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Psychiatric Implications of Abortion: A Case Study in Social Hypocrisy

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Psychiatric Implications of Abortion: A Case Study in Social Hypocrisy

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Current abortion practices in the United States are incompatible with present abortion laws. Because of this physicians are forced to make medical decisions on moral and socioeconomic grounds; as a result they are in a very untenable and essentially hypocritical position. Dr. Rosen discusses the medical, psychiatric, and socioeconomic indications involved in therapeutic abortion as well as the ramifications of criminal abortion. He suggests that higher standards of sexual conduct through education, establishment of consultation centers, extension of facilities providing advice on contraception, and a liberalization of present statutes may offer a partial solution; but he theorizes that the only true solution is to abolish criminal abortion laws and give women the right to decide whether or not they wish to carry a specific pregnancy to term. Dr. Rosen, however, recognizes that present attitudes will not allow this today but concludes that adoption of the Model Penal Code provisions on abortion — with the exception of subsection 3 which he terms an anachronism, inconsistent with present standards of medical practice — will reduce the hypocrisy of the present medical and legal approach to the problem.

ANY DISCUSSION of the abortion problem — and of its psychiatric implications — must of necessity stress the legal and medical hypocrisy involved that is usually so blandly ignored. From twenty to thirty per cent of all pregnancies end in abortion.[1] If a woman, despite exceedingly severe physical or emotional disease, is nevertheless determined to carry her pregnancy to term, she in all probability will be able to do so if all the resources of modern medicine, including modern psychiatry, are employed to treat her. But if she does not wish to carry the pregnancy to term, even the punitive pressure of the official medical code and the various state statutes cannot necessarily force her to do so.

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[1] Fisher, *Criminal Abortion*, 42 J. CRIM. L., C. & P.S. 242 (1951); Hardin, *Abortion and Human Dignity*, Public Lecture at University of California (Berkeley), April 29, 1964 (Distributed by Citizens for Humane Abortion Laws, San Francisco, Calif.).

I. THE COMPLEXITIES OF THE ABORTION PROBLEM

Between ten and twenty criminal abortions are performed every fifteen minutes in this country.[2] Estimates of 2500 per day are not unusual;[3] and it may be a great deal more.[4] The majority are performed on married women between thirty and forty years of age, with two or more children, who have conceived by their husbands.[5] Eighty to ninety per cent of all abortions in the United States are performed by competent physicians,[6] on referral from other physicians.[7]

The abortion problem, as Cameron[8] has stated, seems to be "a meeting point of great and, at times, sharply conflicting human needs and interests . . . ." This is understandable. It is historically determined. It must of necessity constitute one of the most contentious of the medical, legal, social, and economic problems which, again to quote Cameron, "lie so vexed upon the conscience of our society."[9] In Baltimore, for instance, white children between the ages of twelve and sixteen, even though repeatedly pregnant, are more apt to have abortions than their colored sisters who therefore bear a greater number of illegitimate children.[10] Nevertheless, the

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[2] Rosen, *Abortion*, Today's Health, April 1965, p. 24.

[3] *Id.* at 62.

[4] ABORTION IN THE UNITED STATES 178, 180 (Calderone ed. 1958); BATES & ZAWADZKI, CRIMINAL ABORTION 3 (1964); *cf.* GEBHARD, POMEROY, MARTIN & CHRISTENSON, PREGNANCY, BIRTH AND ABORTION 136-37 (1958).

[5] ABORTION IN THE UNITED STATES 61 (Calderone ed. 1958); Kleegman, *Planned Parenthood: Its Influence on Public Health and Family Welfare*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 254, 255 (Rosen ed. 1954).

[6] GEBHARD, POMEROY, MARTIN & CHRISTENSON, *op. cit. supra* note 4, at 198, 212; ABORTION IN THE UNITED STATES 62-63 (Calderone ed. 1958); *cf.* Guttmacher, *The Legal and Moral Status of Therapeutic Abortion*, 4 PROGRESS IN GYNECOLOGY 279 (1963).

[7] ABORTION IN THE UNITED STATES 62-63 (Calderone ed. 1958) (Remarks of G. Lotrell Timanus); Kleegman, *Planned Parenthood: Its Influence on Public Health and Family Welfare*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 254, 256 (Rosen ed. 1954).

[8] Cameron, *Psychiatric Foreword*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS, at xvii (Rosen ed. 1954).

[9] *Id.* at xviii.

[10] The author is indebted to Dr. Frank Furstenberg (personal communication) for information showing that published statistics do not portray actual incidence of pregnancy since, as is generally conceded, white girls are more likely to have economic resources that the colored do not possess (for abortion, delivery elsewhere, and the like). Despite this, Dr. Furstenberg adds, there are over 800 registered deliveries by girls sixteen or under per year in Baltimore of a first child, and an additional 200 per year by girls sixteen or under of a second or third child. (Vital statistics of the Baltimore City

illegitimately pregnant school child, whether white or colored, is almost invariably forced to become a school drop-out. She frequently spends the rest of her life at menial work. The psychiatric problems here obviously are pronounced.[11]

The laws of most of the states could be interpreted to mean that there are *no* legal indications for therapeutic interruption of pregnancy. Forty-four states either ban abortion or permit it for the sole purpose of saving the mother's life.[12] The only psychiatric threat to *life* is suicide; and suicidal patients can be committed involuntarily to psychiatric hospitals where they can remain until delivery. In eight states[13] there is a curious addendum which apparently has never been questioned: therapeutic abortions are legal if performed to save not only the life of the mother but that of the child with which she is pregnant.[14] This would seem to mean that physicians can legally sacrifice the conceptus to save its life; and this kind of double talk, in at least one instance that has come to the author's attention, has been used psychiatrically to justify recommendation for therapeutic interruption of an emotionally crippling pregnancy that nevertheless was carried to term.

Much of our abortion law, while *perhaps* relevant in 1800, possesses no pertinence whatsoever today[15] except through a process of interpretation over the years with which, unfortunately, far too many psychiatrists, obstetricians, lawyers, and hospital administrators are unfamiliar or which they ignore. It may perhaps be that they are mindful of Mr. Justice Frankfurter's comments about the M'Naghten insanity rules,[16] for his remarks apply with equal

Health Department, data circulated 1964.) These recidivists, white as well as colored, are going down the line to poverty.

[11] See Rosen, *Abortion: The Increasing Involvement of Psychiatry*, 2 FRONTIERS OF CLINICAL PSYCHIATRY 1, 8 (Dec. 1965).

[12] Committee on Human Reproduction, American Medical Ass'n, A.P. Dispatch, N.Y. Times, Dec. 1, 1965, p. 1, col. 2. See GEBHARD, POMEROY, MARTIN & CHRISTENSON, *op. cit. supra* note 4, at 192; Guttmacher, *supra* note 6, at 285; Guttmacher, *The Legal Status of Therapeutic Abortion*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 181 (Rosen ed. 1954); Harper, *Abortion Laws in the United States*, in ABORTION IN THE UNITED STATES 187 (Calderone ed. 1958). For a detailed discussion of statutes in American Jurisdictions see George, *Current Abortion Laws: Proposals and Movements for Reform*, 17 W. RES. L. REV. 371 (1965).

[13] Connecticut, Minnesota, Missouri, Nevada, New York, Virginia, Washington, and West Virginia. See Eastman, *Liberalization of Attitudes Toward Abortion*, Current Medical Digest, June 1959, pp. 54, 59.

[14] *Id.* at 59; see George, *supra* note 12, at 337.

[15] Eastman, *supra* note 13, at 60.

[16] *The Royal Comm'n on Capital Punishment: 1949-1953 Report of the Comm'n, Cmd. No. 8932*, 7 ENGLISH PARLIAMENTARY PAPERS 102 (1953).

force to abortion: "to have laws which cannot rationally be justified except by a process of interpretation which distorts and often practically nullifies them . . . is not a desirable system. . . ."[17] It can, therefore, be readily understood why abortion laws "are in a large measure abandoned in practice, and therefore . . . shams."[18]

In any case, to the physician, "life" does not imply merely immediate survival — and only immediate survival — but must be considered a long-range process dependent upon health, both physical and mental.[19] That *life* depends on *health*, and that the legal distinction, at least, between the two is extremely doubtful, was specifically stated by the British Court of Law which in 1938 acquitted an obstetrician charged with having performed an abortion on a fourteen-year old child whom three soldiers had raped and impregnated.[20] Despite the impact of the decision in the case of *Rex v. Bourne*,[21] rape in the United States does not per se constitute a legal ground for interrupting a pregnancy; but some physicians in some hospitals do therapeutically interrupt an occasional pregnancy — extra-legally rather than illegally — for this reason.

