BRIEF

IN THE SUPREME COURT OF THE UNITED STATES, OCTOBER TERM, 1991, PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, *ET AL.*, PETITIONERS AND CROSS-RESPONDENTS, v. ROBERT P. CASEY, *ET AL.*, RESPONDENTS AND CROSS-PETITIONERS. BRIEF OF THE CITY OF NEW YORK, THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, COMMITTEES ON SEX AND LAW, CIVIL RIGHTS AND MEDICINE AND LAW, AND THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION AS AMICI CURIAE IN SUPPORT OF PETITIONERS AND CROSS-RESPONDENTS.

JULIE MERTUS*

INTRODUCTION**

When I was a law clerk, the best advice the judge I worked for gave me was to write every brief for three audiences: the court that will hear the plea, the parties to the case, and, last but not least, the public at large. In making the argument, he emphasized, the facts should speak louder than the law; from the facts, one should be able to discern a just outcome. This advice purportedly applied to all cases and all courts, but in civil rights cases today, a conservative and even hostile federal judiciary often has not played by the rules: judges have been unwilling or unable to listen to the facts. Many judges treat facts as mere distractions, acknowledging them only selectively to serve their own agendas. Advocates are thus challenged to find new ways to force this first audience to open its eyes to the facts, and, if the judges can no longer be reached, to craft arguments directly for the third audience: the court of public opinion.

Drafters of amicus briefs can play a special role in this process because they are free from many of the limitations faced by party attorneys. Counsel

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** NOTE: This Introduction was prepared by Ms. Mertus for inclusion in the *Review*. It was not submitted as part of the Brief.—EDS.

for parties must follow the strategy most likely to produce a victory for their clients. In doing so, they may have to retreat to technicalities or focus on only their strongest claims. As a practical matter, they may be unable fully to develop all legal and factual points. Amici have few such limitations; their briefs can emphasize the broad principles they believe to be at stake. Although amici must operate within certain boundaries in order to gain access to the legal process, they have much greater latitude in selecting and presenting their positions. This freedom allows amici to use their own personal experiences and expertise to help party attorneys tell the full story.

Nowhere have amici curiae assumed this role more than in reproductive freedom cases. In numerous cases at every stage of federal and state litigation, amici have flooded the courts with briefs adding the expertise and opinions of health professionals, psychologists, social workers, historians, legislators, clergy, and ethicists. Some briefs have emphasized the voices of women affected by restrictive abortion laws; others have underscored the concerns of physicians and nurses straining to work under such laws while remaining true to professional and ethical standards. Some have advanced an international perspective, while others have narrowed the question to local concerns.

The brief *amicus curiae* that follows this Introduction was filed with the Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[1] the most recent challenge to the Court's holding in *Roe v. Wade*.[2] In submitting this brief in support of petitioners, the City of New York, the City Bar Association, and the New York City Health and Hospitals Corporation had no desire to repeat or even amplify legal arguments that would be made by others.[3] Instead, the City sought to tell its own story about how pre-*Roe* restrictions on abortion have endangered all women's lives and health, but particularly those of low-income women and women of color. Indeed, as the city that treated the most out-of-state abortion patients in the nation between 1970 and 1973 (the years before *Roe* but after New York's legalization of abortion), New York City is uniquely qualified to predict the catastrophe that a patchwork of abortion laws would cause for women's health and for cities that seek to provide comprehensive health care.

The City's brief is unique in its extensive concentration on the facts and

1. 947 F.2d 682 (3d Cir. 1991), *cert. granted*, 112 S. Ct. 931 (1992) (oral argument heard April 22, 1992) (facial constitutional challenge to certain 1988 and 1989 amendments to the Pennsylvania Abortion Control Act of 1982).

2. 410 U.S. 113 (1973) (state laws interfering with reproductive freedom must be examined under the most exacting scrutiny).

3. Eight other *amicus curiae* briefs were submitted in *Casey*; this is significantly fewer than the 32 friend-of-the-court briefs submitted in Webster v. Reproductive Health Services, 492 U.S. 490 (1989), the last Supreme Court challenge to a broad-based abortion law. In that case, the attorneys for plaintiffs encouraged *amici* support and, to the greatest extent possible, tightly coordinated these submissions. Reproductive freedom advocates adopted a different strategy altogether in *Casey*. In line with their decision not to focus the case on the ultimate issue of whether *Roe* is to remain the law of the land, the attorneys for plaintiffs did not encourage *amicus curiae* briefs. As a result, comparatively few were submitted.

in its attempt to weave those facts into one coherent tale. Here the City plays the role of sage, remembering what many have forgotten. While the City's interests lie with those who fall within its jurisdiction, its story continually focuses upon women's health. The brief was written with the hope that the Justices would listen to these facts and use them in applying any legal tests, but it was also written for other audiences — for the women affected by restrictive abortion laws and for the public at large. It says: remember.

The greatest disagreement among the many attorneys who read this brief was about whether to include any legal arguments. For various reasons, many felt that we couldn't submit a brief "without law." Others, myself included, envisioned a table of authorities citing just one case: *Roe*. Including specific legal arguments threatened to change the brief's focus from women's health to sterile legal issues. In any case, the City did not have unique legal arguments to contribute, only unique factual experience. More generally, why shouldn't amici submit purely factual briefs? Can't the role of amici be to help the party attorneys reach the judiciary with the facts? After all, as my judge had emphasized to me, aren't the facts most important?

Largely as a compromise, the City's brief begins its narrative with an overview of the legal theories supporting reproductive freedom. But the brief never advocates adoption of any particular theory; the City's *legal* point is that all of these theories recognize that reproductive freedom should be protected precisely because of its centrality to women's lives and health. The brief then turns to the City's pre-*Roe* experiences that underscore this centrality, and the factual discussion takes center stage.

