures for Glasgow, which are lo
than those which generally obtain. In an analysis of
women he found that there were 1,376 children and
abortions—that is, approximately 1 abortion to 7 labou

10. The relative proportions of abortion which are
on the one hand, to accident and disease—that is, "
taneous" abortion—and, on the other hand, to intent
and unlawful interference, are impossible to estimate

any degree of accuracy. The main reasons for this are sufficiently obvious when it is remembered that it is often difficult or impossible under ordinary conditions to obtain admission of an unlawful intent. Even where, as in some published hospital records, information on this question is forthcoming, the data are subject to the criticism that clinical material of this kind is for obvious reasons apt to be selectively overweighted by a preponderance of the serious—that is, the unlawful—cases.

11. Attempts have been made with varying success to obtain data of statistical value in regard to the frequency of spontaneous abortion. Thus, for example, Bluhm made an investigation into the family history of clergymen in Germany. The investigation of this selected community, it was felt, was more likely to be free from those complicating issues associated with unlawful interference which obtain in the general community. It was found that the abortion rate in a total of 186 conceptions so studied was 7.5 per cent., with a possible error of ± 2 per cent. due to the smallness of the figures. It is true that these figures relate to a more or less sheltered section of the population, and that it would be unwise to employ them for purposes of general application. Nevertheless they do suggest that spontaneous abortions constitute a relatively small proportion of the total. This is borne out by the investigations of Bumm, who in unselected groups found a spontaneous rate of 5 per cent. These figures are quoted from Freudenberg.*

12. The high degree in which abortion in this country is contributing to the maternal death rate is recognized as constituting a public health problem of great gravity. The Departmental Committee on Maternal Mortality and Morbidity (1932) showed that of maternal deaths directly due to child-bearing 13.4 per cent. were caused by abortion. The dominating cause of the fatal issue in abortion is sepsis; during the years 1930–2 this factor was responsible for 72.5 per cent. of the abortion deaths. It is well known that the majority of these sepsis deaths occur in cases of an unlawful nature. This will be dealt with more fully under a subsequent heading (para. 42).

13. Intimately bound up with this aspect of the subject is the question as to whether there is any evidence of an increase in the frequency of abortion. The data in regard to this matter are uncertain and conflicting. The figures of Beckwith Whitehouse, who found that the abortion rate in a large group of women investigated in the post-war period did not differ materially from a similarly large pre-war group, and those of Malins of thirty years ago, who then found an abortion rate of 1 in 6, tend to argue against any such appreciable increase. In contradistinction to such evidence we have, however, the statements of the Ministry of Health, which show that since 1930, when abortion deaths constituted 10.5 per cent. of the maternal mortality, there has been a steady rise to a percentage figure of 16 in 1933. The committee, further, has received evidence which suggests that within the past decade there has been an increase in abortion of an unlawful nature. This subject will receive fuller consideration in a subsequent paragraph.

14. A consideration of abortion in its relation to the doctor raises issues of a manifold character, with all of which he is concerned in varying degrees. In addressing itself to this subject the committee has regarded itself as called upon to deal especially with the view, which is often expressed, that the existing state of the law renders the circumstances governing therapeutic abortion unsatisfactory both to the doctor and to the best medical interests of his patients. The committee has, in addition, given attention to those aspects of unlawful abortion which more especially concern the medical profession in its capacity as the guardian of the nation's health.

It is found convenient to discuss these questions under the following headings:

The law relating to abortion as it affects the medical profession.

The indications for therapeutic abortion.

The medical aspects of the problem of criminal abortion.

* Freudenberg, K.: Berechnungen zur Abtreibungsstatistik, *Z. f. Hygiene und Infectionskrankheiten*, 1925, civ.

III. THE LAW RELATING TO ABORTION AS IT AFFECTS THE MEDICAL PROFESSION

The Law in this Country

15. The law concerning abortion is set out in Sections 58 and 59 of the Offences Against the Person Act, 1861:

"58. Every woman, being with child, who with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever, with like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be 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, at the discretion of the Court, to be kept in penal servitude for life or for any term not less than three years, or to be imprisoned for any term not exceeding two years with or without hard labour, and with or without solitary confinement.

59. Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour, and being convicted thereof shall be liable, at the discretion of the Court, to be kept in penal servitude for the term of three years, or to be imprisoned for any term not exceeding two years, with or without hard labour."

The Interpretation of the Law

16. In discussing the interpretation of Section 58 of the Offences Against the Person Act, the *Lancet*, on January 29th, 1927, stated:

"Perhaps if it [the law] were re-enacted again to-day an express proviso would be inserted to exempt from criminal liability the fully qualified practitioner who terminated a pregnancy for the *bona fide* purpose of preserving the mother from special danger to life or health. But, as it stands, the law contains no such saving clause; its language is formidable and uncompromising. How comes it, then, that such operations are ever otherwise than criminal? The answer lies in the word 'unlawfully,' which creates the implication that abortion may be lawful as well as unlawful."

What, then, are the circumstances (if any) in which the artificial termination of pregnancy is not illegal? Lord Riddell gave his view of the correct answer to this question when, in his address to a joint meeting of the Medico-Legal Society and the Section of Obstetrics and Gynaecology of the Royal Society of Medicine on January 21st, 1917, he summarized the law as follows:

"It is contrary to the law to procure or attempt to procure a miscarriage except with the object of saving a mother's life or avoiding serious injury to her health. The essence of the offence is a guilty intent. An honest effort to save the life or health of the mother is not illegal, although the practitioner may commit an error of judgement in performing an operation subsequently regarded by other practitioners as unnecessary. He will not be liable to conviction if he honestly believes that what he does is required to save the mother's life or health. If the mother dies in consequence of an illegal abortion, the person performing it may be liable for murder or manslaughter, but these offences cannot be committed in respect of a child in its mother's womb, as the child is not *in rerum natura*. If, however, the child is born alive and subsequently dies, owing to injuries received *en ventre sa mere*, the offender may be convicted of murder or manslaughter."