During the past ten to fifteen years in prestige hospitals in various parts of the United States, statutory indications for therapeutic abortions have been interpreted to include not only the saving of the mother's life, but also the protection and preservation of her health.[22] This latter indication is potentially an exceedingly elastic one. Pregnancies have also been therapeutically interrupted, *legally*, to prevent serious injury, emotional as well as physical, to the mother, or in an attempt to halt the advance of serious organic or emotional disease, or to prevent it. Socioeconomic factors here have been given serious psychiatric consideration.[23]

A therapeutic abortion, to define it as it is now performed, is an abortion performed in order to preserve the physical and emotional health of the pregnant woman, or to save her life, physically and emotionally. It must be performed by a physician and under prescribed conditions that vary, in this country, from state to state

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[17] *Ibid.*

[18] *Ibid.*

[19] Rosen, *supra* note 11, at 1.

[20] Rex v. Bourne, [1939] 1 K.B. 687. See also WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 319 (1957); Eastman, *supra* note 13, at 57-58.

[21] [1939] 1 K.B. 687.

[22] Rosen, *supra* note 2, at 24.

[23] *Ibid.*

and, within specific states, from hospital to hospital.[24] The uterus is evacuated — and this requires stressing — in order to correct, and only to correct, a pathologic condition that has come into existence because of the specific pregnancy involved; the developing chorionic tissue is either potentially or actually damaging and dangerous to the pregnant patient. It must be evacuated or excised. As Guttmacher[25] so succinctly states, the attitude of the physician, theoretically at least, is essentially the basic amoralistic medical attitude so characteristic of the surgeon in his operative removal of all types of pathologic tissue for which, at the present stage of medical knowledge, surgical excision is advised.

This unfortunately, is purely theoretical. Where pregnancy is concerned, few physicians can approach the problem neutrally, with this basic amoralistic medical attitude. As Mandy[26] states, physicians as a whole "think of abortion in one way, speak and write of it in another, and in actual practice conform neither to personally expressed beliefs, nor to established legal or social codes."[27] In contrast to all other medical procedures, medically acceptable indications for therapeutic abortion vary from physician to physician, from hospital to hospital, and — even within the same hospital and on the part of the same hospital board — from day to day. This is regrettable, but emotional involvement in the problem on the part of all concerned is so intense that at present no other, more adequate statement can be made. Not infrequently, for instance, the abortion board of one hospital may refuse to accept a recommendation for interruption; yet on nine separate occasions during the past seven years, patients who have been seen in consultation have then afterwards been therapeutically aborted at adjacent hospitals with, at times, almost the same visiting staff. Illustrative case material, if this were a clinical article, could be cited practically *ad nauseam.*

Basically, this is not the fault of the hospital board, nor is it something for which the individual physician — be he general practitioner, obstetrician, or psychiatrist — can be blamed. The fault lies in the present, almost complete lack of any standard frame of reference; no clear-cut obstetrical, medical, or psychiatric indications

[24] Guttmacher, *The Shrinking Non-Psychiatric Indications for Therapeutic Abortion,* in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 12, 15 (Rosen ed. 1954).

[25] Guttmacher, *supra* note 6, at 290, 293; see also Hardin, *supra* note 1.

[26] Mandy, *Reflections of a Gynecologist,* in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 248 (Rosen ed. 1954).

[27] *Ibid.*

for therapeutic interruption of pregnancy have as yet been defined. Ethical and religious considerations play an exceedingly significant role: the devout Catholic, who feels that life begins at the very moment of conception, for instance, will have one approach to the problem, while the Latter Day Saint will have another, especially since he, with his fellow Mormons, believes that life starts only at the moment of birth.[28] For the purpose of this discussion, however, religious considerations will be disregarded.[29]

As previously mentioned,[30] between two and three out of every ten pregnancies in the United States end in abortion. These may be spontaneous, therapeutic, or criminal. If reported as spontaneous, although illegal abortions are, perhaps, not infrequently so reported, it cannot be considered as either consciously or deliberately induced. A pregnancy may nevertheless be deliberately interrupted — by physical, chemical, or operative means — and the resultant abortion, whether or not it be reported as spontaneous, must then be termed either criminal or therapeutic, depending largely upon whether it has been performed legally or in an extra-legal environment. In either case, someone, somewhere, somehow, for some reason has thought it was indicated. It would otherwise not have been performed.

Socially acceptable indications, however, vary from culture to culture. Attitudes toward pregnancy — and toward its interruption — are incorporated in group mores, in religious tenets, and in legal statutes. Throughout the world, and not in Western culture

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[28] Devereux, *A Typological Study of Abortion in 350 Primitive, Ancient, and Pre-Industrial Societies*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 97, 100 (Rosen ed. 1954); see also DEVEREUX, A STUDY OF ABORTION IN PRIMITIVE SOCIETIES *passim* (1955).

[29] This is despite the fact that in Roman Catholic Chile a recent survey showed that 27 per cent of all women admitted to having had induced abortions, and that in predominantly Catholic France the annual number of abortions equals the annual number of live births. See Avendano & Fraundes-Latham, *A Contraceptive Programme in a Latin American Urban Community*, UNITED NATIONS WORLD POPULATION CONFERENCE (Sept. 1965) (in publication); Tabah & Samuel, *Encuesta de Fecundidad y de Atitudes Relativas a la Formaciòn de la Familia*, 2 MEDICO-SOCIALES 19 (1961); see also Hardin, *supra* note 1.

[30] See text accompanying note 1 *supra*. After rapport was gained with 107 unselected married women patients with two or three children, they were asked, "Have you ever had a legal or illegal abortion?" Fourteen evaded the question. Twenty had not had an abortion, but of these, three had arranged to have it but had had a miscarriage before it could be performed. Sixty-seven had had abortions and then, within two or three years, had had planned pregnancies, or so they stated. And finally, six stated that they had had abortions and had no desire for any further pregnancy; one of these six had had two abortions.

alone, the approach for the most part has been a conservative one. There are nevertheless glaring exceptions.

As previously mentioned,[31] in the United States, nine-tenths or more of all artificially induced abortions, whether therapeutic or criminal, are procured or prescribed for married women, impregnated by their husbands, with three or more children, and over thirty years of age. If legal, they are performed ostensibly for medical or psychiatric reasons; if illegal, the reasons alleged may, perhaps, also be medical or psychiatric. Whether legal or illegal, nevertheless, the reasons, but not the rationalizations advanced, may be, and usually are, socioeconomic. These have been written into the statutes of the various Scandinavian countries;[32] but in the United States, while they frequently influence the attitude of the examining physician and hospital board, they constitute extra-legal rather than legal considerations. Despite their extra-legal nature, it is these that are most frequently involved. They far outweigh all medical and psychiatric factors combined. However, to the physician, only rigidly defined medical conditions (although far from rigidly stated) determine whether or not sufficient justification can be found for recommending that a specific pregnancy be therapeutically terminated.

Any decision on the part of a competent, conscientious, and ethical physician to interrupt a given pregnancy can be reached only after grave and prolonged deliberation. Legally, in a number of countries and a number of states, it can be advised only if the physical life of the mother would actually be endangered by the continued presence of the pregnancy.[33] In other countries[34] and in some states as well, this view no longer prevails.[35] And what is *therapeutic* in some states is *criminal* in others. This requires further discussion in the context of present medical, including psychiatric, indications for therapeutic abortion as they now exist in actual hospital practice.

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[31] See text accompanying notes 5-7 *supra.*

[32] ABORTION IN THE UNITED STATES 14, 21, 25 (Calderone ed. 1958) (Comments of Drs. Brekke, Clemmesen, and Af Geijerstam). See generally Skalts & Nørgaard, *Abortion Legislation in Denmark*, 17 W. RES. L. REV. 498 (1965) (Danish *Act Concerning Provisions Relating to Pregnancy* is reprinted at 522).

[33] Schur, *Abortion and the Social System*, 3 SOCIAL PROBLEMS 94, 95 (1955). See generally TIMASHEFF, INTRODUCTION TO THE SOCIOLOGY OF LAW (1936).