Without mentioning Justice O'Connor's "undue burden" standard,[4] this brief provides some ammunition should the Court adopt that approach. The facts set forth in the brief demonstrate one way in which restrictive abortion laws are unduly burdensome. Moreover, even under the undue burden standard, the Court must give due consideration to the Equal Protection Clause. Accordingly, we may hear attorneys argue that even if an abortion restriction does not have an undue burden on women as a whole, it may nonetheless have an undue burden on a protected class, i.e. people of color. The City's brief introduces a factual predicate for such a case as well.

Above all, this brief seeks to make it very difficult for the Court to escape the facts. These facts alone indicate what outcome would be just. Lessons from history are unlikely to change the minds of many Justices, but knowledge of the past may force them to be cognizant of the dangerous future they would create for women by overruling *Roe*.

4. *See* Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 461-62 (1983) (O'Connor, J., dissenting) (unless abortion restrictions unduly burden women's procreative choices, such restrictions should be subjected to a rational basis test rather than strict scrutiny). *Compare Roe*, 410 U.S. at 155. In *Casey*, the Court of Appeals for the Third Circuit applied the undue burden standard and upheld four of the five challenged abortion restrictions, striking down only the spousal notification provision. 947 F.2d at 697.

No. 91-744, 91-902

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

Planned Parenthood of Southeastern Pennsylvania, et al.,
Petitioners and Cross-Respondents,
-v.-
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Respondents and Cross-Petitioners.

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF THE CITY OF NEW YORK, THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, COMMITTEES ON SEX AND LAW, CIVIL RIGHTS AND MEDICINE AND LAW, AND THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION AS AMICI CURIAE IN SUPPORT OF PETITIONERS AND CROSS-RESPONDENTS

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TABLE OF CONTENTS*

INTEREST OF AMICI CURIAE[5]

The City of New York ("the City") has fought to keep abortion safe and legal. Through its extensive health care system, the City has worked to translate this right into a reality for *all* women. New York City's historic role in this struggle, however, has extended far beyond its borders. Between the time abortion was legalized in New York State in 1970, and the time this Court recognized reproductive freedom as a constitutionally protected right in *Roe v. Wade*, over 350,000 out-of-state women traveled to New York City for abortions; over two-thirds of all New York City abortions performed during this time period were sought by nonresidents. This influx of women, who traveled

* NOTE: This brief is published in the form in which it was submitted to the United States Supreme Court. No editorial changes have been made to text or footnotes. — EDS.

5. The parties have consented to the filing of this brief. Letters of consent are on file with the Clerk of the Court.

at great cost to lives and their health, strained the City's ability to provide for the health care needs of residents and nonresidents alike.

The Association of the Bar of the City of New York ("the Association") has more than 19,000 members. Although the Association has members in nearly every state and in forty countries, most members practice in the New York City metropolitan area. The Association has traditionally focused on issues relating to New York City, including the delivery of safe and adequate health care for all. The Association is deeply committed to the principle of individual liberty embodied in the right to privacy. It has long advocated the constitutional right of women to make reproductive decisions and believes that the challenged legislation abridges that choice.

The New York City Health and Hospitals Corporation ("HHC") is the largest municipal hospital system in the United States, with eleven acute care hospitals, five long-term care facilities, and over twenty community-based primary care sites. Last year it provided hospital and long-term care to over a quarter of a million people. HHC's commitment to women's health is demonstrated by a variety of programs; its specific commitment to reproductive freedom is evidenced by its long-standing policy of providing both pre-natal care and abortions to women regardless of ability to pay.

The City, the Association, and HHC submit this brief to show that restrictive abortion laws have endangered women's lives and health in the past and, if permitted in the future, will have a deleterious impact on the health of women in states with restrictive abortion laws seeking abortions and on health care in New York City. The pre-*Roe* experience in New York City underscores why this Court should reaffirm the principles set forth in *Roe v. Wade*.

SUMMARY OF ARGUMENT

In warning of the inevitable, destructive impact of restrictive abortion laws, no City can better wear the cloak of the sage than the City of New York. Just over twenty years ago, after New York State liberalized its abortion law, the City became the destination of hundreds of thousands of women seeking safe and legal abortions. Ninety percent of the women who could afford to travel to the City for reproductive health care were white; those left behind were frequently at the mercy of back alley abortionists. What happened to these women, how their travels harmed their own health and strained City resources to provide for them as well as others, and why we have every reason to believe that a return to pre-*Roe* days would raise this specter anew, is the focus of this brief.

It was against the backdrop of these experiences that this Court granted reproductive freedom constitutional protection nineteen years ago. Now, as then, states cannot set forth a compelling interest warranting the imposition of such a severe and inequitable burden on women's lives and health. Indeed, in these days when cities like New York are facing acute social and health crises, the harm imposed on women will be particularly harsh. This Court thus

should reaffirm the princples set forth in *Roe v. Wade* and continue to hold restrictive abortion laws to the strictest constitutional scrutiny, striking down those that impose such undue burden on women.

ARGUMENT

I. REPRODUCTIVE FREEDOM IS RECOGNIZED AS A CONSTITUTIONALLY PROTECTED RIGHT PRECISELY BECAUSE IT IS CENTRAL TO WOMEN'S LIVES AND HEALTH.

Reproductive freedom has been placed in the rubric of liberty rights variously as "privacy," *Griswold v. Connecticut*, 381 U.S. 479 (1965) (articulating right to privacy); *Roe v. Wade*, 410 U.S. 113 (1973) (applying privacy right to abortion); "bodily integrity," *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942); "autonomy," *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); "self determination," *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 777 n.5 (Stevens, J., concurring) (1986); "intimate association," *see, e.g.*, Kenneth Karst, *The Right to Intimate Association*, 89 Yale L. J. 624 (1980); "personhood," *see, e.g.*, Jeffrey H. Reiman, *Privacy, Intimacy, and Personhood*, 6 Phil. & Pub. Aff. 26 (1976); and "the interest in independence in making certain kinds of important decisions," *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85 (1977).