Consequences of the Vagueness of the Law

17. It has been suggested that there need be no uncertainty in the mind of the medical practitioner as to his freedom to induce abortion, since the law is in fact adaptable in practice, although not in theory, to changes in social thought. To this argument it may be replied that it is unfair to place upon the doctor the responsibility of interpreting public opinion on such matters. Further, that doctors do differ widely in their views and in their practice there is no doubt. The case of pregnancy following rape below the age of consent

may be taken as an example. The law would seem to imply that a girl aged 13, who is the victim of rape and whose pelvis is too small for safe delivery, should be carried on to full term for delivery by Caesarean section. Is this in accordance with the wish of the community? It is certain that in such a case, quite apart from their religious views, some doctors would refuse to induce abortion, while others would have no hesitation in performing the operation. A similar difference of opinion exists—to take another example—with regard to the legality of inducing abortion for eugenic reasons. Of the leading physicians who submitted memoranda to the committee one apparently regards it as beyond dispute that the pregnancy of a woman of haemophilic stock should be terminated, while another is content to express a "pious hope" that a time will come when abortion may legally be performed to prevent the birth of defective offspring.

18. As bearing on this aspect of the law in relation to abortion the Committee would direct attention to the terms of the Infant Life (Preservation) Act, 1929, Section 1 of which reads as follows:

> 1. (1) Subject as hereinafter in this subsection provided, any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life.
>
> Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.
>
> (2) For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be *prima facie* proof that she was at that time pregnant of a child capable of being born alive.

It is herein specifically implied that death of a *viable* child resulting from interference with a pregnancy carried out in good faith for the preservation of the life of the mother is not an offence against the law. It may be urged with considerable justification that by comparison with this Act the law relating to abortion is inconsistent in the uncompromising nature of its language, especially having regard to the fact that the interference with the pregnancy is here necessarily concerned with the death of a *non-viable* child.

19. Quite apart from the wider questions discussed in paragraph 17, it is often urged that the vagueness of the present law allows of a wide latitude of interpretation and that this may lead to very unfortunate consequences. It is stated, at one extreme, that the law is regarded as justifying abortion on the basis of the mental anxiety, sleeplessness, etc., which accompany an unwanted pregnancy, whilst, at the other extreme, it is contended that the doctor may by his reading of the law allow the patient's health to be seriously prejudiced in the absence of overwhelming evidence that the continuance of the pregnancy is certain to cause death. The committee considers that such statements are by no means without foundation. True, it is now generally believed that the termination of pregnancy in the early months is permitted by law where this is carried out with the object of safeguarding the mother's life or health, and that the doctor who performs the operation in the honest belief that these indications exist is free from the risk of conviction. Nevertheless, in its present uncompromising form, the law must be regarded as containing elements which in certain circumstances may leave the position of the doctor exposed to risks of suspicion and professional damage. It should be recognized clearly that under prevailing conditions it is not conviction alone that is dreaded; indictment of itself, however unjustifiable, may as the result of its concurrent publicity severely damage the professional reputation of a medical man. It has been stated on grounds that the committee believes to be well founded that in the present state of the law practitioners may demur to perform therapeutic abortion, with a consequent risk of sacrific[ing] the health or life of the patients under their care.

Desirability of Revision of the Law

20. Within recent years there has been consid[erable] agitation in favour of a revision of the law [of] abortion. With many aspects of this movement [the] committee is not concerned. It has, however, b[een] represented on many sides, both by the profession [and] by the public, that there is need for an investigation [of] the whole question with the object of clarifying [the] position of the doctor in regard to the law. With th[is] view the committee is in agreement. While it is man[i]festly impossible to provide exact indications for th[e] induction of abortion, the committee considers it m[ost] desirable that the law should at least contain an expli[cit] statement of the principles which should govern the law[ful] artificial termination of pregnancy.

21. Such a rewording of the law, however, would n[ot] in itself remove all the existing difficulties. For th[e] opportunity for difference of opinion in regard to th[e] urgency of the medical indications may expose an honou[r]able practitioner to the risk of his judgement be[ing] publicly impugned even where he is protected against th[e] major risk of criminal intent. It is important that th[e] practice of abortion should be so regularized that doct[ors] can be completely safeguarded against risk where th[e] treatment is determined by entirely reputable decision[s]. The committee thinks that careful consideration shou[ld] be given to the question as to how far this object c[an] be accomplished by insisting that abortion should b[e] carried out only after the approval of two practitio[ners] has been obtained. To remove any question of collusi[on] it might with advantage be required that one of th[e] approving doctors should have some recognized st[atus] on the analogy of the "approval" given by the Bo[ard] of Control under the Mental Treatment Act, 1930. Th[is] the committee believes to be a proposal of very g[reat] importance, the acceptance of which would be one [of] the greatest boons that could possibly be conferred [on] the profession in regard to this whole matter.

Some recent changes in the law relating to abort[ion] in other countries are described in Sub-Appendix I.

IV. THE INDICATIONS FOR THERAPEUTI[C] ABORTION

22. The arbitrary nature of the indications for th[era]peutic abortion renders decisions on this question amo[ng] the most difficult and, at the same time, the most resp[on]sible which the doctor is called upon to make in [his] practice. In the preceding paragraph statutory m[eans] have been suggested by which the interests of both doc[tor] and patient might be safeguarded. The committee belie[ves] that a further means towards the same end would [be] attained if indications which at present are often arbit[rary] and vague were replaced by standards of a more unif[orm] nature and possessing the advantage of a reason[able] measure of general agreement.

23. The committee has carefully considered how such an object can be realized, and has in the follo[wing] pages attempted to formulate in a more or less c[om]prehensive manner under the various systems the med[ical] indications for the artificial termination of pregn[ancy]. It would at the outset make it clear that, in the pr[esent] state of medical opinion, the statement must be reg[arded] as tentative, and that it is merely advanced as a b[asis] for further discussion. In formulating its views the c[om]mittee has obtained the assistance of authorit[ative] exponents of the individual questions dealt with.

