A statement on abortion by one hundred professors of obstetrics

In view of the impending change in abortion practices generated by new state legislation and federal court decisions, we, the undersigned professors and chairmen of obstetric-gynecologic services, believe that it will be helpful to the medical profession at large to enunciate our position with regard to this increasingly liberal course of events. We do so not for the purpose of controlling these events but rather for the purpose of contributing to the solution of an imminent problem of rather staggering proportions.

Many physicians still believe that abortions should be done only for medical reasons and that only they are qualified to determine when these reasons exist. In order to comply with the new laws and court decisions, however, it will be necessary for physicians to realize that abortion has become a predominantly social as well as medical responsibility. For the first time, except perhaps for cosmetic surgery, doctors will be expected to do an operation simply because the patient asks that it be done. Granted, this changes the physician's traditional role, but it will be necessary to make this change if we are to serve the new society in which we live.

There are, of course, patients whose request for abortion should be more carefully scrutinized, but these are rare cases, for example, where the decision was impetuously reached or neurotically motivated. Professional and paraprofessional counseling will play an important role here. There are patients also who should be actively encouraged to consider abortion—for example, women who are unaware of a teratogenic threat to their pregnancies.

How many abortions will have to be done under universal law repeal? There are no accurate data upon which to base an answer to this question. The best estimate for the first year is one million, which amounts to one for every four births. This one-to-four ratio can also be applied to individual hospitals in calculating the number of abortions they will be expected to do.

Can we handle such a load? Yes, with careful planning, conscientious effort, and modern techniques. If only half of the 20,000 obstetricians in this country do abortions, they can do a million a year at a rate of two per physician per week. Already we do more than a million other pelvic operations every year. The doctor with conscientious objections must, of course, be excused, but he will be expected to refer his patients elsewhere. A more difficult dilemma will be faced by the doctor who approves of abortions for some reasons but not all, for he may be accused of being unduly arbitrary or capricious.

It is our belief that even this volume of operations can be handled with existing hospital facilities. It will be necessary to do most of the abortions during the first 10 to 12 weeks, by the suction technique, with the use of local anesthesia, and on an ambulatory basis. These practices have been proved safe and effective for years in other countries where abortion is widely available. The public must be educated to seek abortions in the first trimester, when the risks are minimal. Physicians should learn to do early abortions with suction, since it is a simple, safe procedure requiring less time and entailng less blood loss than conventional curettage. Physicians should also become familiar with administering local anesthesia, with or without short-acting analgesics or narcotics, so that the time, expense, personnel, and complications associated with general anesthesia will be reduced. In order
not to encroach upon bed space and operating room time needed for other patients, it will be necessary to perform early abortions on an outpatient basis. A few hours’ observation in a recovery room should suffice in most cases.

Adequate medical preparation should be made to minimize the risks. The preoperative work-up should include history, physical examination, and appropriate laboratory studies. Aseptic precautions must be observed, blood bank facilities must be available, and a standard operating room facility must be immediately accessible.

Patients with medical complications, patients with pregnancies beyond the twelfth week, and patients desiring sterilization should be hospitalized. Patients undergoing intramyometrial injection of hypertonic solutions should be observed for a minimum of 6 hours and, if subsequently discharged, should be readmitted during the abortion process.

Insofar as possible, all abortions, whether on an inpatient or outpatient basis, should be performed within hospital walls because complications are inevitable and the facilities of a general hospital may be required at any time. Independent clinics will probably not be necessary if all hospitals cooperate in handling their proportionate share of these cases. The practice of abortions in doctors’ private offices is to be condemned.

Needless to say, the fees charged for the performance of abortions on private patients should be commensurate with those charged for similar procedures in the same community.

The space necessary for the performance of up to 50 abortions a week can be found by converting an ordinary treatment room into a minor-surgery unit and providing an adjacent four-bed recovery room. The additional equipment for such a unit need not be expensive. Staff and maintenance costs should be met on a fee-for-service basis. The requisite space will soon be freed by the lessened number of septic abortions and puerperal cases. Although there is no medical contraindication to admitting clean abortion cases to a maternity floor, there are obvious psychological advantages to segregating these cases.

Initial difficulty may be encountered in finding doctors who are willing to do abortions in such large numbers. It may be advisable to assign volunteers to work in the abortion unit on a rotating basis. The objections of the house staff to assuming their share of this new work load should be anticipated and dealt with by the individual directors-of-service. Care should, of course, be observed in selecting paramedical personnel who are sympathetic to women having abortions.

Therapeutic abortion boards will have no place in states with laws such as New York’s, which stipulate that abortion decisions are to be made by the physician and his patient. Committees should, however, be created to record and analyze statistics and to evaluate techniques and complications.

It is impossible to generalize about the need for the consent of husbands, for there is no national uniformity of court opinion on this point. In some states, it has been ruled by the courts that an adult woman is free to make this decision by herself.

Opinions are confused and variable regarding the need for the consent of parents and guardians in the case of minors. The status of “emancipated” and “mature” minors is unclear in many states and will have to be defined by the courts and/or the legislatures. The married minor should be free to make her own decision. It would seem inevitable that the courts will someday decide that any girl who is physically mature enough to conceive should, ipso facto, be granted the freedom to determine the fate of her pregnancies.

If should be emphasized that abortion is medically defined as the termination of pregnancy before the end of the twentieth week. Regardless of the wording of a particular state law, therefore, abortions should not be performed for purely social reasons beyond this gestational age. Every effort should be made, of course, to perform abortions before the end of the first trimester.
Sterilization will play a role in curtailing recidivism. Approval of an abortion request, on the other hand, should not be conditional upon the applicant's submission to sterilization.

An integral part of any abortion program should be postoperative provision of contraceptive advice. Although women should be relieved, insofar as possible, of any sense of shame or guilt from the abortion experience, they should not be encouraged to regard abortion as a primary method of birth control.

Abortion should be made equally available to the rich and the poor. The better-educated members of our society are generally aware of their right to have an abortion. It will devolve largely upon the medical profession to inform all others of this right. Care must be taken to avoid the allegation that abortion is being used as an instrument of social bias.

Many physicians will disagree with some of the thoughts expressed in this statement. Nevertheless, it is our hope that these views will stimulate thinking about abortion and lead physicians to prepare for the demand that will be placed upon them by society and by the rapidly lessening governmental control of abortion practices.

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