[34] *E.g.*, Austria, Cuba, Denmark, Finland, Norway, Switzerland, Japan, and Sweden.

[35] Eastman, *supra* note 13, at 59; Kummer, *Prevention of Psychiatric Complications of Pregnancy and the Puerperium*, 6 AMERICAN PRACTITIONER AND DIGEST OF TREATMENT 1315, 1319 (1955). *But cf.* Russell, *Changing Indications for Therapeutic Abortion*, 151 A.M.A.J. 108 (1953).

II. THERAPEUTIC ABORTION

A. *Medical Indications*

So far as specific medical indications are concerned, these have been shrinking consistently during the past several decades. At present they seem well on the way to becoming virtually, if not actually, non-existent. For instance, with the development of thoracic surgery, the utilization of hormone therapy, and the widespread use of antibiotic medication, even those organic conditions such as essential hypertension, tuberculosis, and heart disease, which previously were thought almost invariably to indicate therapeutic abortion, no longer so invariably necessitate the procedure. A majority of women with uncomplicated hypertension can now carry their child to term if they so desire, and with little or no hazard as far as their own physical well-being is concerned. Interruption of pregnancy because of pulmonary tuberculosis has been declining steadily during the past two decades. Today, in the larger medical centers, obstetricians will rarely see cases of *hyperemesis gravidarum* so severe and so resistant to current methods of therapy as to require interruption. And cardiac surgery is now being performed with increasing frequency on patients with severe heart disease who desire, and are thereby enabled, to carry their child to term. Pregnancy, in other words, need now seldom aggravate organic disease. As Eastman[36] states, it is only that small minority of patients with both rheumatic heart disease and a history of previous cardiac failure who must be excepted from this generalization.

To phrase this differently, if physicians do not wish to force a specific woman to carry a specific pregnancy to term, and if that woman is actually suffering from some severe physical disease then, but only then, the pathological process, provided it falls within certain categories, is in certain hospitals and by certain physicians and hospital boards considered sufficient indication for interruption. In others, it is not — and this needs stressing. This sometimes, surprisingly, has little or nothing to do with the religious construct within which a specific hospital operates, or with the religious convictions of its visiting and resident staffs.

Despite the fact that in this country the law still concerns itself only with the life and health of the mother — and never with that of the unborn child — pregnancies not infrequently are interrupted

[36] Eastman, *Obstetrical Foreword*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS, at xix (Rosen ed. 1954); WILLIAMS, OBSTETRICS 1116 (12th ed. Eastman & Hellman 1951).

on medical grounds for so-called eugenic reasons, not because faulty germ plasm is thought present, but because it is felt that temporary, deleterious, environmental influences may ultimately result in the birth of seriously defective off-spring. The thalidomide problem is a case in point. Therapeutic radiation to the pelvic organs during undiagnosed early pregnancy, to diminish the size of a fibroid uterus in a patient not suspected of being already pregnant, is considered by a number of obstetricians as sufficient indication for therapeutic abortion. And if the expectant mother contracts German measles before the twelfth week of her pregnancy, this, too, in some hospitals (but not in all) is considered sufficient indication, since it is believed, at least in some centers, that thirty per cent of all off-spring will evidence severe congenital abnormalities if such pregnancies be carried to term. Yet, even if this be true, one-third of all children born to women whose pelvic organs have been so irradiated, and two-thirds of all off-spring born to women with rubella, according to statistics so far compiled, show none of the serious defects described in the literature. Some women previously irradiated or with rubella, in fact, have determinedly and against even militant medical advice carried their off-spring to term. Nevertheless, although in a great many hospitals and by a great many obstetricians such potential fetal pathology is now considered sufficient indication for the interruption of a pre-viable pregnancy, this is an extra-legal indication: The law in no state has seen fit to concern itself with the life and health of the developing human organism.[37] Yet no state statute expressly forbids this. Such interruptions, therefore, are not actually *against* the law; they are merely *outside* it, at least so far as the statutes of the individual states are concerned. But only an infinitesimally small number of abortions are performed for this reason.

In any case, in this country during the past two decades, the incidence of therapeutic abortion, at least for purely medical reasons, has declined steadily. Fewer and fewer hospitals unbegrudgingly accept the recommendation to abort, and for a lower and lower percentage of patients.[38] While current medical progress is probably the basic factor here, a number of usually undeclared non-medical

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[37] Schur, *supra* note 33.

[38] Russell, *supra* note 35, at 109; Tietze, *Therapeutic Abortion in New York City 1943-1947*, 60 AMERICAN J. OBSTETRICS & GYNECOLOGY 146 (1950); Wilson, *The Abortion Problem in the General Hospital*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 189 (Rosen ed. 1954).

factors are also involved. These include occasional threats of legal difficulties[39] — an understandable, but for the most part not consciously perceived, fear of untoward professional, administrative, or legal repercussions[40] — and the current, but almost completely disregarded, restrictive legislative statutes.[41]

B. Psychiatric Indications

Whereas, the incidence of therapeutic abortion on the basis of medical indications has been on the decline, recommendations for interruption on psychiatric grounds are now on the increase.[42] This is despite the fact that problems posed by the psychiatric evaluation of emotionally sick, pregnant patients are so complex that at times clarification seems almost impossible. The psychiatrist, like his medical *confrère*, when examining patients who demand an abortion, not infrequently finds himself at an impasse.

Some of the abortion-demanding pregnant women who are referred for psychiatric evaluation turn out to be emotionally ill patients who happen, coincidentally, sometimes even as a symptom of their emotional illness, to be pregnant.[43] They may attempt to force the obstetrician and psychiatrist to interrupt their pregnancies by threatening either illegal abortion or suicide. If the psychiatrist feels that, as a result of the pregnancy, the depressive tendencies which are present will be intensified to the point of potential or actual suicide, he will of course suggest treatment in a psychiatric hospital. Because of the extreme urgency of their demands and the identification with them by their husbands, which prevents the latter from realizing how emotionally ill their wives actually are, it frequently becomes impossible to treat them as other depressed or potentially suicidal patients would be treated. This recommendation is often rejected by patient, by husband, and by parents. Commitment is usually impossible. Most refuse to see the psychiatrist even

[39] Guttmacher, *supra* note 12, at 175; Schur, *The Abortion Racket*, 180 THE NATION 199 (1954).

[40] Schur, *supra* note 33, at 95.

[41] Regan, *The Law of Abortion*, 6 ANNALS OF WESTERN MEDICINE & SURGERY 26 (1952), in LEGAL MEDICINE 834 (Gradwohl ed. 1954); Schur, *supra* note 33.

[42] See Kummer, *Psychiatric Contraindications to Pregnancy with Reference to Therapeutic Abortion and Sterilization*, 79 CALIFORNIA MEDICINE 31 (1953); Rosen, *supra* note 11, at 1.

[43] Rosen, *supra* note 2, at 63; Rosen, *The Emotionally Sick Pregnant Patient*, 1 J. OF CLINICAL AND EXPERIMENTAL HYPNOSIS 54 (1953); Rosen, *The Emotionally Sick Pregnant Patient: Psychiatric Indications and Contraindications to the Interruption of Pregnancy*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 219 (Rosen ed. 1954).

a second time. As an emergency life-saving measure, the psychiatrist may, therefore, recommend interruption. It should be noted, however, that although one successful suicide does occur every half hour in this country, the suicide rate among pregnant women is less than that statistically to be expected for the population as a whole. The Chief Medical Examiner of the State of Maryland, for instance, could "recall only one pregnancy among the last 700 suicides, although some pregnancies may have been missed, since we do not do an autopsy where the manner and the cause of death are established."[44] In any case, it usually is extremely rare. It nevertheless does occur; and it must, therefore, not be overlooked. Pregnant women do kill themselves. Eight per cent of all women who committed suicide in Sweden during the twenty year period from 1925 through 1944, for instance, were found on autopsy to be pregnant and in each case, on investigation, their pregnancy was felt to be the precipitating factor in the suicide.[45] Thus, if a recommendation for interruption be rejected by a hospital board, the risk of suicide as a result, at least occasionally, must be incurred. Statements in available literature denying this reflect either the bias of their authors, or a lack of meaningful follow-up on the patient involved.