A. Cardiovascular Conditions

24. In women of child-bearing age at least 90 per c[ent] of organic heart disease is of the rheumatic type. [Once] established such disease tends to run a progressive co[urse] frequently ending in death from congestive heart fa[ilure] before the age of 40. Therefore, while it is possib[le to] assess with a considerable degree of assurance the im[me]diate risk of pregnancy and labour proving fatal,

more difficult to gauge the remote risk of pregnancy and labour producing an aggravation of the cardiac disability which will shorten life. It is not easy to apportion the blame for aggravation between the strain incidental to pregnancy, the normal downward tendency of the disease, and the extra burden imposed by an additional child on a mother whose activities are already limited by her damaged heart.

25. The great majority of pregnant women suffering from heart disease, given adequate care and supervision, are able to go to term and be delivered, either naturally or by Caesarean section. In a consecutive series of 300 cases there were only seventeen in which therapeutic abortion was performed, and only seventeen in which death occurred either before or shortly after delivery (including two cases in which death followed therapeutic abortion). In only eight of the 300 cases was death attributable solely to the cardiac condition.

26. The following are the main conditions in which the question of inducing abortion ought nevertheless to be considered:

Congestive Heart Failure.—(*a*) A *previous attack* of congestive heart failure is a certain indication for therapeutic abortion. No woman who has suffered from this condition, whether during a previous pregnancy or not, should have another child.

(*b*) Congestive heart failure *during the first three months* is not common, and when it does occur thus early it is probably not directly related to the pregnancy. Nevertheless it is desirable in such cases that the uterus should be emptied, since an added load on the circulation can be anticipated as time goes on, and the heart failure of itself will tend to grow worse. However, to operate in the presence of congestive heart failure without adequate preparation is literally a fatal mistake; but after suitable pre-operative treatment abortion may be induced without undue risk.

(*c*) Pregnancy should be terminated before the end of the third month in those cases in which it is probable that congestive heart failure will appear *before the fifth or sixth month*. During the first three months it is usually possible to judge fairly accurately whether this condition will occur and when it may be expected; and the probable time of its appearance is the most important factor in determining whether the uterus should be emptied. Those women who sleep badly, complain of puffiness of the feet and ankles, and are made breathless on slight exertion are liable to show signs of congestive heart failure by the time the sixth month is reached. In such cases abortion should be performed as early as possible after adequate preparation. The onset of the condition after the sixth month is less dangerous, and usually in these cases the reserve power of the heart can be so restored as to permit of the successful delivery of a living child. The series of 300 cases mentioned above included twenty-one in which signs of congestive heart failure were present when the patients first came under observation. Six of these patients died before or soon after confinement, five are known to have died within four years after confinement, and four others to have been detrimentally affected. These figures indicate the extreme gravity of established congestive heart failure in the pregnant woman.

Auricular Fibrillation.—A woman showing auricular fibrillation in the early months of pregnancy is a thoroughly bad risk, as she is liable to develop serious congestive heart failure. The pregnancy of such a woman should be allowed to continue only in exceptional circumstances. Auricular extrasystoles are commonly the precursors of auricular fibrillation, and should be regarded seriously, especially when the myocardial reserve is already low.

Repeated Haemoptyses.—Repeated small haemoptyses occur occasionally in subjects of mitral stenosis without there being at the time any evidence of congestive heart failure. Occurring in the early months, this is a danger signal which demands immediate attention. The earlier it is observed the more desirable is the termination of the pregnancy.

Paroxysmal Tachycardia.—This condition is uncommon in pregnancy but can of itself be an indication for abortion. Each case must be judged on its merits, particularly in regard to the response to treatment and the functional efficiency of the heart in the intervals between the attacks.

Complete heart-block is not an indication for termination of pregnancy if the reserve power of the heart is good.

Other Conditions.—Other conditions in which therapeutic abortion may be advisable include the following:

(*a*) Where, in a case of mitral stenosis, there is clear evidence of antecedent embolism, cerebral or pulmonary, whether in association with a previous pregnancy, delivery, or puerperium, or occurring apart from pregnancy.

(*b*) Where, in a middle-aged woman, more especially if she is a primigravida, there is clear clinical evidence of myocardial degeneration—enlarged heart, and/or aneurysm, and/or angina on effort.

(*c*) Where a woman has congenital morbus cordis, with much cyanosis and poor tolerance on effort, and where even early pregnancy definitely enhances her disability.

(*d*) Where a young woman, in the early weeks of her pregnancy, is found to have arterial disease with persistent high blood pressure (150 or over) and definitely enlarged heart, since cerebral haemorrhage and/or heart failure and/or sudden death are likely to occur if pregnancy is allowed to continue.

(*e*) Where a woman, in the early weeks of pregnancy, is found to be suffering from progressive bacterial endocarditis. This is generally a fatal disease, but certain unusual cases may be considered as suitable for the induction of abortion when the condition is discovered during the early months.

B. Renal Conditions

27. *Chronic Nephritis.*—There is no doubt as to the ill effects of pregnancy on the kidneys of patients with nephritis. Exacerbation of the disease in such patients is the rule, and reappearance of symptoms in patients with albuminuria, but in whom other symptoms are absent, is a common event. When to this known damaging influence on the kidney of the mother is added the liability to death of the foetus, the desirability of therapeutic abortion in patients with chronic nephritis can hardly be questioned.

Previous Eclampsia or Pre-eclampsia.—Where there is a history of eclampsia or pre-eclampsia in a previous pregnancy the recurrence of similar symptoms at an early stage of a subsequent pregnancy may necessitate the induction of abortion.

Pyelitis.—Therapeutic abortion may be advisable in certain severe cases of acute and subacute pyelitis.

Tuberculosis.—Therapeutic abortion may be advisable where there is tuberculosis of the kidney, with clinical evidence of pyelitis and diminished renal function.

C. Pulmonary Conditions

28. *Tuberculosis.*—The problem of therapeutic abortion in chest conditions is largely confined to cases of pulmonary tuberculosis. The sequence of pregnancy, parturition, and lactation may exert an unfavourable influence on the course of this disease at all stages. During the actual course of the pregnancy there may be some temporary amelioration of the symptoms, or even an apparent quiescence, but this is usually illusory. After parturition, in spite of special precautions and the prohibiting of lactation, there is as a rule a rapid and marked increase in activity, often of acute character. It not infrequently happens that the disease first declares itself after the first pregnancy, and the course is then often acute and rapidly progressive.

