SENATE JUDICIARY COMMITTEE

PUBLIC HEARING ON S.B. #494

March 19, 1971

Chairman Monroe called the meeting to order at 2:40 p.m.

Committee Members Present:
Chairman Monroe
Senator Close
Senator Foley
Senator Dodge
Senator Swobe
Senator Wilson
Senator Young

Others Present:

PROPONENTS
Joan Parks - University of Nevada Student
Eileen Wynkoop
Dr. Robert J. Cavell
Mrs. Eileen Hensen - Assn. of University Women
Mrs. Dorothy J. Button, R.N.
Dr. George Furman
Mrs. Donna Dixon
Dr. Otto Ravenbolt
Dr. Troutner
Mrs. Pat Lewis - Women for Human Rights
Mark Alden
Dr. Paul White
Carl Elges - Pollution Abatement Engineer

OPPONENTS:
Mrs. Patricia Glen
Dan Hansen - Ind. American Party
Ruth Norman - Nevada Comm. to Restore Decency
Bill O'Mara
Mary Davidson - Birth Right Committee
Ruth McGroarty - Concerned Citizens of Greater Las Vegas
James Stevenson - U. of N. President Student and Latter Day Saints
Janice Hansen - Happiness of Womanhood - Sparks
Dr. Darrell Foote
Mrs. Marge Schulzke
Dr. Ernest Schulzke
Agnes Zumstein
Press

S.B. #494 - Authorizes licensed physicians to perform abortions under certain conditions. Senators Swobe, Monroe, Young and Titlow.

Chairman Monroe announced that each person expecting to speak on this bill would be called according to a list previously made up of persons contacting his office. Everyone on the list would be given an opportunity to speak, but would be limited to two minutes unless they specifically asked for more time.

Senator Swobe said this bill is similar to A.B. #4 which was passed by the Assembly by a 22 to 14 vote. This bill in essence is an act that would permit only persons licensed to practice medicine, surgery, obstetrics or osteopathy, without criminal penalty attached, to produce a miscarriage any time prior to fetus viability when necessary to preserve a woman's life. We have drawn an amendment to this bill which would allow the people to have the final vote in determining if the liberalized abortion bill should become law in Nevada.

The proponents of this bill were asked to testify first.

JOAN PARKS, UNIVERSITY STUDENT

She was in favor of the bill because of three reasons. First she felt the present law is uneffective and dangerous. She stated that there are approximately 1,000 illegal abortions in the United States which take 500 to 1,000 lives each year.

Secondly, she felt the present abortion law is unconstitutional under the 14th amendment because it is an invasion of privacy and impaires the constitutional rights of physicians to request them to refrain from medical procedures.

Thirdly, the present law invokes and supports prejudice because the upper class women can seek help outside the state or country, and the lower class women can not afford to and therefore end up with the back alley butchers.

EILEEN WYNKOOP

She was in favor of the bill but felt it would be an injustice to the people of Nevada if the legislature or the committee, both of which are predominantly composed of men, would decide the outcome of this bill. She felt it was of too much social significance and concern to be decided by the legislature and should be put to the people of the state for a vote.

DR. RICHARD J. CAVELL, RENO PHYSICIAN

He is a physician in Reno but was speaking as a citizen denied his rights. He stated that an overwhelming majority of physicians are in favor of liberalizing the abortion laws. He pointed out that this bill does not contain any compulsive demand for abortion. It only contains an option and sets out the guidelines for compliance with that option, and that nothing in the bill compromises the rights of the minorities' religious or ethical beliefs.

He stated that a recent poll showed an overwhelming majority, 77% of those polled, favored liberalization of abortion laws, and that the democratic and republican platforms both called for liberalization of abortion laws.

He stated that this country grew under the concept of individualism and the recognition that the individual had rights. That concept is clearly seen in the west. Intertwined in that concept is the freedom of choice to do with our lives as we see fit, always within the boundries of law and morality.

EILEEN HENSEN REPRESENTING ASSOCIATION OF UNIVERSITY WOMEN

She represents 600 members, all of whom graduated from accredited colleges and universities. The Association is in favor of this bill. They expressed the opinion that abortion is a matter between a woman and her doctor, and a matter of individual conscience.

DOROTHY J. BUTTON, CHAIRMAN, NEVADA NURSES' ASSOCIATION COMMITTEE ON LEGISLATION

This Association has 601 members in favor of modification of the present abortion law, but believes the word "viable" should be defined in the act. Her Association is opposed to the amendment to put this issue on the ballot for a vote by the people. Her statement is attached hereto (Attachment 1).

Senator Wilson asked Mrs. Button what the word "viable" means. Mrs. Button replied that as she defines "viable", it means a fetus that has reached the age whereby it can live outside the mothers' body, which she felt was 28 weeks. However, she understood that the meaning of the Senate was that abortion would be allowed up to the 20th week, and felt that should be a reason for including the definition in the act.

DR. GEORGE FURMAN

Dr. Furman stated that the people speaking as proponents of this bill today are not alone. Also in support of this liberalization are many church groups and medical associations, including the American Medical Association, the Nevada State Medical Association, the Washoe County Medical Association, and 13 states' legislatures who have recently passed liberalized abortion legislation.

Senator Wilson also asked Dr. Furman what the word "viable" means. Dr. Furman replied that it is usually considered that 24 weeks is the age of viability.

MRS. DONNA DIXON

She is in favor of this bill. Her statement is attached as Attachment 2.

DR. OTTO RAVENHOLDT, PRESIDENT OF THE NEVADA PUBLIC HEALTH ASSOCIATION

Approximately 85% of this Association favors changing the abortion laws that now exists.

He is personally in favor of the bill, with the reservation that he would rather see a time limit of pregnancy established rather than the word "viable". That term presumes a test that permitted determination prior to the action, and there is no such test.

He felt there are numerous reasons why abortions should be moved out of the legal realm and into the medical realm. He stated that he had served as coroner and observed many self-induced abortion deaths.

He stated that there was a broad national movement gaining much support which would leave the discretion to the individual woman whether she wishes to bear a child, and we should therefore provide reasonable protections for these women.

Senator Dodge asked Dr. Ravenholdt what time period he would suggest in place of the word "viable". Dr. Ravenholdt answered that 20 weeks is adequate, and he would favor even more stringent limitations.

DR. ERNEST J. TROUTNER, MINISTER OF THE FIRST UNITED METHODIST CHURCH

He advised the committee that he was not speaking for his parish, but as an individual, and was in favor of the bill. His statement is attached as Attachment 3.

Senator Dodge asked Dr. Troutner if there is any mandate against abortion in the teachings of the bible. Dr. Troutner replied that the answer is as multiple as the different interpretations of the scriptures, but it is his understanding that there is not.

MRS. PAT LEWIS REPRESENTING THE ASSOCIATION OF HUMAN RIGHTS

Mrs. Lewis pointed out that the central ideology of the family planning movement over the last half century has been the human right of the woman to determine the number of children she will have. This is also an important foundation for the ability of women to plan their lives to include active participation in activities outside the home and in the business world.

She pointed out that welfare mothers are given very little subsistence to support their children, and yet the state refuses to allow a welfare mother to limit her child bearing. The eventuality is that there are additional children for the state to support.

Mrs. Lewis testified that at the 25th National Convention of the YWCA, which is a movement rooted in the christian faith, they supported "the repeal of all laws restrictive or prohibiting abortion produced by a duly licensed physician."

She also pointed out that if we trust a doctor with our lives, could we fail to trust him to determine whether or not to terminate pregnancies.

She stated that despite anti-abortionists accusations of murder, society does not treat abortion as murder. It carries a lesser penalty than murder, and no woman who seeks or achieves an abortion has ever been charged with abortion, let alone murder.

MR. MARK ALDEN, PRESIDENT OF YOUNG DEMOCRATES

In their last meeting, a vote was taken of this group, and they strongly favor abortion reform for the State of Nevada. He urged the committee to pass the bill.

DR. PAUL WHITE, RENO PHYSICIAN

He is in favor of the bill. His statement is attached as Attachment 4.

Senator Wilson asked him what his definition of "viable" is. Dr. White replied that in obstetrics, "viability" has been defined as the time when a fetus can survive independently of the mother. This has been considered to be 28 weeks, and to provide further leeway, pushed down as far as 24 weeks. He agreed that the word "viabile" in the amendment was very vague. His recommendation would be 24 weeks but felt that this should be a medical determination, and many doctors would not perform one after 24 weeks.

He pointed out that the opponents are calling abortions "murder" but felt that was inconsistent because there are therapeutic exceptions in the present law.

A Doctor from Reno who did not identify himself asked to speak from the audience in assistance to Dr. White. He stated that to perform an abortion between the 3rd and the 6th month of pregnancy, which is technically called a miscarriage at that point, there are many medical reasons and difficulties that would come under strict medical practice as to whether the procedure should or should not be performed. It can not be predicated upon the fact of viability. He felt that for clarification of the law because of layman's interpretation rather than a doctors, a specific time period should be used.

CARL ELGES, CHEMICAL ENGINEER

Mr. Elges is working in the field of pollution abatement. He felt it is imperative to pass this bill because:

(1) As a practical matter abortions are going to be had regardless of the outcome of this bill.
(2) There are more and more people in this state and we are going to have to consider their effect on the environment and social welfare.
(3) To restore faith in our legislatures let this bill be put to a vote of the people.

Chairman Monroe called for opponent testimony.

MRS. PATRICIA GLENN

She is a registered nurse, the wife of a physician, and a mother of ten children. She felt our laws had one purpose, and that is to protect the rights of individuals and society as a whole. The laws should protect those who are not able to protect themselves.

She felt that a woman does have the right to do what she wants with her body, but not with the life of an unborn child.

She pointed out that the logical extension of this type of bill, is euthanasia and mercy killing.

DANIEL HANSEN, INDEPENDENT AMERICAN PARTY OF NEVADA

Mr. Hansen testified on the concept of Right to Life vs. Abortion. His statement is attached as Attachment 5. He also commented that the amendment to put this issue to a referendum vote was a cowardly attempt to escape the responsibility of legislators, and is an affront to representative government, which provides for due and deliberate processes with checks and balances.

Senator Dodge pointed out that illegal abortion is a prevalent fact of our time, and we might have to repeal it as we did the prohibition law, because it does not represent the mores of our time.

RUTH NORMAN, NEVADA COMMITTEE TO RESTORE DECENCY

Mrs. Norman stated that she would also be speaking unofficially for those nurses who do not agree with the official position of the Nevada Nurses Association.

She felt that we (everybody in general) are here today because somebody, particularly legislators of the past, let us be born. She stated that abortion had always been possible for those who were determined enough to seek it.

She felt that the point that a fetus becomes a person is a debatable question, but the burden of proof should be upon those who advocate its destruction. She asked the committee how they could pass this law to deprive the fetus of his right to life, if they were not absolutely sure, and how could they be, that the fetus is a human person.

She described abortions, whether spontaneous or induced; at home or in a sterile environment; as a messy business. She said it is invariably bloody, nearly always painful, and usually emotionally traumatic to the mother. She then proceeded to sickeningly describe the three methods used to abort.

MR. BILL O'MARA

Mr. O'Mara submitted a report signed by 5 doctors on the question of abortions, Attachment 6. He stated that statistics in New York showed that it is almost 3 times more dangerous for a woman to go through a hospital abortion, then it is to allow her to go through birth. He stated that 34 states have the same law as Nevada has now; that is abortions are not allowed unless necessary to save the mother's life.

Mr. O'Mara stated that the American Medical Association is in favor of liberalized abortion laws, but only in precise terms and not as it is presently recommended and not as explained by the doctors here today. He also mentioned that the Clark County Medical Association is against this bill.

He pointed out that the United States Congress has voiced its position as against abortion as a family planning measure.

He pointed out for those proponents who argued that abortion is not considered as murder in the law, the new law passed in the California legislature states that to intentionally take the life of a newborn child with malice is murder.

MARY DAVIDSON - BIRTH RIGHT COMMITTEE

She stated that abortion is an irrevocable act and they wish to offer something less drastic.

She stated that to use abortion as a back-up to unwanted pregnancies is

questionable and asked where all the unwanted children were. She had spoken to the Catholic Welfare Adoption Agency in Reno, and the Adoption Agency at the State Welfare Department in Reno, and was told by both agencies that babies for adoption are becoming less and less available, and presently a couple with two or more children is not eligible for infant adoption. She felt it is no longer a social stigma to have a child out of wedlock, and society has made it possible for these girls to continue their education and become worthwhile citizens.

She stated that a recent survey performed by a professor of pediatrics from the University of Southern California revealed that 90% of all battered children were all planned pregnancies. A contradiction to the statement that abortion stops unwanted pregnancies and abused children.

She stated that 90% of all abortions are performed for the mental health of the mothers, and asked where all the women were who need abortions because of deformed babies.

Senator Dodge asked Mrs. Davidson if it wouldn't be discriminating against a Nevada woman who wanted an abortion, to force her to go out of state to get that abortion. She stated that she felt it wasn't discriminatory, and said she had spoken with Crisis Center in Reno and they reported that they had only one or two calls per month regarding where and how abortions could be had.

RUTH MC GROARTY - CONCERNED CITIZENS OF GREATER LAS VEGAS

She said that a woman does have the freedom of choice and conscience to decide how many, if any at all, children she will bear. However, that decision should be made before conception rather than after. She also agreed that a woman has the right to do what she wants with her own body, but not the life of another human being, whether inside or outside that body.

She attacked the proponent testimony that the present abortion law favors one theological position, and objected that her morality was taught to her by her mother, and that all religions have moral codes.

JAMES STEVENSON - PRESIDENT OF CONCERNED STUDENTS, UNIVERSITY OF NEVADA, AND MEMBER OF THE LATTER DAY SAINTS.

He read a statement attacking the four common fictions about abortion and stating their factual counterparts, (Attachment 7).

He added a fifth fiction which was brought up in this meeting: That is, that if abortion is legalized, illegal abortions would decrease. In all cases studied, it showed that the illegal abortions remained the same, and in one case they increased.

JANICE HENSEN REPRESENTING HAPPINESS OF WOMANHOOD

Their official position is against legalized abortion.

She pointed out that several years ago, this subject would not have been brought up, and is only considered now because of the declining morality. She noted that Florida has a bill which would legalize the killing of old people,

and Hawaii a bill which would require a woman to be sterilized after her second child. She felt that legalized abortion is the first step toward this attitude.

DR. DARRELL FOOTE - PHYSIOLOGIST AND PROFESSOR AT THE UNIVERSITY OF NEVADA

Dr. Foote asked that the record show that he is not representing the University, but is speaking as a concerned individual. He stated that it is hard for him to realize that there are people who visualize a fetus as being nothing more than a mass of protoplasm which is at best a part of its mother's body.

He stated that the fetus has an individual life and is just as real as anyone present today.

MRS. MARGO SCHULZKE

She stated that the suicide rate of pregnant women is 1/6 of that of women who are not pregnant. She felt that women are not fully informed as to the dangers of abortion, and that the information is not commonly available.

She argued that not only is abortion dangerous to pregnant women, but it is also dangerous to all other people in a community where it is permitted because abortion patients are given priority in hospitals and take up many beds that would otherwise be used for medically sick people, and felt that is something Nevada can not afford. She felt it would also overburden the taxpayers as taxes increase because abortion will become a method of birth control.

DR. ERNEST SCHULZKE

He felt there was no way of knowing exactly how many illegal abortions were performed.

He stated that there were three issues with relation to this bill.

(1) Is the unborn child a human entity?
(2) Does that child have the right to life?
(3) Are there feasible alternatives less grotesque?

He felt the legislature should be careful not to take a step as big as this until all the returns are in from other states who have already legalized abortion.

MRS. AGNES ZUMSTEIN

Mrs. Zumstein stated a personal experience which involved a woman who had received an illegal abortion, hearing her aborted baby crying. She felt that abortion is not the thing for all parents.

Meeting adjourned at 5:25 p.m.

Respectfully submitted,
Eileen Wynkoop
Eileen Wynkoop, Secretary

Approved: _____

Testimony for Senate Committee on Judiciary on SB 494

By Dorothy J. Button, R.N.

My name is Dorothy Button. I live at 1590 Hillside Drive in Reno, Nevada. I am chairman of the Nevada Nurses' Association Committee on Legislation.

Nevada Nurses' Association is the professional organization of registered nurses. In 1970 our Association had 601 members. Membership in the Association is voluntary.

We support modification of Nevada's Abortion Law. Our Committee has studied Senate Bill 494. It is consistent with a resolution passed by a majority of Association members at our 39th Annual Convention at Fallon, Nevada on November 7, 1970. Our committee believes that the word "viable" contained in line 24 of the bill should be defined in the Act. We are opposed to the amendment which is to be offered in the Nevada Senate to put the question of liberalized abortion on the 1972 general election ballot. We believe that the Senate should vote on SB 494 as it was introduced before such an amendment is considered. Such an amendment seems to be an abdication of the responsibility for which you people were elected.

Our Association favors modification of Nevada's abortion law: because the present law has not succeeded in eliminating illegal abortions in Nevada; because the birth of an unwanted child is

detrimental to the mental health of the unwanted child, his parents and his brothers and sisters; and because new diagnostic techniques make it possible to determine the presence of certain fetal abnormalities early in pregnancy.

