

ABORTION: A PUBLIC HEALTH AND SOCIAL POLICY PERSPECTIVE

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I INTRODUCTION

A. *The Legal Setting*

On January 22, 1973, the Supreme Court ruled in the companion cases of *Roe v. Wade*¹ and *Doe v. Bolton*² that state statutes prohibiting or narrowly restricting abortion were unconstitutional. Although a number of states had already revoked their restrictive abortion policies in the late 1960's and early 1970's,³ the sudden and dramatic legalization of abortion on a national scale was an unexpected and profound shock to those committed to the right-to-life cause. Since then, the single-minded objective of the pro-life movement has been to overturn the Supreme Court rulings by constitutional amendment. There is, however, no right-to-life consensus as to the form which the proposed amendment should assume. The reason is that anti-abortion advocates are not housed in a single body, speaking with one voice. What binds them together is their shared commitment to the fetus, and from that common bond have emerged two proposals for amending the Constitution. The more radical supports an amendment that would directly reverse our national policy on abortion by specifically guaranteeing the fetus's right to life.⁴ The more modest proposal calls for an amendment that would define the subject of abortion as jurisdictionally reserved to the states, with each individual state empowered to set its own policy free from federal restraint.⁵

Although this quest for a constitutional solution has not yet made any perceptible headway, the pro-life movement has recently scored significant gains on other fronts. On June 20, 1977, the Supreme Court handed a stunning victory to the foes of abortion, when it announced its decisions in *Maher v.*

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1. 410 U.S. 113 (1973).

2. 410 U.S. 179 (1973).

3. By 1973, seventeen states (including New York and California) and the District of Columbia had liberalized their abortion laws, beginning with Colorado in 1967. COLO. REV. STAT. § 18-6-101 (1973).

4. See, e.g., H.R.J. Res. 132, 94th Cong., 1st Sess. (1975).

5. See, e.g., H.R.J. Res. 261, 94th Cong., 1st Sess. (1975).

Roe,⁶ *Beal v. Doe*,⁷ and *Poelker v. Doe*.⁸ In *Maher and Beal*, the Court held that neither the Constitution nor the Social Security Act requires states to provide Medicaid funds for elective abortions; while in *Poelker* it decided that municipalities are not constitutionally obliged to provide or even to permit such abortions in their public hospitals. This judicial response to the abortion controversy was quickly echoed by the legislative branch when the Senate joined the House of Representatives in voting to restrict sharply the use of Medicaid funds to provide abortions for indigent women.⁹ Since both President Carter and Secretary of Health, Education and Welfare Joseph Califano have gone on record as opposing publicly funded abortions,¹⁰ the three branches of the federal government have presented a united front on this emotionally charged and bitterly contested political issue.

B. Framing the Issues

The continuing debate on abortion provides the setting for this essay. A necessary starting point is the recognition that abortion is an extraordinarily complex subject with far-reaching ramifications—relating to such fields of public concern as law, medicine, public health, demography, economics, sociology, psychology, morals, and religion. This article will present and discuss several key questions from the perspectives of public health and social policy, questions which cannot be ignored by anyone seeking to address the abortion controversy with an informed opinion.

The essay begins with a brief inquiry into the pro-life position on the essential character of the fetus. What follows is an assessment of the question whether the pro-life conviction reflects a universal, time-honored moral and biological consensus, or whether it simply represents one competing belief in the marketplace of opinions. Another relevant concern is with the health effects of abortion. From the public pronouncements of pro-life advocates, one might assume that the only pertinent fact about abortion is that it destroys the fetus. Yet the immediate impact of abortion falls also upon the woman who experiences it. Therefore, a balanced perspective requires an examination of the impact of abortion upon the public health. Since the heart of the dispute is over the legal status of abortion, it becomes necessary to consider the public health consequences of both legal and illegal abortion.

The next line of inquiry is directed to the principal long-term objective of the right-to-life movement, which is reinstatement of criminal sanctions against abortion. Since the ultimate goal is to eliminate or at the very least substantially to curtail abortions, the question which invites resolution is whether the criminal law is the appropriate tool with which to accomplish that end. If we conclude that it is not suited to the task but that abortion is nonetheless a social concern which merits public attention, we arrive at the realm of alterna-

6. 432 U.S. 464 (1977).

7. 432 U.S. 438 (1977).

8. 432 U.S. 519 (1977).

9. N.Y. Times, June 30, 1977, at 1, col. 1.

10. N.Y. Times, June 26, 1977, § 1, at 22, col. 6.

tive possibilities. The issue becomes whether models of social response are available that are less drastic and less socially disruptive than the resort to criminal sanctions. Such alternative models not only must effectively address the abortion issue but also must be equipped to attract the support of both pro-lifers and those who oppose the criminalization of abortion.

II

THE STATUS OF THE FETUS

A. *A Social and Moral Response*

To James Buckley, former United States Senator from New York, the social and moral complexities of abortion are reducible to one concern. As he expressed recently at an anti-abortion rally, "A million lives will be taken every year unless we stop [legalized abortions]." ¹¹ Buckley's exclusive focus upon the preservation of fetal life is shared by those who adhere to the right-to-life position on abortion. For them, the spotlight hovers over the fetus alone, while the pregnant woman remains off stage, out-of-sight and out-of-mind. This perspective was bluntly reflected in the viewpoint of a spokesperson for Fairfield (Conn.) Right-to-Life, who announced in a letter to the *New York Times* that "the only question worth asking in the abortion controversy is: What are we aborting?" ¹²

What, indeed, are we aborting? Although pro-life advocates routinely refer to the fetus as an unborn child, Buckley's equation of fetus with baby is rhetoric carried to extreme. In this respect, however, the opposing side is not above reproach, as witnessed by the assertion that the decision to abort an unwanted fetus is as devoid of moral significance as is the decision to extract an aching tooth. What is compelling here is the pregnant woman's conviction that her body contains an unwelcome presence, and whether it be fetus or tooth, this belief overrides any consideration of its intrinsic character. Admittedly, this perspective does not pervade the sentiments of those who stand opposed to the pro-life view on abortion. But its occasional articulation does highlight the divergence of opinion on the nature of the fetus. It is, in truth, this lack of consensus which lies at the heart of the abortion controversy, for as one writer remarked, "After all the constitutional arguments have been heard, the abortion issue comes back to what it really always has been—a question of how one views the fetus." ¹³ Or, as this issue is generally framed: When does life begin?

For the Roman Catholic Church, which stands at the vanguard of the right-to-life movement, there is no doubt that life begins at the moment of conception. Of historical interest is the fact that until 1869 the Church's teaching was that abortion was permissible until forty days after conception for a male

11. *N.Y. Times*, Jan. 24, 1977, at 29, col. 4.

12. *N.Y. Times*, Sept. 6, 1976, at 14, col. 3.

13. Greenhouse, *Constitutional Question: Is There A Right To Abortion?*, *N.Y. Times*, Jan. 25, 1970 (Magazine), at 90.

fetus and eighty days for a female fetus.¹⁴ (How one was to determine the sex of the fetus was a question which the Church fathers prudently avoided.) In that year, however, Pope Pius IX enunciated the doctrine of "immediate animation," which has prevailed to the present day.¹⁵

Those who do not support the Church's position, which has found acceptance by non-Catholic as well as Catholic pro-lifers, generally contend that the beginning of life coincides with some particular stage of biological development. Thus abortion prior to the selected time (which varies according to one's perspective) is morally permissible because it does not entail the destruction of life.

The particulars of the debate as to when life begins cannot be resolved by appeals to scientific truth. The reason is that, as philosopher Daniel Callahan has noted, biology cannot inform us when life begins because *life* is a term devised by humans to apply to certain phenomena observable in nature.¹⁶ We may perceive a biological process under a microscope; but biology cannot pinpoint a moment in time when life begins. Nor, for that matter, can it advise us when life ends, as witnessed by the current medico-legal debate over the formulation of a standard definition of death acceptable to both professions as well as to the larger society.¹⁷

Nonetheless, what is biologically self-evident is that the moment of conception is the beginning of a process which, if uninterrupted, will produce a human being. The issue is not whether the onset of that process marks the beginning of life but whether a moral value should attach at that moment, such that the fetus's continued existence warrants the protection of the law. Thus, what counts is not how one chooses to define the start of life but how one weights the competing claims of the fetus and its unwilling host. For example, a professed opinion that life begins at conception does not compel its holder to embrace the pro-life cause. A person with that opinion might still maintain that, since a life begun in the womb is not yet a life born, the fetus, whatever its potentiality, is not endowed with an absolute right to continued life.