Concurrently, reproductive freedom has been framed as an equality issue, as only women are directly burdened by restrictive abortion statutes. *See Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 71 (1976) ("it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy. . . .").[6] Thus, to ensure that the constitutional guarantee of liberty "extends to women as well as to men," this Court should protect reproductive freedom lest it "protect inadequately a central part of the sphere of liberty that our law guarantees equally to all." *Thornburgh*, 476 U.S. at 772. By requiring women to sacrifice their bodies and their liberty in ways that the state never demands of men, restrictive abortion laws impermissibly reflect "traditional . . . assumptions about the proper roles of men and women." *Mississippi Univ. for Women*, 458 U.S. at 726.

All of these legal frameworks, however varied, recognize and address the same core concern: the centrality of reproductive freedom to women's lives

6. The Court has held that measures classifying on the basis of gender are unconstitutional unless the government can "carry the burden of showing an exceedingly persuasive justification for the classification." *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982) (quoting *Personnel Administration of Mass. v. Feeney*, 442 U.S. 256, 273 (1979)). *See also Craig v. Boren*, 429 U.S. 190, 197-199 (1976). Classifications based on gender have long been subjected to searching analysis because of the substantial burdens suffered by women when gender stereotypes are imposed on them. *See Mississippi Univ. for Women*, 458 U.S. at 726; *Califano v. Goldfarb*, 430 U.S. 199, 211 (1977) (plurality opinion); *Stanton v. Stanton*, 421 U.S. 7, 14 (1975); *Frontiero v. Richardson*, 411 U.S. 677, 684 (1973) (plurality opinion).

and the great harm imposed if the state strips it away. Few women are psychologically[7] or physically[8] harmed by choosing to have an abortion, but many are harmed if they are denied control over the decision in the first place. The burden is not felt by just the woman; unwanted pregnancy and childbirth carry "substantial health, psychological, social and economic implications for the child, the mother, her family, and society."[9] Laws that dictate procreative matters "*take over* the lives of the persons involved: they occupy and preoccupy." Jeb Rubenfeld, *The Right to Privacy*, 102 Harv. L. Rev. 737, 784 (1989).

Loss of control over procreative matters affects every aspect of a woman's life, from her physical health, to her economic status, to her ability to educate herself. By stripping women of any sense of control over their own and their families' destiny, restrictions on reproductive freedom contribute significantly to feelings of hopelessness and in turn to apathy.[10] By intruding upon women's very sense of self, mandating life choices, and frequently harming a woman's mental and physical health, abortion restrictions thus interfere with women's ability to participate in society fully and equally with men.

In holding that the right to privacy is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy," *Roe v. Wade*, 410 U.S. at 153, this Court repeatedly emphasized its concern for the impact of state regulation of abortion upon the lives and health of pregnant women. Crucial to its holding was the recognition that:

> The detriment that the State would impose upon the woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care.

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7. A study commissioned by then Surgeon General C. Everett Koop (avowedly anti-choice) found that abortion causes very few psychological problems and that a distinct "post abortion syndrome" could not be identified. *See* C. Everett Koop, Letter to President Reagan, dated Jan. 9, 1989, reprinted as *A Measured Response: Koop on Abortion*, 21 Fam. Plan. Persp. 31, 32 (1989).

8. "[T]he risk of death from legal induced abortion is no higher at any point in gestation than is the risk of death from childbearing." Christopher Tietze & Stanley Henshaw, *Induced Abortion, A World Review 1986* 110 (1986); *see also* Willard Cates, *Legal Abortion: The Public Health Record*, 215 Sci. 1586 (1982).

9. Nancy Felipe Russo, *Psychological Aspects of Unwanted Pregnancy and Its Resolution*, in *Abortion, Medicine and the Law* (J. Douglas Butler & David F. Walbert, eds., 4th ed. forthcoming 1992). *See also* Henry P. David et al., *Born Unwanted: Developmental Effects of Denied Abortion* (1988).

10. *See generally* Ellen McGrath et al., *Women and Depression* 1-2 & 10-13 (1990). Studies of the differences between women who have experienced unwanted pregnancy and those who have avoided it have consistently found that avoidance of unwanted pregnancy is correlated with a heightened sense of self-competence and control. *See, e.g.*, Nancy Adler, *Sex Roles and Unwanted Pregnancy in Adolescent and Adult Women*, 12 Prof. Psychol. 56, 57 (1981).

Id. at 153.[11]

The detriment that women would suffer should they be denied control over procreative choices is no less today than it was when *Roe* was decided less than twenty years ago. Nor has the centrality of reproductive freedom to women's lives changed. New York City's pre-*Roe* experiences illustrate only one of the great burdens imposed on women's health by abortion restrictions like those at issue in Pennsylvania: that is, the harm attributable to a system in which many women are forced to travel long distances, across state lines for reproductive health care. Because the burden to women's lives and health is so great, this Court, under any legal theory set forth above, should reaffirm that reproductive freedom is constitutionally protected and that regulations that interfere with this right, like any other fundamental right, are subject to strict scrutiny.

II. NEW YORK CITY'S PRE-*ROE* EXPERIENCE COMPELS THE CONCLUSION THAT RESTRICTIVE ABORTION LAWS STRAIN LARGE CITY RESOURCES AND ENDANGER WOMEN'S HEALTH.