The psychiatrist may recommend interruption for other reasons as well.[46] Under certain conditions, he feels abortion to be indicated for patients whose previous pregnancies had repeatedly precipitated post-partum psychotic reactions, and this is so regardless of whether or not depressive and potentially suicidal material be present. If assaultive and possible homicidal drives are becoming intensified, it seems a *sine qua non.* Some psychiatrists will recommend abortion for specific patients with manic-depressive or schizophrenic psychoses who, for whatever reason, are not amenable to therapy. Others believe it to be indicated for previously lobotomized patients because of the very decided risk which, so it is felt, pregnancy imposes upon them. If it seems as though a psychotic reaction will be precipitated as a result of the pregnancy or the stress of early

[44] Letter from Dr. Russell S. Fisher to the Author, June 10, 1964.

[45] Ekblad, *Induced Abortion on Psychiatric Grounds — A Follow-Up Study of 479 Women,* ACTA PSYCHIATRICA ET NEUROLOGICA SCANDINIVICA, Supp. 99, at 94-95 (1955).

[46] See Brew & Seidenberg, *Psychotic Reactions Associated with Pregnancy and Childbirth,* 111 J. NERVOUS AND MENTAL DISEASES 408 (1950); Ebaugh & Heuser, *Psychiatric Aspects of Therapeutic Abortion,* 2 POSTGRADUATE MEDICINE 325 (1947); Lidz, *Reflections of a Psychiatrist,* in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 276, 279, 281-82 (Rosen ed. 1954).

motherhood, a great many psychiatrists would make the recommendation for the sake of the expectant mother's emotional and physical well being. And a fairly large number of psychiatrists are agreed that interruption of pregnancy for psychiatric reasons is indicated in those patients who, because of their very pronounced emotional immaturity, must themselves be babied, cannot be trusted with the responsibilities of an adult, and cannot, in American culture at least, function the way mothers, as adult women, are expected to function. It can otherwise be expected that their emotional disease will crystallize and assume clinical proportions.

For every 500 births in this country, one pregnant or puerperal woman is committed to a psychiatric hospital. To be more precise, pregnancy, childbirth, and the puerperium are precipitating factors thought to account for two per cent of all female admissions to mental hospitals.[47] This may help explain the fact that recommendations for interruption on psychiatric grounds now seem to be increasing.

The psychiatrist, like his colleagues in obstetrics and the other medical specialties, however, can, in general, make this recommendation legally only if he feels that the physical or emotional life or health of his pregnant patient will be endangered by carrying the developing organism to term. Nevertheless, he frequently does give serious consideration to the developing organism itself, as do the obstetrician, the internist, and the gynecologist in cases of rubella or of irradiation to the pelvic organs.

As the obstetrician on occasion considers it medically justifiable to recommend interruption of a pre-viable pregnancy on the basis of actual or potential fetal pathology, some psychiatrists do take into consideration the possible effect of an emotionally unstable environment on the developing human being. Child delinquency and criminal psychopathy require serious consideration by everyone. In an exceedingly thought-provoking article, Jenkins[48] discusses children whose mothers had unsuccessfully tried to abort themselves. He comments about those problems of child and adolescent development which constitute so frequent a source of referral to child guidance clinics, and which ultimately culminate in the appearance of socialized or "gang" delinquents, and of unsocialized, aggressive children, in the juvenile court. It should be noted — and this is

[47] Kummer, *supra* note 35, at 1315; Kummer, *supra* note 42, at 32.

[48] Jenkins, *The Significance of Maternal Rejection of Pregnancy for the Future Development of the Child*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 269 (Rosen ed. 1954).

practically a truism — that the morbid effect of a specific emotionally unhealthy environment on the young child becomes increasingly irreversible as that child grows older. And since schizoid withdrawal in childhood, which so frequently is related to maternal rejection even before birth, is more frequently found in those patients who later develop schizophrenic breakdowns, this in itself becomes one of the most pronounced of the mental health problems with which the country at present is faced.

Schizophrenia in this country fills at least one-quarter of all hospital beds — medical, surgical and psychiatric — as a result of which, "the question of capacity for maternal response and need for emotional support [must] . . . not be overlooked in considering the important problems relating to the question of therapeutic abortion."[49] Nevertheless, when the psychiatrist makes his recommendations, these and other related questions cannot *legally* be taken into consideration, no matter how important they are, and no matter what growing up in an emotionally unstable environment might mean to the child. The established code of ethics of the medical profession and the statutes in force in the various states at present are such that neither this nor any other socioeconomic factor (no matter how pronounced or how compelling) can be considered as a medical justification for interruption.

Yet psychiatric consultations are of prime importance. More and more women who otherwise would request and obtain abortions, legally or illegally, with psychiatric help, now want and find it possible to carry their pregnancies to term. With some, the desire for the interruption is iatrogenic. This becomes apparent almost immediately after the psychiatric consultation begins. With exceedingly superficial psychotherapy, directed on the one hand toward the patient and, on the other, toward her physician under the pretext of discussing with him the problems involved, the patient is then usually able to carry her child to term. With other patients, whose problems primarily are situational, the desire not to have the child disappears after relatively superficial psychotherapy.

However, if symptoms are precipitated on an hysterical basis in addition, the therapeutic problem becomes much more complicated, especially if pronounced nausea and vomiting are present. At times symptoms — and even attitudes underlying symptoms — can nevertheless be treated successfully in relatively few sessions; but if symptoms become exaggerated, neither psychiatrist nor obstetrician may

[49] *Id.* at 275.

at times have any choice. And if the patient also has some chronic disease, like diabetes, which she utilizes in her fight against herself and her environment in order to gain her demands, it may be impossible psychotherapeutically to help her attain any actual desire for the continuation of the pregnancy. She may go so far as to utilize her chronic disease in a quasi-suicidal attempt, discontinuing her insulin for instance, going into diabetic coma and acidosis, and requiring even emergency hospitalization. Nevertheless, when recommended for psychiatric reasons, therapeutic abortion, except in emergency situations, can be considered the treatment of choice only if the abortion itself will not prove more traumatic to the patient than the psychological trauma of pregnancy and childbirth. This always requires careful evaluation on the part of the psychiatrist. But untoward reactions to interruption of pregnancy are rare. It should be noted in connection with the psychiatric indications for abortion that if interruption is recommended for psychiatric reasons, this does not mean that the particular patient, no matter how sick emotionally she may be, will not be able to desire, to bear, and to successfully rear children in the future.

The previous discussion has considered and listed various indications for therapeutic interruption of pregnancy. These are the ones stressed on certificates forwarded by physicians to hospital abortion boards. Nevertheless, in most cases these are merely the rationalizations. The medical, including the psychiatric, indications must be utilized if the abortion is to have legal justification. However, in most cases, the socioeconomic factors are pronounced; and whether the interruption of the pregnancy is legal or extra-legal, the actual indications are, for the most part, socioeconomic.

As Guttmacher states, "The abortion laws make hypocrites of all of us."[50] Taussig comments in detail about what he characterizes as the "frank and universal disregard for a criminal law" — and by implication castigates the law.[51] Every prestige and other hospital in the United States that allows so-called therapeutic abortions is undoubtedly violating the law, unless the process of interpretation that has already been detailed is openly accepted as such. Three-quarters of all California hospitals studied apparently have no objection to scheduling interruptions of pregnancy in their delivery rooms for reasons that would be violative of the California

[50] Guttmacher, *The Law That Doctors Often Break*, Redbook Magazine, Aug. 1959, pp. 24, 25.

[51] TAUSSIG, ABORTION SPONTANEOUS AND INDUCED: MEDICAL AND SOCIAL ASPECTS 422 (1936).

law on the subject if that law were strictly interpreted.[52] The same statement, as Kummer and Leavy[53] stress, can be made about at least ninety per cent of the therapeutic abortions scheduled at one of New York's leading hospitals[54] and in other leading hospitals throughout the country. Yet only nine jurisdictions in the United States have laws that either permit abortion if the health of the pregnant woman is endangered or are so phrased as to allow of this interpretation.[55]

C. *Socioeconomic Factors and Indications*

If one reads the literature, a large number of indications will be found for psychiatric termination of pregnancy. The problem that the psychiatrist finds it necessary to evaluate during his consultation sessions with the patient is that of whether her emotional health will be endangered more if the pregnancy be interrupted or if it be carried to term. *There is no physiological time-limit on interruption. Pregnancies have been interrupted on psychiatric recommendation in women over 20 weeks pregnant, and the women have left the hospital in excellent physical health a few days after the interruption.*

What the psychiatrist decries is that he so frequently, when asked to see a pregnant patient in consultation, is expected to function as a "troubleshooter." Professionally, he can recommend termination of pregnancy only if, in his opinion, *psychiatric* problems are involved. Most of the time, however, the problems involved are socioeconomic rather than what most hospital boards and courts would consider psychiatric. Nevertheless, an occasional hospital does recognize them.[56] It is, of course, exceedingly difficult, and at times impossible, to demarcate socioeconomic and emotional factors so as to state that one has no psychiatric basis while the other has. The total marital situation, the environment in which the child is to be reared, and the financial status of the family all have profound emotional repercussions.