What, then, is being aborted? The only honest reply is that it hinges upon the moral values held by each person who addresses the issue. Hence, the answer to the question of when life begins offers no definitive resolution to either competing interest at stake in the abortion controversy. It may be that one can reasonably hope to beat an opponent into submission with the logic of scientific and statistical data. On the other hand, reliance upon one's claim to a superior morality is a totally useless weapon in a debate between impassioned ideologies unless the claim is backed by a threat of force.

B. *The Law's Response*

Although law makers have not grappled with the question of when life

14. G. GEIS, NOT THE LAW'S BUSINESS? 94 (1972) [hereinafter cited as G. GEIS].

15. *Id.*

16. D. CALLAHAN, ABORTION: LAW, CHOICE AND MORALITY 352 (1970).

17. *See, e.g.*, Capron & Kass, *A Statutory Definition of the Standards For Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87 (1972).

begins, they have consistently denied the status of human being to the fetus. In *Roe v. Wade* the Supreme Court majority stated that since physicians, philosophers, and theologians could not agree when life begins, the justices were "not in a position to speculate as to the answer."¹⁸ Although side-stepping the question, the Court did recognize a "compelling" state interest in the protection of what it referred to as the "potentiality of human life."¹⁹ It proceeded to locate that interest at the stage beginning with viability, which marks the beginning of the third trimester, when the fetus becomes capable of living and developing outside the mother's body.²⁰ The Court concluded that individual states could, though they are not required to, prohibit the abortion of the viable fetus, "except when it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."²¹ Whatever guarantees the Court accorded the fetus, however, were virtually withdrawn by this added proviso that the life or health demands of the pregnant woman would still take priority over the viable fetus's continued existence. After a cursory review of judicial precedents, the Court concluded that legal rights have not been "accord[ed] . . . to the unborn except in narrowly defined situations . . . [and that] the unborn have never been recognized in the law as persons in the whole sense."²²

The traditional rejection by the law of the concept of the fetus as a person is exemplified by the recent decision of the Supreme Judicial Court of Massachusetts in its reversal of the *Edelin* manslaughter conviction.²³ In the controversial Boston trial of Dr. Edelin, a gynecologist charged in 1974 with manslaughter in the death of a 20 to 24 week-old fetus during a legal abortion, the trial judge had properly instructed the jury that "a fetus is not a person and not the subject of an indictment for manslaughter."²⁴ On appeal, the Supreme Judicial Court of Massachusetts held that its review of the testimony required the conclusion that there was no evidence that the fetus had been born alive (that is, whether it had independently breathed outside its mother's body).²⁵ Since the crime as charged could only be committed against a living person, the conviction was overturned.

The *Edelin* reversal was not unexpected because a contrary result would have been without legal precedent. The law is clear that only a living person can be the victim of culpable homicide. A child *en ventre sa mere* (in its mother's womb) is clearly not a person.²⁶ The appropriate legal response to an illicit act of fetal destruction is a charge of unlawful abortion. It is true, however, that the charge of manslaughter committed during the course of an abor-

18. 410 U.S. at 159.

19. *Id.* at 163-64.

20. *Id.* at 163.

21. *Id.* at 165.

22. *Id.* at 161-62.

23. *Commonwealth v. Edelin*, ___ Mass. ___, 359 N.E.2d 4 (1976).

24. *Id.* at 10.

25. *Id.* at 15.

26. BLACK'S LAW DICTIONARY 1300 (4th ed. rev. 1968).

tion is not unique to the *Edelin* case. In fact, convictions have been properly recorded in many such cases, but always for the same reason: not the death of the fetus but the death of the abortion-seeking woman at the hands of the defendant abortionist.²⁷

III

ABORTION AND PUBLIC HEALTH

A. *Health Effects of Criminal Abortion*

In order to rid themselves of unwanted pregnancy, women not only have sought out the services of abortionists of varying degrees of skill, but in desperation also have attempted to abort themselves. As criminologist Edwin Schur explained in his classic work, *Crimes Without Victims*: "To some [women], self-induced abortion may seem a less shameful and frightening way of solving their problem than visiting a criminal abortionist. In other cases, lack of funds or knowledge of just where to turn may lead the woman to attempt the abortion herself."²⁸ In discussing the health implications of self-induced abortion, Schur pointed out:

Although the popular press frequently paints a lurid picture of the professional abortionist and his activities, many women are probably unaware of the greater dangers involved in self-induced abortion. Such techniques as severe exercise, hot baths, falls down stairs, and manipulation of the abdomen are rarely successful in accomplishing their purpose unless undertaken so vigorously that they seriously endanger the life of the woman herself. Chemicals taken orally—purgatives, pelvic and intestinal irritants, drugs stimulating contraction of the uterus, and poisons—are equally hazardous if taken in dosages large enough to abort the fetus. Attempts at laceration with a sharp object . . . demonstrate the extreme desperation of some women.²⁹

The health hazards of criminal abortion were canvassed by the Institute of Medicine of the National Academy of Sciences in a 1975 report of a study entitled, *Legalized Abortion and the Public Health*. The report (hereinafter referred to as the *IOM Report*) listed the following procedures with their accompanying risks:

[A]mong the non-medical procedures used for inducing abortion are eating or drinking quinine or other drugs, introduction of chemicals into the vagina, and mechanical methods such as inserting blunt or sharp instruments into the uterus through the vagina. The drugs quite often lead to poisoning, or

27. R. PERKINS, *CRIMINAL LAW* 142 (2d ed. 1969). See also *People v. Wilson*, 83 Cal. App. 2d 707, 129 P.2d 149 (1942).

28. E. SCHUR, *CRIMES WITHOUT VICTIMS* 22-23 (1965).

29. *Id.* at 23.

vomiting so intense that it results in dehydration and eventual death unless fluid replacement compensates the loss. Inserting chemicals or instruments in the vagina or uterus can lead to: (1) infection; (2) injury to the membranes of the vagina; (3) perforation of the uterus with the possibility of injuring other organs in the abdominal area; (4) bleeding due to retained fetal or placental tissue; and (5) air embolism.³⁰

It is therefore not surprising that the *IOM Report* described criminal abortion as "a serious public health problem . . . [resulting in] numerous deaths and serious illnesses requiring lengthy hospitalization."³¹ One can only roughly estimate the extent of the problem since an underground activity such as illegal abortion does not lend itself to orderly compilation of statistical information. A committee appointed after a 1955 Planned Parenthood conference on abortion concluded that "a plausible estimate of the frequency of induced abortion in the United States could be as low as 200,000 or as high as 1,200,000 per year . . . [with] no objective basis for the selection of a particular figure between the two estimates as an approximation of the actual frequency."³² A subsequent study produced estimates in the mid-range of these figures, concluding that there were 699,000 illegal abortions in 1955 and 829,000 in 1967.³³

There also have been various attempts to gauge the annual death toll from criminal abortions. Although estimates vary, it appears that during the 1960's there were about 200 deaths per year.³⁴ Since then the annual toll has fallen sharply, and in 1975 only four criminal abortion deaths were reported.³⁵ The reason for this dramatic decline is not hard to find. As explained in the *IOM Report*: "Available statistics . . . indicate that the number of reported deaths from other-than-legal abortions declined steadily as less restrictive abortion

30. INSTITUTE OF MEDICINE, *LEGALIZED ABORTION AND PUBLIC HEALTH* 64 (1975) [hereinafter cited as *INSTITUTE OF MEDICINE*]. If one were to set up a museum display of abortion artifacts, the exhibition would not be complete unless it were to include a do-it-yourself abortion inducing kit, containing such items as: crochet hooks, nail files, syringe tips, nutcrackers, darning needles, umbrella ribs, and pieces of wire coat hanger. Watkins, *A Five-Year Study of Abortion*, 26 *AM. J. OF OBSTETRICS AND GYNECOLOGY* 162 (1933); Fisher, *Criminal Abortion*, 42 *J. CRIM. L.C. & P.S.* 242, 246 (1951).

31. *INSTITUTE OF MEDICINE*, *supra* note 30, at 64.

32. *ABORTION IN THE UNITED STATES* 180 (M.S. Calderone ed. 1958).

33. *INSTITUTE OF MEDICINE*, *supra* note 30, at 38.

34. One observer of the abortion scene put the annual figure at between 5,000 and 10,000. S. KLING, *SEXUAL BEHAVIOR AND THE LAW* 4 (1969), an estimate deemed excessive by Dr. Christopher Tietze of the Population Council, who is a leading medical authority on abortion. Dr. Tietze was quoted in 1967 as estimating the annual figure in previous years at about 500, with a possible upper limit of 1,000. *Indianapolis Star*, Sept. 7, 1967, at 4, col. 4, *cited in* G. GEIS, *supra* note 14, at 86. On the other hand, there are fairly accurate estimates that during the 1960's the mortality rate dropped to about 200 deaths per year, a decline which has been interpreted as reflecting general medical progress in the treatment of gynecological complications of abortion. Cates, RoCHAT, Smith & Tyler, *Trends in National Abortion Mortality, United States, 1940-74*, 11 *ADVANCES IN PLANNED PARENTHOOD* 106, 108 (1976).