It is no secret that the abortion restrictions of the past did not end abortions. Rather, they only forced women into back alleys and onto kitchen tabletops for unsterile, health and life threatening procedures. In 1965, for example, illegal abortion accounted for 17 percent of all deaths attributed to pregnancy and childbirth in that year. National Center for Health Statistics, *Vital Statistics of the United States, 1965* Vol. II — Mortality, Part A (1967). Because abortion was illegal at that time, the actual number of deaths owing to abortion was much greater than officially reported. With few exceptions, the only women who could afford safe, hospital abortions were white. Harriet Pipel, *The Abortion Crisis*, in *The Case for Legalized Abortion Now* 101 (Alan Guttmacher ed. 1967) (93% of New York State hospital abortions performed on white women). The women who died from illegal abortions have always been disproportionately women of color; even in the years in which abortion began to be legalized — from 1972 to 1974 — the mortality rate from illegal abortion for women of color was approximately 12 times the rate for white women. Willard Cates & Roger W. Rochat, *Illegal Abortions in the United States: 1972-1974*, 8 Fam. Plan. Persp. 86, 88 (1976); *see also* Steven Polgar & Ellen S. Fried, *The Bad Old Days: Clandestine Abortions Among the Poor in New York City Before Liberalization of the Abortion Law*, 8 Fam. Plan. Persp. 125, 125 (1976).

11. And, on every occasion it has addressed the issue, this Court has unequivocally held that a pregnant woman's health cannot be sacrificed in order to protect her fetus. Striking down a Pennsylvania statute that limited women to the abortion technique that would best ensure that a fetus be aborted alive, the Court insisted that the woman must be free to choose the method of abortion that furthers her own health, regardless of its effect upon the prospects of fetal survival. "[T]he woman's life and health must always prevail over the fetus' life and health when they conflict." *Colautti v. Franklin*, 439 U.S. 379, 400 (1979).

The incidence of incomplete abortions, which can cause sterility and other health complications, was also high in New York City during this time period. In 1962 alone, nearly 1,600 women were admitted to Harlem Hospital in New York City because of fragments of fetal material left in the uterus during an illegal abortion. D.T. Swartz & M.K. Paranjpe, *Abortion Services in a Municipal Hospital*, 47 Bull. N.Y. Acad. Med. 846, 846 (1971). In all New York City hospitals in the 1960s, complications resulting from illegal abortions accounted for more than 20 percent of all pregnancy-related admissions. *See* Emily C. More-Cavar, *International Inventory on Induced Abortion* (1974).

Largely as an attempt to reduce the incidence of mortality and morbidity attributable to illegal abortions, New York State became one of the first states to legalize abortion in April 1970.[12] Under the new law, New York State imposed few restrictions on abortions, stating only that abortion could be performed by a physician within the first 24 weeks of pregnancy (with no gestational age limits specified) or at any time to preserve the life of the woman. N.Y. Penal Law § 125.05(3) (McKinney 1987 & Supp. 1992) (enacted in 1965 and amended in 1970). Although this law safeguarded the health of many women, it did so at great cost both to the women forced to travel across state lines for legal abortions, and to the City's ability to provide for them as well as others.

A. After Abortion Was Legalized In New York State, Large Numbers Of Women Flooded New York City In Search of Safe And Legal Reproductive Health Care.

As soon as the liberalized abortion law took effect, New York City became a magnet for out-of-state women in search of safe and legal abortions. In the first five months of the new law, certificates of termination[13] filed in the City indicated that over half of the procedures had been performed on nonresidents. New York City Department of Health, *All Abortions Performed in New York City Since July 1, 1970* (n.d.) (hereinafter New York City Dep't of Health, Table I). *See also* Jean Pakter et al., *Surveillance of the Abortion Program in New York City: Preliminary Report*, 3 Clinical Obstetrics & Gynecology 267, 284 (Mar. 1970) (hereinafter *Surveillance of the Abortion Program*). By the end of the first year, the percentage of abortions performed on out-of-

12. As this Court has recognized, abortion had not always been criminalized. *See Roe v. Wade*, 410 U.S. 113, 132-36 & n.21 (1973). *See also* Linda Gordon, *Woman's Body, Woman's Right: A Social History of Birth Control in America* 51-52 (1976) (abortion "common" and "safe" in late 1870s). Perhaps it thus is more accurate to state that New York State was one of the first states to *once again* permit safe and legal abortions.

13. The New York City Health Code mandated reporting of all terminations of pregnancy, induced or spontaneous. The certificates of termination included data regarding the number of abortions, weeks of gestation, reason for termination, age and legal residence of patient, mode of termination, and the facility where the termination had taken place. *See* David Harris et al., *Legal Abortion 1970-71 — The New York City Experience*, 63 Am. J. Pub. Health 409, 409 (1973).

state residents had increased to over 67%,[14] dipping only slightly to approximately 65% in the months immediately preceding *Roe v. Wade*. *See* New York City Dep't of Health, Table I, *supra*; New York City Dep't of Health, *New York City Health Department Study Indicates Nearly Half Million Abortions to City Residents Since 1970 Legalization* 1 (Aug. 4, 1977) (press release) (hereinafter New York City Dep't of Health 1977 Press Release).[15]

The official figures do not begin to reflect fully the enormity of the influx of abortion patients into the City. First, they do not include many of the terminations performed at freestanding abortion clinics, which underreported, but which also treated the vast majority of out-of-state patients. *See* Abner I. Weisman, *Open legal abortion "on request" is working in New York City, but is it the answer?*, 112 Am. J. Obstetrics & Gynecology 138, 140 (1972). Second, even the reported terminations were inaccurate since a number of out-of-state women gave false New York addresses, out of the perceived but usually unfounded fear that they would not be able to obtain services if they gave their real out-of-state address. Despite these limitations in reporting, official estimates indicate that New York City became a haven for women seeking safe, legal reproductive health care.

In total, in the two and a half years preceding *Roe*, nearly 350,000 women left their own states to obtain abortions in New York. The Alan Guttmacher Institute, *Abortion and Women's Health: A Turning Point for America?* 3 (1990).[16] Nationally, of all abortions reported on out-of-state residents in 1971, 85.3% were performed in New York State, with the vast majority performed in New York City. Centers for Disease Control, *Abortion Surveillance: 1971* 5 (Dec. 1972).[17] Women came to the City for abortions from

14. The New York State estimate for 1971 nonresident abortions performed in New York City was slightly lower, 63.3%. *See* New York State Dep't of Health, *Report of Selected Characteristics of Induced Terminations of Pregnancy Recorded in New York State: January — December 1971*, table 14 (Aug. 1972).

