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THE POLITICS OF ABORTION

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A year ago, New York City Councilwoman Carol Greitzer told the annual meeting of the National Association for Repeal of Abortion Laws (NARAL), of which she is president, that American women were determined to make abortion an issue in the 1972 elections. No politician who opposed the availability of safe abortions for all women would have women's support in 1972, she warned candidates in emphasizing the political arithmetic that women are a majority of the electorate.

If there was any doubt then that abortion would be an issue in 1972, President Nixon's unprecedented letter last May to Terence Cardinal Cooke, supporting the Catholic hierarchy's effort to repeal the liberal New York abortion law, tossed the issue into the political arena. George McGovern, who was assailed in some of the primaries, particularly in Nebraska and New York, as a supporter of abortion, maintains the issue is a matter for state—not Federal—laws.

Legislatures are in a ferment over abortion legislation, and court dockets are crowded with challenges to old abortion statutes and to new ones devised to replace those declared unconstitutional, such as Connecticut's new and restrictive law which in turn has been upset by a Federal district court. The New York legislature, spurred on by Cardinal Cooke's forces and President Nixon's encouraging letter, repealed its own landmark 1970 statute only to have the repeal bill vetoed by Governor Nelson Rockefeller.

Because most legislators and candidates are men, usually of comfortable means, many of them refuse to face up to the grim fact that those who pay the heaviest price with their health and very lives for the failure to liberalize or repeal state abortion laws are women too poor to afford the safe abortions available to women in better financial circumstances.

It has been estimated that between one million and a million and a half abortions occur annually in the United States. This means that about one-fourth of all pregnancies end in abortion.

In the March, 1971, issue of the *American Journal of Public Health,* Drs. Ian Schneider and Carl Tyler, both obstetricians, predicted that one out of every three U.S. pregnancies will end in abortion if all laws restricting abortion are removed.

Abortion is the only area of medical practice hampered by criminal penalties. This restriction interferes with the patient-physician relationship in a fundamental way. The point was explored in the *Belous* case in California in 1969 in which eighty leading obstetricians from medical schools across the country, in defending Dr. Leon Belous' right to perform an abortion, joined in an eloquent *amici curiae* brief. The brief contended that the criminal penalties attached to abortion force the patient to plead her case and become an adversary of her doctor. By asking him to exercise his professional judgment, she endangers his right to practice medicine and perhaps his very freedom. If he performs the abortion, he is subject to prosecution and must justify his action by testifying in his own behalf. If he refuses to perform the abortion, he is not subject to prosecution and does not have to justify his decision.

Even if the doctor's medical judgment tells him that the best treatment for a particular patient's pregnancy is an abortion as she has requested, proceeding to that treatment may cause him to lose his license to practice medicine and may even send him to jail. The physician therefore has a personal stake in the outcome and cannot render a truly objective medical opinion about the proper treatment of his patient. Her rights are thereby also jeopardized, especially if she does not have the money to pay the added costs of extralegal stratagems such as "psychiatric consultation" which might provide "mental health" grounds for a legal abortion.

The inevitable result of all this is that few doctors

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are willing to perform abortions, and a simple operation is made both expensive and hard to get. Desperate women are driven to clandestine abortions, many of them done under unsafe and unhygienic conditions.

Of approximately one million abortions performed in 1967, fewer than 10,000 were reported in the Federal Government's *Vital Statistics* as done legally in hospitals as "therapeutic abortions"—that is, done to preserve the life, or health, of the mother. The other 990,000 abortions were done illegally by persons ranging in competence from skilled physicians to unskilled and unscrupulous quacks. Some of the women attempted to perform abortion on themselves, using such instruments as coat hangers and knitting needles, often with fatal results. Women who have experienced unsafe abortion attempts frequently develop massive infection, or "sepsis," and arrive at the emergency room in critical condition with fever, hemorrhage, and multiple complications. The hospital stays of those who survive are long, expensive, and disruptive of their family lives.

Septic abortion has been one of the leading causes of death among child-bearing women for many years, with a disproportionate share of the deaths falling among the poor and minority groups who cannot afford safe abortions. In 1967, for example, the death rate attributed to septic abortion, as reported in the Government's *Vital Statistics,* was nearly seven times as high among non-whites as among whites. For a five-year period from 1957 to 1962, Drs. Edwin Gold and Carl Erhardt found that more than half of all maternal deaths (deaths related to pregnancy and childbirth) among Puerto Ricans and blacks living in New York City were caused by septic abortion.