35. *NAT'L CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1975* at 9 (1977).

legislation was passed and implemented throughout the country."³⁶

Medical complications are another aspect of the public health implications of illegal abortion. Accurate measurements are, of course, impossible to obtain. At best, one can attempt a rough approximation from the number of hospital admissions for septic and incomplete abortions. Nationwide estimates are not available, but in New York City alone municipal hospitals reported 6,524 such admissions in 1969.³⁷ It should be understood, however, that not all women suffering side effects from criminal abortion become hospital inpatients. Many are treated as outpatients or by private physicians, while others resort to self-help.³⁸ The adverse psychological effects upon women experiencing criminal abortion are even more difficult to gauge, but common sense would suggest that they are not inconsiderable.

B. Health Effects of Legal Abortion

Although the health effects of criminal abortion can only roughly be measured, legal abortion is subject to more accurate evaluation from a public health standpoint. The role of law in this regard has been emphasized in the *IOM Report*.

Evidence suggests that legislation and practices that permit women to obtain abortion in proper medical surroundings will lead to fewer deaths and a lower rate of medical complications than restrictive legislation and practices.³⁹

In fact, data on the risk of death from legal abortion indicate that it is one of the safest surgical procedures in the United States. In the four years from January, 1972 until January, 1976, three million legal abortions resulted in only 106 deaths (many of them from pre-existing medical complications), translating into a mortality ratio of 3.5 per 100,000 procedures.⁴⁰ The maternal mortality ratio was about four-and-one-half times higher throughout this period.⁴¹ In 1974, for example, the mortality rate was 14.9 per 100,000 live births.⁴² In that year, 3.1 million live births were registered, and 462 women died from compli-

36. INSTITUTE OF MEDICINE, *supra* note 30, at 85.

37. *Id.* at 65.

38. *Id.* at 64.

39. *Id.* at 10.

40. The three million figure was arrived at through information provided by Ms. Ellen Sullivan of the Alan Guttmacher Institute of the Planned Parenthood Federation of America, New York, New York. The Guttmacher Institute conducts an annual survey on the provision of abortion services in the United States. Ms. Sullivan provided figures on the number of abortions performed for each of the years in question. The number of abortion deaths was calculated from the 1972 to 1975 annual summaries. See NAT'L CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1972 (1974); NATIONAL CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1973 (1975); NATIONAL CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1974 (1976); NATIONAL CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1975 (1977).

41. INSTITUTE OF MEDICINE, *supra* note 30, at 79.

42. NAT'L CENTER FOR HEALTH STATISTICS, PUBLIC HEALTH SERVICE, U.S. DEP'T OF H.E.W., 24 MONTHLY VITAL STATISTICS REP. at 3 (Feb. 1976).

cations of pregnancy and childbirth.⁴³ It should also be noted that from 1972 to 1976 the mortality rate per 100,000 abortions fell each year; it dropped from 4.1 in 1972 to 3.5 in 1973, to 2.9 in 1974, and to 2.7 in 1975.⁴⁴ This trend accords with the Eastern European experience that legal abortions became progressively safer over time as surgeons developed their expertise.⁴⁵

Legal abortion is even safer than these figures indicate if performed during the first trimester, for the risk of death increases with each passing week of gestation, ranging from 0.7 per 100,000 procedures at eight weeks or less to 20 per 100,000 at 17 weeks or more.⁴⁶ During the years 1972 to 1975, 85% of legal abortions were performed in the first trimester, for which the overall mortality rate was 1.7 per 100,000 procedures.⁴⁷ According to Dr. Willard Cates, chief of the Abortion Surveillance Branch of the National Center for Disease Control, this last figure is comparable to the risk of death from the intramuscular injection of penicillin for treatment of gonorrhea.⁴⁸

The relatively risk-free nature of legal abortion was stressed in the *IOM Report*, which compared mortality rates for legal abortions with those for several common surgical procedures. The number of deaths per 100,000 procedures was as follows: 3 for tonsillectomy, 5 for tonsillectomy with adenoidectomy, 5 for ligation and division of fallopian tubes (sterilization), 74 for partial mastectomy, 111 for Cesarean section (childbirth), 204 for abdominal hysterectomy, and 352 for appendectomy.⁴⁹ Data on the medical complications of legal abortion support the conclusion that it is a relatively safe procedure. From 1971 to 1975, the Population Council and the National Center For Disease Control conducted a joint study of abortion-related morbidity at thirty-two facilities which performed over 80,000 abortions over that period.⁵⁰ The study revealed that although 12% of the patients experienced one or more complications, the vast majority were mild in nature, involving such minor complaints as vaginitis and breast engorgement.⁵¹ Less than one percent suffered major complications, such as convulsions or hemorrhage requiring blood transfusion.⁵² Another significant finding, as summarized by the National Center for Disease Control in a

43. NAT'L CENTER FOR HEALTH STATISTICS, PUBLIC HEALTH SERVICE, U.S. DEP'T OF H.E.W., 24 MONTHLY VITAL STATISTICS REP. at 13 (June 1976).

44. NAT'L CENTER FOR DISEASE CONTROL (1974-1977), *supra* note 40. This trend was dramatically underscored by the National Center for Disease Control in the May 26, 1978 issue of its weekly national abortion surveillance. It there noted that, in 1976, the fifty states and the District of Columbia reported 988,267 legal abortions. Only ten deaths resulted, which is a death-to-case ratio of 1.0 per 100,000 procedures. There were three deaths from illegally induced abortions, while eleven deaths resulted from spontaneous abortions. NAT'L CENTER FOR DISEASE CONTROL, 27 MORBIDITY AND MORTALITY WEEKLY REPORT 175 (1978).

45. INSTITUTE OF MEDICINE, *supra* note 30, at 77.

46. NAT'L CENTER FOR DISEASE CONTROL, *supra* note 35, at 36.

47. *Id.* at 32, 36.

48. Letter to the author from Dr. Willard Cates, Jr., Chief of Abortion Surveillance Branch, Family Planning Evaluation Division, Bureau of Epidemiology, National Center for Disease Control, Dec. 14, 1976.

49. INSTITUTE OF MEDICINE, *supra* note 30, at 80.

50. NAT'L CENTER FOR DISEASE CONTROL, ABORTION SURVEILLANCE 1974, at 9 (1976).

51. *Id.*

52. *Id.*

1976 report, was that, with minor exceptions, the earlier the abortion during pregnancy the smaller the risk of complications.

Morbidity rates varied with length of gestation. From 7% at six menstrual weeks of gestation or less, the total complication rate fell to a nadir of 5% for abortions at seven to eight weeks. The rate then rose to a peak of 40% at 17 to 20 weeks and declined thereafter. Major complication rates demonstrated a similar pattern. The minimum of 0.3% occurred in abortions at 7 to 8 weeks and the maximum of 2.3% in abortions at 21 to 24 weeks.⁵³

The effect of legalization upon hospital admissions for incomplete and septic abortions was noted in the *IOM Report*:

Existing trend data on hospital admissions and discharges indicate that abortion-related complications have declined over the past several years; in several hospitals the number and rates of women admitted for treatment of incomplete septic abortions fell sharply after the states in which the hospitals were located had introduced nonrestrictive abortion legislation or practices.⁵⁴

This trend is illustrated by a comparison of recent figures on admissions to municipal hospitals in New York City for incomplete and septic abortions.⁵⁵ In 1969 there were 6,524 such admissions. In 1971, the first year after abortion was legalized in New York State, that figure dropped by nearly 50% to 3,643.⁵⁶

An additional public health concern is the psychological consequences of legal abortion. The data indicate that major psychological complications are quite rare. A review of the scientific literature prompted the *IOM Report* to conclude:

[T]he cumulative evidence in recent years indicates that although it may be a stressful experience, abortion is not associated with any detectable increase in the incidence of mental illness.⁵⁷

In that regard, a Population Council survey found that the incidence of post-abortion psychosis ranged from 0.2 to 0.4 per 1,000 procedures.⁵⁸ On the other hand, the risk of post-partum psychosis, psychosis induced by childbirth, is five times higher.⁵⁹ In either case, an investigator would almost invariably discover a previous history of mental illness as the seed-bed for the subsequent trauma.⁶⁰ Several recent studies also suggest that the most common psychological reaction to legal abortion is an immediate and lasting sense of relief.⁶¹

53. *Id.*

54. INSTITUTE OF MEDICINE, *supra* note 30, at 67.

55. *Id.* at 65.

56. *Id.*

57. *Id.* at 6.