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[52] Packer & Gampell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 STAN. L. REV. 417, 430 (1959). For a summary of this article see Kummer & Leavy, *Therapeutic Abortion Law Confusion*, 195 A.M.A.J. 96, 97 (1966).

[53] Kummer & Leavy, *supra* note 52, at 97.

[54] Guttmacher, *supra* note 50, at 96.

[55] Alabama, Colorado, Maryland, Massachusetts, New Jersey, New Mexico, Oregon, Pennsylvania, and the District of Columbia. See Kummer & Leavy, *supra* note 52, at 143.

[56] See Schur, *supra* note 33, at 95.

Yet when physicians feel it indicated, they prefer to have the pregnancies of their patients interrupted legally — necessarily through psychiatric recommendation if the medical indication is absent — rather than to have their patients criminally aborted, as are so many hundreds of thousands. The psychiatrist, as a result, now assumes the major responsibility for deciding whether or not a given pregnancy is legally terminated.

While he dislikes finding himself forced into the untenable position of being asked to make recommendations, or to give decisions, on non-psychiatric grounds, neither does he feel that he can dodge the issue. The patient needs help. Emotional factors in almost every case are profound.

It should be stressed and re-stressed that while socioeconomic conditions never per se legally warrant therapeutic abortion, socioeconomic status, nevertheless, frequently determines whether or not an abortion will be performed, and if performed, whether that self-same abortion will be therapeutic or criminal.[57] Some physicians are more prone to recommend interruption, for instance, for a cardiac patient who is unwed, on relief, and already the mother of several children than for one with the same degree of cardiac pathology who is married, childless, and well-to-do.[58] On the other hand, the difference between having an abortion or a child (so the cynical and frequently heard non-medical aphorism has it) is the difference between having one to three hundred dollars and knowing the right person or being without funds and the right contacts. This is despite the fact that at least two patients, who, so far as could be judged, previously had had non-legal abortions by competent medical personnel, stated that because of consultation and other fees, the legal ones, for which they were now being evaluated, were more costly than their previous illegal interruptions. On the whole, however, throughout the country, fees charged by criminal abortionists are estimated to range from $10 to $6500. The more usual fee is between $250 and $400, depending upon the geographic locale, the abortionist, and the financial status of the patient.[59] A legal abortion for a semi-private patient, especially if that patient have Blue Cross and Blue Shield coverage, should cost much less.

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[57] Rosen, *Abortion*, 1 ENCYCLOPEDIA OF MENTAL HEALTH, 9, 14 (1963); Schur, *supra* note 39, at 200; Sontheimer, *Abortion in America Today*, Woman's Home Companion, Oct. 1955, p. 44.

[58] Guttmacher, *supra* note 24, at 21.

[59] Rosen, *supra* note 57, at 13.

The private patient may pay a great deal more. In any case, this reversal of the usual charge is rather rare.

As Kleegman[60] states, by the very nature of things, ward patients are much less likely to have the necessary consultations requested, including the psychiatric, and to have the necessary recommendations made and accepted by a hospital board, than are their more well-to-do sisters. Ethical and conscientious physicians decry this fact, but nevertheless find it impossible to contravert, even, perhaps, in their own practice. At hospitals where, as for instance at Johns Hopkins, a psychiatrist is assigned to the obstetrical and gynecological service, this inequity disappears. Socioeconomic factors, whether or not they are recognized, are always of prime importance.

III. CRIMINAL ABORTION

Some 10,000 to 18,000 pregnancies are interrupted each year for medical, including psychiatric, reasons. However, there are, perhaps, more than twenty to thirty times as many criminal abortions each year. In some parts of the country these can be obtained so easily that when patients apply for a psychiatric consultation (for the purpose, so they state, of obtaining a psychiatric recommendation to the effect that their pregnancy be interrupted), the very fact that they make such an appointment seems to be almost presumptive proof that they do not wish the abortion, but rather psychiatric help in order to carry their child to term.[61]

Over a million pregnancies, it is estimated,[62] are interrupted illegally in this country each and every year. Abortions statistically reported as spontaneous may, in fact, sometimes be criminally induced. Yet it is rare that an abortionist is arrested and prosecuted. Out of the one- to two-thirds of a million prosecutions that theoretically would be possible, less than 500 actually take place.[63] There may be a number of reasons for this: they no longer endanger a life; the cause is an unpopular one; and the procedure is performed on so many women that prosecution and meaningful investigation becomes impossible.

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[60] Kleegman, *Planned Parenthood: Its Influence on Public Health and Family Welfare*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 256 (Rosen ed. 1954).

[61] Lidz, *supra* note 46, at 227; Rosen, *supra* note 11.

[62] ABORTION IN THE UNITED STATES 178, 180 (Calderone ed. 1958) (Report of the Statistics Committee); Fisher, *Criminal Abortion*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS 3, 6 (Rosen ed. 1954).

[63] Rosen, *Abortion*, Today's Health, April 1965, p. 62; Fisher, *supra* note 62, at 3.

Until antibiotics came into general use, there were 2,000 to 5,000 abortion deaths annually. Now, if the operation be performed by competent physicians as it so frequently is, there need be fewer untold sequelae than from a tonsillectomy. Despite all statements to the contrary, unless infection be present — as it frequently is with botch work but seldom is if the abortionist be competent — or unless the abortus can, under certain circumstances, be subjected to pathologic examination, it seems practically impossible to determine whether a given abortion is spontaneous, criminal, or therapeutic. And since infection today so seldom need be present, this makes the gathering of evidence for a prosecution just as impossible.

As a result, since the problem of law enforcement is so pronounced, an occasional district attorney, perhaps in desperation, may sometimes go to untoward lengths in his attempt to secure a conviction. For example, in cities with laws requiring physicians and hospital superintendents to notify their health departments immediately of all abortion cases in which illegal practice is even suspect, prosecuting attorneys sometimes attempt to obtain abortion information through these statutes.

In one such case, the Appellate Division of the New York Supreme Court held that a municipal rule of this kind conflicted with a statutory prohibition against physicians disclosing information professionally acquired from their patients.[64] This was after the Superintendent of Kings County Hospital refused to comply with a subpoena requiring him to produce all hospital records of all patients admitted and treated for either miscarriage or non-therapeutic abortion. If this subpoena had been complied with, mass information would have been given the district attorney on all abortion cases, whether spontaneous or induced, whether legal or illegal. Requiring reports by physicians to authorities could mean, if carried to its logical extreme, the violation of the individual's privilege against self-incrimination as guaranteed by the due process clause of the fourteenth amendment.

It seems of parenthetic interest that, although in Chicago no such request of physicians has been made, the State's Attorney in 1955 stated that he felt "convinced a large percentage of the medical profession in Chicago is winking at the violation of state abortion laws."[65] Whether or not this is so, it cannot be gainsaid that,

[64] In the Matter of the Investigation into Alleged Commission of Criminal Abortions in the County of Kings, 286 App. Div. 270, 143 N.Y.S.2d 501 (1955).

[65] Sontheimer, *supra* note 57, at 97, 100.