When pregnancy occurs in a woman suffering from *active* tuberculosis the question of therapeutic abortion should be considered in the early months. There is a general consensus of opinion among both obstetricians and physicians that if intervention occurs after the third or the early part of the fourth month the effects on the disease are as marked as if the pregnancy had been allowed to proceed to term. The decision should therefore be made as early as possible, so that if abortion is decided upon it may be induced before the third month.

When a patient with *acute, rapidly spreading disease* is seen, even in the early months of pregnancy, as a

general rule induction of abortion is of little use, as the effects are likely to be unfavourable and the chances of prolonging life are small. Each such case must, however, be judged on its own special features.

If, in the case of a pregnant woman seen in the early months, there is a history of antecedent active tuberculous disease of the lungs or pleurae, or if there is a marked family history of tuberculosis, especially in a primigravida, it should be a routine procedure to carry out a thorough investigation to exclude the presence of active or *recently quiescent* lesions. If definite indications of recent activity are apparent, and especially if laryngeal or intestinal lesions are present, therapeutic abortion should be advised. If in a case of *arrested disease* there have been no active symptoms for three years and the *x*-ray examination shows healed fibroid lesions without cavitation, localized to one or two lobes, and if the patient appears healthy in other respects, the pregnancy should not be terminated. Even in cases where the disease has been more extensive, but where arrest has been stable for some years, the pregnancy may be allowed to proceed, especially if the parents are anxious to have a child, but the risks should be clearly explained to the patient and her relatives.

Other Conditions.—Certain other severe non-tuberculous conditions may have to be considered in relation to therapeutic abortion.

In bronchiectasis the likelihood of septic complications outweighs any possible advantage of abortion.

D. Blood Conditions

29. In certain severe and intractable diseases of the blood, pregnancy may be exceedingly dangerous to the mother and therapeutic abortion may have to be considered ; as, for example, in Leukaemia, Hodgkin's disease, Splenic Anaemia, Aplastic Anaemia, Agranulocytosis, Essential Thrombocytopenia, and refractory forms of Pernicious Anaemia.

E. Gynaecological Conditions

30. Cancer of the cervix is the chief gynaecological indication for therapeutic abortion. If the growth is not beyond reasonable hope of cure the case should be treated by radical operation or by radiation therapy subsequent to therapeutic abortion. If the disease is too far advanced to allow of such therapeutic measures, the pregnancy should not be disturbed.

F. Organic Nervous Conditions

31. Certain severe and refractory cases of chorea gravidarum would seem to be the only organic nervous condition which is improved by therapeutic abortion.

G. Mental Conditions

32. *Psychoneuroses.*—When considering these conditions it is essential to guard against the tendency to use the alleged presence of nervous symptoms as an excuse for terminating an unwanted pregnancy. The first necessity is to make certain that a definite psychoneurosis exists. Even when this is certain abortion is seldom indicated. There are, however, rare cases in which the pregnancy may be considered of psychological importance as a precipitating or aggravating factor, and in which cure is thought to be unlikely if the pregnancy is allowed to continue.

33. *Threatened Suicide.*—There are certain cases in which the risk of suicide is advanced as a reason for therapeutic abortion. In the majority of these abortion is not indicated, but the decision as to this point depends upon the accurate diagnosis and assessment of the merits of each individual case, which can be determined only by a mental expert.

34. *Psychoses.*—Pregnancy occurring in a woman with an established psychosis is unlikely to influence materially the course of the disease. If, however, the pregnancy is thought to be a causal factor, or if it occurs during a remission, abortion may well be justified to prevent aggravation or relapse. In other cases abortion may be deemed advisable, in order to preserve life or to prevent the possible onset of mental disorder.

(*a*) *Manic-depressive Psychosis.*—When this psych occurs during pregnancy the patient usually reco before or after parturition, and there is no proof abortion shortens the attack. In some cases of depress however, the psychosis may be held to be definitely to anxieties and conflicts associated with the pregnan In these cases suicide is a distinct danger, and justifi tion for abortion is probably commoner in this class case than in any other. If it is to be done it should carried out as soon as possible, as the more establish the psychosis is allowed to become the less certain abortion to cut it short, and the greater becomes the of the abortion acting as a psychic trauma with aggra tion rather than alleviation of the mental condition.

(*b*) *Schizophrenia.*—When the onset of this condit takes place during pregnancy abortion may be conside justifiable. While there is little clinical evidence to sh that abortion benefits these patients, the condition is serious that it may be desirable to give the patient benefit of the doubt. If there is intervention it is p ticularly desirable that this should take place as ea as possible, before the psychosis is fully established.

(*c*) *Organic Psychoses.*—Clinical evidence is agai abortion in G.P.I. and chronic epidemic encephalitis. the other hand, abortion appears justifiable in cert psychoses associated with epilepsy—for example, if the are becoming much more frequent or the mental stat deteriorating. Status epilepticus in pregnancy is v rare, but when it does occur abortion appears to indicated.

(*d*) *Previous Insanity.*—When the patient has previo suffered from a psychosis it is not easy to judge whe abortion may be advisable as a prophylactic meas If the former attack or, still more important, atta were associated with pregnancy, abortion might be justifi It must be appreciated, however, that if only one previ pregnancy has been accompanied by a mental breakdo the chances are that the present pregnancy will not so accompanied, and that, even if it were, recovery again take place. It must also be borne in mind abortion would not be a sure preventative. In the of *puerperal or lactational insanity* there is reason believe that the termination of pregnancy is desirab the patient has suffered on two or more previous o sions, or if her mother has suffered from this condi and she herself has so suffered on one previous occasio

H. Miscellaneous Conditions

35. *Diabetes.*—While it occasionally appears that p nancy is responsible for a deterioration in the cond of a diabetic patient, the great majority of such pati may be allowed to go on to term without fear of se damage resulting.