Removing criminal penalties for abortions performed by licensed doctors will permit women with problem pregnancies to consult qualified physicians and to have the benefit of counseling before reaching a complex decision. Illegal abortions performed by unqualified abortionists and the terrible and often unpredictable consequences of self-induced abortion can become things of the past.

Repeal of the criminal abortion law does not in any way infringe upon the right of a pregnant woman to refrain from abortion, but no group has the right to impose its moral code or standards on the rest of society which should be allowed individual choice--a precious right in our democratic society.

Reference has been made to an article entitled "Why Are Nurses Shook-up Over Abortion" which appeared in the Feb. 9, 1971 issue of Look Magazine.[1] Not one of the nurses quoted in this article said the liberalized abortion laws were wrong. These nurses recognized that they were having difficulty with their feelings. Nurses experience the same feelings when spontaneous abortions

occur after the fetus has reached the age where it is identifiable as a small human being.

It has been said that the State cannot afford to pay for abortions for women on welfare. The State Department of Social Services pays the bill for abortions for indigent patients in Hawaii. It will cost the State less to provide an abortion for an indigent woman who wants one than it will cost the State to support that child and its' offspring for the remainder of their lives.

Because of the adverse effects of the birth of an unwanted child upon mental health, a federal commission (The Joint Commission on Mental Health of Children) charged with assessing the care this nation provided to emotionally and mentally disturbed children recommends that abortion as a medical procedure be removed from the criminal law.[2] Nevada Nurses' Association supports abortion reform on this same basis.

New diagnostic techniques make it possible to determine early in pregnancy that a fetus is mongoloid or chromosomally deranged, has hemophilia, muscular dystrophy or Tay-Sachs disease.It is believed that analysis of enzymes produced by fetal cells can lead to prenatal detection of more than 1500 genetic diseases. Basic research to determine specific enzymes for all 1500 of these genetic diseases has not yet

been done, but it is being done. These 1500 diseases cause one out of five childhood deaths.[3,4]

We all know the principal objection to repeal of criminal penalties for abortions performed by licensed doctors has centered on the religious-ethical-moral aspect of the problem. The Nevada Nurses' Association believes it is time for the majority of Nevadans to be freed from a moral code which belongs to a religious minority in the abortion question.

---

[1] Fischl, Irene "Why Are Nurses Shook-up Over Abortion" Look [2] Volume 35 Number 3 February 9, 1971, Page 66.

[2] Crisis in Child Mental Health, Challenge for the 1970's, REport of the Joint Commission on Mental Health of Children. New York: Harper and Row, 1969, 1970, page 31.

[3] Valenti, Carlo "His Right to be Normal". Saturday Review. New York: Saturday Review, Inc. 380 Madison Avenue. December 7, 1968, pages 75 - 78.

[4] "A checkup for the unborn". Life. Volume 69, Number 12, September 18, 1970, pages 73 - 76. Chicago, Illinois 60611: Time, Inc. 541 North Fairbanks Court.

ABORTION HEARING, MARCH 19, 1971 Donna Dixon 2-125

Mr. Chairman, Gentlemen of the Judiciary Committee, and Fellow Nevadans, today in our meeting it is apparent that we could not consider the implications of abortion apart from our concern for the quality of life of the individual, the family, and society.

Most of us present, believe in the continuing revelation of truth, We have tried to apply past experiences and new knowledge to search for moral solutions to comtemporary problems.

Today all men face threats to the quality of their lives undreamed of a few centuries ago. Science has given man power to alter his environment, to modify his physical health, to lengthen his life, to free himself from want--if he will, and at the same time to threaten the very survival of his species.

The impact of scientific knowledge on human life has crea ted a new urgency and ~~and~~ inescable obligation to weigh very carefully the choices we make from now on, the priorities we set for the use of our powers and our resources. Indeed, if man is to have a future at all, we are forced to think of the choices open to us. These are difficult & painful, for they affect not only the beginning & end of human life but the quality of life in all the years that lie between.

People have always wanted children--but not in unlimited numbers. Men & women have always longed for both fertility & sterility, each at its appointed time & in its chosen circumstances. This has been a universal aim, whether people have always been conscious of it or not.

Motivation to prevent a birth, often nonexistent before the sexual act, is very high when a pregnancy is actually established. Abortion is the most widespread method of fertility control in the world.

In recent years the problem of abortion has been causing increasing concern. There are compelling reasons for the present searching inquiry. More & more people are alarmed at the extent of self-induced & criminal abortions.

Gentlemen, ~~my politicians~~, may I bring to your attention the ~~party~~ platforms. The Dem. Platform ~~says~~ "We call for the amendment of our Nevada law to permit a woman to terminate a pregnancy upon her request. We urge our legislators to adopt appropriate legislation to implement this resolution." The Rep. Platform ~~says~~ "Believing deeply in the rights of the individual, we recommend revision and liberalization of the state abortion laws". Now to my knowledge, we have only Dem. & Rep. in the legislature. It seems odd that politicians want the support of their party and the people, but after getting into office they forget the platforms and the people.

SB494 before us today puts abortions where they ought to be- outside the legislature + places the decision Between patient & physician. The bill removes criminal penalties for abortions performed by licensed doctors.

Gentlemen of the Judiciary Committee--after all the discussion today--only one question remains--should abortions be legal or illegal?

We in the West are noted for our rugged individualism-for our faith in the ability of an individual to wisely direct his own life if given the freedom to do so.

Let's uphold that tradition by returning the responsibility

of abortions to our families & their physicians where it rightfully belongs. Other states have already taken the lead in shifting the responsibility for such matters back to the individual. It is high time Nevada does likewise, for why should Nevada women be forced to leave Nevada to secure the freedom essential for wisely directing their lives. Let's give Nevada women & their physicians a vote of confidence by modernizing our abortion law. Thank you.

Unitarian Universalists Association Resolution

Every effort should be made to abolish existing abortion laws, except to prohibit performing of an abortion by a person who is not duly licensed physician, leaving the decision of abortion to doctor & patient.

A STATEMENT FAVORING THE PASSAGE OF SENATE BILL NO. 494

by Dr. Ernest J. Troutner, Chairman of The Nevada Parish of the United Methodist Church - Minister of The First United Methodist Church - Reno.

I believe that Senate Bill No. 494 should be enacted for the following reasons:

1. Good government should enable its citizens to act morally, legally and responsibly. There will be unwanted pregnancies in our communities. Those who are responsible for the incident of conception are entitled to freedom of decision and to support regarding abortion rather than to the contempt of the community and to laws that force unwanted children, forced marriages and the many subsequent personal and social aberrations that follow.

2. Strong support for bills advocating the liberalizing of present abortion laws has been expressed by members of the medical community. Medical doctors and nurses, more familiar than others, with the problems and tensions that the issue of the unwanted child presents, favor legislation to help persons to act responsibly and also to safeguard human life. With considered judgment and care, the professional community recommend the wisdom of this measure and, in this, they deserve citizens' support.

3. In the interest of the women of our commonwealth, this bill should be passed. It provides them with freedom to act responsibly. It protects them from illegal and other sub-rosa remedies. It provides for physical health and well-being. It allows for economically feasible and medically sound treatment in our own area, thus removing prohibitive travel costs, exorbitant fees and the vicious quackery now so lamentably the only option open to those who are most in need.

4. If our citizens are unable to act under present law- legally- many feel forced to act immorally, as well as without approved medical supervision. They feel forced to have unwanted children and are often encouraged to enter ill-prepared-for marriages. Until legislation is changed, we must accept the responsibility for a resulting ever-increasing number of welfare recipients.

5. Because of religious community beliefs in the sanctity of every human life, responsible parents need to affirm that sanctity in the love and care of their children. To take the unborn life of a fetus may far more affirm the goodness and sacredness of human life than to relegate an unwanted child to unwanting parents - to inherit an unwanted and unloved existence.

THE ABORTION ISSUE

Paul L. White, M.D., FACS, FACOG

It is regrettable that much of the opposition to the liberalization or repeal of present abortion laws is permeated with so much emotionalism, blatently false legal arguments, and often untenable moral grounds as well. That people of different religious faiths and beliefs have a right to their opinions and practices, there is no question, but this right presumes also that those who might have more liberal views on abortion have equal rights. There is no question that our present abortion law compels all to a very restricted behavior in this regard. Repeal or liberalization of the law would have no such compulsion on the opponents of abortion.

The legal prohibitions against abortion originated at a time when little was known about human reproduction. Indeed, it was not until 1803, when England, as the first country in the history of the world, passed the first abortion law. Twenty five years later in 1827 the Illinois legislature passed the first law prohibiting abortion in the United States, followed by New York in 1829, and copied thereafter by most of the other states. These laws, when passed, were designed to protect the pregnant woman rather than the embryo or fetus, and rightly so, for the risk of hospital abortions in the 19th century was formidable. At the time first abortion laws were passed they made some medico-legal sense. But now, in view of the progress of medical science, hospital abortions are now even safer than carrying a pregnancy to term.

The government does, of course, have an interest in safeguarding the health of its citizens and protecting them from the unlicensed practice of medicine. However, other legislation fully protects these interests.

It is often claimed that an embryo has certain legal rights and that these legal rights demonstrate that the embryo has a "right to life" meant to be protected by the state. An examination of these arguments, however, shows that the claimed rights of the embryo are actually rights which may be exercised by the child only after birth or are the rights of the potential parents. The asserted rights of the unborn fetus, namely, property and contractural rights including the right of support, require a live birth in order for those rights to vest. There is no legal basis for claiming that the destruction of a human embryo is murder, for it has never been treated as such by our laws, but only as a lesser offense. If abortion is murder, certainly the woman who aborts is a murderer, and yet it is the general rule that the woman involved in such an operation is not charged with any offense. If a sentence of death was passed upon a pregnant woman who was quick with child, her exectuion would be delayed until she gave birth, but there would be no delay if the unborn infant was not yet quick.

The core of the moral problem remains for most the meaning of the word "life". If the theologian insists that the meeting of the sperm and the egg produces life, the pragmatist can point out, with equal validity, that life already exists in both the unfertilized egg and the spermatozoa. "What escapes most people is that life is never created -- it is simply passed on or snuffed out."

We cannot be absolutely certain as to when a fetus becomes a human person, and the concept that at fertilization there is created a human person can be increasingly questioned in the light of modern biology. We know for a fact that

identical twins can be formed from a single fertilized egg and that this cleavage or budding can occur well after fertilization and implantation. Since the soul is indivisible, does the second twin have no soul since it is impossible for him to have only half a soul? 130

In the case of a woman made pregnant by rape, for example, or who is likely to give birth to a mental defective or seriously physically impaired child, removal of the unwanted fetus seems far less cruel than forcing the woman to carry this unwelcome burden for nine months. Indeed the carrying of any unwanted fetus for nine months can, and probably invariably does, have serious emotional and psychological effects on the mother, as well as the child. I am not sure that an ethic of love, which Christianity claims to be, can justify or even continue to tolerate such exquisite torture.

It is evident, that present state abortion prohibitions are in large part the product of religious pressures and have a religious attitude which must be accepted by all members of society. Such laws fly in the face of the First and Fourteenth Amendments and manifest themselves plainly as a trespass on the Establishment of Religion clause, for the state obviously inhibits those who would follow a more liberal view of other religions. They operated directly to coerce unobserving individuals. To decide that a fetus ought to be considered a human being is a subjective belief of religious character.

If an individual may prevent conception, which right falls in the realm of marital privacy which the Supreme Court found was constitutionally protected, why can she not nullify that conception when prevention has failed? The solution finds itself again in the government taking no part in the area. It must be neutral. Those who believe that their religion or morals forbid any attempt to interrupt the reproductive process must worship privately within their own spheres of influence.

Regarding Bishop Green's recent letter to the Roman Catholic parishes in his diocese: I fully agree that this spiritual leader has a perfect right to express his convictions to his flock, so long as it does not involve coercing others to his beliefs or faith. I would point out, however, that the present law does have a therapeutic exception (for preserving the life of the mother). For him to support either directly or even indirectly the present existing law, since this is obviously contrary to his moral beliefs, I find that his position is purely an expedient one. It is no more moral or logical for him to say on the one hand that murder is wrong, but otherwise would not be adverse to supporting directly or indirectly a law prohibiting murder but which would permit a few murders by a privileged class say: by millionaires or by high ranking clergy. Unfortunately, it is on this point that I and Bishop Green must part company.

I have been asked by Dr. Frank Rueckl, chief of the Department of Obs. and Gyn. at Washoe Medical Center, to survey the problem in Nevada and in particular Washoe County, to find out just how many people are estimated as having had abortions out of state during the past year. There are eleven OB.-GYN specialists in Washoe County, and each of them see an average of 4 to 5 women each month who have returned from, or are going to other states to procure an abortion. So the number in Washoe County alone during the past year, seen by Obstetricians-Gynecologists only and not including Family Doctors or General Practitioners, is approximately 600 annually. I also contacted two specialists in Clark County and they both told me their incidence is about the same, or 1200-1500 during this past year. Based on these figures alone I can fairly accurately estimate on the conservative side that during the past year at least 2500 abortions were performed in other states on citizens of Nevada. In numbers, this figure would be about 3% of the number who voted in the last election, or if you presume that two people are involved in each pregnancy, not to count family and friends, a number equal to about 6% of those who voted in the last election were directly involved in an out of state abortion, during this past year alone This gives one a clue as to the magnitude and urgency of the problem. Since both party platforms promissed their supporters that they would liberalize these restrictive laws, you as legislators just cannot evade this issue at this time and attempt to sweep it under the rug. If you do the latter, I can predict that at the time of the next elections those of you who would so blatently disregard your own parties platforms will also be swept under the rug at the next election.

In conclusion as further evidence of the emotionalism on the part of opponents of repeal, I quote from the Nevada State Journal of this A,M. In a news article in which a certain Reno Doctor of Law stated: "that liberalized abortion laws can be physically harmful to a woman, even at the beginning of a pregnancy". To which as a specialist in the field, I would reply: "It is possible, but in a pregnancy carried to term the chances are very much greater."
He quotes further: " The doctors have found in their study that premature deliveries and abortions have caused problems in later pregnancies, such as mental re tardation in children and habitual spontaneous abortions."
Now, ladies and gentlemen, as a specialist in this field and as a long-standing member of the American Fertility Society, with a considerable amount of my practice over the last 16 years devoted to the problems of sterility and infertility in women, I can positively state that: "this is pure unadulterated rubbish, and not based on any reliable scientific facts."
Lastly this doctor of law, referring to the human conceptus or embryo as an independent human being is also misstating the facts. If they were independent as he so claims, many more of the unwanted ones would be parked at your door, for society to care for them through greatly expanded welfare programs and Aid ti Dependant Children. At this stage of development these embryos or fetuses are far less independent than the "tail is of the monkey."

SILVER STATE

INDEPENDENT AMERICAN PARTY of NEVADA

200 MILL STREET - RENO, NEVADA 89501
5904 APPLE VALLEY - LAS VEGAS, NEVADA 89108

THE PRINCIPLES OF THE INDEPENDENT AMERICAN PARTY OF NEVADA ARE:

1. We affirm our allegiance to the Great State of Nevada, and to the Republic of the United States of America.
2. We believe that governments are sanctioned by Almighty God for the benefit of man. However, in the words of George Washington, "government is like fire; a dangerous servant and a fearful master." Therefore, we believe in the Check and Balance System and the Constitutional principle of States' Rights.
3. We believe in the Free Enterprise system and oppose Facism, Socialism, Communism, and all forms of totalitarian government which deprive men of life, liberty, and property. We champion the rights and dignity of the individual and believe in less government, more individual responsibility and a better world under God.
4. We believe that both the Republican and Democrat(ic) Parties have deserted the principles and traditions of the Founding Fathers. We contend that they have become the proponents of Big Government, of crushing taxation, of bureaucratic edicts, of foreign aid to our enemies, and authoritarian regimentation of the citizens of this Republic. We charge that our Government which is controlled by these twin parties is out of the control of the people it was designed to serve.
5. The Independent American Party of Nevada hereby pledges a return to Constitutional limited government.

THE RIGHT TO LIFE VS ABORTION

by Daniel M. Hansen

Smug abortionists have launched a nation wide anti-life crusade unprecedented in American history. Manifesting a sensativity of the Hun, the abortionists seek to overpower reasonable argument with emotional cliches and demands calculated to overpower and obscure the whimperings of an aborted child struggling and gasping for life.

The ugly story, however, is not new. Human life,throughout history, has been regarded with differing values. At one time, King Herod murdered all of the innocent babies in the land up to two years of age, literally tearing them away from their mothers' breasts. The Spartans murdered babies they deemed unfit by abandoning them on hillsides. In Carthage, calloused priests sacrificed young infants to the flaming mouth of the idol Moloch.

Modern barbarians, parading in the banners of "scientific advancement" and "sophistication", now seek license to sacrifice unborn infants at the alters of lust and profit. New York State leads the way in this carnage as over 69,000 infants were sacrificed in that State in the first 6 months operation of their aborted law. Many of these aborted infants, whimpering and asping for breath, still found a bucket for their cradle. One

child so aborted was rescued by a nurse and has lived to be adopted.