"a large segment of the population condones abortion. They consider it either all right or, at worst, a necessity."[66] As a result, law enforcement agencies find it "extremely difficult to obtain convictions or substantial sentences for abortionists."[67] A large segment of the population has had personal experience with the abortion problem, either directly or through some collateral branch of the family. Law enforcement in this area is practically impossible. The operation may previously have been performed on the wives or daughters of jurymen, jurists, lawyers, and physicians. Because referral of pregnant women to an abortionist is widespread, abortion has been characterized in a magazine with a national circulation as the hypocrisy of modern medicine.[68] A high percentage of abortions — an accurate estimate of number is impossible — are performed by competent physicians. And a large number of referrals, sometimes direct and sometimes indirect, in all probability come from honest, conscientious, and otherwise ethical physicians in general practice or in the various specialties (not excluding even psychiatry and obstetrics) who, as Kleegman has so frequently stated, "feel impelled to aid those patients for whom they feel an abortion is indicated, but for whom this can be obtained only through an abortionist."[69] The problem that should be considered is what can be done to eliminate this hypocrisy.

IV. Suggestions for Solution, or Partial Solution, of the Abortion Problem

Prevention of pregnancy through contraception, birth-control, and the methods of planned parenthood[70] has not proven effective enough. Most people would not wish to be too candid about the abortion practices of American society.[71] Everyone would like society to be organized so as to make the practice unnecessary for either therapeutic or socioeconomic and other reasons. Prevention of unwanted pregnancy should be the *sine qua non.* This is not possible, despite the population explosion, in the present state of American culture and at the present stage of psychosocial medical knowledge. Society is, nevertheless, hopefully groping towards this.

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[66] *Id.* at 101.

[67] *Ibid.*

[68] Guttmacher, *supra* note 50, at 24.

[69] Kleegman, *supra* note 60, at 256-57.

[70] *Id.* at 254.

[71] Sontheimer, *supra* note 57, at 44.

In lieu of this, a number of suggestions have been made with a view towards solution or partial solution of the problem. All steps taken in this country have thus far been completely unsuccessful. These include: (a) forced marriage, (b) adoption, foster home, and orphanage care, (c) liberalization by interpretation of existing statutes, and (d) passage of a model abortion law. A few words about each of these would seem in order at this particular point.

A. Forced Marriage

Most abortions are performed on married women. Even the most avid proponents of forced marriage realize that this measure can be applied to only a very small proportion of unmarried pregnant women. In most states, the legal age for marriage without parental consent is twenty-one. In some states, it may be as low as eighteen. But this can be waived by the court when it sanctions even a child marriage,[72] provided the bride-to-be presents a physician's certificate of pregnancy. However, neither child marriage nor forced marriage can be considered an answer to the abortion problem.

B. Adoption, Foster Home, and Orphanage Care

"Few save the biological mother," so Cameron states, "have the necessary degree of devotion and sense of continuing responsibility to provide for the needs of the child throughout its growing years. . . . [I]t would seem that immediate separation of the new-born infant from its mother and its placement either in an orphanage or in a foster home . . . will [not] receive much countenance from public opinion, once the community is fully informed upon the matter."[73] In any case, the founding even of large orphanages has not helped solve the abortion problem.

No one in the technical literature has stressed the heartlessness, the cruelty, and the sadism that the pregnant woman so frequently senses — perhaps correctly, perhaps mistakenly — when physician, minister, or lawyer suggests to her that she carry the child to term and then hand it over, never to see it again, to someone else to raise. Thirty-seven of the last forty-four unwillingly pregnant patients referred here for consultation had, before their referral, adamantly

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[72] Maryland did this for a 13 year-old child in November 1955. Document contained in the files of the Author.

[73] Cameron, *Psychiatric Foreword*, in THERAPEUTIC ABORTION: MEDICAL, PSYCHIATRIC, LEGAL, ANTHROPOLOGICAL AND RELIGIOUS CONSIDERATIONS, at xvii, xviii (Rosen ed. 1954).

rejected all pressure in this direction. All felt exactly the same way about it. Four of the women, — an eighteen year old, unmarried girl who had been raped, the daughter of a taxi driver, the sister of a physician, and the wife of a jurist — objected to "farming the child out for adoption." As they termed it, and in exactly the same words, "I'm not an animal." Each asked, "Do you think I could give my baby away after carrying it for nine months? There's a civil rights movement in this country now. A hundred years ago you could take the babies away from slaves. You can't do that now! And you can't turn me into the kind of an animal that would give my baby away!" Or, to quote the minister, "That's not the problem! It's not whether my wife delivers the child; it's what this pregnancy is doing to her right now and what having this child will mean. She's a warm loving person. She would never give it up to a stranger if she's forced to have it!"

Pronounced psychiatric factors were present in all five women. During the past eighteen years the author has seen only three patients for whom "farming out" of a child for adoption would not have been emotionally exceedingly traumatic and psychiatrically contraindicated. For some twenty-nine patients who came into psychiatric treatment within one to four years after they had accepted this kind of recommendation, what they considered to be the abandoning of their infants required careful, cautious, and (in all but seven) extensive therapeutic consideration. A woman does not lightly leave a baby in a basket on someone else's doorstep, or in a hospital nursery.

C. *Liberalization of the Interpretation of Existing Statutes*

Hospital administrators, hospital staffs, and conscientious physicians differ, to the greatest possible extent, in their interpretation of statutory requirements for therapeutic abortion. According to one article in the popular press, a large percentage of women who now have criminal abortions in all probability could have their pregnancies legally interrupted somewhere in this country, if they had sufficient time, physiologically, to shop from physician to physician, from hospital to hospital, and from state to state.[74]

In a recent article by Kummer and Leavy,[75] it was stated that "it is an accepted fact that pregnancies are terminated by reputable physicians in licensed hospitals for reasons other than to preserve

[74] Sontheimer, *supra* note 57, at 95.

[75] Kummer & Leavy, *supra* note 52, at 97.

the life of the mother, e.g., on health, humanitarian, and eugenic grounds, and thus in open violation of the law." This open violation, however, is by a process of interpreting the law more liberally than the actual wording of the statutes would seem to allow. The article continued as follows:

> But if these interruptions are performed with concurring written opinions of other physicians and with approval of the hospital's therapeutic abortion committee, there is no trouble from law enforcement officials. We have found no recorded prosecution under such circumstances.
>
> The fact that this is accepted medical practice is borne out by the findings of a Stanford Law School survey,[76] which showed that three quarters of the reporting California hospitals would allow induced abortion under circumstances tantamount to violation of that state's prohibitory statute. Furthermore, at a legislative hearing in California, where testimony was heard on a bill which would cautiously broaden the exceptions to include pregnancy from rape or incest, and where pregnancy would endanger a woman's health or perhaps result in the birth of a deformed child, nearly every doctor who testified stated that such a law would only legalize what is now practiced in most non-Catholic hospitals.[77]

However, so they add, "Hospital authorities and physicians vary widely in their interpretation of the laws and their willingness to place themselves in jeopardy of prosecution."[78] And because of this, or in order to be certain of being legally safe from prosecution, a large number of hospitals will not permit a therapeutic interruption of pregnancy unless two physicians — if the recommendation is for psychiatric reasons, this means unless two psychiatrists — make the recommendation which then must be presented to an abortion board usually composed of an internist, an obstetrician, a pediatrician, and a psychiatrist. This adds to the expense of the patient and necessarily causes additional delay.

No hypocrisy may be involved in this procedure. However, no state law allows for anything even remotely approximating this. Occasionally, physicians utilize this procedure, with all its attendant delay, in order to get the patient past the twelfth week of her pregnancy, and then tell her — as sixteen of the patients at Johns Hopkins had been told — that the twelve-week physiologic time-limit for the procedure had been exceeded and that, as a result, nothing could be done.

Any pregnancy, it should again be stressed, can be interrupted

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[76] *Ibid.* See Packer & Gampell, *supra* note 52, at 446-47.

[77] Kummer & Leavy, *supra* note 52, at 97.

[78] *Ibid.*

from the moment it has been diagnosed to the moment of spontaneous delivery. Physicians who maintain that an abortion cannot safely be performed after the twelfth week are either ten years behind in their knowledge of medical practice or are deliberately falsifying medical information to their patients. There can be no excuse for either. They have every possible opportunity to keep abreast of current medical, including obstetrical, progress. If they do not feel that their patient should be aborted, they should in all honesty state so openly and frankly to their patient.

No hospital, incidentally, requires two surgeons to submit certificates recommending that an appendectomy be done, while reserving the right to accept or reject the recommendation after considering it even for several weeks. At the Johns Hopkins Hospital, it is felt that this analogy to an appendectomy is valid. There, certificates from two psychiatrists are not required nor is an abortion board established. No state statute, incidentally, requires this. The practice is unnecessary, although from a historical viewpoint it is easily understood why it was started.