15. *See also* Jean Pakter et al., *Two Years of Experience in New York City with the Liberalized Abortion Law - Progress and Problems*, 63 Am. J. Pub. Health 524, 524-525 (1973). Again, the New York State figure for abortions performed on out-of-state residents in New York City in 1972 was set slightly lower, 61%. *See* New York State Dep't of Health, *Report of Selected Characteristics of Induced Terminations of Pregnancy Recorded in New York State: January — December 1972*, table 6 (Jan. 1974).

16. This figure is tabulated from: New York State Dep't of Health, *Report of Selected Characteristics of Induced Terminations of Pregnancy Recorded in New York State: January - December 1972*, table 6 (Jan. 1974); New York State Dep't of Health, *Report of Selected Characteristics of Induced Terminations of Pregnancy Reported in New York State*, table 5 (April 1971); New York City Dep't of Health, *New York City Health Department Study Indicates Nearly Half Million Abortions to City Residents Since 1970 Legalization* 1 (Aug. 4, 1977) (press release) (hereinafter New York City Dep't of Health 1977 Press Release).

17. Even allowing for differences among the liberalized abortion laws, New York's 85.3% share of out-of-state patients is exceedingly large. According to the Centers for Disease Control figures, states that performed a large percent of their abortions on out-of-state residents in 1971 included: Kansas (60.8%), New York (60%), District of Columbia (36.3%), Wisconsin (32.5%) and California (11.2%). Centers for Disease Control, *Abortion Surveillance: 1971* 5 (Dec. 1972). Nationally, at least 39% of the reported, legal abortions performed in 1971 were on out-of-state residents. *Id.* But, as the CDC noted, since many states did not report residency

every state and from several other countries. In the years preceding *Roe*, the five most frequent areas from which women came were: New Jersey, Ohio, Michigan, Illinois and Pennsylvania — all states with strict abortion prohibitions. David Harris et al., *Legal Abortion 1970-1971 — The New York City Experience*, 63 Am. J. Pub. Health 409, 410 (1973).

Throughout these years, between seven and eight percent of all reported abortions in New York City were performed on Pennsylvania women. The number of reported procedures performed on Pennsylvania women totaled close to 12,000 in both 1971 and 1972, falling quickly to 4,083 in 1973. New York City Dep't of Health 1977 Press Release, *supra*, at table 5.

Although New York City treated all women who needed abortions regardless of residence and ability to pay, the expense of traveling to the City was prohibitive for many women. Women of color, disproportionately low-income and traditionally marginalized from the mainstream women's organizations that facilitated abortion arrangements, were far less able to obtain either the requisite travel funds or information to schedule such a trip. Thus, although roughly half of in-state women obtaining abortions were women of color, only about 10% of the out-of-state residents were nonwhite. New York State Dep't of Health, *Report of Selected Characteristics of Induced Terminations of Pregnancy Recorded in New York State, 1971-1975* 1-2 (n.d.) (hereinafter New York State Dep't of Health, *Report of Induced Terminations*).[18] The vast majority of nonresident women of color who faced an unwanted pregnancy continued to bear unwanted children and to turn to dangerous, illegal abortionists, as if New York had not changed its law at all. *See* Cates & Rochat, *supra*, at 86.

B. The Influx Of Out-Of-State Patients Strained The City's Health Care Resources While Threatening Women's Health.

In the three months between the passage of New York State's liberalized abortion law and its implementation date, health care providers braced themselves for the large numbers of women who would now seek safe and legal abortions in City hospitals and clinics.[19] Their fears were entirely justified.

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status of patients, "the actual proportion of women obtaining out-of-state legal abortion was probably higher than the reported populations." *Id.*

18. Among the City's residents who received abortion services in July 1970 through June 1971, for example, 42.8% were recorded as "non-white" and 10% as Puerto Rican; among nonresidents who had abortions performed, 90% were white, 9.5% were "non-white" and 0.5% were Puerto Rican. Harris et al., *supra* note 9, at 413-414. We have no reason to believe that the demand for abortions by women of color who lived in the City differed much from that of other women of color.

19. For examples of speculation regarding nonresidents, *see* Lacey Fosburgh, *Abortion Law Seen Burdening State*, N.Y. Times, Apr. 27, 1970, at A28 ("The possibility that pregnant women from all over the country might inundate New York hospitals with requests for abortions has created immense organizational and financial problems. . . ."); Jane E. Brody, *City is Planning for Abortions at a Rate of 25,000 a Year*, N.Y. Times, May 30, 1970, at A1 ("The greatest unknown — which has made many doctors fearful that the demand will far outstrip the capacity to perform it — is how many women living under less liberal laws will come to this

Largely as a result of the influx of out-of-state women, the number of women who sought abortions after the law took effect "exceeded the capacity of the system to perform the procedures by a wide margin." Bellevue Hospital, *Some Thoughts on the Abortion Crisis in New York City* 1 (July 31, 1970) (internal memorandum). Municipal hospitals estimated that between one-quarter to one-third of their abortion patients were actually nonresidents using spurious addresses. *See id.*, at 3.[20]

The nonresident patients taxed municipal hospitals' resources and contributed to a growing backlog of women seeking abortions and other reproductive health care.[21] Within two weeks after the new law took effect, 2,500 women registered for abortions in municipal hospitals that were equipped to handle less than a quarter of that total weekly. As a result, in some City hospitals where the demand was particularly heavy, the waiting time grew to as long as six weeks — a prohibitive length of time for many pregnant women. *See Abortion Facilities Under Strain*, N.Y. Times, July 19, 1970, at 7; State Communities Aid Ass'n, *Minutes of the Third Meeting on Implementation of the 1970 New York State Abortion Law* 2, 4 (Aug. 12, 1970) (backlogs for abortions two to seven weeks).