58. *Id.*

59. *Id.*

60. Osofsky, Osofsky & Rajan, *Psychological Effects of Abortion*, in *THE ABORTION EXPERIENCE* 188, 203 (H.J. Osofsky & J.D. Osofsky eds. 1973).

61. INSTITUTE OF MEDICINE, *supra* note 30, at 99.

While some women have reported feelings of guilt or depression, these reactions tend to be described as mild and temporary.⁶²

A focus upon the mental health effects of legal abortion invites an inquiry into the psychological consequences for women who are denied abortion and who subsequently give birth. In 1972 Illsley and Hall surveyed the published literature and concluded:

Although many women who are refused abortion do adjust to their situation and grow to love the child, about half would still have preferred an abortion, a large minority suffer considerable stress, and a small minority eventually develop severe disturbance.⁶³

Although these findings accord with the common sense notion that many women forced to give birth will suffer psychological harm, the *IOM Report* regards the question as one requiring additional study.

C. *The Disproportionate Impact of Health Costs*

There is a final public health factor that cannot be ignored. Unless nationwide access to legal abortion is the norm, non-white women will bear a disproportionate share of the public health costs of criminal abortion. Studies undertaken in the early 1970's to measure national abortion patterns discovered that white women were more likely to take advantage of out-of-state abortion opportunities than were nonwhite women. Women residing in states with restrictive laws were likely to travel to more liberal jurisdictions, particularly New York and California, to obtain abortions. It was found, however, that fewer nonwhite women traveled for this purpose than did white women. One reason for this difference is that nonwhite women generally were less able to afford the travel expenses.⁶⁴ A consequence of this disparity is reflected by statistics on criminal abortion deaths by race from 1968 to 1973. Over that period, the ratio of deaths per 100,000 women of child-bearing age was eight times higher for nonwhite women than for white women: 0.88 deaths per 100,000 nonwhite women, and 0.11 deaths per 100,000 white women.⁶⁵

There is an additional factor that undoubtedly contributes to this differential, which is part of the history of criminal abortion in the United States. Even before the advent of abortion law reform in the late 1960's, a disproportionate number of abortion fatalities were suffered by nonwhite women. When abortion was uniformly prohibited, state laws generally provided an exception for the rare case in which the pregnant woman's life was endangered. Over the years, that narrow proviso was consistently applied more often for private hospital patients than for those on public wards. It is reasonable to assume that the law was often stretched—if not deliberately flaunted—for the former, who were almost invariably not poor and not nonwhite.

Consider, for example, the study which found that 93% of in-hospital abor-

62. *Id.* at 98.

63. R. ILLSLEY & M.H. HALL, *PSYCHOLOGICAL ASPECTS OF ABORTION* 46 (1973).

64. *ABORTION IN THE UNITED STATES*, *supra* note 32, at 99.

65. *Id.* at 84.

tions in New York State were performed on middle-class white women.⁶⁶ Another study estimated that, on a nationwide basis, private patients obtained four times as many hospital abortions as did ward patients.⁶⁷ And in 1965, it was reported that whereas the overall maternal mortality rate was four times higher for black than for white women in New York City between 1951 and 1962, the mortality rate from criminal abortions was nine times higher for black women.⁶⁸ One factor affecting that differential is that the quality of illicit abortion services depends in part upon the ability to pay. As a New York obstetrician once remarked, "The Park Avenue debutante will probably pay two thousand dollars to have it [the abortion] done in her doctor's office—probably also on Park Avenue."⁶⁹ The woman trapped in an urban ghetto cannot afford to pay for the same quality of service.

It is clear from the foregoing that laws prohibiting abortion discriminate against nonwhite women—if not by design, then by effect.

IV

THE FUTILITY OF CRIMINALIZING ABORTION

The practice of abortion, which dates from antiquity, is a phenomenon which has withstood vigorous attempts at suppression. If the maxim is true that the prostitute belongs to the world's oldest profession, then the abortionist's trade must run a close second. The universality of the abortion experience has been catalogued by anthropologist George Devereux in his study of abortion in 350 primitive, ancient, and pre-industrial societies.⁷⁰ An exhaustive review of the anthropological literature led him to conclude that "there is every indication that abortion is an absolutely universal phenomenon, and that it is impossible to construct an imaginary social system in which no woman would ever feel at least impelled to abort."⁷¹

A. *Abortion as Crime Tariff*

The tenacity of abortion-seeking women in the face of legal prohibitions can be explained as an effect of the so-called "crime tariff," a term coined by law professor Herbert Packer.⁷² A tariff operates effectively when the demand for the foreign product in question is elastic.⁷³ Even if the product or service

66. Pipel, *The Abortion Crisis*, in *THE CASE FOR LEGALIZED ABORTION NOW* 101 (Guttmacher ed. 1967).

67. Irwin, *The New Abortion Laws: How Are They Working?*, 48 *TODAY'S HEALTH* 21, 23 (1970).

68. Gold, *Therapeutic Abortions in New York: A 20 Year Review*, 55 *AM. J. OF PUB. HEALTH* 964, 965 (1965).

69. *NEWSWEEK*, Apr. 12, 1970, at 53, 56.

70. Devereux, *A Typological Study of Abortion in 350 Primitive, Ancient and Pre-Industrial Societies*, in *ABORTION IN AMERICA* at 97 (H. Rosen ed. 1970).

71. *Id.* at 98.

72. H. PACKER, *THE LIMITS OF CRIMINAL SANCTION* 277-79 (1968).

73. If, for example, the import duty on Volkswagens were raised by two thousand dollars, its effect would be to propel most Volkswagen enthusiasts to turn elsewhere for new means of trans-

demand is legally prohibited, the consumer who can afford to pay the price will secure satisfaction. It is at this point that the crime tariff begins to operate. It does so in the context of a buyer-seller relationship. The buyer has a need that cannot be satisfied within the law, so the seller steps in to fill the need outside the law. However, when the demand is inelastic, the tariff cannot operate according to plan. It is inelastic when consumers insist upon gratification whatever the cost or risk. There is perhaps no demand more inelastic than that of the woman seeking an abortion, save perhaps that of the heroin addict, who also operates within a crime tariff. The inelasticity of the demand also means that the buyer is more willing to accept an inferior product or service. As Packer explained:

Women . . . who want an abortion do not care what the market price is Here the anticompetitive effect of the crime tariff operates not only on price but also on service. [When] women cannot generally get abortions from those who are in the best position to do a satisfactory job—the members of the medical profession—they are driven to accept a product of inferior grade and quality from the hole-in-corner abortionist. They buy injury and even death from sellers who would be driven out of the market overnight if they did not have the protection of the crime tariff.⁷⁴

B. *Abortion as Consensual Crime*

The persistence of criminal abortion is only partially explained by the desperation of women with unwanted pregnancies. Another reason for its persistence is the unenforceability of the laws directed against it. Abortion, whether self-induced or induced by an abortionist, is a crime without a complainant. As such, it lacks the warning signal of public visibility that compels the police to make a timely response. The crime of abortion does not produce an outraged citizen. There is no one to inform the police that she has been victimized and to assist them in their investigation.

At best, police activity against criminal abortion is limited to token enforcement.⁷⁵ It could not be otherwise because the obstacles impeding detection of the offense present a formidable barrier against even vigorous attempts at suppression. What token enforcement means, of course, is that the vast majority of criminal abortions escape police scrutiny, even though the occasional arrest serves to remind the public that the law is not yet a dead letter. However, from the potential offender's perspective, a law which is seldom enforced is a law which lacks deterrent effect. And when that person is a desperate woman seeking relief from the burden of unwanted pregnancy, the largely empty nature of the law's threat amounts to an open invitation to criminality.

C. *The "Toilet Assumption"*

It is thus quite apparent that police action against abortion, however

portation. They would rationally conclude that, while still preferring the VW, it is simply not worth the added cost. Thus the tariff would accomplish its objective of shifting the demand away from the target item.

74. *Id.* at 280-81.

75. E. SCHUR, *supra* note 28, at 15-16.

energetic, cannot significantly inhibit a practice that has persisted since antiquity. The inescapable conclusion is that whatever the future holds for the abortion controversy it will not be resolved by heeding the pro-life plea for criminalization. A legal commandment is not a magic wand. If the historical record on abortion has established one truth, it is that banning abortion by law does not banish abortion in fact. However, this historical lesson seems to be outside the vision of those who favor criminalization. They believe that since abortion is offensive a law can be enacted to prohibit it, and once the prohibition is enacted the menace of abortion will thereby be eradicated.