Recent changes in the laws of a few states have resulted in an increase in the number of reported legal abortions. The Department of Health, Education and Welfare Center for Disease Control has stated that more than 180,000 such abortions were reported in 1970. According to Dr. Christopher Tietze of the Population Council, as many as 500,000 legal abortions may have been performed in 1971. The increase in the legal availability of safe, competently performed abortions has been directly associated with a marked decline in deaths from clandestine abortion in many of these states, especially New York and California. For example, Dr. Jean Pakter of the New York City Health Department reported that the rate of abortion-related deaths in New York City during the first four months of 1971 was less than one-fourth of what it was in the 1960-1962 period. Meanwhile, the ratio of legal abortions to live births has risen from 1.8 per 1,000 to 447.7 since 1967.

Following the implementation in 1968 of a liberalized abortion law in California, the rate of maternal deaths stemming from abortion decreased nearly sixty-three per cent by the end of 1969. In a report published in an April, 1971, issue of *Obstetrics and Gynecology,* Drs. Gary Stewart and Philip Goldstein stated that abortion-related deaths decreased dramatically in the San Francisco Bay Area while the therapeutic (legal) abortion rate rose. In 1969, there were no abortion-related deaths in the Bay Area.

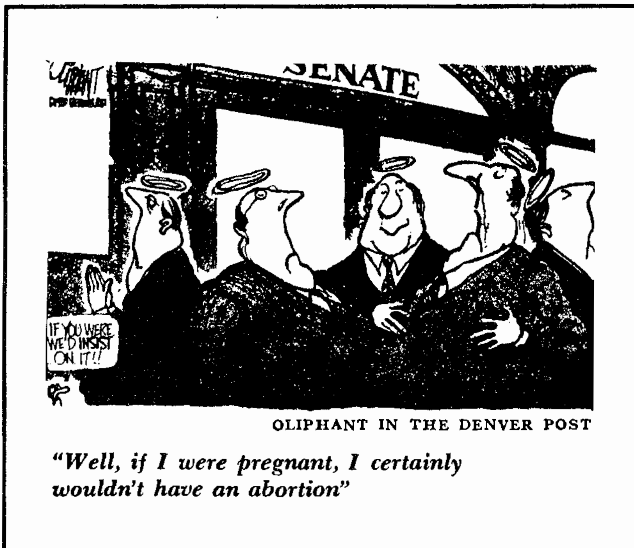
The severely restrictive laws of most states have been the greatest obstacle to safe abortion services. Professor Cyril Means of New York Law School has pointed out that these Nineteenth Century laws were primarily intended to protect women from an operation which was far more dangerous at that time than full-term pregnancy. Subsequent advances in medical technology have made an abortion performed during the first two months following conception six to ten times safer than a full-term uncomplicated pregnancy, according to statistics published by Dr. Tietze of the Population Council. Means cited a common-law principle in arguing against the previous restrictive New York abortion law: *"Cessante ratione legis cessat et ipsa lex"* (Once the reason for a law has ceased to exist, the law itself ceases to exist).

Means regards the discriminatory effect of state abortion laws in favor of the rich, and against the poor, as one of their worst aspects. He points out that, as administered, restrictive abortion laws exempt the rich and penalize the poor more than perhaps any other type of legislation.

Since 1967, seventeen states—Arkansas, California, Colorado, Delaware, Georgia, Kansas, Maryland, Mississippi, New Mexico, North Carolina, South Carolina, Virginia, Oregon, Alaska, Hawaii, New York, and Washington—have revised or repealed their abortion laws, and four of these—Alaska, Hawaii, New York, and Washington—have done away with all but a few restrictions such as the patient's residency, duration of pregnancy, and performance by a physician.

These liberalizations have been effected against a background of rising public acceptance of abortion. A recent Harris poll disclosed that forty-eight per cent of those likely to vote this November favor a Federal law legalizing abortions up to four months of pregnancy, and forty-three per cent oppose it. A Gallup poll following the Harris findings disclosed the rapid rise in support for liberalizing abortion laws. Gallup found sixty-four per cent of the public, including fifty-six per cent of Roman Catholics, now believe the decision to have an abortion should be left solely to the woman and her doctor. This two out of three ratio of public approval compares to forty per cent approval reported by Gallup in a November, 1969, poll.