Sickened by this gruesome chore of death inflicted on them, many nurses in New York are quitting. New Yorkers now experiencing the harsh realities of abortion are already seeking reform. Even "liberal" Gov. Nelson Rockefellor has called for reform.

Undeterred by the sad experiences in other States, Nevada's abortionists - led by Assemblywoman Mary Frazzini - are pushing abortion legislation even more "liberal" than New York's. This ill-conceived legislation if adopted will condone abortion of infants at any time during the 9 month pre-natal life period. (now amended to viability)

At the other end of the spectrum, when and where man has imposed restraints on his animal appetites through worship of his Creator, enabling his development of reason and character, higher civilization came into being and with it a high regard for human life. Greek and Roman civilizations initially manifested this high regard for human life, but as time went on, decaying morality and hedonistic pleasure seeking seeped in, sapping the strength of individuals and families. They consequently sought escape from the responsibilities civilization demands. The value of life dissapated as these degenerates sought to destroy the lives of their own infants via abortion.

Battling for the Right to Life, Hippocrites wrote and promoted the surgeons oath which specifically forbade a surgeon from committing abortion and conversely committed them to the protection and preservation of life. Recently in America, members of the medical profession - specifically, the AMA has adopted a hypocritical oath that allows member surgeons to enjoy the lucrative rewards of baby murder.

Some Nevada physicians have testified in support of the abortion bill by feigning concern for the poor ... lamenting that only the rich can afford to travel to California and obtain an abortion. We suspect that even the poor can afford to travel next door to California. Perhaps it is the fat fees charged by the Dr. Abortionists in California that these Nevada physicians are really concerned about.

It may also be noted in passing that in States such as N.Y., the State is forcing the taxpayer, however repulsive to his individual concience or religious scruples, to pay for "charity" abortions as not many of the "humanitarian" doctors have donated their services to the poor.

In an affront to human decency and natural law many of our State Legislatures are legalizing abortion and following the road to destruction so clearly mapped out by ancient Rome. The Roman State, yielding to the demands of its degenerate constituents, condoned abortion with disasterous consequences ... the more rapid erosion of its very foundation - a moral responsible citizenry. Life once again became cheap as civilization declined and Rome fell.

Our magnificent founding fathers recognized the lessons of history and solemly declared ... We hold these truths to be self evident, that man is endowed by his Creator with certain inalienable Rights ... among which and first and foremost was the Right to Life. Government was instituted to protect that Right.

With the highest regard for life, the American system recognized that man received his Rights from his Creator, not as a dispensation of government - hence what the government did not give ... it cannot legally or morally take away. To assume or act otherwise (except as a penalty for such crimes as murder, rape & etc.) constitutes a threat and attack on the whole system of American Justice. Americans have thus traditionally manifested a high regard for life. Abortion was properly considered a crime. (In fact, at the Nuremburg trials the crime of abortion was judged among the most heinous crimes committed against humanity by the National Socialists.)

It is a scientific biological fact that every human life begins at conception. Remove conception from your personal life history or mine and we would not be. Life in the womb is real life, it is human life and the fetus is not merely a potential human being but is indeed a human being with potential. With callous disregard for the innocent, the abortionists would shrug this fact off - decreeing and demanding license to destroy and deny life at their whim and at various arbitrary times. Should the all important question of life and death be determined on vague assertions, presumptions and notions? Where is the scientific evidence, the logic and reason, the morality, and the historical precedent to justify the abortionists conclusion? Sen. Monroe - I ask Have they proved anything - No
The burden of proof belongs to the abortionist. If life in the womb is not to be regarded as life ... then Abortionist, at what precise point is it not to be so regarded? Remember, Abortionist, we want facts and proof and we presume that our legislators do also. Laws framed from emotional pleas, mass hysteria, and popular fashion are not worthy of our heritage nor conducive to good government. To ask removal of the protection of the unborn's Right to Life is to all the abortionists do - is demand + claim.

ask government to abdicate a basic reason for its existence. Abortion is not a sectarian issue - it is a human issue. A society which legalizes the killing of unborn children is not only violating God's law and nature's, but is opening the Pandora's box to additional hideous abuses of life. Already a bill has been introduced in the Florida State Legislature which would legalize the killing of old people (euthanasia), and a bill in the Hawaii State Legislature would compel the sterilization of all women after the second child.

What of the Rights of Parents? The rights of parents are to be exercised prior to conception. Responsible individuals can if so desired prevent conception and will accept responsibility for their actions. Sex is not used with license without consequence. Civilization demands responsibility. Parents may give life; however, the Right to Life is endowed according to the Declaration of Ind. on every individual by his Creator. Once a child is conceived it is a separate individual even though dependent upon its mother for sustenance. However, that mother has no more right to kill that life than she does to kill the child after it is born and equally as dependent. The state is duty bound to protect that individual's life. The wise framers of our laws that built our nation and nurtured our liberty understood these facts when they designed our abortion laws that recognized the exigencies of life and yet protected the natural rights of both mother and child. Those laws should not be prostituted.

ATTACHMENT 6

2-

Right To Life Committee • 43 N. Sierra • Reno, Nevada 89501

The undersigned do hereby recommend that the attached report on induced abortion be presented to the 1971 Nevada Senate.

John W Brophy M.D.
Gerald E. Flann MD
Noale Broncuoff, M.D.
Walter F. Quinn, M.D.
Ralph J Coppola MD

PLEASE NOTE:

THIS ATTACHMENT, ENTITLED INDUCED ABORTION: A DOCUMENTED REPORT, WHICH MR. BILL O'MARA PRESENTED TO THE COMMITTEE, WAS ONLY INCLUDED IN THE ORIGINAL SET OF MINUTES ON FILE IN THE LEGISLATIVE COUNSEL BUREAU LIBRARY SINCE IT IS SUCH A LENGHTY REPORT.

INDUCED ABORTION:

A DOCUMENTED REPORT

WRITTEN FOR
PRESENTATION TO THE
MINNESOTA STATE LEGISLATURE

January, 1971

by

Thomas W. Hilgers, M.D.

and

Robert P. N. Shearin, M.D.

About The Authors

Dr. Thomas W. Hilgers is a resident in Obstetrics and Gynecology at the Mayo Clinic in Rochester, Minnesota.

Dr. Robert P. N. Shearin is a resident in General Surgery at the Mayo Clinic.

NOTE: The authors of this paper have not intended that it represent the official policy of the Mayo Clinic. In fact, it represents their own personal work as physicians and concerned citizens.

Acknowledgements

The authors would like to thank Mrs. Doris Amundsen, L.P.N., Miss Gayle Riordan, R.N., Mrs. Jerry Hennessey and Mrs. Marge Beauseigneur for their help in the preparation of the manuscript. We would also like to thank Miss Riordan for her help in the researching of the alternatives to abortion. Finally, we would like to thank Fred E. Mecklenburg, M.D., for his aid in the preparation of the final manuscript.

Contents

Preface i

Introduction iii

Chapter One EMBRYOLOGY: THE BEHAVIOR OF THE UNBORN CHILD..... 1

Chapter Two PRESENT STATUS OF LEGAL ABORTION..... 4
- Eastern Europe
- Western Europe
- Asia
- United States

Chapter Three INDICATIONS FOR INDUCED ABORTION..... 13
- Medical
- Potential Deformity of the Unborn Child
- Psychiatric

Chapter Four TECHNIQUES OF INDUCED ABORTION..... 18
- Medical Techniques
- Surgical Techniques

Chapter Five MEDICAL COMPLICATIONS OF INDUCED ABORTION..... 23
- Mortality Rates
- Infection
- Hemorrhage
- Uterine Perforation
- Menstrual Disturbances
- Subsequent Pathologic Pregnancy
- Transplacental Hemorrhage
- Sterility
- Miscellaneous
- Psychiatric Sequelae

Chapter Six CRIMINAL ABORTION..... 32

Chapter Seven HOSPITAL AND STAFF PROBLEMS..... 34

Chapter Eight ALTERNATIVES TO ABORTION..... 36
- Counseling
- Education
- Public Health
- Unwanted Children
- Unwed Mothers
- Anti-poverty Programs

Chapter Nine GLOSSARY OF MEDICAL TERMS..... 43

Bibliography 45

Preface

The authors of this paper, after extensively researching the subject of abortion, have become deeply concerned over what appears to be a growing trend in our country and our state toward abortion as a solution to problems which can best be handled in other ways. It has become clear to us that the abortion concept presents itself, first, as an inherently dehumanizing process which undermines the basic value of human life, and, second, as a symptom of deep underlying social problems to which abortion is a simplistic and, at best, temporary solution. What has been most puzzling, however, has been the willingness of the community and its leaders to accept without challenge the unreflective and subtly persuasive arguments of the pro-abortionists.

When human life exists, no matter what stage of its development, society must, for its own protection, recognize the right to that existence as a paramount right. Pearl S. Buck once wrote that the power of choice over life or death cannot be trusted at human hands, for "human wisdom and human integrity are not great enough" (35). The power of which she speaks is seen in this country, not only in the abortion movement, but also, now, in Sackett's "Death With Dignity" bill which has been presented to the Florida State Legislature so that "life shall not be prolonged beyond the point of meaningful existence" (96). This growing disrespect for human life which we are now witnessing is similar to what was observed only thirty years ago. George Santayana's words in the preface to The Rise and Fall of the Third Reich now become truly significant, "Those who do not remember the past are condemned to relive it"(148).

Choosing abortion as a solution to social problems would seem to indicate that certain individuals and groups of individuals are attempting to maximize their own comforts by enforcing their own prejudices. As a result, pregnant schoolgirls continue to be ostracized, mothers of handicapped children are left to fend for themselves, and the poor are neglected in their struggle to attain equal conditions of life. And the only solution offered these people is abortion. It becomes very disturbing when we think that this destructive medical technique may replace love as the shaper of our families and our society.

We must move toward creating a society in which material pursuits are not the ends of our lives; where no child is hungry or neglected; where even defective children are valued because they call forth our power to love and serve without reward. Instead of destroying life, we should destroy the conditions which make life intolerable. Then every child, regardless of his capacities or the circumstances of his birth, could be welcomed, loved and cared for.

Introduction

Over the last several years, the people in the United States and the State of Minnesota have been witness to an insistent campaign which equates liberalism with the taking of defenseless human life, and which would give one's social and economic convenience precedence over another human's right to exist. The termination of human life is now accepted by some, thought even desirable by others, simply because that life may be unwanted, economically burdensome, prospectively retarded or handicapped.

Some of the leaders of this campaign, including, unfortunately, certain members of the medical profession, have recognized the enormous power of the press and have been occasionally successful in utilizing the media to overcome common-sense opposition to newer, more lethal, abortion legislation (41).

More often than not, partisan opinion has been authoritatively presented as "medical fact." For example, in reports on the incidence of illegal abortion in the U.S., the phrase "one million or more each year" recurs with almost convincing regularity. In fact, it is an extrapolation from data derived from a study of 10,000 women attending the Margaret Sanger Birth Control Clinic in New York during the late 1920's (35). Even if no other study of this nature existed, the reader of average intelligence could reasonable question any comparison between this special group of urban women (45.1% of whom were foreign born) (60), living in an era of relatively primitive contraception, and the whole of American womanhood forty years later. Indeed, there have been other studies. One of these, again based on data from New York City, arrived at a figure of 160,000 illegal abortions in the U. S. (35). The First

International Conference on Abortion, held in Washington, D.C., in 1967, concluded that the figures on the number of criminal abortions in the United States are "based on personal estimates" and that, "No way has yet been found of obtaining reliable statistics that would give an exact figure for the total population" (35). Even Planned Parenthood, during their conference on Abortion in the United States held in 1958, stated in their report of their statistics committee that "a plausible estimate of the frequency of induced abortion in the United States could be as low as 200,000 and as high as 1.2 million... there is no objective basis for the selection of a particular figure between these two estimates..." (24').

The proponents of abortion frequently state that there are 5,000-10,000 maternal deaths resulting from illegal abortion yearly in the United States. However, this data originated in the work of Kopp (1934) (83) and Taussig (1936) (162), in which a highly unrepresentative group of patients were collected, between 1925-1929, from a New York City birth control clinic and eighty-one physicians with country practices (60, 138). This, incidentally, was in the pre-antibiotic era. Again, the Washington D.C. Conference, using data from Vital Statistics of the United States, Vol. 2, Part B, put this into clear perspective when they said, "Statistical inadequacies emphasize the extreme care with which all available figures should be used... a total of 500 abortion deaths per year would be a reasonable figure--based on current data" (35).

Let us not mistakenly assume that any number of illegal abortions or deaths resulting from illegal abortion is at any time acceptable. It is not. However, the public will not be served by arbitrarily inflating their frequencies in an attempt to sway public opinion on this literally vital issue.

Dr. Robert E. Hall, Obstetrician-Gynecologist at Columbia University and a leader in the pro-abortion movement, commented in Abortion and the Law (pp. 232-233), that in Denmark, "the fate of the turned down applicants (for abortion) is noteworthy--only sixteen percent were illegally aborted." And yet, on the very next page (p. 234), he paradoxically concludes: "One immutable truth emerges through this confusing maze: if an individual pregnant woman is determined to get an abortion, she will do so whether it is lawful or not" (56).

These inconsistencies, along with others, so often masqueraded as "scientific thought" or "good modern medical practice", have prompted us to extensively review much of the world's medical literature on abortion in the preparation of this paper.

Specifically written for presentation to the Minnesota State Legislature, it is hoped that the extensive documentation here appended will invite independent assessment of the published body of knowledge on this all-important issue. It is, we found, truly a matter of life and death.

We feel it imperative here to point out a terrible analogy. American law has long cherished and protected the principle that even the most despicable felon cannot be deprived of his life or freedom until he is found guilty "beyond a reasonable doubt." How so then, can Americans acquiesce to the destruction of the unborn child when there is so much more than reasonable doubt as to his humanity and his innocence?

Embryology: The Behavior of the Unborn Child

There is no scientific evidence which would indicate that human life begins at any other point than the moment of conception (94). Noted fetologist, H.M.I. Liley, in her book Modern Motherhood, stated, "From the moment a baby is conceived, it bears the indelible stamp of a separate, distinct personality, an individual different from all other individuals" (89). It is noteworthy that the Abortion Subcommittee of the House Judiciary Committee of the Minnesota House of Representatives studying abortion during the interim between sessions in 1968, accepted the proposition that "any abortion involves the taking of a human life" (174).

The purpose of this section will be to present certain documented scientific information regarding the functional and behavioral aspects of early human life.

The genetic pattern set down at the moment of conception instructs the development of a specific function and anatomy. Truly unique in its existence, it is structurally and functionally totally different from its mother, and dependent only on her gifts of nutrition and time.

Growth and development is rapid and dynamic in the first month of life, with the central nervous system (the brain) seeing its most important growth spurt, and the rhythymic contractions of the heart beginning (85).

The primitive skeletal system has completely developed by the end of the sixth week (8, 128), and the electroencephalogram has detected brain waves as early as forty-three days (157). During the sixth and seventh weeks, the nerves and muscles begin working together for the first time (8), and the lips become sensitive to touch (the first area of the body to do so), and when gently stroked, the child responds predictably (47, 65, 66, 67).

By the seventh week of life, the child's shape and form is unmistakably human. He now has all the internal organs of the adult (47, 128); the stomach produces digestive juices, the liver manufactures red blood cells, and the kidney is eliminating uric acid from the blood (47, 53). His arms are still very short, but hands with fingers and thumbs are recognizable, and the legs have knees, ankles and toes (47, 128). From this point in development, until age 25-27 years, when full growth and development is complete, the only major changes will be in the size and sophistication of the functioning parts (8, 135).

The lines in the hands begin to develop at 8 weeks, and will remain a distinctive feature of the individual (53, 107). The eyelids and palms of the hands become sensitive to touch at about 8 1/2 weeks. At this point, if the eyelids are touched, the child squints; if the palm is touched, the fingers close into a small fist (47, 65, 66, 67).

The sex hormones--estrogen and androgens--have been identified as early as 9 weeks (2). At 10 weeks, Somatotropic hormone (growth hormone) is detectable (2), and at 10 1/2 weeks, the thyroid and adrenal glands have begun to function (2, 147). Also at 10 weeks, it has been possible to record the electrocardiogram (40), and new ultrasonic techniques are used routinely by the obstetrician to detect the child's heart beat (13).

By the end of the third month, the unborn child has become very active. He can now kick his legs, turn his feet, curl and fan his toes, make a fist, move his thumb, bend his wrist, turn his head, squint, frown, open his mouth, and press his lips tightly together (67). He can swallow and drink the amniotic fluid that surrounds him. Inhaling and exhaling respiratory movements begin to move fluid in and out of his lungs. And thumb sucking is first noted at this age (47, 67). He has vocal cords, but cannot cry because he is not strong enough.

The fingernails appear and he starts to urinate (8, 47, 128). By this time, every child shows a distinct individuality in his behavior and the words of noted behavioral psychologist Dr. Arnold Gesell, become significant:

> By the end of the first trimester (twelfth week), the fetus is a sentient moving being. We need not pause to speculate as to the nature of his psychic attributes but we may assume that the organization of psycho-somatic self is now well underway (53, p. 65).