This mind set has been graphically described by social critic Philip Slater as the "Toilet Assumption." As he described it in *The Pursuit of Loneliness*:

The Toilet Assumption [is] the notion that unwanted matter, unwanted difficulties, unwanted complexities and obstacles will disappear if they are removed from our immediate field of vision We throw the aged and psychotic into institutional holes where they cannot be seen. Our approach to social problems is to decrease their visibility: out of sight, out of mind The result of our social efforts has been to remove the underlying problems of our society farther and farther from daily experience and daily consciousness, and hence to decrease, in the mass of population, the knowledge, skill, resources, and motivation necessary to deal with them.⁷⁶

Thus, from the vantage point of the "Toilet Assumption," if old age or mental illness is defined as a public nuisance, we institutionalize—and the nuisance vanishes. Taking this one step further, if abortion is labeled as a public menace, we criminalize—and the menace vanishes. But there is a catch: this process of self-mystification is vulnerable, since it can only function in a political vacuum. In the past, the underworld of criminal abortion flourished beyond the ken of respectable society. The two worlds were, in fact, locked into a conspiracy of silence, broken on occasion by publicized police raids on abortion rings that were easily and quickly replaced. Even the infrequent trial and conviction of some minor abortionist served merely to bolster the myth of law as magic-problem-solver.

Yet times change, and that past cannot be resurrected. Even in the unlikely event that abortion is recriminalized in the foreseeable future, it is certain that the illusion depicted by Slater would be shattered quickly by the reaction of the social force of feminism. It was that social force which bred the women who politicized the abortion issue in the 1960's and who stand guard over the precious victory which was won before the Supreme Court in 1973. If that victory were upset by constitutional amendment, without a doubt their response would, at the very least, prevent the ranks of abortion-seeking women from being returned to their one-time isolation chambers in the back wards of public consciousness. It is also likely that the more radical wing of the feminist movement would not hesitate to move beyond legally permissible forms of social protest and political action. There is, in fact, every likelihood that recriminalization

76. P. SLATER, *THE PURSUIT OF LONELINESS* 15 (1970).

would be greeted by active feminist support for and criminal involvement with medically staffed abortion rings. The "Toilet Assumption" which Slater deplored is still alive and thriving; but in the context of abortion it cannot be revived because the society which fostered its illusion is beyond recall.

D. *Abortion and The Enforcement of Morality*

To those who equate abortion with murder, the historical experience of criminal abortion is largely irrelevant. Their concern is directed rather to the claim of a superior morality, accompanied by the firm conviction that any law which has rejected their case has been stripped of its moral legitimacy. What they seek in the political arena is vindication for the morality which proclaims the fetus's life, not its expendability. Their quest offers no room for compromise, no room to indulge the social and public health costs which inevitably flow when abortion is driven underground. Instead, their attention is focused upon the role of law as the enforcing and educating arm of their moral judgment on abortion. As expressed by the Most Reverend Joseph L. Bernardin, Roman Catholic Archbishop of Cincinnati:

Underlying all forms of legal constraint is the reality that law, though imperfect, is needed to protect values which are basic to society and to forbid behavior which grossly violates such values. So, if abortion does violate a fundamental value important to society, it is appropriate that it be proscribed by law An amendment to the Constitution will reduce the number of abortions . . . [in part because] the educative impact of the law will teach that abortions ought not to be sought or performed.⁷⁷

Perhaps Archbishop Bernardin is right in saying that "if abortion does violate a fundamental value important to society, it is appropriate that it be proscribed by law." In actuality, however, the uniform consensus which supports the criminalization of murder and other grave breaches of the social order has not extended to abortion. To the contrary, a public opinion poll revealed that in 1976, two-thirds of a nationwide random sample of Americans agreed with the statement that "the right of a woman to have an abortion should be left entirely up to the woman and her doctor."⁷⁸ A similar result was reported by *Time*, which had commissioned a nationwide survey on "what Americans really think about sex."⁷⁹ According to the poll's findings, which were published in November, 1977, 48% of the respondents declared that abortion was "morally wrong," whereas 44% thought otherwise.⁸⁰ Nevertheless, 64% expressed the belief that, irrespective of the moral question, abortion should remain a woman's legal right.⁸¹ Thus, while the destruction of fetal life is admittedly appalling to many Americans, it has not aroused that groundswell of

77. N.Y. Times, Feb. 26, 1977, at 19, col. 3.

78. Arney & Trescher, *Trends in Attitudes Toward Abortion, 1972-1975*, 8 FAM. PLAN. PERSPECTIVES 117 (1976).

79. TIME, Nov. 21, 1977, at 68.

80. *Id.* at 74.

81. *Id.*

popular sentiment which would suggest the presence of a basic or fundamental social value.

Even though no dominant social morality condemns abortion, pro-life advocates have called for its prohibition by invoking the role of the law as moral educator. As a proponent of this philosophy, Archbishop Bernardin has expressed his faith in the power of law to impose its will largely through the force of its moral presence. That is, aside from the deterrent impact of legal sanctions which operate by instilling fear, he feels that women will voluntarily forsake the abortion alternative by adopting the law's message as their own.

It is unlikely that the Archbishop's expectation is grounded in reality. It is not simply the historical record that casts doubt on the effectiveness of prohibition by law. An added factor is the rise of feminist consciousness since the 1960's, which has spawned a self-perpetuating generation of women committed to an ideology proclaiming its own morality on abortion. For these women, the law prohibiting abortion stands condemned as an unacceptable infringement upon the inherent right of every woman to safeguard her bodily integrity and to exercise exclusive control over her reproductive destiny.⁸² From their standpoint, that right is as surely grounded in morality as is the fetus's right to life in Archbishop Bernardin's view. Moreover, a commitment to feminist ideology is not required for a woman to reject the moral legitimacy of the law if it indicates a lack of concern for her welfare by ordering her to proceed with an unwanted pregnancy. In such a case, self-interest and not moral conviction will prompt her scorn for a law banning abortion. Thus, one moral standard is pitted against another, and it is fanciful to expect either feminist or right-to-lifer to yield moral ground merely because the law has officially come down on the side of the other. When viewed as a contest between competing moralities, the abortion controversy clearly indicates that the function of laws against abortion is not to educate but to coerce. Law does not inherently lack the moral authority to instruct behavior. Simply, the law is not suited to that task when it is aimed at prohibiting a product or service for which there is a widespread demand and which is regarded as rightfully theirs by those who seek its gratification. On such occasions, the law will be perceived as an instrument of political coercion, and not of moral guidance, by those whose will it seeks to thwart.

The issue is not whether a law banning abortion warrants such contempt; rather, it is whether the law can amass the credibility necessary to undermine the moral perception of those who reject its pronouncement of fetal inviolability. The prospect that those who favor abortion will accept fetal inviolability has the same chance for success as the prospect that right-to-lifers will accept the moral authority of the law that currently applies to abortion.

E. Methods of Non-Punitive Social Control

Pro-life sympathizers tend to interpret their commitment to the fetus as non-negotiable, and their ideological opponents are similarly inclined in their

82. This is the spirit which pervades some feminist publications. See, e.g., SCHULDER & KENNEDY, *ABORTION RAP* (1971).

commitment to giving women themselves the right to decide whether or not to have an abortion. Nevertheless, room still remains for concerted planning in which both sides would be free to search for alternatives to abortion without fear of compromising their respective loyalties. For that to happen, however, pro-life advocates must first be prepared to abandon their inclination to regard the mechanism of legal prohibition as society's only fitting response to abortion. Although they cannot be expected to cease campaigning for a constitutional amendment, it is not unreasonable to expect pro-life forces to support measures designed to steer women away from abortion by forms of social control less drastic and less socially disruptive than the criminal law.

If such a shift in approach were forthcoming, it would not be without precedent. The repeal of Prohibition was precipitated by growing public awareness that criminalization was not the appropriate solution to the social problem of alcohol abuse.⁸³ Unfortunately, however, the search for policy alternatives designed to discourage alcohol consumption never really got off the ground. On the other hand, the quest for viable alternatives to criminalization has found recent expression in policy proposals toward littering and cigarette smoking, disparate forms of behavior which, like abortion, are largely impervious to the threat of criminal sanctions. These programs suggest fresh approaches to the abortion dilemma.

Littering has traditionally been handled as a public nuisance offense subject to the imposition of a minor criminal penalty. Our streets, highways, and landscapes testify to the widespread disregard for and ignorance of prohibitions against such conduct. The citizen who is not ecologically minded has no incentive to comply with a law which is virtually devoid of deterrent effect. The public realizes that the police lack the manpower for adequate enforcement, as evidenced by the fact that littering is so widespread. However, states like Oregon have pioneered a system which has effectively whittled away at one of the more notorious by-products of the littering impulse—the throwaway bottle. The state enacted a so-called "bottle bill," to provide consumers with an economic incentive to retain empty bottles by requiring a small monetary deposit as part of the purchase price for bottled beverages.⁸⁴ As this social experiment in Oregon and the states which have followed suit clearly demonstrates, branding behavior as criminal is not necessarily the most effective way to discourage it.