Exophthalmic Goitre.—Therapeutic abortion should a general rule, be avoided in the mild cases of ex thalmic goitre, inasmuch as improvement is often ciated with pregnancy, but in severe cases associated toxic myocarditis abortion may be indicated.

Diseases Arising Out of Pregnancy.—These include vomiting and toxic jaundice. Such conditions occasio call for therapeutic abortion.

Neoplasms.—Malignant tumours generally do not stitute an indication for therapeutic abortion, with exception of certain cases of carcinoma of the (see para. 30).

Repeated Dangerous Labours.—The doctor is consulted during early pregnancy with a vie induction of abortion because the patient's pre labours have caused grave anxiety by reason of mech difficulty, inertia lasting several days with subse risks of sepsis, adherent placenta causing haemorrhag sepsis, and other conditions. Many of these wome suffering in addition from *mental trauma*, following repeated ordeals of pain and danger, which cause and depression. It is a fact that the mortality of bearing rises steadily after the fourth pregnancy therefore where previous labours have been dangero statistical risk will increase with successive labour the consideration of these patients it is important to whether previous difficulties have been due to

mechanics such as pelvic contraction and malpresentation, or due to disturbed function, illustrated by severe inertia, adherent placenta, and haemorrhage. The former group can generally be treated safely by Caesarean section, but in the latter group there may still be danger even if Caesarean section be performed. Further, these women are often in a state of depressed health and vitality, due to their previous difficult labours, and for them Caesarean section is not as safe as for the normal healthy pregnant woman. Each case in this group must be considered on its merits. Most doctors will agree that where the dangers or difficulties are such that they are liable to be repeated, possibly with greater intensity, it is correct to perform abortion.

Rapidly Repeated Pregnancies which cause Depressed Health.—It is well known that there are women who have had many pregnancies at short intervals, which have reduced them to a condition of physical and mental debility. If, after consultation and examination, it is certain that their physical and mental health is being affected and there is reasonable certainty of chronic invalidism resulting from the current confinement, then induction of abortion should be seriously considered.

Pregnancy following Rape below the Age of Consent.—It is well known that girls under 16 years of age usually pass through labour without difficulty or danger. A valid medical reason based upon physical considerations can seldom be advanced on account of age alone, but whether the severe *mental* injury, caused by an experience so dreadful as childbirth at a tender age, should not be accounted an even greater indication than physical danger is a point to be considered very seriously.

I. Hereditary Conditions

36. Whilst under existing conditions reasons based on eugenic considerations are generally regarded by medical men as falling outside the scope of therapeutic abortion, the committee believes that there are certain cases of this class which constitute justifiable indications. It is of the opinion that therapeutic abortion should be considered when, in the light of modern medical knowledge, there is reasonable certainty that serious disease will be transmitted to the child. The following are conditions in which such indications may occur.

Mental Deficiency.—The offspring of two mental defectives will almost certainly be mentally defective, while the offspring of a mental defective mated with a normal person may be defective or psychopathic and will probably transmit to one or more members of the next generation either mental deficiency or some psychopathic trend (such as a tendency to alcoholism, epilepsy, insanity, congenital psychasthenia, or drug addiction).

The following are conditions in which abortion might be thought allowable:

(*a*) If both parents are certified mental defectives.

(*b*) If the father and one child are certified mental defectives.

(*c*) If the father is psychopathic and one child is a certified mental defective.

(*d*) If two certified mentally defective children have already been born (even when neither parent is apparently defective or psychopathic).

Other Hereditary Conditions.—Hereditary conditions which might be thought to justify the termination of pregnancy in the interests of eugenics include certain good conditions, hereditary deaf-mutism, and hereditary blindness.

THE MEDICAL ASPECTS OF THE PROBLEM OF CRIMINAL ABORTION

Prevalence and Danger of Criminal Abortion

37. In previous pages reference has been made to the gravity of the problem of criminal abortion from the standpoint of public health. In modern civilized communities the deaths from abortion comprise a large proportion of the total maternal mortality rate. The Final Report of the Committee on Maternal Mortality and Mortality (1932) indicated that in England and Wales 13.4 per cent. of maternal deaths were caused by abortion. This figure, although high, is considerably lower than the rates found to obtain in some other countries—for example, Germany, Holland, and Sweden.

38. Attention has already been drawn to the fact that there is no means of assessing accurately the extent of the practice of criminal abortion. It is notorious that, where there has been criminal interference, expert advice may be called only in the event of untoward symptoms developing. Further, in many instances where there is a strong suspicion of unlawful interference it is extremely difficult to obtain evidence to warrant the case being so classified.

39. The statistics of deaths from criminal abortion give no true indication of the frequency of the practice, since it is certain that for every fatality there is a large number of women who escape with their lives. In the absence of definite statistical evidence, the committee nevertheless considers that the opinion universally held by the medical profession that interference with pregnancy for reasons other than medical is widely prevalent among all classes of society must be accepted as truly indicative of the general situation.

40. The dominating cause of post-abortion mortality is sepsis. In England and Wales during the years 1930–2 sepsis accounted for 72.5 per cent. of the abortion deaths. The reports on maternal mortality in New York and Philadelphia give percentage rates of 73.4 and 86.2 respectively.