The child grows very rapidly during the fourth month of life. His weight increases six times and he grows 8-10 inches in length (61).

In the fifth month (16-20 weeks), the unborn child will become one foot tall, and weigh approximately one pound. Hair begins to grow on his head and eyebrows, and a fringe of eyelashes appear. The child sleeps and wakes just as he will after birth (132) and he may even be aroused from sleep by external vibrations (47). The skeleton hardens and the muscles become stronger. Finally, his mother perceives his many activities (81).

Dr. Gesell notes that:

> Our own repeated observation of fetal infants (an individual born and living at any time prior to 40 weeks gestation) left us with no doubt that psychologically they were individuals. Just as no two looked alike, so no two behaved alike. One was impassive when another was alert. Even among the youngest, there were discernable differences in vividness, reactivity and responsiveness. These were genuinely individual differences, already prophetic of the diversity which distinguishes the human family (53, p. 172).

The study of the unborn child (fetology) is a relatively new science and yet in its short existence it has put into perspective what the obstetrician has known for years, i.e. when working with the pregnant woman, there are two patients to be considered. Recent research supports the notion that the child in its mother is a distinct individual in need of the most diligent study and care. Both patients, mother and child, require and challenge the fullest expertise of the medical art.

Present Status of Legal Abortion

In two-thirds of the world abortion is prohibited except in cases where the woman's life is in jeopardy (164). The remaining one third, including the Soviet Union, most of Eastern Europe, Scandinavia, Great Britain, Japan, China, and a small portion of the United States permit abortion under certain other circumstances (164).

The permissive laws range from New York's abortion on demand under twenty-four weeks and the Soviet Union's abortion on demand under twelve weeks, to Scandinavia's strictly controlled abortions for broadly defined indications (155, 163, 164).

A review of some aspects of representative permissive abortion laws is here presented in an attempt to understand this phenomenon which killed over 1,546,000 human beings in 1964 in but 6 of these countries (Bulgaria, Hungary, Czechoslovakia, Yugoslavia, Poland, and Japan) (91, 102).

Eastern Europe

In 1920, the Soviet Union instituted abortion on demand but in 1936, restricted the operation to strictly medical and eugenic grounds (137). With this exception and that of Poland, where abortion was permitted in the case of rape, abortion was illegal in eastern Europe during the pre-World War II period (137). The post war period saw, in much of this area, a breakdown of law and order with consequent increases estimated in the incidence of rape and illegal abortion, essentially no effort being directed to contraception (102, 107). In 1947, East Germany relaxed its abortion law, permitting it for medical,

ethical, eugenic and sociomedical indications (19). This, however, led to an increase in both legal and illegal abortions and the law became restrictive again in 1950, with some relaxation occurring in 1965 (19). From 1951 the communist-bloc countries of Eastern Europe began to relax, and in some instances subsequently restrict, their laws regarding abortion (140).

Rather than enumerate the present laws of the Soviet Union, Poland, East Germany, Czechoslovakia, Hungary, Rumania, Bulgaria, and Yugoslavia regarding abortion, let us note certain similarities and dissimilarities.

All of the countries listed essentially restrict abortion to the first trimester, i.e., the first twelve weeks of pregnancy, exceptions being made only when there is grave danger to the woman's life or if serious eugenic reasons prevail (137). The fact should be kept in mind when attempting to compare abortion morbidity and mortality statistics from these communist countries with the statistics from countries without equal restrictions.

The least restrictive laws, i.e., abortion on demand, were found in the Soviet Union, Bulgaria, Hungary, and, until 1966, Rumania. In that year, Rumania, where a great number of abortions were being performed, restricted the operation to socio-medical indications because of "great prejudice to the birth rate" (as well as), "severe consequences to the health of the woman" (137, 163). In 1968, Bulgaria slightly restricted its abortion law, denying abortion to childless women except on medical grounds (164).

The other countries of Eastern Europe are generally similar in their allowance of abortion on widely interpreted socio-medical grounds (137). Most of these countries require contraceptive counseling as part of their abortion procedure (102).

It is interesting to note that in Yugoslavia the abortion commission must point out the dangers of abortion and the advantages of contraception. Also, "A health worker should regard abortion as biologically, medically, psychologically, and socially harmful. Corresponding to the principles of socialist humanism and medical knowledge, human life must be respected from its beginning" (137).

East German Professor K.H. Mehlan states the reasons for which the communist countries of Eastern Europe weakened their abortion laws as, first, no highly effective contraceptives were available at that time and second, a desire to wage an intensive compaign against illegal abortion. He goes on to say, however, that "Legalizing abortion does not mean a permanent solution to the problem; the People's Republics have noted this too. Criminal abortion will be combated in the future in the following ways:

1. Promotion of the desire to have children by a generous family policy.
2. Establishment of counseling centers for contraception to enable each woman to prevent an unwanted pregnancy; this is meant as a measure of health protection.
3. Promotion of sex education aiming at appropriate attitudes between sexes" (102).

Bucic and Knezevic, speaking of abortion as a means of birth control in Yugoslavia state: "In comparison to other methods of birth control, interruption of pregnancy represents the most grave and dangerous method because of its expansiveness and its consequences" (23).

Budvari, speaking in regard to legal abortion in Hungary and its value as a birth control measure and in Hungary's efforts against illegal abortion concludes "It appears to us that the best solution is not the 'liberalization' of abortion, but the use of contraceptives, particularly oral contraceptives.

This way appears to us to be more humane, more ethical, and more 'medical' than 'authorized abortion'" (24).

Western Europe

The abortion laws of non-communist Europe are generally of three types: those which restrict abortion except in life-saving circumstances, as in France, Austria, and Germany; those which permit abortion for certain more or less broad medico-social reasons, as well as eugenic reasons and instances of pregnancy following sexual offenses — these types of laws exist in Scandinavia (18, 19, 68, 140, 163). The third type of law is found in Great Britain which has gone beyond the Scandinavian models to permit abortion for a unique quasi-social reason, although it seems clear that the legislators did not wish to approve, literally, of abortion on demand (3, 95).

The British Abortion Act 1967 permits abortion on four grounds:

a. (if) the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated; or
b. that it would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated; or
c. that it would involve risk or injury to the physical or mental health of any existing children of the pregnant woman's family greater than if the pregnancy were terminated
d. that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped (95).

A provision for conscientious objection on the part of the physician is present in that "no person shall be under any legal duty to participate in any treatment authorized by the Act to which he has a conscientious objection unless the treatment is necessary to save the life or prevent grave permanent injury to physical or mental health of a pregnant woman" (95).

Although fetal age is not specifically mentioned in the Act, it is commonly understood to restrict abortions to fetuses of less than twenty-eight weeks, as specified in the Infant Life Act of 1929.

It may be interesting to mention a few opinions of the British Medical Defence Union on the interpretations of the Act's provisions likely to protect the physician from civil or criminal proceedings. If, for example, a physician who conscientiously objects to abortion is confronted by a pregnant woman he should (to be "safe") ask himself the question: "Might this be a case where abortion could be lawful and in which my opinion to the contrary could be challenged on the ground that my good faith was impaired by my conscientious objection?" (95). If the answer is in the affirmative, the gynecologist must refer the woman to a colleague "untroubled by conscientious objection" (95).

Again in the opinion of the Medical Defence Union, while the consent of the woman is always required prior to abortion, that of her husband, while it should be sought, is not essential even if he strongly objects to the abortion. Also, in the case of a girl between the ages of 16 and 21, the physician may, only with the girl's permission, seek the consent of her parents for the abortion but such consent is not essential. If the girl is under age 16, the physician should in all cases inform her parents and ask their consent for the operation but, again, such consent is not deemed essential. In the last case the Union admits the possibility of the parents suing the abortionist for assault upon their daughter but feels that "it is very improbable that such a claim would be upheld" (3).

More than one year after the British law was enacted, the Royal College of Obstetricians and Gynecologists reported on a questionaire of members

concerned with its functioning. In the same issue of the British Medical Journal an editorial concerning the report pointed out that a third of the abortions were being carried out by a tenth of the consultants. It also noted that "it appears from the report, consultants are agreeing to terminate every pregnancy on request without serious question, not because they believe in that course, but because the brevity of their decision allows proper time for the treatment of other patients and the teaching of staff and students. If abortion on demand was made legal that would not make it ethical" (34).

The editorial continues: "It is fashionable nowadays to speakof a 'failure in communication' if people do something that seems against all reason and their own interests when a better course is known. But the fact is that many people are unreasonable and lack any sort of foresight. They may well be the most likely to neglect contraception measures and to think abortion will brighten their day as harmlessly as a shampoo" (34).

Asia

Of the three most populous nations of Asia--China, Japan and India--the former two appear to have de facto abortion on demand. India permits abortion only when there is risk to the life of the woman (31). While little has been published concerning the Chinese statute on abortion, their practice is fairly well known (176). The Japanese Eugenic Protection Law of 1948, as amended in 1949, is on the other hand, quite well known and similar to Scandinavian abortion laws in that it permits abortion when the woman's "health may be affected seriously by continuation of pregnancy or by delivery from the physical or economic viewpoint" (160).

Manabe has commented that the unsettled social conditions which were a

feature of the postwar period in Japan, coupled with the infrequent use of the relatively crude contraceptives then available were both factors, along with the high incidence of pulmonary tuberculosis as a complication of pregnancy, in the enactment of the Japanese abortion law (91). It is conceded by several authors that broad interpretation of the "economic hazard" clause witholds abortion in Japan from essentially no one (91, 160, 164). Indeed, the total number of abortions in Japan each year is estimated to be at least double the reported number of 700,000 to 900,000 due to tax cheating by the approximately 12,500 specially trained MD-abortionists (59).

United States

Prior to 1967, essentially all of the fifty states prohibited induced abortion except where the mother's life was in jeopardy (52). The American Law Institute, in 1959, recommended in its Model Penal Code that abortion be legally justified by any of three grounds: (1) when continuance of the pregnancy would gravely impair the physical and mental health of the mother--(2) when the child would be born with a grave physical or mental defect--(3) when the pregnancy resulted from rape, incest, or felonious intercourse, including illicit intercourse with a girl under the age of sixteen (52). They recommended that abortion on these grounds be performed only by a licensed physician and only after consultation with at least one colleague (144). In the years prior to 1967 these recommendations were considered and rejected by the legislatures of Illinois, Minnesota, New York and New Hampshire (52).

Colorado, on April 25, 1967, enacted an abortion law modeled after the A.L.I. proposal, but only after considerable "molding of public opinion" in that state by its proponents (41). Since Colorado's relaxation, twelve states have

adopted similar laws, and 4, Hawaii, Alaska, Washington and New York have adopted new laws which allow abortion on demand (88).

Because these latter state laws are more permissive than any abortion laws in the world, they will, as represented by the New York law, be presented here:

> The people of the State of New York represented in Senate and Assembly, do enact as follows:
>
> Section 1. Subdivision three of section 125.05 of the penal law is hereby amended as follows.
>
> 3. "Justifiable abortional act." An abortional act is justifiable when committed upon a female with her consent by a duly licensed physician acting (a) under a reasonable belief that such is necessary to preserve her life, or, (b) within twenty-four weeks from the commencement of her pregnancy. A pregnant female's commission of an abortion act upon herself is justifiable when she acts upon advice of a duly licensed physician (1) that such act is necessary to preserve her life, or, (2) within twenty-four weeks from the commencement of her pregnancy. The submission by a female to an abortional act is justifiable when she believes that it is being committed by a duly licensed physician acting under the reasonable belief that such act is necessary to preserve her life, or, within twenty-four weeks from the commencement of her pregnancy.
>
> 2. This act shall take effect July first, nineteen hundred seventy (155).

Distinctive features of this law include: (1) attempts at self abortion " upon the advice of a duly licensed physician" are permitted--(2) demand of the pregnant woman is a sufficient ground for abortion up to twenty-four weeks pregnancy--(3) there are no provisions regarding the age of consent, place of abortion, common basis for determining gestational age of the fetus, or any other legal problems likely to spring from its implementation, including the liability of the physician or hospital that conscientiously objects to the performance of abortion.

The Medical Society of the State of New York opposed enactment of this bill (79). Subsequent to its enactment, the MSSNY felt it necessary to discuss certain points in its "Abortion Guidelines" (paraphrased--except where quoted):

A. The term abortion applies only to the end of the 20th week of gestation (four weeks earlier than the legal deadline).

B. After 20 weeks, emptying the uterus "constitutes an actual birth process."

C. The phrase "within twenty-four weeks from commencement of her pregnancy" would be confusing because the "exact date when pregnancy begins cannot be determined accurately."

D. "Where the infant is born alive, a birth certificate is required. The subsequent death of such an infant necessitates the filing of the usual death certificate" (emphasis ours).

E. "Because the chances of fetal survival increase each week, abortive acts should not be initiated after the 20th week gestation."

F. "THE MEDICAL SOCIETY OF THE STATE OF NEW YORK WOULD LIKE TO CAUTION ALL PHYSICIANS THAT AN ABORTION PERFORMED AFTER THE TWELTH WEEK OF GESTATION IS FRAUGHT WITH TREMENDOUS DANGER." (Emphasis is theirs). (79).

As is well known to Minnesota legislatures, M.S.A. 617.18, extends legal protection to the unborn child in all cases except those in which miscarriage "is necessary to preserve her (the woman's) life, or that of the child with which she is pregnant..." (112).

Indications For Induced Abortion

The "medical" indications for induced abortion are commonly classified under three headings: (A) medical, (B) potential deformity of the unborn child and (C) psychiatric. We will consider each of these in that order.

Medical

Medical science has made truly amazing advances over the last 30 years and as a result it is very rare for pregnancy to be so hazardous as to necessitate its termination. In fact, there are few medical conditions which, in the present state of medicine, comprise automatic indications for abortion (22, 38). Toxemia of pregnancy, diabetes, hypertension, pulmonary tuberculosis, acute rheumatic fever and congenital heart defects were all, in times gone by, considered good indications for abortion. Now, with our up-to-date knowledge, the risks are rarely so great that they require abortion (38). To indicate just how rare this really is, Dr. Denis Cavanaugh, the Chairman of the Department of Obstetrics and Gynecology at the St. Louis University School of Medicine and the Director of the Obstetric Service at St. Louis City Hospital, recently reported that between July 1, 1966 and July 1, 1968, there were 5,102 deliveries without a single maternal death (St. Louis City Hospital serves the underprivileged almost exclusively and would expect a high maternal mortality rate). During this two year period, only one abortion was considered necessary to save the life of the mother (25).

Let it be said that there are situations in which a pregnancy may have to be terminated because the mother's life is imperiled. When this situation arises, it poses one of the most difficult decisions in medicine and always represents an

unpleasant endeavor. When the death of one of your patients is the only alternative available, then the decision weighs heavily. Fortunately, this is now very infrequent.

Potential Deformity of The Unborn Child

There is fast developing a public hysteria which calls out for the destruction of the unborn child because he may be born with a physical, mental or motor handicap. This has come about primarily because of recent uninformed publicity given to Rubella (German Measles) as a cause of such deformities. We must acknowledge this hysteria and, in fact of it, look soberly at the problem.

Women in the child-bearing age will not all contract german measles if they come into contact with the disease. In fact, 80-90% of these women are immune and will never contract the disease (10). This large percentage of women have nothing to be concerned about. With appropriate use of the new Rubella vaccine (licensed for use in 1969 by the FDA), the remaining 10-20% will also be removed from the "at risk" category (25)--a point seldom mentioned by proponents of abortion.

The incidence of congenital deformities resulting from Rubella infection during pregnancy has been deliberately distorted in order to make a case for relaxing the abortion law. It is imperative then that we take a closer look at this.

Moloshok reviewed 15 prospective studies which were done to elucidate the true incidence of deformity resulting from maternal infection. He found that the overall incidence for the first trimester of pregnancy (first 12 weeks) was 16.9%; 23.4% in the first month, 21.3% in the second month and 10.4% in the third month. After three months, there was no increased incidence of deformities (113). Doctor Harvey of the State Department of Health in Indiana and Doctor Thompson of the Department of Obstetrics and Gynecology at the Indiana University School of Medicine gave evidence before a legislative committee to study the Indiana abortion

law. They pointed out that in the 1964 Rubella epidemic there were 280 cases of German measles in the first trimester of pregnancy. Of these, there were only 43 babies (15.4%) who had deformities (25).

Rendle-Short reported that of those children who are affected: (1) 50% have partial to complete hearing loss, but that most of them can be corrected or improved by a hearing aid; (2) just under 50% have some form of congenital heart defect--the most common of which is patent ductus arteriosus (P.D.A.). All of these defects are potentially curable by modern surgical techniques especially P.D.A.; (3) 30% have cataracts which are often unilateral and most affected children have fair vision; (4) mental retardation, while it is often severe when present, is only present in 1.5% (not much greater than the overall incidence of 1% within a given community) (139). Spontaneous abortions and stillbirths are increased and some severely affected children will die within the first months after birth. Rendle-Short states emphatically that "when presented with the true situation, most parents will not press for termination of pregnancy (139).