With regard to cigarette smoking, a general consensus recognizes the folly of criminalization, though proposals to ban cigarettes are still heard occasionally. The nicotine habit is simply too deeply ingrained in smokers to be broken by the imposition of criminal sanctions. Nor is there any desire to adopt a policy which would encourage a black market, for such an alternative market would immediately dwarf the dimensions of illicit traffic in heroin and marijuana combined. As a result, alternative approaches are being pursued in an effort to minimize the public health costs associated with cigarette use. One such approach is found in the Smoking and Health Program of the National

83. R. QUINNEY, *THE SOCIAL REALITY OF CRIME* 306-07 (1970).

84. OR. REV. STAT. ANN. § 459.820 (1977).

Cancer Institute, where researchers are seeking to reduce toxicity by developing a "safe" cigarette. As the *New York Times* reported last year:

Since the program began in 1968, more than 150 different cigarettes have been devised, reducing the toxicity by various methods—the use of additives and "extenders," of different types of paper and filters, and of types of tobacco, aimed at reducing those components of cigarettes that have been shown to be hazardous to the smoker's health, particularly tar and nicotine.⁸⁵

The program's research director, Dr. Gio B. Gori, operates on the principle that if people must smoke, the only sensible policy is to make cigarettes less harmful.⁸⁶

Another approach focuses upon the popular instrument of social control, taxation. For instance, a recent cigarette tax bill introduced before the Colorado General Assembly provided in pertinent part that "in addition to any other tax on cigarettes . . . a tax of 15 cents shall be levied on each package of 20 cigarettes if a cigarette in the package contains 16 or more milligrams of tar."⁸⁷ A precedent for the Colorado bill is the tar and nicotine tax which was imposed by the New York City Council in 1971.⁸⁸ The tax, which was not to exceed 4 cents per pack, was deliberately set at a low level because the Council feared that higher tariffs would promote cigarette smuggling. A year later, in 1972, an analysis was released which concluded that the tax had had "at least some of the public health impact intended."⁸⁹ In 1975, however, the law fell victim to a state legislative enactment suspending all New York City cigarette taxes for one year, and has not been revived.

So far two unsuccessful efforts have been made to enact similar measures at the federal level. The first attempt was in 1968 and the second was in 1973, when Senator Frank Moss introduced a bill entitled the Cigarette Tar Tax Act. The Moss proposal included a sliding tax scale ranging from 8 cents per pack of 20 cigarettes containing 10 milligrams or less of tar up to 30 cents for a pack containing more than 20 milligrams of tar.⁹⁰ As he explained the rationale of the bill on the Senate floor:

Tar and nicotine levels continue to fall, but the incentive to smoke low tar and nicotine brands is currently based only on health considerations. A tar and nicotine tax would give the cigarette industry and the smoker the incentive to go low tar and nicotine at even greater rates.⁹¹

85. *N.Y. Times*, Jan. 30, 1977, § 4, at 8, col. 5.

86. *Id.*

87. House Bill No. 1218, Colo. Gen. Assembly (1977).

88. Tar and Nicotine Ordinances, Local Law 34, § 5 New York City, N.Y. Admin. Code § D46.80 (repealed).

89. Drayton, *The Tar and Nicotine Tax: Pursuing Public Health Through Tax Incentives*, 81 *YALE L.J.* 1487, 1503 (1972).

90. 119 *CONG. REC.* S4335 (daily ed. March 12, 1973).

91. *Id.*

Although the Moss proposal was not enacted into law, Congress has probably not seen the last of such bills. In a recent television interview, Senator Edward Kennedy lauded the concept and suggested that Congress examine it closely.⁹² Furthermore, its sound public health grounding has attracted sufficient support around the country to suggest that the Colorado proposal will be followed by others.

V

RESOLVING THE ABORTION DILEMMA

A. *Abortion as a Last Resort*

Are we then left with a philosophical standoff, in which neither side is prepared to budge from its entrenched ideological position? Or perhaps does some middle ground offer hope for policy approaches mutually acceptable to those who stand at opposing ends of the abortion spectrum? There is, indeed, a basis for commonality of interest stemming from the recognition that, from a feminist standpoint, abortion is perceived more often than not as a regrettable and avoidable course of action. Admittedly, the women's movement is committed to a militant pro-abortion stance. However, the women's position on abortion must be understood in the context of its overall policy on birth control, for it is here that one finds the foundation for proposals compatible with the ideals of feminist and right-to-lifer alike.

Although the feminist philosophy has achieved widespread acceptance only during the last decade, its roots trace back to the 1870's when women first began to clamor for what they labeled the right to "voluntary motherhood."⁹³ Because their Victorian sensibilities could not accommodate contraception, they proposed abstinence as the means to that end.⁹⁴ By the 1910's the emphasis had begun to shift, and the next phase of what has become known as the "birth-control movement" was marked by a prolonged, and still unfinished, struggle for unrestricted access to contraceptive products and family planning services.⁹⁵ The subsequent campaign for legalized abortion was the next logical step on the road to reproductive independence. What that campaign has not signified, however, is feminist endorsement of abortion as the preferred means of fertility control. That role belongs to contraception.

In other words, according to the rationale supporting the pro-abortion policy of the women's movement, if contraception is the first line of defense in the war against unwanted pregnancy, then abortion is the tactic of last resort. As

92. May 18, 1977, on the morning program "Good Day!" on WCVB-TV, Boston. A graduated tax on tar and nicotine content was also proposed recently by the National Commission on Smoking and Public Policy in a report to its parent organization, the American Cancer Society. Powledge, *No Smoking: New Sanction for Old Habits*, 8 HASTINGS CENTER REP. 11 (1978).

93. L. GORDON, *WOMAN'S BODY, WOMAN'S RIGHT* 95 (1976).

94. *Id.* at 98-101.

95. *Id.* at 186.

such, abortion should serve as the back-up for contraceptive neglect. Although those who speak for the women's movement would not deny abortion to one deliberately disregarding contraceptive protection, such conduct would not be widely approved as an acceptable form of birth control.⁹⁶

Thus, a public health policy aimed at women and designed to prevent unwanted births would seek to maximize their use of contraception in order to minimize their resort to abortion. Consider, for example, that the annual number of pregnancies expected per 100,000 women of child-bearing age is 14,300 when moderately effective contraceptives (condom or diaphragm) are used, but soars to between 40,000 and 60,000 when contraceptive protection is omitted.⁹⁷ In other words, 25,000 to 45,000 pregnancies from this population can be avoided simply through reliance upon moderately effective contraceptives. If these pregnancies were avoided, public health benefits would accrue on two levels. First, those women escaping unwanted pregnancy would avoid a medical procedure which, although relatively safe, is not totally risk free. Second, since up to 45,000 abortions would not be performed, the surgeons, nurses, operating theaters, hospital beds, and out-patient facilities necessary to accommodate them would thereby be released for other medical needs.

Aside from concern for health effects, a moral consideration enters into feminist endorsement of contraception over abortion as the primary instrument of fertility regulation. Feminists believe that adherence to a pro-abortion policy does not require a corresponding dismissal of the fetus as valueless. Rather, the fetus's claim to life simply matters less than the right which every woman must have to rid herself of the burden of unwanted pregnancy. Consequently, unless alternatives are unavailable, a woman's reliance upon abortion to control fertility exhibits an indifference to the fetus which undermines the moral base of her legal right to freedom in making reproductive decisions.