The waiting time was exacerbated by the fact that, owing to the time incurred in traveling to the City, out-of-state women on average received later abortions than did in-state women. New York State Dep't of Health, *Report of Induced Terminations, supra*, at 2. No more than 10 percent of New York City residents having an abortion in the City in 1972 did so after the first 12 weeks of pregnancy. In contrast, a quarter of the women who traveled to New York from states with restrictive abortion laws had their abortions after 12 weeks of pregnancy. Jean Pakter et al., *Legal Abortion: A Half-Decade of Experience*, 7 Fam. Plan. Persp. 248, 255 (1975); The Alan Guttmacher Institute, *supra*, at 5.

Abortion through the fifteenth week of pregnancy is tenfold safer than childbearing, and the risk of death from abortion is no higher at any point in gestation than is the risk of death from childbearing. Willard Cates et al., *Mortality From Abortion and Childbirth: Are the Statistics Biased?*, 248

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state for legal termination of their unwanted pregnancies."); Jane E. Brody, *State's Liberal Abortion Law Takes Effect Today Amid Prospects For Delay*, N.Y. Times, July 1, 1970, at A36 (reporting that a number of hospitals were already fully booked for abortions through July).

20. A residency requirement not only would have been difficult to implement, but also would have directly conflicted with the policy of City hospitals to treat all patients in need, regardless of proof of residence. *See* N.Y. Unconsol. Laws § 7382 (McKinney 1985 & Supp. 1992) (establishing HHC); The New York City Health & Hospitals Corp., *Mission Statement* (adopted May 18, 1968).

21. Extensive City hospital plans were developed to manage these resource problems. *See, e.g.*, Joseph J. Rovinsky, *Abortion in New York City: A Consideration of the Practical Problems Which May Follow Elimination of Statutory Restrictions on Termination of Pregnancy* (July 1, 1970) (predicting demand for legal abortions and estimating difficulties in immediately meeting needs of new patients); New York City Health & Hospitals Corp., *A Program Analysis of the New York City Health and Hospital Corporation's Abortion Services* (June 1972) (proposing changes for meeting needs of abortion patients).

J.A.M.A. 192, 196 (1982); Christopher Tietze & Stanley Henshaw, The Alan Guttmacher Institute, *Induced Abortion: A World Review* 110 (1986). Still, "for each week of delay, the risk of complications after legally induced abortions increases approximately 20%; the risk of death increases approximately 50%." American Public Health Ass'n, *APHA Recommended Program Guide for Abortion Services (Revised 1979)*, 70 Am. J. Pub. Health 652, 654 (1980). *See also* David A. Grimes, *Second Trimester Abortions in the United States*, 16 Fam. Plan. Persp. 260, 263 (1984) (terminations performed at 16 or more weeks gestation are 24 times as likely to result in fatal complications as procedures performed at eight or fewer weeks).[22] At the same time, however, complications are less likely to become fatal or result in sterility if they are monitored and treated. *See* J. Joshua Kopelman & Gordon Douglas, *Abortions by Resident Physicians in a Municipal Hospital Center,* 111 Am. J. Obstetrics & Gynecology 666, 670-71 (1971). Yet most nonresident patients returned home immediately following their procedures and thus did not have access to follow-up care. Indeed, the most "important problem concerning nonresidents [was] the lack of follow-up with regard to possible complications." *Surveillance of the Abortion Program, supra*, at 294. A few women died after receiving abortions in New York City because they had returned to their home states where follow-up care either was not readily available or was available only for those who risked criminal prosecution. *See* Jean Pakter et al., *Impact of Liberalized Abortion Law in New York City on Deaths Associated with Pregnancy: A Two-Year Experience*, 49 Bull. N.Y. Acad. Med. 804, 811 (1973) (hereinafter *Impact of Liberalized Abortion Law in New York*) (summarizing cases of four nonresident City abortion patients). In this sense, the pre-*Roe* system of shuttling women across state lines for health care helped sign some women's death certificates and ensured others prolonged health complications.

City hospitals and clinics eventually were successful in addressing many of the health care problems stemming from their new patient population. The waiting time for abortions decreased, an increasingly higher proportion of terminations were performed before 13 weeks gestation, and the rate of complications from the procedures declined.[23] The new law therefore at least partially

22. For abortions performed at seven or eight weeks of pregnancy, the risk of developing major complications is almost 0.2 per 100. At 13 or 14 weeks, that risk increases to about 0.6 per 100. And at more than 20 weeks, 1.5 per 100 patients develop major complications. The Alan Guttmacher Institute, *Abortion and Women's Health: A Turning Point for America?* 32 (1990).

23. For example, New York City municipal hospitals reported 23 admissions for incomplete abortion for every 100 deliveries performed in 1969; by 1971, less than a year after New York liberalized its abortion law, the number of admissions for incomplete abortions fell to 13 per 100 births. Institute of Medicine, *Legalized Abortion And The Public Health* 65 (1975); *see also* Harris et al., *supra* note 13 at 411 (abortions performed at increasingly early stages of gestation), and at 415-16 (complications decreased); John Sibley, *69,000 Abortions in 6 Months Here*, N.Y. Times, Feb. 7, 1971, at 70 (abortions performed at earlier stage of gestation; waiting periods for abortions decreased).

achieved its intended goal: women were provided with the right to safe and legal abortions, and the incidence of mortality and morbidity associated with abortions in New York declined as a result. *See* Jane E. Brody, *Decline in Maternal Death Rate Linked to Liberalized Abortion*, N.Y. Times, Oct. 13, 1971, at A13 (1971 maternal mortality rate lowest in City's history); *Impact of the Liberalized Abortion Law in New York City, supra*, at 807-808. But this success was not without a price — both to the entire City health care system and to the health of women who were forced to travel long distances to the City. And the success was far from perfect: for the thousands of women who could not afford to travel — disproportionately women of color — New York's law afforded no hope.