Where state restrictions have merely been modified, access to abortion has been made easier for the wealthy but not for the poor. Along with economic discrimination, pregnant women who are poor and seeking an abortion face bureaucratic delays, unnecessary anguish, and serious medical complications. These delays often result in the abortion being performed during the second "trimester" of pregnancy



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"Well, if I were pregnant, I certainly wouldn't have an abortion"

(months four-six), requiring hospitalization and higher costs. The Joint Program for the Study of Abortion (JPSA), conducted by Dr. Tietze for the Population Council, shows much higher risks for women having second trimester abortions.

This discrimination was recognized by U.S. District Court Judge Gerhard A. Gesell in 1969 when he declared the District of Columbia's abortion statute to be unconstitutional. Citing the equal protection clause of the Fourteenth Amendment, Judge Gesell ruled that it was necessary for the community to make abortions available to the poor as well as the rich. The Supreme Court later reversed Judge Gesell in handing down its first decision on the subject of abortion, declaring in *Vuitch* that the D.C. statute was constitutional.

In another decision now under appeal to the Supreme Court, a U.S. District Court in Georgia clearly recognized the fact that ". . . physicians and psychiatrists are more accessible to rich people than to poor people, making abortions more available to the wealthy than to the indigent . . ." but declared this not to be a violation of the equal protection clause.

As alluded to in the Georgia decision, a significant part of the discrimination experienced by the poor under restrictive abortion laws is the requirement, in most states, of obtaining declarations from one or two psychiatrists that an abortion is necessary to preserve or restore the mental health of the woman seeking an abortion.

This peculiar situation is the direct result of the traditional medical view that pregnancy is "normal." The profession clings to this view in spite of the fact that pregnant women experience a variety of recognized signs and symptoms, undergo important physiological changes, are exposed to a significantly increased risk of death as the direct consequence of being pregnant, and seek medical attention whether the pregnancy is desired or not. However, the view that pregnancy is "normal" means that there must be some justification for interrupting the pregnancy with a "therapeutic" abortion. Since modern medical technology has made it possible, in most cases, to get a woman with even severe heart or kidney disease through the stresses of pregnancy, the burden of "justification" has fallen on the chimera of "mental illness." This is consistent with the traditional medical attitude that, in the words of psychoanalyst May Romm, intense conflict about a pregnancy or about giving birth to a child is "psychopathological."

Under the ground rules of this situation, the woman must feign mental illness, threaten suicide or other catastrophe, and the psychiatrist must ascertain that the woman will be in danger to herself and/or others if she does not obtain the abortion. Such a prediction is impossible to make, and as much has been admitted by prominent psychiatrists on both sides of the question. In addition to being a demoralizing and degrading experience for the woman, mandatory psychiatric justification for abortion is a waste of the psychiatrist's time and a prostitution of psychiatry. The additional costs it imposes on the performance of a fifteen-minute operation add another burden to the economic discrimination experienced by the poor, to say nothing of the barrier of sophistication required in acting through a psychiatric encounter. The charade of routine psychiatric consultation, however, is only one of the obstacles to safe abortion for the poor.

The cost of a safe but illegal abortion in most places is in the range of $600-$1,000, and even this much does not always guarantee a safe abortion. But in New York and Washington, D.C., the price of a safe, legal abortion during the first trimester (three months) of pregnancy has fallen to around $150-$200. This decreased price level was predicted last year by Dr. Louis Hellman, HEW Deputy Assistant Secretary for Population Affairs, at a national conference on abortion held in New York City: "We are in the marketplace, and the thing that will bring the rates down quicker than anything I know of is for states other than New York to have liberal abortion laws."

The lowered prices, however, are still beyond the reach of many women who desire abortions. Dr. Jean Pakter of the New York City Health Department reported that during the last six months of 1970, nearly half the abortions performed in New York municipal hospitals and in the service wards of voluntary hospitals were paid for with Medicaid funds. Most of the rest were paid through private insurance plans such as Blue Cross. Abortions are being paid for with HEW funds under sections of the Social Security legislation in those states where abortions are not restricted by law. Even in New York, however, where this payment practice has been well established and is continuing, a see-saw court battle has developed over the use of

Medicaid funds for abortion. Those favoring such use won a major round recently when a panel of three Federal judges upheld Medicaid payments for abortions, saying that to refuse aid "would deny indigent women the equal protection of the laws to which they are constitutionally entitled."