Amniocentesis has been presented as the SUPER-diagnostic tool in which to determine fetal deformity early. However, the risks of provoking early labor or stabbing the child's body with the needle are not mentioned. Indeed, it is not 100% effective. Normal children have been aborted on the basis of test results (80, 111) and normal babies have been born after the parents were told they should have an abortion because amniocentesis revealed the child to be deformed (55).

In any case, to adopt this policy would mark a drastic departure from responsible medical and social ethics. No longer would the medical profession be oriented towards the individual and his problem (in this case, the unborn child). In NO WAY can abortion be called therapeutic for the unborn child, for there is no tomorrow for the aborted baby. While it is comforting to feel that

abortion is being performed for the sake of the unborn child, honesty requires us to recognize that we perform it for adults.

Psychiatric Indications

In Colorado, 71.5% of all abortions are being done for psychiatric reasons (42). The similar figures for California and Oregon are 90% and 97% respectfully (9, 124). One would get the impression that mental illness in the pregnant woman is extrely common and very serious when present. However, in fact, in all of these states, the "mental health" clause has distinctly been abused. This abuse, Doctor Cavanaugh says, has led to a decline in the quality of patient care and a gross dishonesty in medical practice--particularly psychiatry (25). We must, therefore, look carefully at the psychiatric problems associated with pregnancy.

Noyes and Kolbe's textbook of psychiatry states that "experience does not show that pregnancy and the birth of the child influence adversely the course of schizophrenia, manic depressive illness or the majority of psychoneuroses" (120). On the other hand, those psychoses which are initiated by pregnancy rarely persist. Patients tend to recover after a comparatively short period of time and in some cases may recover spontaneously before full term is reached. Women who show permanent impairment of mentality following childbirth belong to the class of potentially psychotic for whom pregnancy is merely an ancillary factor in the pathogenesis of the psychosis (5). In such women, an induced abortion cannot be curative and it may have unresolved conflicts with guilt and added depression which is more harmful than the continuation of the pregnancy (7, 12, 48, 57, 69)--(see section on complications--psychiatric sequelae).

There is evidence to suggest that serious mental disorders arise following abortion more often in women with real psychiatric problems and that paradoxically, the very women for whom legal abortion may seem justifiable are also the ones

for whom the risk is highest for post-abortion psychic insufficiency (44, 69).

It should be pointed out that suicide in the pregnant woman is extremely rare. In fact, it is about 1/6th the rate seen in nonpregnant women of the same age (141). Furthermore, as Asche pointed out, it is virtually impossible to ascertain accurately whether a woman is suicidal (43). In the State of Minnesota, the Minnesota Maternal Mortality Committee, reported only 14 suicides associated with pregnancy in well over 1.5 million live births between 1950-1966 (11). (The Minnesota Maternal Mortality Committee studies in detail all deaths in women which occur during pregnancy or within a period 90 days following delivery). Ten of these 14 had delivered before the suicide, and all 14 were married (11). In retrospect, these deaths probably could have been prevented if adequate psychiatric care had been obtained and utilized (15). The explanation of why so few pregnant women commit suicide appears to be that women--including the unwed--receive a good deal more attention from society when pregnant than when not pregnant. Also, there may be certain physiologic and instinctive factors which manifest themselves in greater maternal protectiveness (15, 141).

Eminent psychiatrists from throughout the world agree that, if all the evidence is taken into careful consideration, few neurotic or psychotic women are ever benefited by termination of pregnancy and that the few that would be are extremely difficult to select (5, 7, 12, 15, 37, 39, 48, 57, 58, 69, 72, 74).

When abortion is substituted for adequate psychiatric care (and there is much evidence to suggest that this is happening--9, 42, 124), then there is a distinct danger of minimizing established psychotherapeutic principles (58). Unfortunately, it is the distressed woman who ultimately faces the full impact of this minimization. She is the one who cries out for help and she is also the one who is turned away.

Techniques of Induced Abortion

Potts has reported on the many ways of producing an abortion in a pregnant woman, many of them of only theoretical utility (136). He has described certain medical methods, including agents that destroy the fetus or placenta such as x-rays, antimitotics and antimetabolites, together with agents that interfere with the maternal reaction to pregnancy such as monoamine oxidase inhibitors, non-steroidal estrogens, and immunological methods (136). Recent reports by Karim and Roth-Brandel and others reveal their use of a new abortifacient agent, prostaglandin, which when administered by continuous intravenous drip usually induces premature labor and results in abortion. Its side effects are presently being studied (76, 77).

Surgical techniques of abortion are of three general types: (1) scraping out or sucking out the fetus and its membranes from the uterus through the cervix and vagina after the cervix has been dilated with an instrument; (2) stimulation of premature labor and delivery, with or without ensuring the death of the fetus before delivery; and (3) hysterotomy, or direct surgical incision into the uterus with removal of the fetus, membranes and placenta (136).

Presently available tests for pregnancy are usually unreliable until at least two weeks after a missed menstrual period, meaning that the human embryo is at least four weeks old when its existence is first discernible. One factor which frequently tends to delay the diagnosis of pregnancy is the slight vaginal bleeding often seen in early pregnancy and which the pregnant woman may mistake for a menstrual period. Another such delaying factor is the more or less constitutional menstrual irregularity which may lead a woman to accept the absence of menstrual period for a month or more.

During the first twelve weeks of pregnancy, corresponding in practice, therefore, to an embryonic-fetal age of four to twelve weeks, abortionists rely upon dilatation of the cervix and sharp curettage alone or suction curettage, which is usually followed by sharp curettage to ensure that no remnants of the fetus are left behind (130). In this procedure the woman is placed on her back on the operating table, her knees apart and hips and knees bent. She may be given general anesthesia, local anesthesia--by injections alongside the cervix (usually the only pain-sensitive structure involved) or no anesthesia, depending on the size of the uterus and cervix, the ease with which it dilates, the age of the fetus (and therefore its size), and the preference of the operating doctor (4, 78, 176).

The vagina is then cleansed with an antiseptic solution. A toothed instrument is clamped onto the cervix which is pulled toward the operator. The canal through the cervix is found with a long thin instrument called a sound, and then widened, usually by passing a series of progressively larger probes or dilators through it until it can admit the sharp curved curette or the tubular suction curette. Curettes for abortion range in size from 3.5 mm to 15 mm or about 1/8 inch to 5/8 inch, the larger sizes being necessary to tear through and scrape or suck out the tissues of the fetus, placenta, and membranes in the later stages of this first twelve week period of gestation (78). During the period from the fourth through the twelfth week of pregnancy the fetus has grown from 1/5 inch to 3 1/2 inches, has differentiated its organ systems, has arms and legs, has fingers and toes each provided with nails. Centers for bony development have appeared and begun to deposit bone in the skeleton which has been cartilage up to now (43). It may be of interest to the reader to read from the respected Williams Obstetrics, thirteenth edition, 1966, page 192: "A fetus born at this may make spontaneous movements if still within the amniotic sac or if immersed in warm saline." (43).

If sharp curettage has been done, the pieces of the fetus with its membranes are placed on a sponge or in a pan and sent to the pathologist for identification. In suction curette equipment there is usually a glass jar placed in line with the suction apparatus so that fetal parts will be trapped and not interfere with the machinery (78). In this case the glass bottle is simply unscrewed and sent to the pathologist.

Stimulation of premature delivery, by a variety of means, is the method of choice by those who abort women pregnant for more than twelve weeks (129). Dilatation and curettage is not used after about twelve weeks' gestation because it becomes prohibitively dangerous due to the larger size of the fetus and uterus, each now with larger blood vessels. The uterine wall is becoming progressively softer and thinner, the more likely to be perforated by a hard instrument. The fetal skeleton is becoming harder and the fetus more difficult to remove.

Stimulation of effective uterine contractions, essentially the stimulation of premature labor, may be accomplished by injecting a variety of substances into the uterine cavity, either inside of or outside of the fetal membranes themselves. Most commonly used are concentrated salt (abandoned by the Japanese as unsafe after 1950), sugar, and formaldehyde solutions (4, 136), irritant soaps, pastes (173), and rivanol (a mild antiseptic widely used in Japan) (91).

Schiffer (146) has reported on the technic used in 28 abortions ranging from 14 to 24 weeks' gestation. The woman's abdomen was washed and prepared with antiseptic. Then, under local anesthesia a long needle was inserted through the abdominal wall, through the uterine wall and into the amniotic sac surrounding the fetus. As much of the fluid in this sac as possible was withdrawn through the needle, and, when possible, an equal amount of sterile salt solution was then injected and the needle withdrawn (146). Labor pains began,

on the average, 27.5 hours after injection and the fetus was delivered an average of 11 hours later (146). Some of Schiffer's patients received intravenous oxytocin, a drug used to strengthen uterine contractions, during the abortion (146). It is noteworthy that the reason that these substances stimulate labor is not yet known (91, 146).

During the period from twelve to twenty-four weeks' gestation the fetus grows to be about 13 inches long, weighing 1 1/4 pounds, with hair on its head, wrinkles in its skin and obvious sex organs. Survival of this 24-week size baby, though rare, has been reported (43).

The Japanese often use a mechanical means to stimulate the pregnant uterus to start labor in performing mid-trimester abortions. Manabe reported on the use of the metreurynter--a balloon on the end of a flexible tube which is placed through the cervix between the uterine wall and the fetal membranes (91). The balloon is then filled with 3 to 10 ounces of sterile saline, causing it to become lodged in the uterus. The flexible tube is then hooked up to a pulley system between the woman's legs and a weight of 1 to 2 pounds is attached, exerting downward traction on the cervix. The Japanese feel that this force both dilates the cervix and stimulates the uterus to contract in an effort to expel the balloon and with it the unborn child (91). The average time from metreurynter inflation to delivery of the fetus--usually alive--varies widely but one report gives this figure to be about 26 hours (91).

Manabe states that "the ultimate aim in abortion is always the most physiologic delivery of the fetus, to ensure the safety of the mother" (91). He has found that the metreurynter method or the intrauterine instillation of 0.1% rivanol offer many advantages over other methods for mid-trimester abortions because "they result in a far more physiologic labor, evidenced by the fact that the fetus is normally delivered alive" (91). He points out that "most

fetuses, however, die shortly after delivery if fetal age is less than the middle of the seventh month. Survival of the fetus even several hours after delivery would pose serious moral and ethical dilemmas" (91).

The least frequently used means of producing an abortion is the hysterotomy, which entails incision into the uterus and removal of the fetus. This method is used in pregnancies generally over 14 weeks. It is a major surgical procedure usually done through an abdominal incision. Up to about 16 weeks of pregnancy, it may be done through the vagina. After 16 weeks it is thought to be unsafe vaginally (136).

Medical Complications of Induced Abortion

The American College of Obstetricians--Gynecologists has stated: "The inherent risks of a therapetuic abortion are serious and may be life-threatening, this fact should be fully appreciated by both the medical profession and the public. In nations where abortion may be obtained on demand, a considerable morbidity and mortality has been reported" (46).

This is supported by a statement issued by the Royal College of Obstetrician-Gynecologists (Great Britain): "Those without specialists' knowledge, and these include members of the medical profession, are influenced in adopting what they regard as a humanitarian attitude to the induction of abortion by a failure to appreciate what is involved. They tend to regard induction of abortion as a trivial operation, free from risk. In fact, even to the expert working in the best conditions, the removal of an early pregnancy after dilating the cervix can be difficult, and is not infrequently accompanied by serious complications. This is particularly true in the case of the woman pregnant for the first time. For women who have a serious medical indication for termination of pregnancy, induction of abortion is extremely hazardous and its risks need to be weighed carefully against those involved in leaving the pregnancy undisturbed. Even for the relatively healthy woman, however, the dangers are considerable." (46).

Mortality Rates

Obviously, the worst complication resulting from a legal abortion is death itself. In Table I you will see listed the legal abortion mortality rates for several countries which have eliminated the legal safeguards to abortion. Included also are the 10 maternal deaths which New York City had during the first 3 months following enactment of their law.

In the majority of countries, including New York State, a woman is more likely to die from legal abortion than she is if she were to carry the pregnancy to term (this is in contradiction to what proponents of abortion would have us believe). It must be emphasized that these figures are for legal abortion, done by licensed physicians in fully accredited medical facilities. The tragedy is that these deaths are preventable simply by having a strong abortion law. In Minnesota, this tragedy is compounded by the fact that there is probably no safer place in the world for a woman to have her baby (134).

TABLE I

LEGAL ABORTION MORTALITY RATES

Country/State	Deaths/100,000 legal abortions	Reference
Finland	66	122
Denmark	41.4	136
New York City	greater than 40	150
Sweden	39.2	136
Great Britain	30	1
Yugoslavia	10	75
Japan	7	121
Hungary	7	161
Czechoslovakia	2.5	84

(Those countries with extremely low death rates have laws which generally do not allow abortion after 3 months and as such are not comparable to present changes in United States abortion laws) (137).

Addendum: Minnesota Maternal Mortality Rate=14/100,000 live births (142).

There are a whole host of major complications resulting from legal abortion which at their worst cause death, but much more frequently result in either temporary or permanent damage to the woman or her offspring. Again, using the world's medical literature as documentation, these complications will be presented in some detail. They will, however, be limited to the 4 main

methods through which abortion is procured in the United States: dilatation and curettage, suction curettage, saline instillation and hysterotomy.

Infection

Pelvic infection is a common sequel to legal abortion. While the incidence varies slightly from country to country, consensus reveals an astonishingly high rate. (See Table II).

TABLE II

THE INCIDENCE OF PELVIC INFECTION FOLLOWING LEGAL ABORTION

% Early Infection	%Late Infection	Method	Country	Reference
5.0	-	D & C	Germany	26
5.0	15.0	D & C	Czechoslovakia	81
4.9	-	D & C	Czechoslovakia	165
4.0-5.0	12-15	D & C	Czechoslovaia	28
5.0	-	D & C	Rumania	159
7.0	-	D & C	USSR	123
2.6	9.7	D & C	Poland	106
	28.2	D & C	USSR	87
	12.0	D & C	USSR	143
2.0	-	D & C	Bulgaria	143
1.6-2.3	-	Saline	Sweden	16
15.4	-	Saline	Great Britain	104
10.4	-	Saline	Japan	171
1.0	-	Saline	Denmark	172
2.0	-	Suction	Great Britain	170
3.9	-	Suction	Czechoslovakia	29
5.0	-	Suction	Germany	30
10.0	-	All methods	Great Britain	36

The incidence appears to be highest 2-3 weeks after the abortion at a time when the patient has been lost to follow-up. There is also good evidence to suggest that the young woman pregnant for the first time stands a much greater risk of infection (15.8%) (165).

These infections are the direct result of the instrumentation involved in the abortive technique and are manifest as salpingitis (infection in the fallopian

tubes) or endometritis (infection in the lining of the womb). When out of control, these infections can cause septic shock with rapid death or pelvic thrombophlebitis (inflammation and blood clot formation in the pelvic veins) with sudden death by pulmonary embolus (blood clot from the pelvic veins which dislodges and is carried to the lungs). These infections can also result in sterility because they scar the tubes to a point where they no longer function properly.

Hemorrhage

Major hemorrhage is another complication and can result in death by exsanguination. Again, the incidence is much too high to be acceptable from a medical standpoint. (See Table III).

TABLE III

INCIDENCE OF MAJOR HEMORRHAGE FOLLOWING LEGAL ABORTION

% Major Hemorrhage	Method	Country/State	Reference
2.3	D & C	Germany	26
5.0	D & C	Czechoslovakia	153
8.6	D & C	Rumania	159
2.6	D & C	Poland	106
14.2	D & C	USSR	87
5.9	D & C	Bulgaria	156
21.0	All methods	Great Britain	36
8.0	All methods	Colorado	170
3-7.8	Saline	Sweden	16, 17
15.4	Saline	Great Britain	104
3.6	Saline	Japan	171
2.0	Saline	Denmark	172
3.8	Suction	Great Britain	170

To think that this won't happen in Minnesota is naive. During the first year of Colorado's new abortion law, 8% of patients needed one or more blood transfusions (most of these abortions were done by dilatation and curettage, or suction curettage) (42). It should be mentioned that every time a blood transfusion is given, there are certain inherent risks, e.g., allergic reactions and serum hepatitis (105).

Uterine Perforation

Perforation of the uterus can occur as a sequel to dilatation and curettage. This occurs primarily because the surgeon operates by "touch" alone and not under direct vision. Secondarily, the pregnant uterus is much softer than the non-pregnant uterus, lending itself to easier perforation. The incidence of perforation throughout the world is presented in Table IV.

TABLE IV

THE INCIDENCE OF UTERINE PERFORATION AS A RESULT OF LEGAL ABORTION

% Perforation	Country/State	Reference
0.11-0.28	Germany	26, 158
0.14-0.80	Poland	70
0.10-0.18	Rumania	103, 166
0.45	Czechoslovakia	134
0.20	Poland	106
1.2	USSR	87
0.4	Bulgaria	156
1.2	Great Britain	36
1.2	New York City	133
1.2	Colorado	42

It is sad to note that New York City and Colorado are both experiencing relatively high rates of uterine perforation (1.2%). If in the process of perforation, the bowel or a blood vessel is torn, overwhelming infection and/or hemorrhage may occur which require an exploratory abdominal operation (30-65% with a perforation will need this operation) (133, 134, 166). Subsequent pregnancy following a perforation is put in jeopardy because the perforation scar may rupture as the uterus expands.