41. There is strong evidence for the view that the great majority of the deaths from abortion follow illegal interference. The high degree to which sepsis contributes to the mortality confirms this view. In the absence, however, of any reliable data regarding the total incidence of abortion in the community and, among those cases that are known, of the relative proportions of the spontaneous and the criminal types, an accurate estimate of the extent of the danger to the public health inherent in the illegal interference with pregnancy is difficult to establish. It has generally been considered that it is legitimate to assume that the bulk of the sepsis deaths follow instrumental interference, and from this it has been concluded that the overwhelming proportion of the abortion death rate is caused in this way. This view, in addition, has behind it the clinical experience of all who have directed special attention to these questions. At the same time there has been singularly little evidence of a convincing nature published in this country and based upon an adequate series of figures. Recently Parish[1] has studied 1,000 cases of abortion treated as in-patients in St. Giles's Hospital, Camberwell, during the years 1930 to 1934. In this total 485 women admitted illegal interference, 111 by means of drugs only and 374 by means of instruments (syringe 108, syringe and drugs 170, catheter 7, slippery elm bark 16, knitting needle 5, abortionist 9). In 246 there was no evidence of interference, and in this group pathological factors which were present were regarded as providing the explanation. In the remaining 269 the aetiology was unknown. It is significant that in the group of 374 due to admitted instrumentation the febrile rate was 88.2 per cent. and the death rate 3.7 per cent., whilst in the group of 246 due to pathological conditions and with no history of interference the febrile rate was only 5.7 per cent. and the mortality rate *nil*. This record tends to confirm the commonly accepted view that illegal interference contributes in an overwhelming degree to the mortality from abortion. The figures just quoted refer to hospital cases, and, therefore, to clinical material of a selected character from which it would be unwise to generalize in regard to the conditions obtaining in the country as a whole. Probably it may safely be assumed that the secrecy surrounding the illicit practice implies that for this type hospital figures are more selectively overweighted with the serious cases than obtains for spontaneous abortion. Nevertheless, the figures of Parish do tend in a convincing manner to emphasize that the criminal operation plays a dominating part in the death rate from abortion.

[1] Parish, T. N.: "A Thousand Cases of Abortion," *Journ. Obstet. and Gynaecol. British Empire*, December, 1935, p. 1107.

42. It is unnecessary to state that the high degree in which sepsis contributes to the death rate is to be explained by the fact that the interference is, in general, carried out by persons who are unskilled, and often dirty in their person and careless in their methods. The committee obtained evidence from medical men with considerable experience in the investigation of the medico-legal circumstances associated with such deaths which revealed the appalling conditions under which abortionists often undertake their work. For example, in a case in which a woman was found with a piece of catheter in the cervix the abortionist charged with the crime was discovered to possess numerous similar fragments which she apparently used over and over again. It was proved that she had been responsible for a large number of cases of septic abortion.

SOCIOLOGICAL FACTORS

43. Among the factors that constitute the sociological background of criminal abortion there are two that stand out prominently. There is, first, the relatively greater frequency of the practice in the towns as compared with the rural districts. The higher urban incidence is a feature of all modern communities. The Registrar-General states that in England and Wales during 1930 the percentage of the total maternal mortality due to sepsis caused by abortion was 35.1 for London, 24.6 for county boroughs, and 19 for rural districts. In some Continental towns the rate is higher. Thus, in Berlin, during the years 1922–4, the percentage of the maternal sepsis death rate due to abortion was 81.2, whilst in Stockholm it has been computed that during the five-year period 1926–30 post-abortion sepsis accounted for more than 50 per cent. of the total maternal death rate.

44. The second finding of sociological importance in respect of criminal abortion is its relatively high frequency amongst married women. This fact has been repeatedly emphasized in the evidence which the committee has had presented to it. Parish, in his investigation of 485 abortions in which illegal methods were admitted, found only forty-one—that is, 8.2 per cent.—in single women. In further cases the illegal procedure had been carried out by widows or women known to be living apart from their husbands. "In seventy-eight out of 100 patients who were questioned fully, poverty appeared to be the determining factor, in nine cases obstetric fears due to previous difficult confinements were given as the reason for procuring abortion, and in the remaining thirteen cases the excuses given were considered to be trivial."

45. In any attempt to assess the extent of the danger to the health of the community caused by criminal abortion it is important to remember that, in addition to the toll which it exacts each year in the form of deaths from sepsis and other causes, there is a much greater number of women whose health is injuriously affected, often permanently, by the damage which they then sustain. It is known that many of the gynaecological beds of our hospitals are continuously occupied by women with chronic pelvic inflammation which is traceable to this cause.

IS CRIMINAL ABORTION INCREASING?

46. The committee has been unable to obtain unequivocal evidence to support the often-expressed view that illegal abortion is increasing. The Registrar-General's figures show that the total deaths in England and Wales attributed to or associated with abortion during the six years from 1928 to 1933 were as follows: 488 (244), 605 (238), 568 (300), 503 (229), 538 (262), 560 (257). These and the number of deaths during the corresponding years from post-abortion sepsis, which are shown in brackets, reveal no appreciable trend during this period. At the same time, as has previously been indicated, the Ministry of Health figures, which are based upon the reports of maternal deaths received through the local health authorities, show that the percentage of the maternal mortality attributable to abortion has increased from 10.5 in 1930 to 16 in 1933.

PREVENTIVE MEASURES

47. The committee believes that the placing of th peutic abortion on a sound basis in respect of the would tend to some extent to reduce the incidence unlawful abortion in so far as it would remove occasions for the illicit practice being resorted to women in whom there may be adequate medical grou but who, under present conditions, find it difficult obtain the necessary medical sanction. The commi is convinced that the adoption of some such method has advanced to ensure greater protection than existi present of the doctor who carries out therapeutic abor with honourable intent would, by increasing the *bona fide* practice, tend to a corresponding lowering of unlawful procedure.

48. The committee has carefully considered how *notification of abortion*, which has been recommended influential quarters, would be likely to assist in contro the present position. It is satisfied that, apart fr providing data regarding the incidence of the therape operation, this procedure could not be expected to furn any reliable information regarding the incidence and risk associated with abortion in general. The consid tions which explain the difficulty in obtaining accu clinical data, to which reference has already been m apply with equal or even greater force to notification, is certain that strenuous resistance would be offered the patients and their relatives to such inquiries might be made by the medical officer of health, and effect of the plan might well be to increase the reluct of the patients to consult a registered medical practitio

49. It would be inappropriate for the committee express an opinion in regard to such matters as the so the economic, and the ethical factors which are mately bound up with the widespread practice of unla abortion. These constitute aspects of the question which the doctor, in his confidential relationship with public, is often brought into immediate contact, and influence and meaning of which he is naturally peculi able to appreciate. At the same time, the validity of claim that such considerations should be advanced they have been advanced in influential quarters, in fa of the legalization of abortion for other than m reasons, is not one on which the profession in its corp capacity can be expected to express an opinion. of course, impossible to divorce these larger question which the community as a whole can alone adjudi from one consideration which is of profound significan the public health, and which indeed constitutes a s argument in support of the propaganda to which refe has just been made. This is that the legalizing of tion, under certain controlled conditions, for social economic reasons, would, by regularizing the pra rescue the public from the risk to life and h implied in an illicit procedure in the hands of unsk persons.