But this is again a digression. Boards may or may not accept the recommendation. Or there may be resistance to the submission of the recommendation to a board from husbands (who must legally sign permission for the procedure), from other members of the family, from friends, from physicians, or from almost anyone else close enough to the patient to be emotionally involved in the situation. Even psychiatrists are not exempt.

But reliance on the medical profession to relieve the abortion problem by interpreting existing laws more liberally can produce very unsatisfactory and unpleasant results. For example, the parents of a psychotic pregnant girl, who at the time the problem arose was in the closed section of a psychiatric hospital, requested that she be seen in consultation because, although her treating psychiatrist felt that the pregnancy should be interrupted, he stated that he could not make the recommendation because according to him this was against the law. The psychiatrist stated that, for the sake of the emotional health and life of this girl, she should be aborted. She therefore was seen in consultation. One wonders why he had not himself made the recommendation. It was later made in accordance with the law of the state in which this took place. The recommendation was accepted by the hospital. However, before it could be carried out, the psychiatrist wrote to the girl's parents, the girl, and the hospital, labeling the interruption a flagrant violation of the

law and stating that the hospital, the parents, and the girl would be criminally responsible. The hospital and its lawyer decided otherwise.

Further evidence of the insufficiency of attempting to solve today's abortion impasse through more liberal interpretation of existing laws is provided by follow-ups on ten cases in which therapeutic abortion was recommended but rejected — seven by a hospital and three by the husband.[79] Of these cases, one resulted in suicide, six criminal abortions were performed, one patient applied for divorce immediately after the child was born, and one woman, following the birth of the child, killed all her children and herself. The tenth patient, for whom the recommendation was rejected when her husband refused to give his written permission, was later aborted at an adjacent hospital where she registered as a single girl.

Abortion is generally thought of by physicians as a medical problem, but this concept is purely and simply an artifact of present social mores. Physicians are able to make recommendations for interruption; but when they do make such recommendations, it is only within the framework of the laws of the individual states in which they happen to practice. They cannot make them otherwise. But because this is a sociological problem and a legislative one for the most part, even when physicians try to meet the problem on medical terms, actual practices become more and more confused.

The problem is analogous to that which the courts so often raise with psychiatrists about whether a specific individual is or is not "insane." There is no such term as "insanity" in the psychiatric lexicon. The term has a social and legal meaning, not a medical or psychiatric one. Two different psychiatrists, therefore, who have examined the same defendant and have reached the same conclusion, when they attempt to speak to a court in terms of "insanity" may as a result give what appears to be conflicting testimony leading to diametrically opposed conclusions. No psychiatrist, it should be remarked, is professionally competent to discuss non-medical and non-psychiatric concepts such as "insanity," even though the law so frequently insists that he must.

The same impasse applies as far as the psychiatrist is concerned, to the abortion problem. What is a sufficient medical indication to one psychiatrist, may not be a sufficient indication to another. The problem can be neither raised nor resolved on purely medical

[79] Rosen, *Abortion: The Increasing Involvement of Psychiatry*, 2 FRONTIERS OF CLINICAL PSYCHIATRY 1, 11 (Dec. 1965).

grounds, in view of present abortion statutes. And because of the wide-spread public demand for abortion facilities, the fact that the law does not necessarily mirror public opinion, although it is amenable to popular pressure, becomes doubly apparent here.

Although Timasheff and Ehrlich were discussing other aspects of legal disequilibrium, Timasheff's comments about the disharmony between real forces and verbal formulae[80] and Ehrlich's emphatic contrasting of the living with the positive law[81] highlight the problem. A great deal of thought must be expended, and a great deal of discussion must take place, before concrete, meaningful suggestions can be made. The fact that between 1,000 and 2,500 abortions are performed each and every day in this country means that in discussions of the subject, the question almost invariably is raised as to the usefulness of laws that are as constantly and consistently disregarded by the populace as are the present abortion laws.[82]

D. Passage of More Liberal Abortion Laws

Liberalizing present abortion statutes to include socioeconomic, along with medical and psychiatric grounds, would at the very least seem indicated. A number of proposals have been made. On November 28, 1965 the Board of Trustees of the American Medical Association (AMA) submitted to its policy-making House of Delegates, for endorsement or disapproval, a report (1) urging that appropriate legislation be enacted, wherever necessary, so that all physicians may legally give contraceptive information to their patients, and (2) calling for amendments to state abortion laws "so as to reflect medical conscience and public opinion."[83] This report was prepared by the AMA Committee on Human Reproduction. If adopted by the various states, it could have gone far towards taking the hypocrisy out of the abortion practices of our society. It is to be regretted that on December 1, it was rejected by the House of Delegates.[84] It is inevitable that, in one form or another, it will come up for reconsideration.

The report favored the enactment of legislation so that pregnancies can be legally interrupted in licensed hospitals on writ-

[80] TIMASHEFF, INTRODUCTION TO THE SOCIOLOGY OF LAW 356-63 (1936).

[81] EHRLICH, FUNDAMENTAL PRINCIPLES OF THE SOCIOLOGY OF LAW 477-85 (1936).

[82] ABORTION IN THE UNITED STATES 181 (Calderone ed. 1958).

[83] The report has not yet been published.

[84] Committee on Human Reproduction, American Medical Ass'n, A.P. Dispatch, N.Y. Times, Dec. 2, 1965, p. 24, col. 4.

ten certification by two licensed physicians, neither of whom would be performing the abortion, provided that continuance of the pregnancy gravely impairs the physical or mental health of the mother; or if there is substantial risk that the child will be born with great physical or mental defects; or if the pregnancy has resulted from statutory or forcible rape or incest. This report, therefore, merely grants official recognition to current lay and professional attitudes and practices towards the abortion problem. The total family situation, and the ability of the mother to care for the child should likewise be taken into consideration.

V. Recommendations of Authoritative Bodies that have Studied the Problem

A large number of concrete proposals about the abortion problem have been made, and a large number of studies have been published. At least 2,000 articles and books have appeared on the subject. In England at present, the abortion bill introduced in Parliament by Lord Silkin (November 1965),[85] along with the

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[85] The bill as introduced appeared as follows:

An Act to amend the law relating to termination of pregnancy by registered medical practitioners.

Be it enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows: —

1. It shall be lawful for a registered medical practitioner to terminate pregnancy in good faith —

(*a*) in the belief that if the pregnancy were allowed to continue there would be grave risk of the patient's death or of serious injury to her physical or mental health resulting either from giving birth to the child or from the strain of caring for it, or

(*b*) in the belief that if the pregnancy were allowed to continue there would be grave risk of the child being born grossly deformed or with other serious physical or mental abnormality, or

(*c*) in the belief that the health of the patient or the social conditions in which she is living (including the social conditions of her existing children) make her unsuitable to assume the legal and moral responsibility for caring for a child or another child as the case may be, or

(*d*) in the belief that the patient became pregnant as the result of intercourse which was an offense under sections one to eleven inclusive of the Sexual Offenses Act 1956 or that the patient is a person of unsound mind.

2. A termination of pregnancy under paragraph (*c*) or (*d*) of section 1 of this Act shall not be performed after the end of the sixteenth week of pregnancy.

3. In a prosecution under section 58 of the Offenses against the Person Act 1861 (which makes it a felony to administer drugs or use instruments to procure an abortion) the burden of proving that a termination of pregnancy performed by a registered medical practitioner was not performed in good

January 1966 report on abortion of a committee of the Church Assembly[86] there, shows to how great an extent revision of the British law on abortion is overdue. Yet this law is much more liberal than is its American counterpart.

There are two British studies that should be mentioned here. The first is the 1936 Birkett Report[87] on the medical aspects of abortion that was prepared by a committee of the British Medical Association. The second is the Report of the Inter-Departmental Committee on Abortion[88] that appeared later under the joint auspices of the Ministry of Health and the Home Office. These recommended wider dissemination of contraceptive advice by local authorities, clarification of the scope of therapeutic abortion, adequate medical facilities for care of abortion patients, and measures to relieve the financial strain of childbirth.