Menstrual Disturbances

Menstrual disturbances following abortion are not infrequent. (See Table V). This usually means gross irregularity in the appearance of the menstrual period, heavy bleeding with the menses or complete absence of menstruation. These

disturbances may persist for many years (123). They are mostly the result of endouterine adherences or infection (32). This may lead to a number of more technical problems which need not be detailed here.

TABLE V

THE INCIDENCE OF MENSTRUAL DISTURBANCE FOLLOWING LEGAL ABORTION

% Menstrual Disturbances	Country	Reference
3.1	Hungary	167
2.0	Czechoslovakia	28
1.0	Czechoslovakia	83
11-12 (5 year followup)	USSR	123
2.2	USSR	87
6.0	USSR	143
5.2	Poland	106

Subsequent Pathologic Pregnancies

Subsequent pregnancies are more often pathologic following abortion and this without question represents one of the most serious complications of induced abortion. The prematurity rate in Czechoslovakia prior to abortion on demand was 5% (not much different from the United States). Several years later, this had increased to 14% (84, 154). Hungary and Japan have reported similar trends (33, 45, 62, 110). The incidence in any one individual seems to be well correlated with the number of abortions a woman has; Hungarian studies reveal that the likelihood of premature delivery after one abortion increased to 12% (136); after two abortions--15%; and after three abortions--24% (33). It should be pointed out that prematurity is the leading cause of infant death in the United States (145), and one of the major contributors to mental and motor retardation (43). The authors are not aware of any studies which have been done regarding psychiatric sequelae following premature birth as the result of a previous abortion, but would suspect a high correlation.

A number of countries have reported a significant increase in incidence of ectopic pregnancies (pregnancies which occur someplace other than in the womb)

(45, 125, 136). In fact, Japan sees ectopic pregnancies in 3.9% of women which is 4 to 8 times more frequent than in the United States (59). Ectopic pregnancies are not infrequently life threatening because of rupture and hemorrhage. Again, tubal malfunction secondary to infection seems to be the prime cause.

Spontaneous abortions and fetal death before the onset of labor are reported to be significantly more common following legal abortion in those countries with weak abortion laws (45, 84). Complicated labors (prolonged labor, placenta previa, adherent placenta) (63, 154) and excessive bleeding at the time of delivery (154) are also more common when compared to women who have not had legal abortions. These all result in increased obstetrical intervention.

Transplacental Hemorrhage

It has long been known that a woman who is Rh-negative is very susceptible to a special kind of problem if her consort is Rh-positive. Any given pregnancy may be a stimulus for the mother to develop antibodies against the baby's red blood cells (i.e., she becomes sensitized) so that in a subsequent pregnancy, these antibodies may destroy the baby's red blood cells resulting in an anemia in the unborn child which may be life-threatening. This sensitization occurs through the leakage of the baby's red blood cells into the mother's circulation (transplacental hemorrhage) usually at the time of delivery. Therefore, first born children are rarely affected. In spontaneous abortion, this sensitization rarely occurs (86). However, with all methods of induced abortion sensitization has been reported to occur in 3-10% of Rh-negative women (50, 51, 73, 93, 127, 168). Recent advances have allowed us to prevent this complication in 100% of women treated. However, because tests on the fetus cannot be performed to rule out

sensitization of the mother, a number of women, who have not become sensitized, will be needlessly subjected to this expensive treatment.

Sterility

There are a number of complications which do not appear immediately following the abortion. Poland has reported that 6.9% of women were sterile 4 to 5 years after abortion (106). Japan has reported 9.7% with subsequent sterility on 3 year followup (59) and other countries have had similar experience (82, 98, 100, 109). This appears to be the result of inadequate regeneration of the lining of the womb following dilatation and curettage and/or infection as previously mentioned. There is evidence also to suggest that the sterility may have an adverse psychological effect on the woman (49). As Jeffcoat stated, "If this happens when a first pregnancy is interrupted for non-recurrent indication, such as rubella or fleeting psychological upset, the situation is tragic" (71).

Miscellaneous

A number of miscellaneous complications occur which deserve mention. (1) The Czech's have reported that 33% of patients had decreased sexual libido 9 months after the abortion (27). Similarly, a study from Poland showed 14% to have decreased libido 4 to 5 years after the abortion (106). This is theoretically related to the psychotraumatic experience of the interruption and emotional weakness that follows (27). (2) Changes in the coagulability of the blood following legal abortion, although rare, have been reported (152, 175, 178, 179). (3) Most pregnancies following hysterotomy will need delivery by ceserian section to eliminate the possibility of rupture of the hysterotomy scar. (4) Endometreosis is a common sequel to hysterotomy (136). (5) A particular problem associated with suction curettage appears to be perforation of the bladder (104, 133).

Psychiatric Sequelae

The psychiatric sequelae of induced abortion are most difficult to elucidate. Reports on the incidence of emotional difficulties following abortion vary from 0-85%--the true figure lies someplace in between. The difficulties appear to be more common in mature and motherly women than in the more immature, psychopathic and unmotherly (126). This may be because the husband is most often the prime mover to an abortion in the married woman and in the unmarried, parents and friends are prime movers (49). As mentioned previously, the woman with real psychiatric illness prior to an abortion is at greater risk to develop significant psychiatric problems post-abortion than is the psychiatrically "stable" woman (44, 69).

Martin Ekblad interviewed 479 women prior to abortion and again 2 1/2 to 3 years later. At followup, he found 10% felt the operation unpleasant; 14% had mild self reproach; and 11% had serious self reproach and self regret (44). This is perhaps the best single study which has been conducted in this area.

Seigfried, in 1951, studied 61 women, 2 years after abortion, and found 13% to have serious self reproach (151). Beck, in 1964, studied 50 women 4 months after legal abortion and found that 18 had conscious guilt feelings about the abortion and 9 had suppressed remorse which was expressed as various psychosomatic symptoms such as abdominal discomfort, vomiting, pruritis vulvae, dysmenorrhea, frigidity, headache, insomnia, fatigue, etc. (15). Niswander and Patterson, in 1967 studied 17 women, 8 months post-abortion for rubella. Eleven of the 17 reacted unfavorably and 8 had a long term negative experience (118).

It would appear that 15-25% of all women undergoing legal abortion will have some long term psychologic reaction. According to Helene Deutsch, the

CORRECTION: The paragraph at the bottom of page 31 should read:

It would appear that 15-25% of all women undergoing legal abortion will have some long term psychologic reaction. According to Helene Deutsch, the pregnant woman can initially deny the unborn child, but once she admits she is pregnant, she feels an unconscious attachment to him. The longer she stays pregnant, the more the child becomes a part of her. As a result, after an abortion, many women feel that part of them is gone (88).

Criminal Abortion

The proponents of abortion have said that only by relaxing our present abortion law will we ever be able to eliminate the problem of criminal abortion and its accompanying morbidity. This thought does NOT stand up when one looks at the world's experience in abortion (see Table VI).

TABLE VI

THE EFFECT OF LEGAL ABORTION ON CRIMINAL ABORTION RATES

Country/State	Effect of Criminal Abortion Rate	Reference
German Democratic Republic	Increased with liberal abortion law Decreased with strict abortion law	97, 99, 101
Japan	No effect	160
Great Britain	No effect	1, 6
Yugoslavia	Increased	108, 114, 119
Hungary	No effect	62, 100, 114, 161
Czechoslovakia	No effect	100, 114, 169
Switzerland	No effect	54
Bulgaria	No effect	33, 100
Poland	No effect	100
Colorado	No effect	42
USSR	No effect	114

Not one country has seen a decrease in the criminal abortion rate as the result of adopting weak legislation. On the other hand, some countries have actually seen an increase. The German Democratic Republic is a good example. They saw an increase in the criminal abortion rate during the years 1947-1950, a time when they had a relaxed abortion law. In 1950, they adopted a law allowing abortion only for strict medical indications, this was followed by a precipitous fall in the number of criminal abortions (97, 99, 101).

There are a number of reasons given for this paradox. It seems that the law plays an inherent educative role in forming the social ethic of any given society. When this social ethic is changed by eliminating all the legal safeguards to abortion, a whole new class of women, dependent upon that social ethic, find themselves asking for abortion (6, 99). It also seems clear that women desire privacy when they are aborted and the legal framework, no matter how loose, does not allow for this (62).

The consistency of the pro-abortion argument can again be seriously questioned. At a how-to-do-it symposium conducted by the National Association for Repeal of Abortion Laws, Manhattan obstetrician, Dr. Richard Hausknecht, paid tribute to the "outcasts of medicine"--those doctors who long have done illegal abortions. "THEY'RE A LOT BETTER AT WHAT WE ARE ATTEMPTING TO DO THAN WE ARE!", he admitted (177).

Hospital and Staff Problems

A most practical consideration is the drain legal abortion may place on our hospital facilities and on those people who work in our hospitals. Only ten years after legalizing abortion, the Soviet Union reported that they had 227,100 beds available in their hospitals for abortion patients. In contrast, there were only 109,400 beds available for the whole gamut of gynecologic disease (117). One of the largest hospitals in Budapest, Hungary, reported that 52.3% of all the beds in their hospital were being occupied by abortion patients (125). Reports from California already indicate a similar trend (124). This is indicative of the tremendous strain which we can expect to see on existing facilities and personnel. To complicate this further, some nurses feel that abortion on a mass scale will have a long term effect on recruitment to the nursing profession (116). Likewise, physicians in both the United States and Great Britain have expressed a deep concern over a possible decrease in recruitment to the specialty of Obstetrics and Gynecology (1, 33).

The increased demand on facilities has led to a delay in admitting patients in need of treatment for serious conditions both in this country (California) (124) and abroad (1, 90, 116). The British reported that 2 women, who subsequently proved to be suffering from pelvic cancer, were delayed admission several months because abortion cases had to be given priority (1).

Disenchanted by the pressure brought about by the New York abortion boom, many nurses are quitting and seeking jobs in hospitals where abortions are not performed (131). As one nurse said, "No matter what anyone tells you, and no matter what your religious beliefs, it is a physically grotesque thing to work at for 8 hours a day" (131). Nurses in Colorado have had to resort to

after-hours group psychotherapy in order to handle their conflicts (88). Physicians are no less immune. Many countries have reported increased depressive reactions and breakdowns among their guilt ridden physicians (33, 138). It seems that a robot-like constitution is needed when carrying out large numbers of abortions (33).

Residents in obstetrics and gynecology in California have expressed their dissent at having to spend "inordinate portions of their learning time in carrying out too many distasteful abortions" (24, 92). And the British have reported that the teaching and training of junior medical staff and students has suffered since institution of their new law (1).

The inherent morale of the medical profession and the strain on our medical facilities are <u>real</u> problems with many practical implications. These <u>must</u> be considered in detail.

Alternatives to Abortion

Humane alternatives to abortion are available today in Minnesota and throughout the United States. These alternatives redirect our ingenuity and imagination from the logistics of increasing the availability of abortion, toward abolishing the social and economic pressures which lead some women to seek it. When we support the woman and her family in time of distress, we then, with the help of creativity, fulfill the keystone of the art and science of medicine.

Based on the knowledge that the majority of women who have a negative or ambivalent reaction to their pregnancy during its early stages do, in fact, as the pregnancy advances, develop a more positive acceptance of the pregnancy, supportive care of the pregnant woman becomes all the more reasonable (43). Much has been said of the unwanted child, yet the majority of women who expressed ambivalent or rejecting attitudes toward the pregnancy in the early months, now, in the third trimester, express positive, or at least more accepting, attitudes toward the baby (43).

Indeed this phenomenon of early rejection and later acceptance has been spelled out by Gardiner in Williams Obstetrics, 13th edition, 1966:

> The initial acceptance and adaptation to the pregnancy by the particular patient will depend upon the implications regarding future responsibilities and future personal and intrapersonal relationships engendered by the pregnancy. At that stage (the first three months), the pregnancy exists only as an abstraction and can be accepted or rejected depending upon the character and personal significance of future implications (43 at P. 345).
>
> So real and life-threatening are these emotional reactions to these women that they not only reject the existence of the pregnancy before they, themselves, are engulfed and destroyed. Under the spell of this distorted thinking and

> reasoning, the medical hazards of instrumental abortion fade into insignificance (43 at p. 346).
>
> It is not unusual (however) for women who will become good mothers, or those who have already demonstrated their excellent maternal qualities with their older children, to react initially to the diagnosis of pregnancy with resentment, frustration and depression, only to express strong, genuine, positive feelings of acceptance as the pregnancy advances and fetal movements appear (43 at p. 345). (Emphasis ours)

Considering this, it seems fair to ask what happens if their fearful request for abortion is denied. Hook reported that of 249 women refused an abortion in Sweden, 86% gave birth, 11% had induced abortions (22% had threatened to do so), and 3% had spontaneous abortion. Of this group 12% had threatened suicide but no sucides or suicide attempts occurred (64). Kolstad reported that of 113 women refused abortion in Norway and who carried the pregnancy to term 84% were glad that the pregnancy was not terminated, 9% were uncertain as to their feelings, and only 7% were discontented (82). Furthermore, Murdock showed that by supporting pregnant women throughout their pregnancy, the pressures for abortion were significantly decreased. He suggested that the pregnancy carried to term may have been a positive factor in the mother's return to normalcy (115).

Knowing, then, that support of the pregnant woman is a sound principle, we must be willing to change social policy and extend our help to those who need it. If our values are sound they will be for us a source of practical ideas, of answers for human tragedy. To this end, a number of practical alternatives will be presented.

1. COUNSELING

A. A woman who requests an abortion is acting to meet a crisis

in her life--she may be acting out of fear and in a state of high tension, oblivious to other solutions that may be possible. Therefore, it is imperative that PSYCHIATRIC, PSYCHOLOGIC, LEGAL and RELIGIOUS advice be made immediately available to these women.

One private organization recently started in Minnesota has been BIRTHRIGHT, Inc. This organization provides volunteer women to establish a one-to-one, nonjudgemental relationship with the distressed woman to act as both counsellor and friend. Available to the BIRTHRIGHT VOLUNTEER is the whole gamut of professional services, usually at little or no cost to the woman.

2. EDUCATION

A. We let our young people embark on marriage with very little idea of how to find fulfillment and happiness in this responsible and beautiful relationship. Should we not provide MARRIAGE AND PARENTHOOD CLASSES to all of our high school students. Not merely sex education, but rather an in depth approach to the problems and joys of marriage (149).

B. Young medical students are not taught to be aware of social pathology. As they grow older, they realize their medical education has not prepared them to cope with maternity problems. These subsequently ill-equipped doctors frequently feel powerless, threatened and afraid to deal with these social issues. Should we not urge MEDICAL SCHOOLS to change some of their priorities and provide for the young

an opportunity to DEVELOP A SOCIAL CONSCIENCE?

C. Should there not be an attempt at reducing the social stigmata attached to the unwed mother through PUBLIC EDUCATION programs? Programs of this type should be aimed at greater understanding of the associated difficulties and the importance of being nonjudgemental.

D. ACCEPTABLE FAMILY PLANNING techniques should be made available to those who voluntarily desire them. Further research should be encouraged in this area.

3. PUBLIC HEALTH

A. VACCINATION PROGRAMS should be set up so available vaccines can be used to prevent diseases which may be crippling. Presently, measles, German measles, polio, small pox, diphtheria, and tetanus are preventable through vaccination (149).

B. Should not increased attempts be made to provide ADEQUATE HEALTH MANPOWER? Medical schools are needed to provide more doctors and the use of nurse midwives and pediatric assistants should be thoroughly explored (21).

C. RESEARCH into the cause of devastating illness should be encouraged.

D. PUBLIC EDUCATION programs similar to those conducted on venereal disease should be considered in order to inform women on the dangers of self-induced abortion.

4. UNWANTED CHILDREN

A. In some cases, the birth of a defective child imposes enormous economic burdens on the parents. Should we not seriously

consider the possibility of BIRTH INSURANCE to pro. families from such eventualities? In this way, every family would have the means to see to it that their baby has proper care and attention. The other children in the family would not be deprived of educational and other advantages because of their handicapped brother or sister (149).

B. ADOPTIVE AGENCIES should be encouraged to further develop their art. Adoption in general should be encouraged but particularly the adoption of children of minority races and those with handicaps.

5. UNWED MOTHERS

A. Phillip Sarrel, M. D. at Yale University has instituted a COMPREHENSIVE MEDICAL, SOCIAL AND RECREATIONAL CARE PROGRAM through which he has attempted to break the vicious cycle in which the girl who becomes pregnant is often cast out from society and can't complete her education. He says that "if you meet the educational needs of the girl while pregnant, give strong support through her peers and the neighborhood workers from the community in which she lives, provide good nursing and obstetrical care, warm and empathetic, the depressing vicious cycle crumbles." He continues that "In our most recent follow-up, instead of finding an expected 700 repeat pregnancies, we found only 50. Most of the girls are married and in a stable relationship with their husbands. Everyone in the program, except 3 or 4, has kept her children. We have more girls going to college than having second

babies." (20)

B. WORK-WAGE HOMES where unwed mothers can receive guidance and care in a private home should be encouraged. Various social agencies in the state of Minnesota are already implementing these.