50. The example of Soviet Russia is of special in in this connexion. It is claimed that the placi abortion in skilled hands has reduced the risks minimal figure. Thus, in 1926 artificial abortio Moscow was carried out on 29,306 women with no tality, while in women admitted to hospital after abortion the mortality was 1.2 per cent. In a to 175,000 operations performed in Moscow there were deaths—that is, 1 in 19,000.

51. The committee is unequivocally of opinion within the range of those medical conditions which pregnancy dangerous to life and health, the avoidan pregnancy is to be encouraged as a procedure of g value in that it protects the woman against the ri which pregnancy exposes her, and at the same ti eliminates the occasion for therapeutic abortion the temptation to adopt unlawful methods.

ABORTION AND PROFESSIONAL SECRECY

52. It sometimes happens that a doctor, on being in to attend a woman on whom an illegal operati been performed, is faced with the problem of w it is his duty to give information to the police.

the British Medical Association, after special consideration of the matter, decided that the conduct of the doctor in this particular situation should be governed by the following resolutions:

(i) that a medical practitioner should not under any circumstances disclose voluntarily, without the patient's consent, information which he has obtained from that patient in the exercise of his professional duties;

(ii) the Association is advised that the State has no right to claim that an obligation rests upon a medical practitioner to disclose voluntarily information which he has obtained in the exercise of his professional duties.

It is obviously desirable, however, that the medical profession should assist in every legitimate way in combating the evil of criminal abortion. The committee therefore considers that the doctor, on ascertaining that a patient has undergone an illegal operation at the hands of an abortionist, should endeavour to obtain the consent of the patient to his reporting the matter to the police authorities.

VI. CONCLUSIONS AND RECOMMENDATIONS

53. The following are the main conclusions and recommendations of the committee.

THE LAW CONCERNING THERAPEUTIC ABORTION

I. The Offences Against the Person Act of 1861 prohibits the *unlawful* induction of abortion. The wording of the Act may be thought to imply that abortion may be lawful as well as unlawful, but in the law as it stands no specific authority is given for terminating pregnancy, except under the conditions already discussed in paragraph . The Committee considers it to be most desirable that this very unsatisfactory situation should be remedied by revision of the law.

II. While professional opinion appears to differ on the question of the desirability of legalizing abortion to prevent the birth of a mentally or physically defective child, it is generally believed that the operation should be permissible when the indications are that continued pregnancy or labour will endanger the life of the mother or seriously injure her health.

III. Nevertheless there are substantial grounds for believing that, even when such indications are present, the doctor sometimes hesitates to perform the operation through fear, if not of conviction, at least of indictment, with the publicity and the risk of professional damage which this entails.

IV. Further, since opinions may differ as to whether the patient's condition is such as to warrant therapeutic abortion, the doctor runs the additional risk of his judgement being publicly impugned in the event of the operation being followed by the death of the patient. There is reason to believe that this consideration acts as a deterrent, with consequent danger, in some cases, to the life or health of the patient.

V. The committee therefore strongly recommends not only the clarification of the legal position, but also the institution of some system of authorization of abortion in the individual case. It suggests that the doctor contemplating therapeutic abortion should be obliged to obtain the sanction of a professional colleague of recognized status, on the analogy of "approved" practitioners under the Mental Treatment Act.

THE INDICATIONS FOR THERAPEUTIC ABORTION

VI. The committee presents suggestions as to the conditions in which the advisability of terminating pregnancy for medical reasons may call for consideration. The committee recognizes that it is impossible to lay down hard-and-fast rules, and that each case must be judged on its merits.

VII. Whilst under existing conditions reasons based on eugenic considerations are generally regarded by medical men as falling outside the scope of therapeutic abortion, the committee believes that there are certain cases of this class which constitute justifiable indications. It is of the opinion that abortion should be considered when, in the light of modern medical knowledge, there is reasonable certainty that serious disease will be transmitted to the child.

SECRET ABORTION

VIII. The frequency of secret abortion cannot be exactly ascertained, since the very secrecy of the practice makes statistical assessment of its prevalence impossible. That the induction of abortion, usually by unskilled persons, for reasons other than medical, is very common in all ranks of society there can, however, be no reasonable doubt.

IX. The committee considers it to be of the greatest importance that the grave dangers to life and health entailed by the practice of secret abortion should be represented to the public and to those concerned with the public welfare.

X. The committee believes that the measures which it has suggested for the protection of the practitioner would, by increasing the *bona fide* practice, result in diminution of the frequency of the secret procedure.

XI. While the committee has no doubt that the legalization of abortion for social and economic reasons would go far to solve the problem of the secret operation, it realizes that this is a matter for consideration by the community as a whole, and not by the medical profession alone.

XII. With a view to combating the evil of secret abortion the committee recommends that the practitioner, on ascertaining that a patient has undergone an illegal operation at the hands of an abortionist, should endeavour to obtain the consent of the patient to his reporting the matter to the police authorities.

XIII. Although the committee has drawn attention to conditions in which the termination of pregnancy is indicated, it believes that in such cases the avoidance of pregnancy is the more rational plan and one to be encouraged as a procedure of double value in that it protects the woman against the risks to which pregnancy exposes her, and at the same time it eliminates the occasion for therapeutic abortion and the temptation to adopt unlawful methods.

SUB-APPENDIX I

THE LAW RELATING TO ABORTION IN FOREIGN COUNTRIES

Artificial abortion is illegal in most foreign countries, including Belgium, France, Switzerland, Austria, Germany, Scandinavia, and the United States. In recent years, however, there has been considerable agitation for reform of the abortion laws, and in a few countries such reform is receiving official consideration or has already been effected. The most notable examples are Russia, Poland, and Czechoslovakia.