III. A SUPREME COURT RULING UPHOLDING PENNSYLVANIA'S ABORTION RESTRICTIONS WOULD USHER IN A NEW ERA OF ENDANGERMENT OF WOMEN'S HEALTH.

The number of out-of-state women forced to seek reproductive health care in the City decreased immediately following this Court's ruling in *Roe*. In one year, from 1972 to 1973, the distribution of induced terminations of pregnancy by residence was completely reversed; in 1972 over 60% of the patients were nonresidents, but in 1973, 60% were residents, although the number of residents having abortions in the City remained more or less constant. *See* New York City Dep't of Health, Table I, *supra*; New York State Dep't of Health, *Report of Induced Terminations in New York State, supra*, at 1. From then on, while the number of resident abortion patients stabilized, the percent of out-of-state women seeking abortions in New York City continued to decline: to 23% in 1975, 18% in 1976, 10% in 1980, and 6.7% in 1985.[24] *See* New York City Dep't of Health 1977 Press Release, *supra*, at table I; New York City Dep't of Health, *Report of Induced Terminations By Residence, New York City 1980-1989*, table 9 (Jan. 22, 1991).

The number of abortions performed on Pennsylvania women in New York City declined correspondingly, from nearly 12,000 in 1972, to 1,618 in 1974, 761 in 1976, and to fewer than 300 in 1989. New York City Dep't of Health 1977 Press Release *supra* at 1; New York State Dep't of Health, *Induced Abortions Recorded in New York State: 1987-1989 with Five Year Summary*, table 28 (1991). Nationally, the impact of *Roe* was even more evident. In 1972, 44 percent of all abortions in the United States were obtained outside a woman's state of residence; by 1974, just one year after *Roe*, only 10 percent

24. Today, new restrictive abortion laws passed in neighboring states have contributed to a noticeable increase in nonresident abortions. *See* New York City Dep't of Health, *Report of Induced Terminations By Residence, New York City 1980-1989*, table 9 (Jan. 22, 1991) (setting 1989 nonresident rate at 7.6%). *See generally* Virginia G. Cartoof and Lorraine V. Klerman, *Parental Consent for Abortion: Impact of the Massachusetts Law*, 76 Am. J. Pub. Health 397, 397 (1986) (more than 1,800 minors residing in Massachusetts traveled to other states for abortions in first two years of Massachusetts' parental consent law).

of women having an abortion were forced to travel out of state for the procedure. *Digest*, 8 Fam. Plan. Persp. 70, 70-71 (1976) (summary of Centers for Disease Control, *Abortion Surveillance, Annual Summary, 1974)* (hereinafter *Digest of 1974 CDC Abortion Surveillance*); *see also* Edward Weinstock, et al., *Abortion and the Need for Services in the United States, 1974-1975*, 8 Fam. Plan. Persp. 58, 62-63 (1976) (state-by-state summary of redistribution of abortion services post-*Roe*).

As an immediate and direct result of legalization, the incidence of mortality from illegal abortions fell to nearly zero. *See* New York City Dep't of Health 1977 Press Release (no fatalities reported as result of illegal abortion 1973-1977); *Impact of the Liberalized Abortion Law in New York, supra*, at 815. The rate of complication from both legal and illegal abortions also declined, because procedures were performed both under safer conditions and at an earlier stage of gestation. *See* Christopher Tietze, *The Public Health Effects of Legal Abortions in the United States*, 16 Fam. Plan Persp. 26 (1984); Grimes, *supra*, at 263. A retreat from the principles set forth in *Roe* would only reverse this trend. Such a regression would once again endanger women's health and would now, perhaps more than ever, hamper the City's ability to meet the health care needs of residents and nonresidents alike.

A. The Influx Of Nonresident Women Seeking Abortions Will Burden An Already Overextended City Health Care System, At Great Cost To Women's Health.

The City of New York is confronting a growing health and social crisis which would be exacerbated by any new obstacles to reproductive freedom, including any changes that would increase the City's patient population. This crisis is evidenced by the following facts:

- 2.3% of all babies born in 1990 at facilities operated by the New York City Health and Hospitals Corporation ("HHC") tested positive for HIV.
- 5.2% of mothers who gave birth at HHC facilities in 1990 were narcotics addicts.
- Nearly 50,000 children are currently in the City's foster care program because their parents are unable to care for them.
- In fiscal year 1991, the City filed more than 8,000 neglect petitions against the parents or foster parents of nearly 17,000 abused and/or neglected children.
- In 1990, nearly 16% of all births at HHC facilities were to teens.
- At least a third of the women giving birth at HHC facilities in 1990 had sought little or no prenatal care.
- Over a quarter of all babies born in HHC facilities in 1990 were low birth weight.

See New York City Health & Hospitals Corp., Office of Women's Health, *Selected Characteristics of Live Births: 1990* (Nov. 1991); New York State

Dep't of Health, *AIDS in New York State* (1990); Memorandum of Josie Morales, Office of Women's Health, New York City Health & Hospitals Corp., to Meredith Feinman (Dec. 6, 1991).

Given its commitment to reproductive freedom, the City, through HHC, has made abortion available to all women, regardless of ability to pay.[25] Indeed, in January 1990, the City increased access to abortions by implementing a new policy of providing medically necessary abortions, free of charge, to women whose incomes lie between 100% and 185% of the poverty level. As HHC announced in introducing the plan: "This policy is entirely in concert with HHC's public mission — to make health care available to all, regardless of ability to pay." New York City Health and Hospitals Corp., *Announcement of Policy to Fellow Providers* (Jan. 12, 1990).[26] Since the State of New York will not share in the cost of abortion procedures under this program, the City has borne the full expense — nearly $1 million annually.