In the United States, current pressure for the revision of the abortion laws and for their liberalization goes back to 1955, when the Planned Parenthood Federation of America called a three-day conference of specialists in obstetrics, psychiatry, public health, biology, sociology, biostatistics, forensic medicine, law, and demography, to discuss the problem.[89] The majority of those participating signed a statement recommending: (1) the encouragement, through early, continued, and realistic sex education, of higher standards of sexual conduct and of a greater sense of responsibility toward pregnancy; (2) the establishment of consultation centers for women seeking abortion, modeled after the Scandinavian centers now in existence. Such consultative centers would operate under joint medical and sociological auspices, perhaps through the sponsorship of state health and welfare departments; (3) the extension under medical supervision of facilities for providing advice on contraception, which would be freely available to all desiring it; and (4) the study of the various abortion laws by authoritative bodies (*e.g.*, the National Conference of Commissioners on Uniform State Laws, the

faith in the belief specified in this Act, or within the time specified for terminating pregnancy, shall rest upon the Crown.

4. Nothing in this Act shall affect the law relating to the requirement of consent to surgical operations.

5.—(1) This Act may be cited as the Abortion Act 1965.

(2) This Act shall not extend to Northern Ireland.

[86] This report is discussed in the Manchester Guardian Weekly, Jan. 6, 1966 p. 9, col. 3.

[87] See generally GEBHARD, POMEROY, MARTIN & CHRISTENSON, PREGNANCY, BIRTH AND ABORTION 234 (1958).

[88] *Ibid.*

[89] ABORTION IN THE UNITED STATES *passim* (Calderone ed. 1958).

American Law Institute, and the Council of State Governments), which would frame a model law that could, perhaps jointly, be presented to the states to replace existing statutes.[90]

[90] Section 230.3 of the Model Penal Code is an excellent proposal with the exception of § (3) which requires one physician to check on another. If the first physician is venal, unethical, or incompetent, his certificate should not be accepted and he should not be on a hospital staff. The section as drafted appears as follows:

(1) *Unjustified Abortion.* A person who purposely and unjustifiably terminates the pregnancy of another otherwise than by a live birth commits a felony of the third degree or, where the pregnancy has continued beyond the twenty-sixth week, a felony of the second degree.

(2) *Justifiable Abortion.* A licensed physician is justified in terminating a pregnancy if he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape, incest, or other felonious intercourse. All illicit intercourse with a girl below the age of 16 shall be deemed felonious for purposes of this Subsection. Justifiable abortions shall be performed only in a licensed hospital except in case of emergency when hospital facilities are unavailable. [Additional exceptions from the requirement of hospitalization may be incorporated here to take account of situations in sparsely settled areas where hospitals are not generally accessible.]

(3) *Physicians' Certificates; Presumption from Non-Compliance.* No abortion shall be performed unless two physicians, one of whom may be the person performing the abortion, shall have certified in writing the circumstances which they believe to justify the abortion. Such certificate shall be submitted before the abortion to the hospital where it is to be performed and, in the case of abortion following felonious intercourse, to the prosecuting attorney or the police. Failure to comply with any of the requirements of this Subsection gives rise to a presumption that the abortion was unjustified.

(4) *Self-Abortion.* A woman whose pregnancy has continued beyond the twenty-sixth week commits a felony of the third degree if she purposely terminates her own pregnancy otherwise than by a live birth, or if she uses instruments, drugs or violence upon herself for that purpose. Except as justified under Subsection (2), a person who induces or knowingly aids a woman to use instruments, drugs or violence upon herself for the purpose of terminating her pregnancy otherwise than by a live birth commits a felony of the third degree whether or not the pregnancy has continued beyond the twenty-sixth week.

(5) *Pretended Abortion.* A person commits a felony of the third degree if, representing that it is his purpose to perform an abortion, he does an act adapted to cause abortion in a pregnant woman although the woman is in fact not pregnant, or the actor does not believe she is. A person charged with unjustified abortion under Subsection (1) or an attempt to commit that offense may be convicted thereof upon proof of conduct prohibited by this Subsection.

(6) *Distribution of Abortifacients.* A person who sells, offers to sell, possesses with intent to sell, advertises, or displays for sale anything specially designed to terminate a pregnancy, or held out by the actor as useful for that purpose, commits a misdemeanor, unless:

(a) the sale, offer or display is to a physician or druggist or to an intermediary in a chain of distribution to physicians or druggists; or

(b) the sale is made upon prescription or order of a physician; or

(c) the possession is with intent to sell as authorized in paragraphs (a) and (b); or

(d) the advertising is addressed to persons named in paragraph (a) and confined to trade or professional channels not likely to reach the general public.

(7) *Section Inapplicable to Prevention of Pregnancy.* Nothing in this

VI. CONCLUSION

Current abortion practices and current abortion laws in the United States are incompatible with concepts of human dignity.[91] They may, perhaps, have applied between 1750 and 1900.[92] They would be understandable in ancient Sparta, and apply there, but they would have been as out of place in the more mature society of Athens at the time of Pericles and Socrates, as they are in America today.[93]

Yet, because of them, physicians today are forced to make medical decisions on moral and socioeconomic grounds. Because of the progress of medical knowledge and medical techniques, present statutory provisions with respect to abortion have little or nothing to do with present-day, considered medical judgment. Physicians, including obstetricians and psychiatrists, as a result, find themselves in a completely untenable and essentially hypocritical position.

The law does not prohibit the surgeon from recommending that an appendix be removed (although appendiceal tissue is composed of living cells), or that a patient be operated on because of cancer. The law does not prohibit any physician from recommending, if he feels it medically (including psychiatrically) indicated, that a specific patient be aborted. But the law at times does prohibit — or can be interpreted as prohibiting — the obstetrician or gynecologist from carrying out a considered medical recommendation for interruption. And it is in this that the hypocrisy of the situation can be seen in its pure culture.

Surgeons perform life-saving operations. A good deal of their time, however, is devoted to elective surgery. This can be for something as minor as the removal of a wart, or as major as the excision of a gall bladder. Medical (including psychiatric) indications for interruption of a pre-viable pregnancy can likewise be those of a threat to the emotional or physical life of the patient (and there-

Section shall be deemed applicable to the prescription, administration or distribution of drugs or other substances for avoiding pregnancy, whether by preventing implantation of a fertilized ovum or by any other method that operates before, at or immediately after fertilization. MODEL PENAL CODE § 230.3 (Proposed Official Draft, 1962).

91 Hardin, *Abortion and Human Dignity*, Public Lecture at University of California (Berkeley), April 29, 1964 (Distributed by Citizens for Humane Abortion Laws, San Francisco, Calif.).

92 Eastman, *Liberalization of Attitudes Toward Abortion*, Current Medical Digest, June 1959, pp. 54, 59.

93 *Cf.* Kummer & Leavy, *Therapeutic Abortion Law Confusion*, 195 A.M.A.J. 96, 97 (1966).

fore among those necessitating emergency surgery), or they may be less severe and on a par, for instance, with other conditions for which elective rather than emergency surgery is indicated. Most of our statutes, rigidly interpreted, permit only the former. Sterilizing procedures, if requested by our patients, can be performed in either case. But if interruption of a pre-viable pregnancy is requested, the law at present dictates what medical opinion should be. It does not do this when an appendectomy is concerned, or an oöphorectomy.

But over and above all this, the law takes no cognizance of the fact that we are dealing with responsible human beings who should be accorded all the dignity the law accords them in other areas. Women in our society are no longer chattel. Our abortion laws have long, usually faithfully but some times faithlessly, and always inadequately, served to help keep them so. Mature legal consideration of mother, family, children, and society would lead legislatures not to pass more liberalized abortion laws but to abolish such laws altogether.

Mature women, as mature human beings with all the respect and dignity to be accorded mature human beings, should have the right to decide whether or not they wish to carry a specific pregnancy to term. The responsibility for the decision, right or wrong, is already theirs. The extra-legal abortion rate shows that they have already illegally assumed it. It should be theirs *legally.*

Abortion, like sterilization voluntarily requested, is a medical procedure, advisable and indicated for medical (including surgical and psychiatric) pathology, and for familial, sociologic, socioeconomic, and humanitarian reasons.

But this is for the future. Our present hypocritical attitudes, conscious or unconscious as they are, will not allow of this today. The recommendations of the American Law Institute, if adopted, will help take at least some of the hypocrisy out of our present medical and legal approach to the problem.

And this is devoutly to be desired. For our women are not chattel. And human beings should be treated with dignity even by our abortion statutes.