RUSSIA

In Tsarist Russia abortion was punished by solitary confinement. The Revolution of October, 1917, abolished the penalties and made abortion free. This measure was ineffectual because the secret abortionists of the past continued their nefarious practices. The Commissariat of Hygiene, on November 18th, 1920, therefore took steps to regulate the practice of abortion by legislation. The following are the most important articles of the statute:

1. Interruption of pregnancy shall be free and permissible in Soviet hospitals.
2. Abortion by unqualified medical practitioners is prohibited.
3. Any midwife guilty of performing an abortion will lose the right to practise her profession and will be tried by Popular Tribunal.
4. A doctor who performs an abortion outside a hospital for the purpose of financial gain shall be subjected to the Popular Tribunal.

The following are included in the medical and social indications for abortion:

1. Pregnancy resulting from rape or assault.
2. Pregnancy of an unmarried girl not of full age.
3. Pregnancy in a mother of a family of at least three children who is earning her own living and would be unable without difficulty to provide for a larger family.
4. Medical indications: tuberculosis, alcoholism in the parents, epilepsy, psychosis (November, 1933).

With rare exceptions abortion is prohibited after the third month, and it cannot be repeated until nine months have elapsed since a previous abortion. A woman desiring the operation must apply to the proper authority, who considers all the circumstances. The procedure is permitted only by duly authorized practitioners and hospitals, and it is claimed that 80 to 85 per cent. of all abortions are now registered. Secret abortion is now rare in towns, but is still relatively prevalent in rural areas.

POLAND

In Poland the law relating to abortion was revised in 1932, and the operation is now permitted in the following circumstances when performed by a qualified physician with the woman's consent:

1. When the woman's life or health is endangered by the pregnancy.
2. When the pregnancy is due to interference with a girl under 15 years of age, abuse of the totally or partially mentally defective, the use of threats or violence to obtain sexual consent, or the misuse of a position of authority or of special circumstances of power or danger.

CZECHOSLOVAKIA

Recently the Government of Czechoslovakia has considered a Bill designed to legalize abortion in the following circumstances when the operation is performed with woman's consent by an authorized medical practit in a public hospital:

1. If the termination of pregnancy is advisab prevent the risk of the mother's death or of s injury to her health.
2. If it is proved that conception took place rape or after the violation of a girl under 16 of age.
3. If it is proved that the child would be gr injured mentally or physically.
4. If the woman is mentally ill and her guar gives his consent to the abortion.
5. If the pregnancy could not be completed, the child could not be reared without adv affecting the nutrition of the mother or other pe under her legitimate care.

It is proposed that, when it is not possible to per an abortion in a public hospital, it will be sufficien the operating physician to obtain the consent of a league besides that of the woman herself. This however, has not yet been passed into law.

SUB-APPENDIX II

The committee wishes to express its gratitude fo valuable help received from the contributions of the fo ing, who attended meetings of the committee to evidence and/or submitted written memoranda:

Mr. A. S. Blundell Bankhart; Sir Comyns Berk Dr. C. P. Blacker; Dr. J. Crighton Bramwell; D Forrester Brown; Miss F. W. Stella Browne; Pro A. W. M. Ellis; Dr. A. R. Gilchrist; Dr. C. M. H Howell; Dr. J. S. Manson; Dr. P. K. McCowan G. C. Mort; Dr. Sydney A. Owen; Dr. W. B. Purch Sir Bernard Spilsbury; Dr. L. J. Witts; Dr. R Young.

APPENDIX VIII

REPORT OF COMMITTEE ON MINERS' NYSTAGMUS

Preliminary

The Committee was appointed by the Council on July 23rd, 1935, with the following reference: "To consider and report upon the possibility of securing improved methods of procedure in the diagnosis and certification of miners' nystagmus."

The Committee consisted of the following members:

Sir John H. Parsons, C.B.E., LL.D., F.R.C.S., F.R.S., London (Chairman).
E. Kaye Le Fleming, M.A., M.D., Wimborne (Chairman of Council).
H. S. Souttar, C.B.E., F.R.C.S., F.R.A.C.S., London (Chairman of Representative Body).
N. Bishop Harman, LL.D., F.R.C.S., London (Treasurer).
Herbert Caiger, F.R.C.S., Sheffield.
Millais Culpin, M.D., F.R.C.S., London.
R. G. Gordon, M.D., F.R.C.P.Ed., Bath.
R. Francis Jones, M.A., M.B., B.Ch., Tamworth, Staffs.
T. L. Llewellyn, M.D., B.S., Nottingham.
S. Spence Meighan, M.B., Ch.B., F.R.F.P.S., Glasgow.
H. Campbell Orr, M.B., Ch.B., F.R.F.P.S., Wolverhampton.

The Committee is indebted to J. J. Healy, M.B., Ch.B. (Llanelly) and D. H. Russell, M.C., M.D., F.R.C.S.Ed. (Wakefield) for their assistance in the course of its deliberations. It also desires to thank the large number of medical practitioners—ophthalmic surgeons, cert surgeons, and general practitioners in mining distr who rendered valuable assistance by completi questionary.

The Committee presents its report under five headings:

I. Introduction.
II. The psychoneurotic aspect of the disease.
III. Certification.
IV. Preventive measures:
  (*a*) Illumination in coal mines.
  (*b*) Preliminary examination of the eyes.
V. Management of certified cases.

I.—INTRODUCTION

1. Miners' nystagmus is an occupational disease o miners, of which the characteristic symptom and p sign is an oscillation of the eyes.

2. Affection of the eyes of colliers has been kno over a hundred years, but miners' nystagmus as su first described by Decondé in 1861. A historical a of the disease may be found in the First Report Miners' Nystagmus Committee of the Medical Re Council, 1922.

3. Throughout its history miners' mystagmus has been the subject of dispute. At first the dispu entirely concerned with problems of causation: Di was based on oscillation chiefly, and caused litt culty; hence assessment of incapacity was easy. the cause of the disease is generally held to be d