B. Alternatives to Abortion

The search for alternatives to abortion begins with two lines of inquiry: (1) the prior contraceptive use patterns of women who have obtained abortions; and (2) the extent of contraceptive practice by women generally. The first question has been investigated in several studies,⁹⁸ the findings of which warrant the conclusion that poor contraceptive vigilance—and not contraceptive failure—accounts for most unplanned pregnancies. In fact, most of these studies have offered estimates ranging between 40% and 80% as the proportion of abortions performed on women not utilizing any method of contraception at the time of pregnancy.⁹⁹ In addition, a 1971 article attributed 85% of unwanted teen-age pregnancies to the absence of contraceptive protection.¹⁰⁰ Regarding

96. See, e.g., Kleegman, *Abortion and Womankind* in 2 ABORTION IN A CHANGING WORLD at 202 (R. Hall ed. 1970).

97. Tietze, *Mortality with Contraception and Induced Abortion*, 45 STUDIES IN FAMILY PLANNING 6-8 (1969).

98. INSTITUTE OF MEDICINE, *supra* note 30, at 119.

99. *Id.*

100. *Id.* at 119-20.

the second inquiry, the evidence is more encouraging. What has clearly emerged is a trend toward improved patterns of contraceptive use by women from all child-bearing age groupings. One aspect of this trend is that the proportion of married couples practicing birth control has jumped from 50% in 1960 to nearly 70% in 1973.¹⁰¹ Since married women account for between 25% and 30% of legal abortions, however, there remains a considerable unmet contraceptive need within this population group.¹⁰²

The contraceptive use patterns of teenagers has been a matter of much concern, for one out of every three abortions is obtained by a woman under the age of 20.¹⁰³ In describing those patterns as "poor," the *IOM Report* explained that "contraception use is closely related to age, in that younger women are less likely to have practiced contraception at all, or if they have used some method, to have used it less carefully and consistently than older women."¹⁰⁴ However, the trend toward increased resort to the practice of birth control has not been confined to adult women. According to a study by Zelnick and Kanter, there has been a dramatic rise in contraceptive use by teenage women. The authors compared the results of surveys which they had conducted in 1971 and again in 1976, each of which was designed to measure the sexual and contraceptive habits of a national probability sample of never-married women between the ages of fifteen and nineteen.¹⁰⁵ Not unexpectedly, the researchers found that teenage sexual activity had increased. They reported that whereas 26.8% of the 1971 sample of fifteen to nineteen year olds had experienced intercourse, that figure had climbed to 34.9% by 1976.¹⁰⁶ Taking into account the growth in teenage population between 1971 and 1976, the actual number of teenagers with sexual involvement increased by almost 30%.¹⁰⁷

Comparisons between the two surveys point to significant improvement in two categories of contraceptive use: the proportion of those sexually active teenagers who always used contraception rose from 18.4% to 30%,¹⁰⁸ and the proportion of those who indicated that they had employed some means of contraception during their most recent sexual encounter increased from 45% to 63%.¹⁰⁹ There was, however, one opposing trend. The percentage of sexually active teenagers who never resorted to contraceptives increased from 17% in 1971 to 25.6% in 1976.¹¹⁰ Equally disturbing was the authors' conclusion that few teenage women initiate birth control practice when they begin sexual activity; many, in fact, delay doing so until after experiencing pregnancy.¹¹¹ Although

101. N.Y. Times, Oct. 10, 1976, at 59, col. 1.

102. NAT'L CENTER FOR DISEASE CONTROL, *supra* note 35, at 2.

103. *Id.*

104. INSTITUTE OF MEDICINE, *supra* note 30, at 119.

105. Zelnick & Kanter, *Sexual and Contraceptive Experiences of Young Unmarried Women In the United States, 1976 and 1971*, 9 FAM. PLAN. PERSPECTIVES 55 (1977).

106. *Id.* at 56.

107. *Id.*

108. *Id.* at 62.

109. *Id.* at 63.

110. *Id.* at 62.

111. *Id.* at 55.

the data furnished by Zelnick and Kanter are generally encouraging, its impact must be measured against the findings of a study published by the Alan Guttmacher Institute (the research arm of Planned Parenthood), which reported that about half of the 3.7 million individuals in the fifteen to nineteen year age group who do not use any contraceptives are not currently receiving family planning assistance from either organized clinics or private physicians.¹¹² Furthermore, only 30,000 sexually active girls aged fourteen and under, a mere 7% of the total, are under family planning supervision.¹¹³ According to the Guttmacher Institute, "It is likely that the majority of the nearly 700,000 unintended teenage pregnancies annually occur among these unserved young women."¹¹⁴

Unfortunately, the federal commitment which sustained significant enrollment increases in family planning programs in the late 1960's and early 1970's has decreased significantly since 1973. From 1968 to 1972, such programs underwent a 32% annual growth rate in the number of patients served.¹¹⁵ But since that time, there has been a substantial decline in federal funding to the detriment of both adult and teenage women. With regard to the latter, this decline is, according to the Guttmacher Institute,

probably the main reason that the annual rate of increase in enrollment of teenage patients has slowed down (from a high of 52% in 1972 to 20% in 1975), despite liberalization of public laws and policies affecting access of teenagers to birth control services.¹¹⁶

Even so, the past few years have not been devoid of progress, a fact which is in part testimony to the dedication of those who provide family planning services. One indication of improvement is that between 1971 and 1975 the number of teenagers enrolled in birth control clinics more than doubled from 450,000 to 1.1 million.¹¹⁷ Nevertheless, pursuit of a broadly based abortion-reduction policy must necessarily encompass an expanded network of family planning programs designed to reach both adult and teenage women. As far as the needs of the latter are concerned, the Guttmacher Institute has suggested:

The progress of the last five years makes evident that this could be accomplished rapidly and at low cost, given adequate public support for expanded clinic programs and a priority emphasis by health providers that already serve adolescent populations (such as school health services and free clinics). Family physicians could also be helped to better understand the fertility control needs of their teenage patients.¹¹⁸

Such a broad-based policy must also entail support for measures designed to ensure that birth control services are made available by every abortion facility.

112. ALAN GUTTMACHER INSTITUTE, 11 MILLION TEENAGERS 45 (1976).

113. *Id.*

114. *Id.*

115. *Id.* at 46.

116. *Id.*

117. *Id.* at 44.

118. *Id.* at 55.

However, in addition to birth control counseling, abortion facilities must be prepared to offer contraceptive counseling. The *IOM Report* has explained:

[R]ecent research indicat[es] that many women are able to conceive again very soon after an abortion and therefore require immediate attention to contraceptive protection. Boyd and Holmstrom studied the ovulation patterns of 61 women following abortion and found that all but one of them ovulated within five weeks of the termination. Although the average number of days was 22, the earliest verified ovulation occurred 10 days following the abortion. These figures suggest that abortion facilities should be equipped to provide contraceptive devices themselves, or to refer their patients to effective family planning services within one week after the abortion to prevent the risk of repeated conception before contraceptives are obtained. Rovinsky has suggested that the critical variable in preventing future unwanted pregnancies is not contraceptive counseling, but the actual provision of the contraceptives themselves.¹¹⁹

Sex education at the high school level is another approach which must be investigated. The results of a survey conducted in 1976 by Zelnick and Kanter cast serious doubt on the efficiency of such instruction. For example, when asked if they knew when during the menstrual cycle they were at greatest risk of pregnancy, only 40.6% of the sample responded correctly.¹²⁰ Of those exposed to a course in sex education, 44.6% knew the correct answer, compared to 31.8% of those without such classroom instruction.¹²¹ Although this differential indicates some benefit from sex education classes, more than half of the students who already had the appropriate classroom exposure still failed to answer correctly.

The overall ineffectiveness of sex education instruction cannot be traced solely to data which indicates that teachers are not getting through to most of their students. What is even more disturbing is the fact that most sex education courses do not discuss the reproductive cycle. A recent survey of school districts throughout the United States disclosed that even where sex education was taught, family planning was the least likely topic to be covered.¹²² In fact, it was discussed in only 39% of the districts offering sex education classes.¹²³ Prostitution on the other hand, was discussed in 41% of the districts, while the figures for masturbation and seminal emissions were 51% and 55% respectively.¹²⁴ It is not surprising that one study concluded that such "limited" sex education instruction had absolutely no effect upon the prevention of teenage pregnancy.¹²⁵

There is no intention here to disparage the need for "realistic" or "meaningful" sex education. While efforts in sex education should no doubt be pur-

119. INSTITUTE OF MEDICINE, *supra* note 30, at 122.

120. Zelnick & Kanter, *supra* note 105, at 59.

121. *Id.*

122. ALAN GUTTMACHER INSTITUTE, *supra* note 112, at 36.

123. *Id.*

124. *Id.*

125. *Id.*

sued, it may be that the most valuable service our schools could perform is to channel sexually active students into family planning clinics, if such clinics are available. As Zelnick and Kanter remarked in their 1976 study, it may very well be true that "as in other areas of education, the transfer of knowledge [about sexuality and fertility regulation] in formal settings may be likened to carrying water in a basket."¹²⁶ If their intuition is correct, such information would be better furnished outside the school environment. If so, the major task of those who "teach" sex education would be to advertise the services offered by family planning clinics, emphasizing in the process that such facilities are pledged to respect privacy and to refrain from moral judgments.

If this position is accepted, policy goals must reflect a commitment to maximizing access to family planning information and birth control products. In June, 1977, the Supreme Court took a giant step in this direction when it applied the first and fourteenth amendments to strike down a New York statute directed against contraceptive sales and advertising.¹²⁷ Under that statute it was a crime to sell or distribute contraceptives to anyone under the age of sixteen, for anyone other than a licensed pharmacist to distribute contraceptives to persons over fifteen, and for anyone to advertise or display contraceptives.¹²⁸ The necessity for this remedial action had been underscored in a 1976 report by the Nassau Coalition for Family Planning, which deplored the lack of family planning facilities for sexually active teenagers in Nassau County.¹²⁹ In calling for aggressive action to pressure the release for birth control information and access to contraceptive materials (its report noted that pharmacists frequently refused to sell non-prescription contraceptives to teenagers), the Coalition explained its sense of urgency by referring to the high abortion and illegitimacy rates for Nassau County teenagers.¹³⁰ It is this urgency—and the remedial measures that it demands—which lies at the core of a rational, nonpunitive approach to the abortion question.