The Office of Economic Opportunity, which is providing Federally subsidized family planning services for approximately 500,000 low-income women across the nation, has an internal policy prohibiting the use of OEO funds for abortions. Even if this restriction were removed, most state laws would prevent the use of this money for abortion services. Nonetheless, a management survey of OEO family planning programs completed in early 1971 revealed that sixty per cent of the project directors wanted this restriction removed to be able to provide abortions for women requesting them.

There seems to be little doubt that the poor and disadvantaged minority groups are taking advantage of the greater availability of abortions where legal restrictions have been removed. The ratio of abortions to live births was higher among New York City nonwhite women between July, 1970, and March, 1971, for example, than it was for whites. More than half of all abortions among New York City residents during the same period were experienced by nonwhites and Puerto Ricans. During the second year of the operation of Colorado's new liberalized abortion law, more than half the patients had yearly family incomes of less than $6,000.

Nationwide, about two-thirds of the abortions reported to the Population Council's Joint Program for the Study of Abortion (JPSA) from July 1, 1970, to June 30, 1971, were performed on white women. Twenty-six per cent of the abortions were performed on black women. Nearly sixty per cent of the abortions were performed on private patients, but only thirteen per cent of the private patients were black. While more detailed analysis is not yet available, the significance of these data can be inferred tentatively from the fact that the complication rate for nonprivate patients was approximately twice as high as that experienced by private patients. This phenomenon is probably explained by the clinical impression that private patients tend to appear earlier for abortion, when it is safer, are in better health to begin with, and are more likely to have a private physician to return to for assistance should any complications develop.

In a recent issue of the *American Journal of Obstetrics and Gynecology,* 100 professors of obstetrics joined in making an unprecedented "statement on abortion." The professors, many of them chairmen of obstetrics departments at leading U.S. medical schools, strongly recommended that most abortions be performed during the first three months of pregnancy on an outpatient basis. In clear recognition of the issue of economic discrimination, they stated, "Abortion should be made equally available to the rich and the poor."

The report of the President's Commission on Population Growth and the American Future emphasized the discriminatory effect of abortion laws and their effect on the health of the poor. The Commission recommended that state laws be liberalized to conform with the New York State statute, allowing abortions to be performed by licensed physicians on request. The Commission also recommended greater public and private financial support of abortion services.

The Population Commission recommendations are consistent with an earlier statement by the American Public Health Association. APHA's "Recommended Standards for Abortion Services," adopted in November, 1970, state: "Abortion services are an integral part of comprehensive family planning and maternal and child care. . . . The public interest requires that health agencies . . . make every effort to provide safe, accessible abortion services at reasonable fees for all who are in need of such services."

In his rejection of the conclusions of the Population Commission report, President Nixon made it clear that he does not think that abortion should be available to either the poor or rich, even though it is available to both—with different risks and costs. It is not clear to what extent Mr. Nixon's opposition to abortion is personal, or the result of his assessment of the political effect of his opposition on Catholic voters.

Those who grasp the abortion issue with an eye toward winning the Catholic vote, however, may find it a two-edged sword. The Women's National Abortion Action Coalition (WONAAC), a militant young organization dedicated to political action to end barriers to safe abortion, has gathered strength and momentum steadily in recent months. It must be remembered that most of the 500,000 reported legal abortions performed in 1971 were experienced by young single women, some of them Catholic, many of them well-educated or in college, politically active or able to vote, and acutely conscious of the difficulties encountered in obtaining a safe abortion.

In July, 1972, WONAAC sponsored the third Women's National Abortion Action Conference at Hunter College in New York City, which drew more than 800 local representatives from all over the country. WONAAC's goals include the repeal of all abortion laws and restrictive contraceptive laws. WONAAC is also supporting Congresswoman Bella Abzug's proposed Federal Abortion Rights Bill. Its leaders have organized their activities with a view to fall elections. While WONAAC does not support or oppose individual candidates, its members are pressing candidates at all levels for commitments to repeal outdated and inequitable abortion laws.

As Carol Greitzer said, somebody had better start counting the women.