C. FLORENCE CRITTENDEN HOMES for unwed mothers (and other similar homes) can better be utilized to help the girl continue her education, find help with emotional problems and guidance for the future (149).

D. BIRTHRIGHT, Inc. is available to all women, pregnant and distressed, including the unmarried.

6. ANTI-POVERTY PROGRAMS

A. Continuing efforts at providing adequate JOB TRAINING programs and CHILD CARE CENTERS should be encouraged. It would seem that any government financial subsidy (welfare) would best serve the individual and the community if it were directed toward the FAMILY UNIT.

B. Perhaps the Volunteers In Service to America (VISTA) program, or some similar involvement program, could be considerably enlarged so all people interested in helping the poor may have that opportunity.

C. President Johnson, in his 1968 State of the Union message encouraged action in both the areas of crime in the streets and maternity care. There is just a chance that an improvement in maternity care, with its focus on the family at the beginning, might be an opening to the solution of the troubles that are engulfing our big cities (21).

Let no one suggest that these considerations are remote from the subject of abortion. Parent and child both exist within the context of the community and even the love of a family needs security and support. The programs described here are in no way all-inclusive. They represent only a mere beginning. We can and must go further.

Glossary of Medical Terms

ABORTION: The premature expulsion from the uterus of a nonviable fetus (i.e. a child which is incapable of living outside the mother's womb). Artificial a., induced abortion; an abortion which is brought on purposely. Criminal a., an abortion which is not justified by the circumstances. Induced a., abortion brought on intentionally. Therapeutic a., abortion induced to save the life of the mother.

AMNIOCENTESIS: The obtaining of amniotic fluid by putting a needle through the mother's abdominal wall then through the wall of the uterus and into the fluid surrounding the baby.

AMNIOTIC FLUID: The fluid which surrounds and protects the baby while still in the womb.

ANEMIA: A condition in which the blood is deficient in quantity.

ANTIBODIES: A modified serum protein synthesized by an animal in response to an outside stimulus.

ANTIMITOTIC: Adrug which inhibits cell division.

ANTIMETABOLITE: A compound which acts to replace an essential body chemical

CERVIX: The mouth of the womb.

CONGENITAL: Existing at, and usually, before birth.

CURETTE: A kind of scraper or spoon for removing growths or other matter from the walls of cavities.

DILATATION: The condition of being dilated or stretched beyond the normal dimensions.

DYSMENORRHEA: Painful Menstruation.

EMBRYO: The developing human being from one week after conception to the end of the second month.

ENDOMETRIOSIS: A condition in which tissue more or less perfectly resembling the uterine mucous membrane occurs aberrantly in various locations in the pelvic cavity.

EUGENIC: Serving in the production of physically and mentally improved offspring.

FETUS: The developing human being from two months after conception until birth.

GESTATION: Pregnancy.

GYNECOLOGIST: A physician skilled in the treatment of diseases of the genital tract of women.

HYPERTENSION: High blood pressure.

IMMUNE: Protected against any particular disease.

INTRAVENOUS: Solutions given through a needle directly into a vein.

MANIC-DEPRESSIVE: Denoting a mental disorder in which periods of depression alternate with periods of excitement.

MENSES: The menstrual period.

OBSTETRICIAN: A physician who is specifically trained in that branch of surgery which deals with the management of pregnancy, labor and the puerperium.

PATHOGENESIS: The development of morbid conditions or of diseases.

PLACENTA: The cakelike organ within the uterus which establishes communication between the mother and child by means of the umbillical cord. P. previa., The placenta covers the mouth of the womb.

PRURITUS VULVAE: Intense itching of the external genitals of the female.

PSYCHOSIS: The deeper, more far reaching and prolonged behavibr disorders.

RUBELLA: German measles.

SCHIZOPHRENIC: A condition which represents a cleavage of the mental functions.

STERILE: Not fertile; infertile; barren; not producing young.

TRIMESTER: A period of three months.

UTERUS: The womb.

REFERENCE: Dorland's Illustrated Medical Dictionary. 23d edition. W. B. Saanders Co. Philadelphia and London. 1957.

Bibliography

1. Abortion Act (1967), The. Findings of an Inquiry Into the First Year's Working of the Act: Conducted by the Royal College of Obstetricians and Gynecologists. Brit. Med. J. 2;529-535, 1970.

2. Abramovich, D. R. The Importance of Fetal Physiology and Endocrinology in Obstetrics. The Med. J. of Aust. 2:408-411, August 23, 1969.

3. Addison, P.H. Abortion Act 1967. Lancet. 2:503-507, 1968.

4. Alpern, W., et al. Hypertonic Solutions for Termination of Pregnancy. Am. J. Obstet. Gynec. 100:250-254, 1968.

5. Anderson, E. W. The Psychiatric Indications for Termination of Pregnancy. Proc. Roy. Soc. Med. 50:321, 1957.

6. Anonymous. Abortions. First Notification. The Economist. Nov. 2, 1968.

7. Arbuse, D.I., et al, Neuropeychiatric Indications for Therapeutic Abortion. Amer. Pract. Dig. Treatment. 1:1069, 1950.

8. Arey, L. B. Developmental Anatomy. Sixth edition. Philadelphia, W. B. Saunders Co., Chapters 2, 6, 1954.

9. Associated Press. 5,183 Abortions Since Law Was Changed. Rochester Post-Bulletin. Oct. 29, 1970.

10. Banatvala, J.E. Laboratory Investigations in the Assessment of Rubella During Pregnancy. Brit. Med. J. 1:561, 1968.

11. Barno, A. The Minnesota Mortality Study. Am. J. Obstet. Gynec. Jan. 15, 1968.

12. Bartemeier, L.H.--in Aarons, Z. A. Therapeutic Abortion and the Psychiatrist. Amer. J. Psychiatry. 124:745, 1967.

13. Barton, J. J. Evaluation of the Doppler Principles as a Diagnostic Aid in Obstetrics. Am. J. Obstet. Gynec. 102:563-570, 1968.

14. Beck, D. Interruption of Pregnancy and Guilt Feelings. Schweiz. Med. Wschr. 94:357, 1964.

15. Bernstein, I. C. Psychiatric Indications for Therapeutic Abortion. Minn. Med. 50:51, 1967.

16. Bengtsson, L. P. Legal Abortion Induced by Intrauterine Injections (1): Technique, Effect, Risks, and Mode of Action. Lakartidninger. 64:5037, 1967.

17. Bengtsson. L. P., et al. Legal Abortion Induced by Intrauterine Injections (2): An Analysis of the Lund Material. 1960-1966. Lakartidninger. 64:5046, 1967.

18. Borell, U. and Engstrom, L. Legal Abortions in Sweden. World Med. J. 13:72-75, 1966.

19. Breitenecker, L. and Breitenecker, R. Abortion in the German Speaking Countries of Europe. Abortion and the Law. David T. Smith, editor. Cleveland, The Press of Western Reserve University, 1967.

20. Briefs: Official Publication of the Maternity Center Association. Attitudes Blocking Progress in Maternity Care. 34:39, March, 1970.

21. Briefs: Official Publication of the Maternity Center Association. Social Pathology and Maternity Care. 33:19-23, February, 1969.

22. British Medical Association Committee on Therapeutic Abortion. Indications for Termination of Pregnancy. Brit. Med. J. 1:171, 1968.

23. Bucic, M., et al. Le Probleme de L'avortement Dans la Regulatione des Naissances en Yugoslavic. Annales de Mededine Legale. 47:513-518, 1967.

24. Budvari, R. La Lutte Contre L'avortement Criminel et la Regulatione des Naissances en Hongrie. Annales de Mededine Legale. 47:519-520, 1967.

24'. Calderone, M. editor. Abortion in the United States. Hoeber & Harper, New York, New York, 1958.

25. Cavanaugh, D. Reforming the Abortion Laws: A Doctor Looks at the Case. America. pp. 406-411, April, 18, 1970.

26. Cee, K. On the Clinical Problems of the One Stage Interruption of Pregnancy. Zbl. Gynaek. 86: 524, 1964.

27. Cepelak, J., et al, Influence of Interruption of Pregnancy on the Sexual Life of the Woman. Cesk. Gynaek. 25:609, 1960.

28. Cernoch, A. Some Problems Encountered in Connection With Artificial Interruption of Pregnancy. Cesk. Gynaek. 25:646, 1960.

29. Chalupa, M., et al, Interruption of Pregnancy With the Use of the Vacuum Exhaustion. Cesk. Gynaek. 31:467, 1967.

30. Chalupa, M. Use of Vacuum for Artificial Interruption of Pregnancy. Zbl. Gynaek. 51:1803, 1964.

31. Chaud, A. Legalising Abortion for Birth Control. J. Of Indian Med. Ass. 45:95-97, 1965.

32. Coja, N., et al, Menstrual Insufficiency After Lawful Interruption of Pregnancy. Obstet. Ginec. 10:263, 1963.

33. Connor, E. J. Therapeutic Abortion. Audio Digest Ob. Gyn. Vol. 17, No. 16, Aug. 18, 1970.

34. Consultant's Report on Abortion, An editorial. Brit. Med. J. 2:491-492, 1970.

35. Cooke, R. E., Hellegers, A. E., Hoyt, R. G., and Richardson, H. W., editors. The Terrible Choice: The Abortion Dilemma. New York, Bantom Books, 1968.

36. Courtney, L. O. Proc. Roy. Soc. Med. 62:834, 1969.

37. Curran, D. Psychiatric Indications for Termination of Pregnancy. New Zeal. Med. J. 60:467, 1961.

38. Decker, D. G. Medical Indications for Therapeutic Abortion: An Obstetrician's View. Minn. Med. 50:29, 1967.

39. Deghwitz, R. The Influence of Pregnancy on Neurological and Psychiatric Diseases. Fortsch. Neurol. Psych. 32:105, 1964.

40. de Smoler, P. E. Fetal Heart Activity is Recorded Routinely by the 10th Week of Life. Medical Trib. Feb. 2, 1970.

41. Downing, S., et al. Abortion Under the New Colorado Law. Nebraska State Med. J.55:24-30, 1970.

42. Droegemueller, W., et al. The First Year of Experience in Colorado With the New Abortion Law. Am. J. Obstet. Gynec. 103:694-698, 1969.

43. Eastman, N. and Hellman, L. William's Obstetrics, 13th edition. New York, Meredith Publishing Co., 1966.

44. Ekblad, M. Induced Abortion on Psychiatric Grounds. A Follow Up Study of 479 Women. Acta. Psychiat. Neurol. Scand. Suppl. 99:238, 1955.

45. Family Planning Federation of Japan. Harmful Effects of Induced Abortion. n. p., Family Planning Federation of Japan, 1966.

46. Fitzgerald, J. A. Abortion on Demand. Medical Opinion and Review, 1970.

47. Flanagan, G. L. The First Nine Months of Life. New York, Simon and Schuster, 1962.

48. Fultz, G. S. Therapeutic Abortions. South. Med. J. 1954.

49. Geiser, M. Numbers and Thoughts on the Legal Abortions in Switzerland and Abroad. Schweitz. Med. Wschr. 86:1006, 1956.

50. Gellen, J., et al. Maternal-Fetal Microhemotransfusion As A Result of Induced Abortion. Orr. Hetil. 107:732, 1966.

51. Gellen, J., et al. Surgical Termination of Pregnancy as a Cause of Rhesus Sensitization. Brit. Med. J. 2:1471, 1965.

52. George, B. J. Abortion and the Law. David T. Smith, editor. Cleveland, The Press of Western Reserve University, 1967.

53. Gesell, A. The Embryology of Behavior. Chapters 4, 5, 6, 10. New York, Harper and Bros., 1945.

54. Getaz, D., et al. Family Planning. Gynaecologia. 155:27, 1963.

55. Gordon, Hymie, M. D. Personal Communication.

56. Hall, R. E. Abortion and the Law. David T. Smith, editor. Cleveland, The Press of Western Reserve University, 1967.

57. Harrington, J. A. Psychiatric Indications for the Termination of Pregnancy. Practitioner. 185:654, 1960.

58. Hauschild, T. B. The Role of the Psychiatrist in Therapeutic Abortion. Med. Bull. U. S. Army Eur. 20:322, 1963.

59. Hayasaka, Y., et al. Japan's 22 Year Experience With a Liberal Abortion Law. XIIth International Congress of FIAMC. Wash., D. C., Oct. 11-14, 1970.

60. Hellegers, A. E. Law and the Common Good. Commonweal. pp. 418-423, June 30, 1967.

61. Hellman, L. M., et al. Growth and Development of the Human Fetus Prior to the 20th Week of Gestation. Amer. J. Obstet. Gyn. 103:789-800, 1969.

62. Hirschler, I. The Situation of Abortion in Hungary. Mehlan, K-H., editor. Internationale Abortsituation, Abortkampfung, Autikonzeption. Leipzig, Georg Thieme, 1961.

63. Hofman, D. Statistical Studies on Some Obstetric Relations, Especially the Relation of Abortion to Late Postpartum Complications. Zbl. Gynaek. 87:1537, 1965.

64. Hook, K. Refused Abortion: A Follow Up Study of 249 Women Whose Applications Were Refused by the National Board of Health in Sweden. Acta. Psychiat. Scand. 39:Suppl. 168, 1963.

65. Hooker, D. Early Human Fetal Behavior With a Preliminary Note on Double Simultaneous Fetal Stimulation. Proceedings of the Association for Research in Nervous and Mental Disease. Baltimore, Williams and Wilkins, Co., 1954.

66. Hooker, D. The Origin of Overt Behavior. Ann Arbor, U. of Mich. Press, 1944.

67. Hooker, D. The Prenatal Origin of Behavior. U. of Kansas Press, 1952.

68. Ingerslev, M. The Danish Abortion Laws. Medicine, Science and the Law. 7:77-82, 1967.

69. Jannsen, B. Mental Disorders After Abortion. Acta. Psychiat. Scand. 41:87, 1965.

70. Jaworski, E. Perforation of the Uterus in Legal Interruption of Pregnancy. Pol. Tyg. Lek. 18:734, 1963.

71. Jeffcoate, T. N. A. Indications for Therapeutic Abortion. Brit. Med. J. 1:581, 1960.

72. Johnson, J. Termination of Pregnancy on Psychiatric Grounds. Med. Gynaec. Sociol. 2:2, 1966.

73. Jørgensen, J. Rhesus-Antibody Development After Abortion. Lancet. 2:1253-1254, 1969.

74. Joyston-Bechal, M. P. The Problem of Pregnancy Termination on Psychiatric Grounds. J. Coll. Gen. Pract. 12:304, 1966.

75. Jurukovski, J. Complications Following Legal Abortion. Proc. Roy. Soc. Med. 62:830-831, 1969.

76. Karim, S. M. M. Therapeutic Abortion Using Prostaglandin $F_2\alpha$. Lancet. 1:157-159, 1970.

77. Karim, S. M. M., et al. Use of Prostaglandin E_2 for Therapeutic Abortion. Brit. Med. J. 3:198-200, 1970.

78. Kerslake, K., et al. Abortion Induced by Means of the Uterine Aspirator. Ob. Gyn. 30:35-45, 1967.

79. Klemfuss, R. State M. D.'s Clarify Abortion Stand. News Release. Medical Society of the State of New York, Mar. 26, 1970.

80. Kohn, G., et al. Tetraploidy in Cells Cultured From Amniotic Fluid. Lancet. 2:778, 1970.

81. Kolarova, O., at al. Complications After Artificial Interruption of Pregnancy. Cesk. Gynek. 25:694, 1960.

82. Kolstad, P. Therapeutic Abortion: A Clinical Study Based Upon 968 Cases From a Norwegian Hospital, 1940-1953. Acta. Obstet. Gynec. Scand. 36:Suppl. 6, 1957.

83. Kopp, M. E. Birth Control In Practice. New York, R. McBride & Co., 1934.

84. Kuck, M. Abortion in Czechoslovakia. Pro. Roy. Soc. Med. 62:831-832, 1969.

85. Langmen, J. Medical Embryology. Baltimore, Williams and Wilkins, Co., pp. 147-153, 1963.

86. Lee, D., et al. Incidence of Feto-maternal Transfusion in Spontaneous Abortion. J. Obstet. Gynaec. Brit. Comm. 76:1120-1122. 1969.

87. Lekhter, A. M. Experiences in the Study of the Sequelae to Abortions. Sovet. Zdravookhr. 25:27, 1966.

88. LeRoux, R., moderator. Abortion. Am. J. Nursing. 70:1919-1925, 1970.

89. Liley, H. M. I. Modern Motherhood. New York, Random House, 1967.

90. Lister, J. Unwanted Pregnancy--Medicated Survival--The Metric Spoon. N. E. J. M. 280:1463-1465, 1969.

91. Manabe, Y. Artificial Abortion at Midpregnancy by Mechanical Stimulation of the Uterus. Am. J. Obstet. Gynec. 105:132-146, 1969.