Those who search for abortion alternatives must also recognize the necessity of adequate funding for birth control research. Although safer and more effective methods of contraception are clearly required, the development of new techniques has been hampered by financial constraints. As the Ford Foundation pointed out in its November, 1976 report, *Reproduction and Human Welfare*, both public and private funding for research on reproductive biology and contraception have declined markedly since 1972.¹³¹ This downward trend is expected to continue. The Foundation noted that there were 230 promising avenues of research requiring an allocation of 165 million dollars for 1977 alone.¹³² In 1974, the United States provided 68% of the total global funding for birth control research, which amounted, however, to only 80 million dollars from

126. Zelnick & Kanter, *supra* note 105, at 59.

127. *Carey v. Population Services International*, 431 U.S. 678 (1977).

128. N.Y. EDUC. LAW § 6811(8) (McKinney 1972).

129. N.Y. Times, Aug. 8, 1976, § 11, at 18, col. 3.

130. *Id.*

131. O. GREEP, M.A. KOBLINSKY & F. JAFFE, *REPRODUCTION AND HUMAN WELFARE: A CHALLENGE TO RESEARCH* 400 (1976).

132. *Id.* at 554.

both public and private sources.¹³³ Expenditures have continued to rise in other developed countries, but not enough to compensate for the decline in American funding.

The need to discover new methods of birth control is underscored by the fact that the two most effective means of contraception, the Pill and the IUD (intra-uterine device), are also the least safe. Up to the age of thirty, the mortality risk from pregnancy and childbirth is considerably higher than that associated with any form of birth control.¹³⁴ However, the mortality rate for women over thirty who both smoke and use the Pill is considerably higher than that of nonsmoking Pill users, as shown in the following chart:¹³⁵

<i>Mortality Rate</i>		
<i>(Per 100,000 Users of the Pill)</i>		
<i>Age-group</i>	<i>Smokers</i>	<i>Non-Smokers</i>
30 – 34	10.4	1.8
35 – 39	12.8	3.9
40 – 44	58.4	6.6

One should bear in mind that for legal abortion, the mortality rates per 100,000 procedures were: 1.7 for those from ages thirty to thirty-four; 1.9 for those from ages thirty-five to thirty-nine; and 1.2 for those from ages forty to forty-four.¹³⁶ In sum, the evidence indicates:

Among women under 30 years of age the total risk to life associated with each of the four major methods of fertility control (pill, IUD, diaphragm or condom or first trimester abortion) *used alone* is about equal, and is very low (1-2 per 100,000 women per year), significantly lower than the birth-related risk of death without fertility control.

Beyond age 30 the risk to life . . . increases rapidly for *pill users who smoke*, until, after age 40, it is much higher than the risk experienced by women using neither contraception nor abortion For all other methods the risk remains constant or (in the case of nonsmoking pill users or those using traditional methods without abortion backup) increases moderately, but remains far below the level of mortality associated with complications of pregnancy and childbirth without fertility control.¹³⁷

The conclusion which Dr. Tietze of the Population Council has drawn from this evidence is that the most prudent way to practice birth control is to use a condom and a diaphragm, backed up by early legal abortion in the event of contraceptive failure.¹³⁸ The evidence recounted here supports the plea for a reversal of the trend reported by the Ford Foundation.¹³⁹ Surely a national

133. *Id.* at 399.

134. Tietze, *New Estimates of Mortality Associated with Fertility Control*, 9 FAM. PLAN. PERSPECTIVES 74 (1977).

135. *Id.* at 75.

136. *Id.*

137. *Id.*

138. *Id.* at 76.

139. See text accompanying notes 131-33 *supra*.

budget exceeding 500 billion dollars annually can accommodate the modest needs of such a vital research concern.

One immediate objection to the foregoing proposals regarding dissemination of family planning and contraceptive information would come from the followers of the right-to-life movement, who tend to support the Roman Catholic Church's ban on birth control. But not all right-to-lifers support the Church's position. It is therefore not unreasonable to assume that those who label themselves as "conservative" on abortion and "liberal" on birth control could accept these proposals as compatible with their professed ideals. It is granted that many such persons would consider their principles compromised if they were to support programs to develop family planning services for abortion facilities. Yet this is a legitimate instance in which the end, preventing abortion, justifies the means, providing contraceptives to women who might otherwise repeat the abortion experience. In fact, one could maintain that lack of support by right-to-lifers might reasonably be interpreted as complicity by omission in a policy that promotes abortion by withholding one source of contraception.

One might also anticipate an unfavorable reaction from those disturbed by the prospect of easily available family planning services for teenagers, whether in school or in a clinic. After all, most parents would not readily accept a situation in which their teenage daughter finds it a routine matter to be outfitted with a contraceptive package and, if need be, a clinic which provides the necessary abortion. But, however unsettling it may be, teenage sexuality is a fact of life which certainly cannot be willed away. Another fact of life which cannot be ignored is that for all women (but especially for teenagers) contraception is preferable to the trauma of unwanted pregnancy. Even if not followed by abortion for the pregnant teenager, that trauma is likely to result in the even worse shock of unwed motherhood with its disruptive and often ugly social consequences.

C. Abortion and the Social Policy Alternatives

Thus far the discussion of alternatives to abortion has focused upon contraception as the appropriate preventive medicine for that "disease" known as "unwanted pregnancy." There is, however, another goal that must be pursued. Public policies should be implemented to convert unwanted to wanted pregnancies by removing socio-economic constraints that pressure women, especially working women, to turn to abortion. This policy is called for because insofar as our society is not prepared to subsidize the financial burdens of childbirth and child care, its nonaction is tantamount to a pro-abortion policy. Consider, for example, the lack of day care facilities in the United States. As the Guttmacher Institute has noted:

Subsidized day care services are needed for at least seven million children under six, but there are facilities for only four million children of all ages. The overwhelming majority of those children are being taken care of by "sitters" or relatives in the child's home or in other unlicensed private family homes, many of which, according to the National Council of Organizations of Children and Youth, "are at best custodial and at worst

destructive." Only about three-quarters of a million children of all ages are being cared for in licensed or approved facilities that meet minimum standards of acceptability.¹⁴⁰

In one sense, this widespread neglect at all levels of government is an incitement to abortion. The reason is that for many working women who become pregnant, access to subsidized, low cost day care programs is essential if they are to stay employed. If that option is foreclosed, those who are determined to remain in the work force cannot but realize that abortion offers an inexpensive and quick way out of their dilemma.

Women in the labor force are exposed to additional constraints that are relevant in this context. Wage discrimination exerts economic pressure against women;¹⁴¹ the absence of pregnancy and maternity benefit employment schemes are policies of omission which may tip the balance toward abortion. Similarly, employment practices which frown upon pregnancy also tend to encourage abortion. These abortion incentives can be removed. For example, when Sweden liberalized its abortion law in 1939, the government also enacted a series of measures best described as anti-abortion incentives.¹⁴² One such measure prohibited dismissal from employment on account of pregnancy, while another provided working mothers with up to six months paid leave of absence after giving birth.¹⁴³ Aside from such social assistance programs, the government also expressed support for birth control by establishing a network of family planning clinics.¹⁴⁴ In other words, its policy was that legal access to abortion should be coupled with equal access to a socio-economic climate conducive to attractive abortion alternatives. It is this nearly forty year-old policy that should guide us in developing our own anti-abortion incentives.

VI CONCLUSION

Much of what passes as concern for the fetus is in truth the punitive reaction of those who perceive abortion as an instrument of left-wing ideology; their anti-abortion stance is simply a smokescreen enabling them to vent their antagonism for the social forces of sexual liberation, women's rights, and secularism. There is ample opportunity for those who lobby for the fetus to refute this allegation. One cannot expect them to abandon their campaign for a constitutional amendment on abortion. However, it is not asking too much that they demonstrate their good faith by enlisting in another campaign: one which seeks to implement policies that not only will prevent abortions but also will enhance the lives of countless millions of American women and their families.

140. ALAN GUTTMACHER INSTITUTE, *supra* note 112, at 41.

141. See Burnett, *Family Economic Integrity Under the Social Security System*, 7 REV. L. & SOC. CHANGE 155 (1978).

142. D. CALLAHAN, *supra* note 16, at 186.

143. *Id.*

144. *Id.*