The inevitable influx of out-of-state patients, should restrictive abortion laws be permitted, would exacerbate the City's health care crisis and threaten the City's current efforts to meet the needs of its residents. An increased abortion patient load in New York City hospitals will increase the delay in scheduling abortion procedures. The average wait for an abortion in HHC facilities is already 11 *working* days, with a range up to 28 *working* days. Four hospitals have a backlog of more than four weeks. New York City Health & Hospitals Corp., *Waiting Time for Abortion Services, 1990 HHC Survey Results* (Sept. 1990). Any further increase in waiting time will preclude some women from having abortions altogether; it will subject others to later procedures, at greater danger to their health. *See* American Public Health Ass'n, *supra*, at 654.

Moreover, as in pre-*Roe* days, the health of women who live in states with restrictive laws will suffer. Many of the women who are not able to travel across state lines for reproductive health care will die or be sterilized from unsterile, illegal abortions. And the women who can travel will have more dangerous abortions, because the procedures will be performed at a later state of gestation and follow-up care will not be available. *See, e.g.*, Grimes, *supra*, at 261, 265. In these times of crisis, the City will be strained in meeting the

25. "[N]o woman is turned away if she is unable to pay in full or in part for an abortion." Letter from Raymond J. Baxter, Acting President, New York City Health & Hospitals Corp., to Pat Maher (Feb. 26, 1990). In HHC hospitals, a down payment for abortion services may be requested, but not demanded, before services are rendered. Also, a deferred payment schedule based on financial capabilities can be arranged. Still, "[u]nder no circumstances are services to be delayed, however, pending payment arrangements." *Id.*

26. In supporting federal legislation to establish universal access to health care and to reform the health care delivery system, HHC recently reaffirmed its "mission [to] provide[] universal access to all" and its recognition that "quality appropriate health care is a human right." New York City Health & Hospitals Corp., *HHC Resolution Adopting a Corporate Policy Supporting Federal Legislation to Establish Universal Access to Health Care and to Reform the Health Care Delivery System* 1 (Nov. 1991). *See also* Dr. James R. Dumpson, Chairman, HHC Board of Directors, HHC's Annual Public Meeting, Manhattan/Bronx Session (Nov. 6, 1991) (speech setting forth HHC's commitment to low-income New Yorkers).

needs of these additional patients. Pennsylvania can set forth no compelling state interest that must be advanced through imposition of such a great burden on women's lives and health.

B. Both Resident And Nonresident Women Of Color Will Be Harmed The Most If Roe *Is Not Reaffirmed.*

The burden of restrictive abortion laws will unjustly continue to rest most heavily on women of color. Nonresident women of color are still more likely to be low-income and, thus, less able than white women to travel to other states for reproductive health care. As noted previously, of the 350,000 women who traveled to New York City for abortions between 1970 and 1973, only 10% were women of color, notwithstanding that women of color constituted over a third of the population of abortion recipients. *See Digest of 1974 CDC Abortion Surveillance, supra,* at 70-71.[27] Since women of color remain disproportionately poor today, there is no reason to believe that this statistic would not repeat itself if the principles set forth in *Roe* are not reaffirmed.[28] Just as in pre-*Roe* days, then, many nonresident women of color facing unwanted pregnancies will be forced to bear unwanted children or be compelled to turn to dangerous, back alley abortionists for medical care.

Low-income communities — which are disproportionately nonwhite — also will be impacted the most by any further strains on the City health care system. *See* Memorandum from Josie Morales, Office of Women's Health, New York City Health & Hospitals Corp., to Meredith Feinman (Feb. 12, 1992) (City's municipal hospital population is 84% nonwhite). The shortage of physicians is already particularly acute and the backlog for abortions longer in hospitals serving low-income and minority populations. But, at the same time, these are the populations at highest risk for unwanted pregnancy. *See* Stanley Henshaw, *Characteristics of U.S. Women Having Abortions, 1987,* 23 Fam. Plan. Persp. 75, 77 (1991).

That low-income and minority New Yorkers face a dire health care crisis is illustrated by the following facts:

- In nine low-income minority communities in the City, only 701 non-hospital based primary care physicians are available to serve 1.7 million residents; only 28 of these physicians are able to offer their patients the minimum elements of a primary health care network.
- Compared to New York City as a whole, the death rate for people aged 15-44 in Harlem is 240 percent higher; for those aged 44-65

27. Today, although a smaller number of nonwhite, pregnant women have abortions than white women, the rate of abortions per 1,000 women is twice as high for nonwhite women than for white women. *See* Stanley K. Henshaw, *Characteristics of U.S. Women Having Abortions,* 19 Fam. Plan. Persp. 5, 7 (1987).

28. Indeed, studies confirm that women of color are more likely to be deterred from having safe, legal abortions even today if they must travel long distances for health care. *See* James D. Shelton et al., *Abortion Utilization: Does Travel Distance Matter?,* 8 Fam. Plan. Persp. 260, 262 (1976).

years of age, it is 128 percent higher. These are not deaths that arose from violence and drugs; the leading killers in Harlem are cancer, heart attack, hypertensive disease, diabetes, and bronchitis.

— In Central Harlem, the hypertension death rate is 1,000 percent higher than in the City as a whole.

— In low-income communities in the City, the infant mortality rate is at least double and in some cases more than triple the infant mortality rate in other New York City communities.

Christel Brellochs and Anjean B. Carter, Community Services Society, *Building Primary Health Care Services in New York City's Low Income Communities* 2, 21 (1990) (survey of health care in City's low-income communities).

The current economic recession and cuts in state and federal funding have put the City in the position of being asked to provide more services with fewer resources. The City's ongoing efforts to enhance the level of care provided by City hospitals will be hampered by any increased burden, including an influx of out-of-state abortion patients. In this sense, the overruling of *Roe* would only result in the further medical disenfranchisement of the patients who already have the least access to health care.

CONCLUSION

Should this Court sanction restrictive abortion legislation, it will allow the endangerment of *all* women's lives and health, but particularly those of low-income women and women of color. We cannot afford a retreat to the

past. For the reasons stated above, this Court should reaffirm the principles set forth in *Roe v. Wade.*

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