92. Marder, L. Liberal Therapeutic Abortion: Cure or Cause of Mental Illness. Audio Digest Ob-Gyn. Vol. 16, No. 17, Sept. 2, 1969.

93. Matthews, C. D. and Matthews, A. E. B. Transplacental Hemorrhage in Spontaneous and Induced Abortion. Lancet. 1:694-695, 1969.

94. Mecklenburg, F. E. N. W. Progress. June 19, 1970.

95. Medical Defence Union. The Abortion Act 1967--Memorandum from Medical Defence Union. Brit. Med. J. 1:759-762, 1968.

96. Medicine's Week. American Medical News. P. 2, Dec. 14, 1970.

97. Mehlan, K-H. Abortion Statistics and Birth Frequency in the German Democratic Republic. Deutsch. Gesendh. 10:1648, 1955.

98. Mehlan, K-H. Late Sequels of Legal Abortion. Deutsch. Gesendh. 11:876, 1956.

99. Mehlan, K-H, editor. The Situation of Abortion in the German Democratic Republic. Internationale Abortsituation, Abortbekampfunz Antikonzeption. Leipzig, Georg Thieme, 1961.

100. Mehlan, K-H. The Effects of Legalization of Abortion on the Health of Mothers in Eastern Europe. Proceedings of the 7th Conference of the IPPF, Singapore, 1963. New York, Excerpta Medica Foundation, 1964.

101. Mehlan, K-H. Reducing Abortion Rate and Increasing Fertility by Social Policy in the German Democratic Republic. Proceedings of the World Population Conference, 1965.

102. Mehlan, K-H. Combating Illegal Abortion in the Socialist Countries of Europe. World Med. J. 13:84-87, 1966.

103. Melik, S., et al. Experience Acquired in 8,545 Cases in Interrupted Pregnancies. Obstet. Ginec. 10:225, 1963.

104. Menzies, D. N. et al. Therapeutic Abortion Using Intraamniotic Hypertonic Solutions. J. Obstet. Gynec. Brit. Comm. 75:215, 1968.

105. Merritt, J. A., et al. Management of Emergencies: Untoward Reactions to Blood Transfusion. N.E.J.M. 274:1426-1428, 1966.

106. Midak, E. Early and Late Sequelae of Abortion. Pol. Tyg. Lek. 21: 1063, 1966.

107. Miller, J. Dermal Ridge Patterns: Techniques for Their Study in Human Fetuses. J. Peds. 73:614-616, Oct., 1968.

108. Milosevic, B., et al. Contraceptives Versus Abortion. Proceedings of the Fourth Conference of the Region for Europe, Near East, and Africa Of the IPPF. New York, Excerpta Medica Foundation, 1965.

109. Milosevic, B., et al. Sterility With Special Reference to Induced Abortion. Srpski. Arh. Celukupno. Ledarstro. 94:1. 1966.

110. Milteny, K. Demographic Significance of Induced Abortion. Demografia. 7:419, 1964.

111. Milunsky, A., et al. Tetraploidy in Amniotic Fluid Cells. Lancet. 2:979, 1970.

112. Minnesota Statutes Annotated. Vol. 40, Secs. 609.66 and 624. St. Paul, West Publishing C;., 1964.

113. Moloshok, R. E. Fetal Considerations for Therapeutic Abortion and Sterilization. Clinical Obstet. Gynec. 7:82-99, 1964.

114. Muller-Dietz, H. Abortion in the Soviet Union and in the East German States. Rev. Soviet. Med. Sci. 1964.

115. Murdock, K. M. Experiences in a Psychiatric Hospital. Abortion in America. Rosen, H., editor. Boston, Beacon Press, 1967.

116. News. Am. J. Nursing. 70:2074, Oct., 1970.

117. Nikonchik, O. K. Protection of Women's Health in the U.S.S.R. Sovet. Zdravookhr. 24:3, 1965.

118. Niswander, K. R. and Patterson, R. J. Psychologic Reactions to Therapeutic Abortion. Obstet. Gynec. 29:702, 1967.

119. Novak, F. Effects of Legal Abortion on the Health of Mothers in Yugoslavia. Proceedings of 7th Conference of the IPPF. Singapore, 1963. New York, Excerpta Medica Foundation, 1964.

120. Noyes, A. and Kolbe, L. Modern Clinic Psychiatry. Sixth edition. P. 99. Philadelphia, W. B. Saunders, Co., 1963.

121. Nozee, G. Abortion in the Far East. Proceedings of the 8th International Conference of the IPPF. 1967.

122. Olki, M. The Situation of Abortion in Finland. Mehlen, K-H., editor, Internationale Abortsituation, Abortbekampfung, Antikonzeption. Leipzig, George Thieme, 1961.

123. Osadchaia, O. V. Immediate and Remote Results in Induced Abortion. Zdravoorkhr Belorussii. 9:59, 1963.

124. Overstreet, E. W. Therapeutic Abortion: Current Problems and Trends. Audio Digest Ob-Gyn. Vol. 16, No. 23, Dec. 2, 1969.

125. Ozsvath, I. Experience With Interruption of Pregnancy. Nepegeszsegugy. 42:121, 1961.

126. Pare, C. W., et al. Follow Up of Patients Referred for Termination of Pregnancy. Lancet. 1:635-638, 1970.

127. Parmley, T. H., et al. Transplacental Hemorrhage in Patients Subjected to Therapeutic Abortion. Am. J. Obstet. Gynec. 106:540-542, 1970.

128. Patten, B. M. Human Embryology. Third edition. Chapter 9. New York, McGraw-Hill Book, Co, 1968.

129. Pathak, U. N. Intra-amniotic Saline Induction for Termination of Early Pregnancy. West Indian Med. J. 15:89-93, 1966.

130. Peketz, A., et al. Evacuation of the Gravid Uterus by Negative Pressure (Suction Evacuation). Am. J. Obstset. Gynec. 98: 18-22, 1967.

131. Peters, D. R. N.Y. Nurses Quit Over Abortion. National Catholic Reporter. Nov. 6, 1970.

132. Petre-Quadrens, O., et al. Sleep in Pregnancy: Evidence of Fetal Sleep Characteristics. J. Neuro. Sci. 4:600-605, 1967.

133. Physicians International Press. Separate Facilities for Elective Abortion Endorsed. Ob-Gyn News. 5:1, 1970.

134. Poradorsky, K. Lacerations of Cervix and Perforation of Uterus in Artificial Interruption of Pregnancy. Cesk. Gynek. 25:682, 1960.

135. Potter, E. Pathology of the Fetus and Infant. Chicago, Yearbook Publishers, Inc., 1961.

136. Potts, D. Termination of Pregnancy. Brit. Med. Bull. 26:65-71, 1970.

137. Potts, M. Legal Abortion in Eastern Europe. Eugenics Review. 59: 232-250, 1967.

138. Ratner, H. A Public Health Physician Views Abortion. Ill. Med. J. May, 1967.

139. Rendle-Short, J. Maternal Rubella: The Practical Management of a Case. Lancet. 2:373, 1964.

140. Roemer, R. Abortion Law: The Approaches of Different Nations. Am. J. Public Health. 57:1906-1922, 1967.

141. Rosenberg, A. J., et al. Suicide, Psychiatrists and Therapeutic Abortion. Calif. Med. 102:407, 1965

142. Rosenfield, A. B., et al. Recent Trends in Infant and Maternal Health in Minnesota. Minn. Med. 53:807-816, 1970.

143. Rozoviskii, I. S. Abortion and Its Sequelae. Sovet. Med. 24:94, 1960.

144. Russell, K. and E. W. Jackson. Therapeutic Abortion in California. Am. J. Obstet. Gynec. 105:757-765, 1969.

145. Schaeffer, A. J. Diseases of the Newborn. Second edition. P. 29. Philadelphia, W. B. Saunders, Co., 1966.

146. Schiffer, M. A. Induction of Labor by Intra-amniotic Instillation of Hypertonic Solutions for Therapeutic Abortion or Intrauterine Death. Ob-Gyn. 33:729-736, 1969.

147. Shepherd, T. Onset of Function In the Fetal Thyroid: Biochemical and Autoradiographic Studies From Organ Culture. J. Clin. Endo. 27:945-958, 1967.

148. Shirer, W. L. The Rise and Fall of the Third Reich. 13th Printing. Greenwich, Conn., Fawcett Publications, Inc., May, 1970.

149. Shriver, E. K. When Pregnancy Means Heartbreak. . . Is Abortion the Answer? McCall's Magazine. April, 1968.

150. Sibley, J. Boston Woman, 23, Dies After Abortion Performed in Office of Physician Here. The New York Times. Oct. 17, 1970.

151. Siegfried, S. Psychiatric Investigation of the Sequelae of Interruption of Pregnancy. Schweiz. Arch. Neurol. Psychiat. 67:365, 1951.

152. Skipetrov, V. P. Changes in the Blood Coagulation in Artificial Abortion. Vop. Okhr. Materin. Det. 11:69, 1966.

153. Sklovska, M. Loss of Blood by Artificial Interruption of Pregnancy. Cesk. Gynek. 25:664, 1960.

154. Slunsky, R. Course of Delivery of Women Following Artificial Interruption of Pregnancy. Cesk. Gynek. 29:97, 1964.

155. State of New York in Assembly. Chapter 127, Laws of 1970. Mar. 23, 1970.

156. Stefanova, Z., et al. On the Question of Complications Connected With Artificial Interruption of Pregnancy Performed at the First Maternity Hospital ' Tina Kirkowa'. Akush. Ginek. 3:8, 1964.

157. Still, J. W. J. Wash. Acad. Sci. 59:46, 1969.

158. Stojanov, S. Perforation of the Uterus With the Curette in Interrup tion of Pregnancy. Zbl. Gynaek. 83:321, 1961.

159. Streja, E., et al. On Morbidity From Intentional Abortion in Women Working in the Textile Industry. Obstet. Ginec. 10:259, 1963.

160. Suzumura, M. and S. Kikuchi. Induced Abortion in Japan--Review of the Literature. J. of the Jap. Ob-Gyn Society. 13:179-197, 1966.

161. Svendi, B., et al. Maternal Death in Relation to the Obstetric Cases of 10 years in Bekes County. Nepegeszsegugy. 45:24, 1964.

162. Taussig, F. J. Abortion--Spontaneous and Induced: Medical and Social Aspects. St. Louis, C. V. Mosby, Co., 1936.

163. Tietze, C. Abortion in Europe. Am. J. Public Health. 57:1923-1931, 1967.

164. Tietze, C. and S. Lewit. Abortion. Scientific American. 220:21-27, 1969.

165. Trca, S., et al. Relationship Between Development of Inflammation After Induced Abortion and the Duration of Pregnancy. Cesk. Gynek. 29:613, 1964.

166. Vasiliad, M., et al. On Uterine Perforation. Obstet. Ginec. 10:247, 1965.

167. Veress, S. Hormonal Disorders Following Surgical Abortion. Orv. Hetil. 107:1369, 1966.

168. Voight, J. C., et al. Feto-maternal Hemorrhage in Therapeutic Abortion. Brit. Med. J. 4:3956, 1969.

169. Vojta, M. Some Questions of Unwanted Pregnancy and Legal Abortion As a Solution At the Present Day. Rev. Czech. Med. 5:207, 1959.

170. Vojta, M. Therapeutic Abortion by Vacuum Aspiration. Obstet. Gynaec. Brit. Comm. 74:768, 1967.

171. Wagatsuma, T. Intra-amniotic Injection of Saline For Therapeutic Abortion. Am. J. Obstet. Gynec. 93:743-745, 1965.

172. Wagner, G. Induction of Abortion By Intraovular Instillation of Hypertonic Saline. Dan. Med. Bull. 9:137, 1962.

173. Walker, A. H. C. Termination of Pregnancy Using "Utus" Paste. The Practitioner. 203:324-328, 1969.

174. Weaver, C. R. Report: House Judiciary Committee: Subcommittee on Abortion Laws. State of Minnesota, House of Representatives. Interim Activities and Recommendations. Jan. 1968-Dec. 1968.

175. Wroblewski, M., et al. Evaluation of Blood Clotting and Fibriniolysis in Early Pregnancy and After its Interruption. Ginek. Pol. 36:141, 1965.

176. Wu, P. The Use of Vacuum Bottle in Therapeutic Abortion--A Collective Survey. Chinese Med. J. 85:245-248, 1966.

177. Zimmerman, D. R. How Doctors Perform Abortions. Ladies Home Journal. P. 38, Nov. 1970.

178. Zwarik, E. Afibrinogenemia After Artificial Interruption of Pregnancy. Zbl. Gynaek. 86:1097, 1964.

179. Zwarik, E. Study of Blood Coagulation and Fibrinolysis in Connection With Artificial Interruption of Pregnancy. Gynaecologia. 162:197, 1966.

FOUR COMMON FICTIONS ABOUT ABORTION AND THEIR FACTUAL COUNTERPARTS

FICTION NUMBER ONE

Five to ten thousand American women die from illegal abortions every year.

THE FACTS

"I would quarrel with Niswander on only one point, namely, his perpetuation of Taussig's thirty-year-old claim that five thousand to ten thousand American women die every year as the result of criminal abortions. Whether this statistic was valid in 1936 I do not know, but it certainly is not now. There are in fact fewer than fifteen hundred total pregnancy deaths in this country per annum; very few others could go undetected and of these fifteen hundred probably no more than a third (500) are the result of abortion. Even the 'unskilled' abortionist is evidently more skillful and/or more careful these days. Although criminal abortion is of course to be decried, the demand for its abolition cannot reasonably be based upon thirty-year-old mortality statistics."[1]

-Dr. Robert E. Hall, President of the Association for the Study of Abortion, Inc.
Dr. Hall is a leading proponent of liberalized abortion laws.

FICTION NUMBER TWO

A great need exists for therapeutic abortions when the mother has a medical problem.

THE FACTS

"On the basis of a twelve-year experience with therapeutic termination of pregnancy, we concur with the growing opinion that for most clinical conditions the natural history of a disease is not influenced deleteriously by an intercurrent pregnancy. Neither is the course of pregnancy often seriously affected by a complicating medical condition."[2]

- J.J. Rovinsky and S.B. Gusberg
A conclusion reached during a study conducted at Mount Sinai Hospital, New York.

Footnotes.

1. Robert E. Hall, "Commentary," in David T. Smith, ed., Abortion and the Law(Cleveland:Western Reserve University Press, 1967), 228.
2. Joseph J. Rovinsky and S.B, Gusberg, "Current Trends in Therapeutic Termination of Pregnancy," American Journal of Obstetrics and Gynecology, 98(1967) 11-17

FICTION NUMBER THREE

Suicide is a common result of depression accompanying an unwanted pregnancy.

THE FACTS

"A California study of suicides revealed only three involving pregnant women. Statistically 17.6, at a minimum, could have been expected in the population studied. All three of the suicides involved stress between the man and woman, rather than rejection of pregnancy. The authors, Drs. Allan J. Rosenberg and Emmanuel Silver, conclude that perhaps pregnancy has a psychically protective role."[1]

-G.G. Grisez, Abortion: The Myths, The Realities and the Arguments (1970)

FICTION NUMBER FOUR

Psychic trauma often associated with unwanted pregnancies can be alleviated by abortion.

THE FACTS

"The psychically abnormal find it more difficult than the psychically normal to stand the stress implied in a legal abortion. This means that the greater the psychiatric indications for a legal abortion are, the greater will be the risk of unfavorable psychic sequelae after the operation."[2]

-Martin Ekblad in a follow-up study of 479 women granted abortions under Swedish procedures.

"The feeling is growing apparently among the leaders in psychiatry that therapeutic abortion on psychiatric grounds is often a double-edged sword and frequently carries with it a degree of emotional trauma far exceeding that which would have been sustained by continuation of pregnancy."[3]

-Dr. Nicholson J. Eastman in a foreword to a symposium edited in 1954 by Dr. Harold Rosen, a proponent of abortion law relaxation.

Footnotes.

1. Grisez, Abortion: The Myths, The Realities, and the Arguments. (New York: Corpus Publications, 1970) 79.
2. Martin Ekblad, "Induced Abortion on Psychiatric Grounds: a follow-up study of 479 Women," Acta Psychiatrica et Neurologica Scandinavica, sup.99 (1955) 94-95.
3. Nicholson J. Eastman, "Obstetrical Foreword," in Rosen, ed.

NOTE:

THERE IS NO SERIOUS PROBLEM FROM ILLEGAL ABORTIONS IN NEVADA.

Dr. Hall places the annual death rate from illegal abortions at "no more than" 500. The U. S. Bureau of Statistics places it at about one-half that number. Even if one accepts Dr. Hall's inflated figure, and spreads those 500 deaths among the 50 states, Nevada would have no more than 10. But Nevada is one of the smallest states. Proportionally, it would have considerably fewer than the number proposed. Therefore, it would not be unrealistic to conclude that Nevada has no more than 2 or 3 deaths due to illegal abortions per year again based on the inflated figure of a leading proponent of liberalization. To argue that these 2 or 3 deaths justify the execution of many times that number of babies seems calloused in the extreme.

The foregoing quotations are not isolated ones. For a thorough study of the abortion controversy you are referred to Germain Grisez's book referred to in the footnotes on page 2.